CDC Ebola Response Oral History Project

The Reminiscences of

M. Carl Kinkade

David J. Sencer CDC Museum

Centers for Disease Control and Prevention

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M. Carl Kinkade

Interviewed by Samuel Robson
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Interview 1 of 1

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Q: This is Sam Robson, here today with doctoral candidate Carl Kinkade, at the CDC [United States Centers for Disease Control] Roybal Campus in Atlanta, Georgia. Today is August 3rd, 2016, and I have the fortune to talk to Carl today about his efforts on behalf of CDC as part of our Ebola response, 2014 to 2016. Thank you so much, Carl, for being here. What I always ask people to start out is if you can pronounce your full name for me, and tell me your current position with CDC.

Kinkade: My name is Carl Kinkade. My current position is informatics. It's actually health information system adviser for Liberia—I've recently accepted a new position in Liberia in the process of moving there. It's a weird title, and it actually is a position that usually is held by someone from USAID [United States Agency for International Development]. I'm not sure how many CDC people we have with the title of health information system adviser. They do, it's usually health management information system adviser, HMIS, which is their routine surveillance a lot of countries use through the ministries of health, and USAID usually funds someone to do a position like that in various countries. In this case, it's a little unique for us, because we see it as an opportunity to integrate surveillance on lab [laboratory] and other aspects to enhance surveillance for Liberia. So that's my new title.

Q: That's brilliant. I look forward to getting into that more. This is going to be a unique interview as far as all the ones I've done here, and it's cool. But backing way up, first, can you tell me when and where you were born?

Kinkade: I was born in Temple, Texas, in 1967, and then from Texas moved to Nebraska. Most of my life I've grown up in Nebraska.

Q: Where in Nebraska?

Kinkade: Rural Nebraska, just northwest of Grand Island. And went to school at Lincoln. Most of my education, undergraduate and graduate degrees are from the University of Nebraska–Lincoln, so I'm a Husker. Grew up late elementary school through college in Nebraska. I'm more of a Nebraskan than a Texan.

Q: What kinds of things were you into as a kid growing up in Nebraska?

Kinkade: I was very rural and lived on a farm. My dad was originally from Nebraska, Mom from Texas. I was into sports. I played four sports in high school, played baseball in college. Did a lot of farm stuff, as you can imagine as a kid, detasseling and roguing corn, which is our task I did every summer from twelve years up. When I get my Social Security statements, I see I've paid taxes since I was twelve. Which not many people can say that they've paid tax since they were twelve, other than rural people. [laughter]

Nebraskans and Iowans can. But yeah. It was an interesting place to grow up. Especially compared to now that I live in the Atlanta area and my older son graduated from a large high school. His high school had about four thousand students. That's more than our towns had. It's just a whole different—it's just a different way of growing up. You live in a small town, you get involved in everything. You're in sports, you're an officer for different clubs, you know everybody, and parents you don't even know will correct you. Now, here, parents are reluctant to correct their own kids, much less someone else's kids.

Q: Right, no doubt. [laughter] What did your parents do?

Kinkade: My dad taught-slash-farmed, and my mom worked at a department store.

Q: What did you imagine for your future when you were that age? Like, late teens?

Kinkade: Interesting. I didn't know. My undergrad was in architecture. Early on, I liked architecture and I liked design. I knew it would be something along that path. I took a drafting class in high school, liked it, did well at it, and still wasn't very creative—it was just a mechanical process. It really wasn't until college where you start getting to design classes and get this full appreciation of what it takes to design. From a kid/teenager perspective, I didn't know. I knew I was going to Nebraska, applied to one university, figure it out when I get there. It hasn't really gone that whole path—even though I went the architecture route, I'm far from that now.

Q: What was it like at the University of Nebraska?

Kinkade: Good. I enjoyed school there—too much, probably. I got my undergrad [undergraduate degree] there in architecture, my graduate degree from there in urban planning. I was in the US Peace Corps, so I had a gap between undergrad and graduate school when I was in the Peace Corps. I was the sole Nebraskan in my group—one Iowa guy, one Kansas guy, one Nebraskan guy, so we had a little bit from the Midwest. Everyone else was from the West Coast, or for some, whatever reason, Minnesota and Wisconsin. I'm not sure why those states, but they had a lot of Peace Corps volunteers.

Q: Where'd you go?

Kinkade: The Philippines.

Q: The Philippines.

Kinkade: Yup. And I met my wife there. I met my wife in the Ph—she's Filipino, and there weren't even any Asian people in my school that I remember growing up. They're all Caucasian farmers, middle-class. It was interesting to first go to Lincoln—it was of course different than the rural town I grew up in, which is Dannebrog, Nebraska—actually, out in the country between Dannebrog and Carroll. That was my first challenge, getting used to all the—that this was the campus, right? Thirty thousand kids running around.

Lincoln's a great city, and it was a great university to go to school in. Architecture college itself isn't very big, so you get this smaller-school feeling to it. But it was very, very good—you know, a good education.

Q: When I imagine the stereotypical Peace Corps volunteer, I don't imagine an architecture student. What caused you to join the Corps?

Kinkade: I sort of felt like I accidentally joined the Peace Corps. The reason I say that is I had gone to—my last semester of college I spent in London. I finished my architecture degree in London. While I was gone, all my mail went to my parents' house. When I got home, I was going through this box of mail that came while—the time I was there. And there was this postcard from the Peace Corps, and it showed this guy walking down some dirt road, I think he's in an Africa-type setting. It said, "You could be here." You just basically filled out the—if you want more information you fill it out and send it in. So I filled it out and sent it in, not really serious about it, just looking—what is going to be my next step? Is it grad school? Is it Peace Corps? Is it working? Is it—whatever.

In Nebraska, to become a licensed architect, you have two routes to go. One route is to get just your undergrad, which is four years, and then you have to work for six years through a structured type of work—you can't just work. There are set areas you have to complete—number of hours of certain areas of architecture you have to complete throughout your internship. Once you've done that for six years, you can sit for the exam.

Or you can go to graduate school, because Nebraska, University of Nebraska, is a four-two program, versus some universities have a five-year program in architecture you can come out and do, similar to our six-year. You would go to grad school for two years, come out and work for three years, and then you can sit for your exam. I was thinking, I could either just go start working and then come back to grad school, or go to grad school. Whatever, I didn't know. So I sent this postcard in, not serious about it. Got a call from Kansas City, saying, "Can you come talk to us?" Still not serious about it. I went to two of my professors, and I asked each of them the question, "Should I do this or should I go to grad school? Should I work? What do you think?" One professor told me, "Get in grad school, finish your degree, get out and get your license, get to work." The other one told me, "Do whatever you're going to do. I don't care if it's grad school, Peace Corps, all of the above, whatever. Do whatever you're going to do, but be on your feet by the time you're thirty-six." So, I sort of took that route, and it put me on my feet by the time I was thirty-six.

I went to the interview, still not serious about it. Had the interview. The lady asked me if I would be interested in going to Russia. I said, "I don't know Russian, but I'm open to it." She said, "Good, because I've already put you in the Russian group." She says, "But you won't leave until next spring" —this was summer of '93—"so I would advise you to go back to University of Nebraska, take a Russian class, and that will help you immensely when you get there." Fine. So I signed up for Russian, which was very hard. I'm not a good language person anyway. About halfway through the semester, they contacted me and said the program had been postponed because of political reasons—

they don't know what my next assignment would be, they'll get a hold of me. And that was it.

I had already been working at the Downtown Lincoln Association, working on renovating downtown Lincoln and the Haymarket area. I continued to work there, and dropped the Russian class. [laughter] I should have still taken it just to learn Russian, but it was not fun. But in February of '94, they called me and they said, "How about the Philippines?" And I said, "Okay." "You leave this month." "Okay." And that was it. Within three weeks from that phone call, I was on a plane going to Seattle. We spent three days in Seattle, where I met the rest of my group, and my birthday was there, so I had my birthday while I was in Seattle, so that was a really nice bonding experience with my fellow Peace Corps volunteers. Then we flew to the Philippines, spent three months—I lived with a family for three months. You learn the language, the culture, how your job applies in that country. My job was basically an urban planning role, a planning role, to work with land use planning with one of the provincial offices—the island of Catanduanes. Then, once you've finished the three months, you swear in as a volunteer and you start your two years. So that was it. I loved it. I loved the Peace Corps. I've always said that I want to go back when I retire and do it again in another country. My wife, who I met there, is a Filipino. She's a nurse, and of course now she's a US citizen here, and so our long-term goal is to go do a Peace Corps again, she and I together, as something related to health somewhere.

Q: Are there any memories, when you look back at your time in the Philippines during Peace Corps, that really stick out to you?

Kinkade: There are probably a couple of them. One is that I remember very vividly, when we got off the plane in Manila—you know, I'd only been to really developed countries, and you land in the airport, International Airport Manila, and you come out on this tarmac, and it was hot and it was humid, and it smelled of hot tarmac. You still remember that smell and that heat wave that hits you. I still remember that very vividly. The volunteers—our group was very close, and our country director there had said that we're the closest group of anyone he's ever known of. We all just got along really, really well. We still today, we stay in contact with each other. This is supposed to be our twenty-year reunion this year. This summer. We just couldn't get it planned. So that was a big, a vivid memory of this, a smell and a feeling of that tarmac at the airport. And then the volunteers, as we trained in the town we were at, which is in the central south part of the Philippines. You live with a family, and then you would go to a little—sort of like a high school campus, where we would take classes in the day and then we'd go back to live with our families. That was my next interesting experience, was moving in with this family. They get paid to house you, but they are required to give you your own bedroom, which is not common for a lot of Filipino families. A lot of them sleep in the same room. By me taking one of my bedrooms, they had nothing else. They had one room for all the kids and the parents, and they strung up a big mosquito net and they all just slept under it as a family. With, of course, me in the other room. So that was another one. It was one of those experiences of—you move from America, where it's pretty common for Americans

to have their own—kids to have their own bedroom. There are of course families that don't, but many families do, and I grew up that way, I had my own bedroom. When you start growing up or living with families where that's not as common, and they share bedrooms—they're very intimate spaces, you know? It's just a different lifestyle.

Q: What happens after Peace Corps?

Kinkade: That's how you start realizing, we live on this big island of America, which of course I love, but it's an island from the rest of the world. There's a big part of the world that's nothing like what we live in. Especially not rural Nebraska. I've been fortunate enough to work in about fifty countries, and I've worked across Asia and the Middle East and Africa and South America and Central America, and you see differences, of course. But you see similarities. Everywhere I've gone, the families want to take care of their kids. They want their kids' lives to be better than theirs. I would say that's the same as Nebraskans. Matter of fact, I've been in this big dialogue right now with one of my Nebraska people I grew up with—I'm on Facebook with a variety of people, from Nebraskans to Georgians to international people I've become friends with and connect with on Facebook. This discussion of [Donald J.] Trump and whatever had come up, and of course a lot of Nebraskans are typically very conservative and Republican—whether they agree with Trump or not, they're going to lean toward a Republican. This guy and I were swapping messages on Facebook, and one of the articles that he had posted was about the girl and her mother who had presented at the DNC, [Democratic National] Convention, and he couldn't believe that the DNC would bring in an illegal parent, illegal

immigrant onstage, and why weren't they in trouble for that. Then he had comments about this immigration policy is not [unclear]. My response was, I can't blame anyone for trying to better their lives. Here you have a family who risked everything to come to America, to have kids and raise a family, and there's a good chance they're working jobs that you don't want to work, and long jobs or two jobs, and making a lot of sacrifices for themselves to better their lives for their kids. I can't blame anyone for doing that. Not going to agree or disagree about policies, irrelevant, but people, I can't blame them for what they're trying to do for their families, and you see it across the world. Everyone, irrelative of their faith or their wealth, they're trying to make their lives better for their families, same as mine did.

I think Peace Corps brought that to me, it brought, here's this whole world out here that's different than what you grew up with. And that changed my focus. When I came back, I was less interested in architecture and more interested in community urban planning. Still didn't know public health. I was still in my world of city planning, and architecture and planning are of course related. My thinking of this is how cities need to be thought about, and how do we benefit the people that are living in that city? So I started grad school in urban planning, with an emphasis on environmental planning and city planning.

Q: How was that?

Kinkade: It was good. No, I loved it. I really like environmental planning, actually. I probably should be in environmental health. [laughter] We do actually have a number of

urban planners, community planners, at CDC; I think most of them are in environmental health, in National Center for Environmental Health or ATSDR [Agency for Toxic Substances and Disease Registry]. But one of the things I learned in graduate school was GIS. Geographic Information Systems is a tool that now we use across federal agencies, but at the time, public health didn't really use GIS that much. But urban planners did. That was one of the software packages we learned in grad school, around doing community plans. I used it a lot. Ultimately helped teach some of the GIS classes at University of Nebraska. One of my professors, who is a social planner, was on the board of health for the city, county of Lincoln—Lincoln, Lancaster County. He came up to me and asked me to go to a meeting with him with the city health department. I was like, "Why?" [laughter] "Why would I want to meet with the city epidemiologist? I'm not even sure what epidemiology is." [laughter] He said, "Trust me, just come with me to this meeting." So I went with him and met the city epidemiologist, and they talked—she and the environmental health director talked about—they wanted someone with a strong math background and they wanted someone who knew GIS, and they wanted someone who could review city plans from a public health perspective, and they wanted someone who could help with epi [epidemiology] analysis. At the time, I thought I wasn't too interested in the epi part because I really didn't understand the epi part, but I was interested in the potential for reviewing city plans from a city public health perspective. I thought that sounded sort of interesting, and the whole geospatial component of it, of helping all the programs at the city health department that used GIS to help their programs. I left there still not sure if I would take it. I was working full-time as an intern architect, I was going

to grad school full-time, I was still in the Army Reserves, because I used to be Army Reserves for—I was in Army Reserves for twelve years.

Q: Oh, okay. [laughter]

Kinkade: I was actually in Army Reserves still while I was in the Peace Corps, which is a funny side note. Then my wife had just given birth to our son. I just didn't have time to do an internship with the city health department. My professor was like, "I really think you should do this." So I agreed to do it. Ultimately, I left my architect intern position to work more hours at the city health department. When I graduated, I then was hired on as an assistant epidemiologist for the city of Lincoln, and loved it. I loved local health. I still love local health. I think that in the public health arena, local health is where the real public health is being done. It's your community, and you see the benefits and understand the people it's affecting directly. It's boots-on-the-ground public health work, and the people are great. You don't make a lot of money, but it's great work.

That's how I got my feet into public health. I started taking some epi classes, then going to workshops and just trying to build my epi strength, and then the state health department contacted me to see if I would come do for the state of Nebraska what I was doing for the city. I ultimately left the city, went to the state, and I was at the city for five years and then left to go to Nebraska [Department of] Health and Human Services.

Q: Do you remember what year you made that transition?

Kinkade: That would have been—what year was that? That would have been maybe ’99? Somewhere in there? The same time I had been there a bit, the company, Esri, which is the Environmental Systems Research Institute, they’re sort of the Microsoft of the GIS world. They make the software that everyone uses for GIS. They contacted me and said, would I be interested in coming to work for them, to do what I was doing for Nebraska, but for all the states? I thought, huh, that sounds interesting. So I left Nebraska and went to work for Esri—moved to St. Louis. Their headquarters is actually in California, but they have a regional office in St. Louis. I worked with all the state health departments in all the major cities, helping them use GIS better to do their public health work.

It was a fun another five years. Then I got a call from Atlanta. It was actually a contractor for Atlanta, BearingPoint, and they contacted me and said, would I be interested in coming to CDC to oversee [unclear] GIS for CDC. I thought, hmm, that sounds interesting. I flew to Atlanta, had an interview, and ultimately moved here. Came as a contractor and then became an FTE [full-time equivalent employee] from there, and then I oversaw the GIS—I was the enterprise GIS coordinator for CDC for a number of years until some of the reorg [reorganization] stuff happened and the agency just didn’t want to do that anymore, I guess.

But about that time, I started focusing a lot on international work, and that changed my focus away from GIS specifically into broader informatics work, and surveillance and assessments and that whole realm of data management/informatics work that I think we

don't do as good a job as we could be doing, and we're trying to fix that, I think. That's my current role.

Q: That's your current role. [laughter]

Kinkade: It's a weird path, and people ask me often, because I've taught a lot of GIS classes for CDC, sort of a GIS [unclear] for the agency. I've taught a lot of—probably over one thousand CDC people and partners, taught the Field Epidemiology Training Program—I don't know how many countries, a lot of countries. All the ones in Africa, Central America, all the northern—South America, the South Caucasus region, the 'stans around Kazakhstan, all of Asia. It's a skill that public health people want to have—they want to map out their data, and they have to put a map out. Where are things happening? Standard epidemiology. Things happen in places. I got really engaged in that process, and that's opened other doors.

Q: What were you doing right before you got involved in the Ebola epidemic?

Kinkade: I was sort of this lone wolf. I was in a different center. I was in CSELS [Center for Surveillance, Epidemiology, and Laboratory Services]. But our work had changed a bit because of the reorg, so it was [unclear] and that reorg'd into OSELS [Office of Surveillance, Epidemiology and Laboratory Services], then reorg'd into CSELS, and where it's currently at—it's a mess now. But CSELS had sort of—GIS wasn't going to be one of their focuses, even though early on it was thought that was going to happen. I had,

because of my teaching of the international offices, our Guatemala office had reached out to me to let me know that—and this is in 2009—to let me know that there was this funding that Global Health, the Center for Global Health, was going to have to support—a technical support core to support the Global Disease Detection offices. We have GDD, or Global Disease Detection offices, duty offices, in China, Thailand, Bangladesh, India, Kazakhstan, Republic of Georgia, Egypt, Kenya, South Africa, Guatemala. Those either work regionally, like South Africa is kind of to south Africa, but Kenya supports a bigger area regional, and Guatemala supports all of Central America, Panama, and the Dominican Republic. They're now even encroaching into South America, because they've done a lot of work with Colombia. I'd worked a lot with Guatemala, going on to teach GIS classes, helping them with emergency preparedness stuff. This process starting within CGH [Center for Global Health], called TSC support—this technical support core of people that had certain skills that the international offices weren't going to have these people on staff. But they needed the skills occasionally, or to build their capacity or to build their partner's capacity. So lab people, and in my case, informatics and GIS.

I applied for the funding, got it, and basically, they paid CSELS for part of my salary for me to go out and support these offices. From 2009 through the next five years, 2014, I was traveling across these countries. I would go into all of them, usually at—well, depending—once a year, if not twice a year. It sort of became who raised their hand. Guatemala raised their hand a lot, Kenya raised their hand a lot, so I went to those at least a couple times a year. But also in 2014, the Global Health Security Agenda started catching steam, and we did a demonstration project in Uganda and Vietnam, and I was

sent to Vietnam. I worked in Vietnam for the global health security demonstration project. I was there for a total of about three months, and that was in, I guess, August, September of 2014. Then the next—yeah, is that right? ’14, ’13? I’m trying to get my years right—maybe it was ’13. Because the next, ’14, is when we had the Ebola response start. And August 2014 was my first trip to Liberia. So it would have been 2013.

Q: It was the demo [demonstration] project in Vietnam?

Kinkade: It was the demo project in Vietnam, yeah. After that project ended for the moment, we didn’t know what was going to happen with global health security at the time, I still continued my work with Global Disease Detection, and that led up to the Ebola response.

Q: I know at some point in here you’re also—I think you’re almost finished with your doctorate?

Kinkade: Yeah, I’d been working on my doctorate for a while, and it’s been a process, because not only do I travel a lot for work, but I’m a first responder for CDC, and so I’ve deployed to Kenya for the Rift Valley fever outbreak, Saudi Arabia for the pandemic, Myanmar after Cyclone Nargis hit, Haiti after the earthquake, Katrina—I was deployed to Katrina when I first came to CDC, and my second son was born while I was gone. I missed his birth. My wife still reminds me of that, that I was not home when my son was born. But a reminder—at the time, Katrina was a big thing, and I wasn’t at some bar

drinking, but it was actually doing a lot of public health—hopefully good public health work. So I've done a lot of emergency response work, like I hinted at earlier—I was in the Army Reserves. I started that in college to help pay for my college, and I was activated for Desert Storm. For 1991, the six months of '91, first half a year of '91, I was deployed for Desert Storm. I was still in the Reserves when I got back from the Peace Corps and then finished my time, and once I was finished with my second contract, I was done. But I had that background. When I started getting into public health work, the GIS and military combination got me involved with the first response program at CDC. I'm still a first responder, even though now my focus has been Liberia for the Ebola response. But yeah, it's been a busy few years. [laughter]

Q: How did you get roped into doing Ebola?

Kinkade: I'm trying to think of the first call I got to be involved. I think that I've done a lot of data management with responses, and I think the first call was I needed to help with data management in Liberia. One of the deployment coordinators in the Emergency Operations Center is a friend, he's deployed me many times, so when the criteria comes up, oh, this is Carl. He's like, "Carl, you want to go?"

Q: Who is this?

Kinkade: Gray [Lawrence] Smithson.

Q: Oh, gotcha.

Kinkade: Gray, when he sees things come across his desk that fits stuff that I've helped with in the past, he'll just call me up, send me an e-mail and say, "This is going on. Interested?" Once you've done it a few times, you figure out that from their perspective, it's usually easier just to send someone who's done it. At least you're not trying to get someone who's never traveled abroad or doesn't have the medical records or doesn't have an official passport or doesn't have a—you know, there's just a lot of stuff that gets involved, as we saw through the Ebola response. Trying to engage so many people to deploy that don't typically deploy.

It was initially a data management role. We need someone to come in and work with the Ministry of Health [and Social Welfare] to help them get the Ebola data into their unit better, to analyze the data better, to get sit reps, or situation reports, or daily situation reports, information better, to help build that capacity with them during the response. In August 2014, that's what I was sent there to do.

Q: What was the situation like as you found it?

Kinkade: So we got there. The team was still small in Liberia. In August 2014, I came in at the very end of the month. Initially, the summer was only—a few people had come in and out, the Epi Info team would come in and help set up the VHF [viral hemorrhagic fever] module, provided some training. We had a few people that had come in-country,

we still didn't have a big team yet. August was still maybe twenty people there, I think, if that. We didn't have a big footprint yet, as we did later. But it was a wreck. Not from a CDC perspective, just a response perspective. Data, information, the case investigation forms and stuff would come in in various ways. It was filled out on paper, and then if it was out in some county—Liberia has fifteen counties, and they call them counties like we do, and they're sort of modeled after the US. They would hand it off to a driver who would hand it to some other driver, and it'd eventually make its way to the central office and then would get entered in. When I came in, they were working seven days a week, trying to get—and it's still not current—trying to enter all the data in. This is suspect, probable, and confirmed cases. The data just wasn't current. Information wasn't current. We had a roomful of people, half of them volunteers, and then our folks would come in and work and they'd just do data entry all day. It was a bit of a wreck.

Q: What implications did that have for the response?

Kinkade: That we didn't know our numbers. Everything was, we think this is a number, and we can't confirm that from case investigation forms. There was at the same time a parallel system, so to speak—I loosely say "system," because it was a Gmail inbox. As counties would get a new case, they would just e-mail that Ebola inbox. And then they would take that Ebola inbox and tally them up, and that became the sit rep. There wasn't a lot of QA/QC [quality assurance/quality control] with it, it was numbers that were in there, and as people are e-mailing stuff around, it could be the same case, it could be a different case, or it could be cases that weren't even reported. But here we have a national

sit rep being generated from a Gmail inbox. Which has a whole other discussion around security and confidentiality and PII [personally identifiable information] and all that stuff. But at the time, all of that was sort of out the window. And it's still being used a lot, which is—even though we brought it to the attention of the Ministry of—or there's advisers, right? It's not my show. It's not about Carl. It's not about CDC. It's Ministry of Health Liberia, it's for the Liberian people, and we advise them the best we can. We've reminded them that we really shouldn't be using Gmail for anything that has identifiable information in it, because servers are wherever in the world—they have zero control over those. We're trying to change that. It's slow. But we've advised and are trying to come up with another mechanism for them to do it—that's part of what I'll do when I get there, is to have them not do stuff like that. Integrate a whole system, across from finance to logistics to lab and surveillance, where we can better serve the Ministry of Health and the poorest population.

Q: When you get there, is there someone from CDC who's working on informatics there, who's able to catch you up to speed, or how do you learn all of this—situation?

Kinkade: Yeah, there was—really, it was people that were doing other stuff that wasn't their focus. They were epis, typically, who were doing some field investigation-slash-helping with the data management. And the data management people were usually epis. We tend to think that an epi can go in and do it, which may or may not. Depends on the epi. If it's an epi that has a strong data management background, which some do and some don't. It just depends. This case, the girl who was there working on it, who sort of

was my colleague, had handed it off to me, Becky [Rebecca D.] Merrill. She had some solid skills, and she's like, here's what we've been working on and here's where it's at, good luck. [laughter] And then gone.

I fortunately got along very well with the lead person for the Ministry of Health. Luke and I—Luke Bawo was his name, and Luke and I would—he moved me into his office, so I sat in his office with him. We advised, as close as I can—I still have that same relationship. My official office once I move will be in the office with him, so he and I will share an office. We've been sharing an office now for two years on and off, but now permanently, for another at least two years. He may be sick of me by then, but—I even told him, I said, "Hey, if for some reason you need a private conversation"—because sometimes you have those. We all have that. I said, "We could have a code word. You've just got to say the code word and I'll get up and leave." And he's like, "No. There's nothing that's going to be said in this office that you can't hear." He's a very interesting person to work with. He and I get along well. He's one of these people that you either like him or you don't like him.

Q: What does that mean?

Kinkade: He's got a strong personality and he's loud. When he's in the room, he wants to run the room. That offends some people. I just shake my head, and I know his person—I know he comes across as sort of gruff, but I also know that he's willing to listen. If you bring logic to the conversation, he will stop and listen and evaluate that. You bring

emotions to the table, he'll return emotions. And it gets ugly, and I've seen it. Very, very—very badly, I've seen his emotions come out. Matter of fact, I was in his office, and the *New York Times*—it was right in the middle of the outbreak, maybe September of 2014. But our numbers spiked around October, so the numbers are crazy. And two *New York Times* reporters came in to interview him. I'm of course sitting at a desk, sitting right next to him. My desk is by the door; his is further away, and I always joke that I was his receptionist. I want to get a plaque, still, that says "Luke's Receptionist" on it. But they're in there, and Luke had agreed to an off-the-record conversation with them. The guy comes in, they sit down, and he puts his recorder on the desk. And Luke says, "This is an off-the-record conversation. And if you want an official communication, you can go down to our group that does communications for the Ministry of Health. But if you want an off-the-record conversation I'll talk to you." The guy was like, "You're afraid to talk to me on record? With me recording this?" His personality's one of those that you don't want to poke the bear. [laughter] Luke just lit him up. He's like, "You can get out. I don't care if I talk to you or not. I'm busy. Whether you write a *Times* article or not's irrelevant to me." He just went off on this guy. The guy put his recorder away and had the conversation, I guess, off the record.

So yeah, he's not afraid to—irrelevant who it is, to light him up. He lit up our country director. At the time, one of our country directors [Brendan L. Flannery], he had asked me to arrange a meeting with Luke. We set the meeting up, and he got his laptop out—he was showing Luke some information. And Luke goes, "Do you just want me to rubber-stamp this?" It took him aback. There was this discussion between partners about some of

the processes and ways to move forward around some of the surveillance activities, and evidently, Luke wasn't aware of this conversation. When he [the country director] came in to have the conversation, he thought that he [Luke Bawo] was aware of it—he'd been part of it. And he's just following up with him, going, "Does this look right to you?" He was legitimately doing a good thing, trying to engage Luke in the Ministry of Health, and come to find out, he didn't know anything about it. And he [Bawo] just went off on him. [laughter] I just sat back on my chair and went, oh no. Once the meeting was over and done I had a private conversation with him. I said, "Luke's actually not a bad guy, but he's not going to rubber-stamp things." Then I went to Luke and said, "He's really not a bad person—he thought you knew. He wouldn't come in here and expect you to rubber-stamp something. That's just not his personality." It just came across that way and things had to get—we had to get things smoothed over, but it was rough there for a bit.

Q: It sounds like a good thing that Luke has this intermediary kind of. [laughter]

Kinkade: That ends up being my job. I'm like the in-between person. "Can you arrange this meeting?" "Yes." I've been interpreting responses.

Early on, when we got there, it was a mess. We were still trying to figure out our role and all our people coming in. It's hard because you have multiple partners and the response is growing, the outbreak is growing. Ministry of Health doesn't necessarily have the structure to deal with it, and that's coming into place as the partners work with them on defining what their emergency operation would look like. The roles of people and getting

them ramped up on their skill sets and stuff to do it. That just takes time—we don't have that in place. That's the whole point of—part of what global health security is, the emergency response part, is how we build that capacity before a response. So when it does happen, you know what an incident manager is, and they know what roles need to be filled. That had to be done sort of on the fly, and it had some painful growing. But it all worked out.

Part of our own problem we had there was part of our own system, the VHF module in Epi Info didn't perform the best. It was made more for a cluster-type investigation, not as a national surveillance system. It went in as initially this cluster investigation tool, up in the northern—first in Guinea, and then moved over to Liberia when a response was up in Lofa [County], near the border with Guinea. As the cases grew, that tool was already in place. We kept continuing to use it, and it wasn't really what it was designed to do, and it started having problems. At the end of December 2014, we had stopped using it in Liberia and tried to migrate over. They have a national surveillance system, the routine surveillance system. Its aggregate data is reported monthly by the local health departments up at the counties and into the central office. That system was used before the response. All the counties used it. The discussion was, why not build a module on it for Ebola? They're already using it, so they know how to use it; we're not trying to get them to use something different, and just use that. That's ultimately what we went to in January 2015. We ended up migrating the data over and entering data in there, which probably should have been done to begin with, but you don't know then. At the time you had this tool that's been used in Guinea, Epi Info is a decent tool, and free. Our staff were

there to train them on it and help them set it up. If you try to describe what kind of tool would you need and how to get it set up and started in the middle of a response, you would say, free and relatively straightforward, and experts come out to train us on how to use it. Why wouldn't you do that?

Q: No doubt. Although that's interesting, because I've heard—I don't know if you've met Sara Hersey, country director in Sierra Leone, but she's talked about Sierra Leone's own struggles with the Epi Info program. I think eventually they modified it and tried to make it work for Sierra Leone, continued to use it, but interesting to see how the different country offices adapted.

Kinkade: Yeah, they kept going. Where we gave up. But they almost gave up. I had some conversations with Ray [Raymond L.] Ransom when he was in-country in that data management, informatics role with them, and he was almost there, too—they were getting so frustrated with the tool. Again, it wasn't anything bad about the tool, it's just that's not what it was designed to do. We were making it do things it wasn't designed to do. It caused a lot of early-on friction in Liberia. Now, when I even bring up Epi Info—we've had these little cluster outbreaks in Liberia since the main outbreak ended. Then I would tell them, "This is actually the time for the VHF module. This is what it was designed for." And they won't even talk—don't even mention the word. I'm like, alright. It's got a bad taste in their mouth right now. But it is still a good tool. We're in discussion now of how to get Epi Info used there more as a general tool, not necessarily the VHF module, but Epi Info, and we're close with [Johns] Hopkins [University] and we have a

Hopkins contract there, so they're one of our implementing partners. They're going to go in and try to train them and show they how to build epi dashboards and some other stuff. I hope it'll go well. I think it's a good tool that's free, and it doesn't hurt to add it to their toolbox. If they're willing to let their feelings go from the response. I know they have their own perception of what the tool is, but VHF module is really just—is not really Epi Info. It's a custom-built module of Epi Info.

Q: I have a good understanding, now, of some work you did there, and some other work. Can you remind me again what—do you remember what date you arrived in Liberia?

Kinkade: Actually, I don't know the date.

Q: That's okay. Month was August?

Kinkade: It was end of August. So end of August, I got there. I was gone for the month of September—we're still in twenty-eight-day rotations at that point. I got back the end of September, and at that point another person, Jesse [D.] Blanton, came in and took my place, and then Terry [Terrance Q.] Lo took his place, and then at that point, Luke had told the CDC that he didn't want any more rotations of people he didn't know. He said, "I want three people. I want Terry, Jesse, and Carl, that's it, supporting me." So we started a rotation, the three of us. From 2014 until probably the first part of this year, maybe January 2016, the three of us were rotating. When one person was in-country, another

two were here, supporting from Atlanta, and then we would come back. We would just rotate.

Q: Was that a full-time job, supporting from Atlanta?

Kinkade: Basically. I don't think I've ever filled out my EOC [Emergency Operations Center] timecard that way. But it basically was. You were always on calls and swapping e-mails and doing your best to support them in-country.

But then really starting about January, maybe even a little bit before that, it became just me. Terry ended up rotating out, going back to his other work, and Jesse was in the rabies program, and he rotated out, doing his international rabies work. Then it was just me. And now it's been just me since then. I come and go there for a month or more and then come back briefly, then back. I was there in January, I was there in Mar—well, I tried to go back in March and then got caught up in the Brussels stuff. And then April and May and June. Now I'm back until I move.

Q: Have each of those, then, been limited, twenty-eight-day deployments? Or have you gotten to the point where you can be in-country for a longer stretch?

Kinkade: Yeah, and I always could have been longer because I've had my State Department medical clearance. The hang-up is always that people have to have the training—there's a training class you have to take and you need to have a state medical

clearance. I already had all that, so I actually was not held up by the twenty-eight days. We were on that cycle early on, and we left it alone. But that, and my wife gets mad when I'm gone more than a month.

Q: Yeah.

Kinkade: And then back home, and then more than a month again, and then so—

Q: Hey, family's a super-legit [legitimate] reason to come back. [laughs]

Kinkade: It's a balance. It was a balance. I would feel guilty when I'm in-country that I'm not home. Then I feel guilty when I'm home, and then work—there's things there that are happening that I need to be part of. You could be in on a call, you can swap e-mail, but it's not the same thing. You need to be in the room. It's what's hard. It's been hard for me to balance that. From my professional perspective, I would just be in Liberia the whole time and work. But then, you have kids. You have a wife that was working and trying to be a single mom. It's hard. It's one thing to go to a response—all of my responses have—almost all of them have been a month-ish. I was in Haiti for a month, I was in Saudi Arabia a couple times, a month each time—you go there for a month, back, and same with Rift Valley fever and a lot of other stuff. Myanmar, all—I was actually gone three months on that trip. But that was a weird year. I went from Namibia to Uganda to Myanmar to Afghanistan. A total of about three months I was gone. But for the most part, I'm not gone more than a month. In the year with Vietnam, I spent three

weeks in China and then went straight to Vietnam for four weeks—I was gone seven weeks and then came home. It's hard. You miss band concerts, you miss sporting events, lacrosse games or baseball games or basketball. But if I got [unclear]—my older son, I coached all his basketball teams. My younger son, I haven't volunteered to coach any of them, because the last basketball season that I coached for my older son, I was deployed for Haiti. I had to get a dad to take my place, and he coached the rest of the season. That's not fair to families, to have me gone. You volunteered to do it, and you've got to do it. And I still run my scouts, I'm an assistant scoutmaster for Boy Scouts, my older son's troop. He's done now. My younger son, I'm his den leader and assistant cubmaster for the pack, for the Cub Scouts, so I still engage that way from a volunteer perspective, but I have a lot of adults that step in when I leave. It's hard. That's hard. It's hard when—for my wife, she's a nurse, she's in the hospital working. She's trying to get someone to take our son out after school and do all those things when I'm gone. And the two sort of snowstorms we've had here over the last few years, I was gone for both of them. I missed them both. She's like, "Carl, it's snowing here," and I'm like, "Just don't go anywhere." I go, "It's not that you can't drive, but Atlantans can't drive in snow. Just stay home. It'll melt in a few hours and the craziness will end." In Nebraska, they all grew up in snow, so you can trust the drivers around you know somewhat how to drive in snow. [laughter] Here, I'm not so sure. Just stay home.

Q: It's probably for the month of September, then, you were there in 2014? Is that right? You get there at end of August—

Kinkade: Yeah, so I got there, I went back—that may have been a little bit more than twenty-eight days, I can't remember. Because it seems like I went back in the first part of October or last days of September. But it may have been the first part of October. I don't remember exactly. But then I went back, and then Terry went and Jesse went and then I came back in January.

Q: In January. Okay. So a couple deployments in 2014, and then the deployment in January?

Kinkade: Yeah, and then January, and then it went about every three months I would do another month around. I don't actually even know my total number of deployments, but—

Q: It has been quite a few.

Kinkade: —a lot. [laughter] For 2016, I was there in January, February, and then came home in March so I could do the FACT [Foreign Affairs Counter Threat] training, because now we're required to do this FACT training. I came back to do it, and then I was on my way back to Liberia at the end of March when I was in Brussels when the bomb went off. I was at the airport. That ruined that whole trip because they of course shut the airport down, and everyone who was not hurt, we got pulled off into flight hangars, and we all were stuck in a flight hangar. They guarded the flight hangar. We were all there, and they took care of the wounded people in that part of the airport. But

then we were stuck in Brussels. There were two polio people that just happened to be on the same flight with me. They weren't going there for the response, they were going there for polio work. The three of us end up getting together, and we walked to a hotel. There was no transportation, city was shut down. We weren't going to stay in this commercial flight hangar all night, and there's no heat and concrete floors, so after we were there for a number of hours, I went over to one of the Belgian leaders and said, "Do we have to stay here?" They're like, "No. There aren't." "We're going to go then." We left and we got a room in the Crowne Plaza, and the embassy sent us a note—we let them know we were okay, and the CDC, and everyone else, and then they had advised us to shelter in place, because at that point they thought there was still someone else in town.

We were stuck there for a couple days. They ended up just canceling their trip, and they took a train to Amsterdam and flew back to Atlanta. I still tried to get to Liberia, so I took a train to London. It was interesting because I took the train to London from Brussels, out of the main station in central Brussels, where all those trains go out of. It was a zoo and locked down, because they closed all the entrances except for one so they could search everyone's bags. But I took the train into London, and get into London, and the Piccadilly line is closed because of a strike. That's the one that goes to the airport. Then I had to work my way around London back up to where the Heathrow Express goes out of, then got out to the airport, and about nine o'clock that night, they canceled the flight to Nigeria. I was flying from London to Nigeria to Liberia. Then they canceled the flight to Nigeria. Then it was like, all right. Enough. [laughter] I've tried. I called the EOC and said, "I've tried." It wasn't going to be a big trip. We had a cruise planned for spring

break, so I had to be back in time for that for my family. I try to make sure that stuff like spring breaks and stuff—I travel so much that I try to make sure that I am home and we do something with the family for stuff like that. It wasn't going to be a long trip, anyways—it was going to be a few weeks, a couple weeks—I can't remember the exact time frame, but a little over two weeks, I think. I ended up just coming back to Atlanta. Then I left later that next month to return. But it—so yeah. That was a nice curve ball of a trip. Then, of course, everyone's worried because they—oh no, we got three CDC people in the airport. Actually, there was another person—I think there was four. The fourth person, we never saw him. The EOC had his name on some e-mails, that there was someone else there, and I think he was in a different hotel than us. Ended up going to different hotels. We never did see him.

Q: I apologize to the future audience who's listening, because this is a diversion, but I'm interested in—how did you learn something was wrong initially? You're just in the airport, and then what happens?

Kinkade: There was a response from some of the workers. We had just pulled up on the plane; we had just come up, connected to the jet way, all that stuff, and the workers outside—the ones who guide you in the plane, and all the folks who were the ground crew—they sort of stopped and looked behind them. They still didn't catch anything—we didn't notice that, of course. The pilot noticed that. The pilot commented that something has happened, he's not sure what. Then he came on and said, "There's been a bombing at the airport, and we've got to figure out what we're going to do."

Q: How did people react to that?

Kinkade: It was quiet. The plane was quiet. I think no one knew what was going on. They pulled a plane back away from the jetway, then offloaded us to go to a building. They didn't want us going to the airport—they were trying to divert us around to this commercial flight hangar. They pulled it away from the jetway, and then we had to go to the stairs and go that route. It was an interesting process because everyone—I mean, everyone, the flight crew, everyone, were in this hangar. You're just standing there. [laughter] You have nowhere to go. Matter of fact, as we were walking around the airport to go around to the front side of where the—we had to go through some convoluted way to get to this building, which took us back around to the front, so you could see the damage from the front side of the airport, which you couldn't see before from the back—and you could smell it.

Q: What did it smell like?

Kinkade: Just sort of this explosive smoke smell, burning-stuff smell. You could smell it. If you remember on one of the news clips, you'd see these series of six ambulances coming in. It's one I've seen over and over and over on the news. We were right by the fence—they came by us. We watched this line of ambulances come into the—very early in the—right after the explosion. I watched them go by. Then later in the news, I see that

same scene, and so I knew we were right by the fence where they went by as they were moving us over to the flight hangar.

Q: Oh, my gosh. Well, thanks for describing that. [laughter]

Kinkade: Off-topic, but interesting.

Q: It's obviously super interesting. Going back to—let's stay in the fall of 2014 for a second. Are there any other memories that you particularly remember, going back to that time?

Kinkade: One of them is actually how Luke and I became good friends. Luke walked in, and I had just met him, been introduced. "This is Luke Bawo, he's head of this whole thing." [unclear], "Carl Kinkade." Said, "CDC guy, whatever." Luke goes, "You drink beer?" I go, "Yeah, I drink beer." He goes, "Alright, we'll have to find a time to drink a beer." "Fine." That kind of went off—we didn't drink a beer right away, of course. Every day we had team meetings. Every night. Every night we were set on this schedule of—everyone stayed at the Mamba Point Hotel. We had the CDC office that was in the old embassy compound, across town from where the Ministry of Health was at. The car would take us to the Ministry of Health, we'd work all day, and then we'd take the car back. Then we had a team meeting every day. As a team, we were together a lot. You're there in the evenings, and then you're catching up with Frank and Pierre and the rest of

the team. Then at the Mamba Point Hotel. Of course, everyone's back there for dinner and whatever, and still working.

We really didn't have time to drink a beer, but then one day Luke says, "You want to go out tonight to drink a beer?" "Fine." So here we are. It's probably the first week or second week of September, and the Ebola numbers are crazy. Monrovia's quiet. We didn't know at the time. At the time, we were thinking, this is not so bad. There's not that bad of traffic, and the city's not that busy. Now we know it's not—it is. [laughter] Now we know traffic is terrible and whatever, because at the time it was no one was driving, and you just didn't know that, because that was my first impression of Monrovia. So Luke gets a friend of his, Mohamed. Luke and Mohamed take me over to a little local grill/bar thing called Old Folks. We're sitting outside at a little table, the three of us, and we're having a beer, and he orders a fish, so they cook up his fish on the grill, and they bring the fish over, and the three of us are going to share this fish. The first thoughts are, here we are in the Ebola response, and we're all eating from the same plate. I had some thoughts about that, but you just do it. Then the place starts filling up, and filling up with people, and more people and more people and more people, and this place is getting packed. I'm going, I don't know. Now I'm getting a little nervous. As it starts to get a little bit dark, I missed the team meeting. I think either Luke senses that I'm uncomfortable, or he's uncomfortable, I don't know, but at some point he's like, "Are you ready to go?" "Yeah." So they gave me a ride back to the hotel.

But according to Luke, I was the first CDC person to have a beer with him. He had asked some previous CDC folks to have a beer and they said they weren't allowed to. I don't know that they weren't allowed. They probably just needed—they had to get back for the team meetings, where I skipped it. [laughter]

Q: Right, right, you were willing to break a little schedule—

Kinkade: Yeah.

Q: —to integrate—to meet the guy, and—yeah.

Kinkade: It was important. It was important to have that out of the Ministry of Health building, relationship-building. You're in the building and it's work and everyone's busy and you can't just sit and have a conversation and get to know the person. And you can do that. You get away from everyone else, you can have that conversation to ask about his family and ask—it was good to know. And it did. Since then, we've been great friends. Now I feel like I have a relationship with him and I can be extremely honest. If I see stuff that I just don't think is going in a great direction, I can be honest with him. I can just say, look, nah, I may not do it this way. Here's the way I would probably do it.

Q: Do you have an example of that?

Kinkade: Well, we're currently going through one now, which I've had a few conversations about. [laughter] We have the IDSR [Integrated Disease Surveillance and Response] process that's been going through. This is the disease surveillance process of the reportable diseases for—the international reportable diseases. The paper process is kind of done, so this is where, if one of these internationally reportable diseases comes up at a local health clinic, this is the process they would go through to report it, and then the investigation would happen. Then that sort of trickles up through the system to the central/national level that can be combined with lab data to look at, is this a confirmed case of X? But that's paper. The discussion is, that's great, but it'd be nice to have an electronic version of that, so it happens automatically. It can tell us, is something going on that we need to be aware of? WHO [World Health Organization] has a system they have tested in Pakistan and Yemen called eDEWS. It's Electronic Disease Early Warning System. But as far as I know, it's never been nationally stood up—maybe in Yemen? Pakistan was a pilot—I don't think in Pakistan it's used anymore. That concerned me. But they're paying for it, they pushed Liberia to go this route, and a pilot started in March of this year through about right now. It should be over now—it's supposed to end the end of June, but I haven't gotten a report back on, did the pilot end, and is there tweaks happening to the system, or what's going on? Because we've provided feedback along the way of things that need to be fixed. It's worked okay. I've told Luke that. They have, like I told you before, this other system they use for their routine surveillance, the DHIS 2, which is District Health Information System. It's built by the University of Oslo and it's used by, I don't know, fifty countries, a lot of them in Africa. It's aggregate reporting monthly. Those are just rules that you put in. You're telling them to report monthly. You

could just tell them to—if this disease comes up, report it immediately. It's just a process change, not necessarily a system change. There are ways to tweak it in your system. Tanzania and Rwanda have done that, and some other countries have taken the same system but built a module to it instead of creating a whole new system for their eIDSR [electronic Integrated Disease Surveillance and Response system].

I have had that conversation with Luke. I said, "Look, I realize that you were bought into eDEWS because WHO paid for it, and they're really pushing for it. I've always been on the fence on it." Matter of fact, he's called me out on that. "Carl, get off the fence." I'm like, "Well, you're yet to give us requirements. You're trying to put a system together for something you don't have requirements for. What are the requirements? Let's figure out the best system—way to do it."

The pilot has gone okay. I think it's had some limited success, but it has some other stuff that really concerned me. I would have much rather seen them use their existing system and just modify it to include the IDSR, rather than [create] a parallel system. I've told him that. We'll see what happens. He's told me, he has said that he's not married to the eDEWS. If we find out that that's just not going to work and he wants to go a different direction, they're willing to do that. I'm not convinced of that, that he really thinks that. I think the WHO puts a lot of pressure on him. It'd be interesting to see if he would actually back out of it if it really didn't work. But it's smartphone based—excuse me. It's phone-based, so it can use—basically, what I call street phones, the basic dumb phones, for SMS messages or smartphone/Android based, or internet—it has a lot of interesting

options to it. The problem is a lot of the local health clinics don't have internet, don't have phone coverage. So now they've had another avenue of trying to report the data through satellite phones. It was like, alright, now you're going to use a satellite phone for some rural clinic to report it, and then the interfaces aren't the same between devices, and is it the same as the IDSR form that's been used on paper? There's just a lot of potential glitches. That's all going—that stuff's been happening right now, when I'm not in-country to help them with it. And that's frustrating from my perspective, is that I really need to be there right now, having these conversations. You're trying to do it through e-mail, and it's like, ugh. But, you know, got to sell the house, got to pack a family, got to move a kid to college, got to—

Q: You'll be spending a lot of time in Liberia coming up.

Kinkade: Yeah, going to be there a long time, you know—[laughter]—starting in, hopefully, September.

Q: But this is an interesting pattern in your thinking, Carl, that you want to take the system that they have going in Liberia and make it work.

Kinkade: Right. Well, it does work. Other countries have shown it. So tweak what you have versus put something else in. It worries me, because when you start having countries that have limited resources, and you start having multiple systems, funding's going to go away, we're going to leave. I told Luke this a year ago—I was like, "You've got to start

getting a plan together on how you want to move forward, because when this response ends, the partners are going to go. Money's going to go. You need to maximize their involvement now, while you can." And he started seeing it. Last fall, partners started pulling out. And he still didn't have a plan together. USAID led a workshop on building a strategic plan for their health information system. They've been there for a while before us. They've supported them through a lot for—when it comes to system-type stuff and governance and policies and the routine surveillance, they funded. Their logistical area, they funded. Their HR [human resources] system, they funded. They've done a lot of work there. We're the new kids on the block, from that perspective, and hopefully [when you] add our perspectives, it will be good. I always worry, you have to walk this fine line of—you don't want to step on their toes, because they've been there. At the same time, we bring some other stuff to the table when it comes to lab expertise and surveillance expertise and some other areas. My role is really walking that line because they have done this sort of role. This is something they do frequently in countries where CDC doesn't. All of a sudden, we're encroaching a little bit. But I think the country leadership and Atlanta leadership's—we all understand that in order to make decisions, we've got to have information. The better we can help them put a system together that allows us to get better information, more timely, we can make better decisions, and not let something like this happen again. Everyone gets that. USAID gets that and the Ministry of Health gets that, WHO gets that—we all get that. It's just a matter of walking the fine line of, you reach out more to partners. Do you really need to ask that question? You kind of know the answer, maybe. But you ask them anyway, just to make sure they feel like they're

engaged in the process—you're not just stepping over them or past them, so you have to do a lot of massaging. [laughter]

Q: Right, right, right. Diplomacy between—

Kinkade: Diplomacy, just to make sure that you're, "Here's CDC again, just doing their own thing." You don't want that to happen. You want that perception. So I work closely with the USAID office in [Washington], DC, and I work closely with the USAID office in Liberia, and of course, you just had a big turnover for USAID, so other folks who were there working on it are now gone. The new people are in, so that's a little bit of an advantage for us, in that the new people won't come in feeling like we're stepping on their toes. Because they're now maybe feeling the opposite—they're stepping on our toes, and I don't want them to think that. But you get what I'm saying. They've been there four years, all of a sudden here's this new CDC guy going, "I'm here to fix it."

Q: Right. [laughter]

Kinkade: And it's like, no.

Q: Back in 2014, 2015, are there any other big parts of your work that we haven't addressed yet, or any—just looking back in time, any developments that we haven't talked about?

Kinkade: No, I mean, I think a lot of it has been—a lot of my role has been working in the Ministry of Health. I work there all day, every day. When I go in-country, that's where I go. I go there. Other people may go to a meeting there, then they're offering to run other places. I would say that I'm probably one of the oddballs in the group where other people go there for a meeting and leave. I'm there all day every day. Because of that, I have had a lot of interaction with the Ministry of Health and staff there. Involved with surveillance, involved with the informatics part, involved with all the sort of information processes for burial teams and contact tracing and lab data and surveillance data. You end up with your hands in a lot of pots. Trying to make sure—and for the Ministry, they're all coming into the same people. They end up managing an incident through [Microsoft] Excel, and you're in there trying to help them understand their data better, and we think we want them to leave Excel, then realize they're really comfortable with Excel, so fine. Do what you're going to do in Excel. Much as we try to tell countries to get off Excel, it seems like ministries of health around the world live in Excel. And it's like, okay. Fine. [laughter]

But yeah, it's been interesting. One other thing that happened, I think it's kind of interesting. Right before I had left for the first response, each fall there's a school, a middle school, [Alton] C. Crews Middle School, a number of years ago had contacted me to ask me to come present on infectious diseases. They read this book called *Code Orange*, which is about smallpox. They had asked me to come in and present about smallpox and other infectious diseases. Each fall, I would do that. Seventh-graders would read this book. Once they finished that, I would come in, we'd do this presentation on

infectious disease and whatever. This year, they called me right before I was leaving to see if I would come back in again to do that presentation to the students. I told them, "I can't because I'm leaving for Liberia. But when I get back, we can figure out a date that'll work and I can add some Ebola conversation in." At this point, I'm thinking I'm going one time. I'm just being deployed once, I'm going to come home, and I'll be back here. At that point, we had no idea how long the Ebola response would go.

I returned, and I contact the school, let them know I'm back, if you want me to do this I'll be happy to, whatever. We agree on a date, which just by pure accident was day twenty-two. Day twenty-one, we do active—we're actively monitored for twenty-one days when you come back. Day twenty-two, as long as the first twenty-one days there is nothing popped up, day twenty-two you're zero risk. So we schedule day twenty-two. Then the week of the presentation, the teacher sends me an e-mail saying, "Can you send us some information about Ebola?" I said, "Fine." I set up a bunch of—our website and some other sites and whatever here. Then I get a call from the principal saying that they've had parents complain that I'm coming to the school, and they're trying to figure out how to deal with this. Did I have any other information that they could share with the parents to alleviate this concern? I again just sent, "Our website has everything. Here's our website, our Ebola website. It talks about what active surveillance—what zero risk is, and what the symptoms are. It's all on there, so here it is." I'd had twenty-one days of active monitoring at that point; I didn't have direct contact with blood or blood products or people that were sick with Ebola; so I'm really zero risk. They said, "Okay, this may go on to the county. The Gwinnett County superintendent may have to make this decision."

That's exactly what happened. The school sent it to the superintendent for the county, and it came back that they ended up being nervous about the PR [public relations] around it. The principal asked if I would be willing to Skype the presentation. [laughter] So my son put the presentation on a CD [compact disc], and he drove it over and gave it to them. Of course, at CDC, we don't have Skype on our machines—we do now, for business, but before we didn't. The EOC machines have Skype, but those are always wiped when they come back to CDC. But our CDC work machines aren't allowed to have any peer-to-peer-type software. I couldn't even do Skype from CDC at the time. So I had to go home and call in from my house to them, and do a Skype presentation, and this infectious disease discussion, and talk about Ebola, which was really nice. I ended up getting this packet in the mail which had letters from every student. They had some great letters—you could tell that some of them actually listened. It's interesting because then, my younger son, who's in Brookwood Elementary [School], he had come home—and teaching—we told the faculty there and the staff that, here's what's going on, just so you're aware, when I was leaving for the Ebola response. When I was coming home, the teachers had made a little banner for me that my son was going to show, and have for me when I came home. And one of his classmates went home and told her parents that one of her classmates' dad has Ebola. [laughter]

Q: Whoa.

Kinkade: So this parent calls the school, of course, going, "What is this about some kid in the school's parent having Ebola?" And they're like, "No, he doesn't have Ebola. He

works for CDC, he's been part of the Ebola response, he does not have Ebola." You have to deal with stuff like that when you come back, which I'm sure lots of folks did. Because people were nervous. This was the fall of 2014. The media is all over this and creating hype, and it made a lot of folks nervous.

Q: That's really interesting to hear.

Kinkade: It's interesting that, I think I would say—CDC is, of course, a major federal agency. But prior to the Ebola response, and the media having so much hype about CDC, a lot of people still didn't really understand—we'd still get questions from people. They're like, "Is CDC a federal agency?" And you're like, "Yes." [laughter] Sometimes we act like an academic institution, but we are a federal agency. I think that in some ways, we could probably reach out to our own community better than we probably do. For Boy Scouts, there is a public health merit badge. For two different groups of Boy Scouts from our troop and some other troops I pulled in, I've helped them get it here. All the requirements of the merit badge, I would reach out to people in those areas and get the leading people in those areas. We would conduct it here at CDC, and did it in a very ad hoc way. Matter of fact, the first time I did it, I did it on a Saturday. Initially, the security folks were like, no, you can't do it. We had all these scouts on Roybal Campus on a Saturday, when they have less staff—because they just have less security staff around weekends. And I had to reach around them and get it done. When I went to pick the badges up, they told me, the guy who gave it to me said, "Here are your badges, but don't ask to do this again." [laughter] I'm like, "Okay, thank you." It's like, here we are,

trying to potentially educate our future public health professionals. If one or two or three kids out of these Boy Scout troops become a public health professional, we've done our job. And not just that, but we're a major employer within the Atlanta area, so this should be part of our job. I would really like to see that actually become an official thing. You know, we do this every summer, and have Boy Scout troops and Girl Scout troops—I don't know if the Girl Scouts are called troops, but—in here to do that. I think that's great outreach.

Q: Yeah, that sounds like a great program.

Kinkade: It's not hard. We have plenty of staff that volunteer to do it, it's just a matter of putting it together. I've done it a couple times. There is a Boy Scout magazine, which I really wish I would have written the article for that with them here. How many Boy Scouts earn their public health merit badge at CDC? You sort of forget, right? You're at CDC and you work here every day, you sort of forget that if you're this kid in Nebraska, they don't go to CDC. To them, it's something on the news, and you sort of forget that, you just come to work every day.

Q: Right. No doubt. [laughter] Can you tell me about the decision-making process then for going to Liberia? How you were called to do that, and I don't know, talking with your family about it?

Kinkade: The move?

Q: Yeah, the move.

Kinkade: That was a conversation started over a year ago. It was one of these—we know we have a certain level of work that needs to be done that involve informatics, whether it's lab or IDSR or routine surveillance and etcetera. We've been very engaged in that conversation early on, in the response with the Ministry of Health. Early on, I had conversations with Atlanta folks and then with whoever was a country lead at the time. Later it was Cristen Suhr, who was our deputy director—she was the first one there as a permanent staff. No, no, excuse me, Brian [D.] Wheeler was there first, and then Cristen. I had conversations with both of them, that they really need this. We need to be engaged with this, more than just TDY [temporary duty] people. I'm willing to do it if they want to do it. Ask my wife that question, but I'll cross that bridge when I come to it.

They started trying to figure out how to make it work. Brian and Cristen had worked on it, worked with Atlanta, and gone back and forth. I was still in CSELS—I was still a staff under CSELS, not CGH. That made it a little trickier because you had to get me out of CSELS and into CGH, and to do that—and that did happen. December of 2015, I came into the Ebola-affected Countries Office under Barb [Barbara J.] Marston. That's who I'm still under, I think. I'm not sure if I'm under Des [Desmond E. Williams] yet in Liberia, I think I'm still under Barb. Or maybe both, I have no idea. I report to whoever they ask me to report to. [laughter] But the conversation got more serious, and we had to

figure out how to make it work with NSDD-38s [National Security Decision Directive 38s], because they didn't have the NSDD-38 for an informatics role.

Q: What's NSDD-38?

Kinkade: NSDD-38s are the State Department's, like, official slot for a permanent direct hire. There are direct hires, which are government people, and then there are LESes, which are locally employed staff, and then I think you have other things that can happen from a contractor-type role. But NSDD-38 is like the State Department's version of our FTE.

Q: Oh, I understand.

Kinkade: You have to have those slots for these roles, and we didn't have one initially. They had to go and massage it to get it to work out. A lot of folks had to say—understand that—why is this important or not, and do we agree to it, and is it worth taking one of our slots? We only had ten total for the country office, and then eventually it was decided. But it took a long time to go through their system, and then when I first asked my wife, I said, "Do you want to move to Liberia?" "No." [laughter] Very short answer. "No." So I countered that with, "Think of it as an adventure. Liberia's not bad, and it's on the coast, Atlantic Ocean-side. It's sort of a coastal community," just like her town that she grew up in. "There's a lot of fresh fish"—my wife loves fish—"and rice." She loves fish and rice. "You won't have to work, you can just do whatever it is you want to do. It's a different

lifestyle because you're part of the embassy group now, and it's just a different lifestyle. And it would be a great cultural experience for our son—he'll go in the fifth grade there." She thought, huh, sounds like an adventure. And that was [unclear]—her response then was, "Yeah, I'm up for it."

It wasn't until June—I think June of this year that I got the official offer to take the position. It took up till the end to get it, even though Cristen and Brian had worked on it a year ago, or started working on it a year ago. Now we're just working through the paperwork process. The first thing you have to do is everyone in your family has to get a medical clearance, and then you have to do the travel orders and moving and all that stuff, and it just takes time.

Q: How do your sons feel about it?

Kinkade: My younger son is not happy. He loves—he has friends all around him. Every side of us, every house around us, has kids his age, and they all play together. They're running in and out of our house and their houses, so that's all he knows. He was born there. It's his house. Our older son, of course, is at UGA [University of Georgia], but at the same time he—at least last year, he came home often. He came home a lot to take care of the house and mow the lawn and to help my wife, since I was gone. From his perspective, he likes having home there. Athens to Snellville is a forty-five-minute drive. It's easy. So he would actually come home much more than I did in college. But now he has an apartment, and so I don't think he would—even if we were here, I don't think he

would come home as often. Before, he was in a dorm and had a community bathroom and shower, and I think he just wanted to—you want to go home to be in your own bedroom and your own bathroom. He wouldn't have that. He doesn't have that now this year, anyway. I think he would come home less anyway. But he has said, he's kind of a home—mama's boy type kid. I think he enjoys coming home. But yeah. His first request was that he gets the house. [laughter]

Q: Okay. Negotiator.

Kinkade: And we said, yeah, no. You're not getting the house, sorry. [laughter] But it's been like, "Alright, I want this furniture." He's been pointing out the furniture he wants for his apartment, which we are giving him some of it. It's just a matter of when. They had rented a moving truck, a U-Haul truck, to move some of their stuff, him and his roommate, because his roommate is someone he went to high school with, and they lived out in—not too far from us, and so they moved both at the same time. He wanted all—our living room couch and stuff then. The receiver for our TV in the main living room where we watch TV now. He's like, "I want to take all this with us." We're like, "A, we at least have a month to go yet, we want to sit on a couch." [laughter] "B, we're showing the house to people, and you don't want to show them an empty house. I think you'll be fine for a month of not getting this stuff." When I was in college, we had, like, a curb-type couch, hand-me-down couch that someone had thrown out, and cable wheels for—you know, those wheels you put cable on? Those wooden, like, I'm not sure what they're called.

Q: Oh, sure.

Kinkade: We used it as a coffee table.

Q: Right, right. I know those, yeah.

Kinkade: Those things you wind cable around.

Q: Spool.

Kinkade: Spool. Like, a big spool. A big wooden spool. [laughter] That was our coffee table, something we got free from someone. That's college furniture, and that—

Q: Oh, yeah, I'm familiar.

Kinkade: Stuff you don't worry about people breaking.

Q: I got my couch from the house across the street, on the curb. [laughter]

Kinkade: [laughter] And so now he's getting ours, and so it's like, it's kind of too nice for a college kid. These college kids are completely different than I was coming out of high school. [laughter] I remember my first spring break, it was like, eight guys in a one-

bedroom, condo-type place at Padre Island. We slept on the floor, we slept on the bed—there's eight of us in one room. It had two beds in there. And my son went on his first spring break last year, and they're in a three-bedroom townhouse in Miami, and I'm like, that's not college. [laughter] You need to stay in some roach motel like the rest of us had to do. Fight over who gets the bed and who gets the floor. [laughter]

Q: Rite of passage.

Kinkade: That's part of the ballgame.

Q: Yeah. That's fun. Another thing I wanted to ask you, Carl, while you're here—we talked on the phone before having this interview about this cool system that you're developing for integrating a bunch of different—I'm not going to put it very well, but different areas of the response into the same system. Am I saying it right?

Kinkade: The health information system for Liberia.

Q: Yeah.

Kinkade: Yeah. Within the Ministry of Health in Liberia, they have—and in all systems, ours too. CDC. Everyone has different systems for different stuff. We have HR systems, you have—and this is both us and them. You have, in Liberia, logistics systems, and you have the routine surveillance system and the IDSR surveillance system, and you have a

lab. In this case, theirs are all sort of separate stuff, which is not uncommon. I mean, ours is sort of that way. We may have ways to link them and pull information, but they're really separate systems. But Liberia's not very big. One of the early-on discussions I had is that sometimes, when we walk into situations as a CDC person, you think like a CDC person. A lot of our stuff is big. We look at big, national surveillance systems. We're looking globally at stuff. They're just big.

Liberia is kind of like Nebraska. Nebraska has Lincoln and Omaha, and then there's the rest of Nebraska. That's kind of Liberia. Liberia has Monrovia, and then there's the rest of Liberia. It's really a state, and it's not even a big state. The state epidemiologist for Nebraska is Tom [Thomas] Safranek. Tom and I have been friends for a lot of years, and so my thought was, as we're having conversations with Luke and others, I'd call it, how would Tom approach this problem? Because Tom's going to approach this problem differently than Dr. Frieden's going to approach it. Or one of our leading surveillance folks for one of our programs in CDC, they're thinking nationally, they're thinking, we've got to be able to do this system for however many millions of people. This is a small state, and they just approach it differently than we do nationally. How can we start—A, how do we simplify the system? B, how do we make sure that information's exchanged in between them? Early on, we had these conversations about how do we start integrating some of this, just to help them make decisions across data sets, and sharing some of this central stuff that's common between them like a health facility. A health facility is a health facility. You have a health facility registry, you maintain that one registry, and it feeds the surveillance system, it feeds the lab, it feeds HR system—they

all come from that one. There's a change, you change that one, it changes on all systems. That's it.

That's what we're working on. We're working on integrating across all their systems. They have an HR system, they have a logistics system, they have the lab, they have—or it's in process, the lab—pilot's supposed to be starting soon. They have IDSR, and then what's going to be eDEWS, the eIDSR, routine surveillance, which is DHIS 2. Then they have a whole research component, and they have—I'm missing something—there's like, seven systems. The goal—right now, they're all separate. Either they're in place, or in the process of becoming something. Because some of them weren't electronic before the Ebola response. So partners are trying to move in that direction. It's one of our—not us, another partner. We're just trying to make sure that those partners that do do that for them, do it in a way that allows it to be integrated across the systems. HR should be HR use—or the finance system was the other one. HR should be connected with finance. Yeah. That's logical. I think ours does that. But then also, that gets connected back into the response, because when you look at—if you're the emergency operations center and you need to deploy your health personnel for a response, the emergency response component has to have access to, or at least some kind of connectivity to, their HR system. But when you deploy someone during an event, non-work time, that commits funds. That then has to, of course, be connected with finance systems. These are all the things we're working through right now, is how would you do that across systems to where they have a logical system that, when they do have a response activity, we have the surveillance activity that pulls up. There's a case of something, we have lab for

confirmation, we have EOC, they can pull stuff from the HR system and finance can pay for it and logistics can get it there. The overall process for the health information system is integrating all those together. Hopefully, it's getting there. It's a slow process. I think CDC understands that that's important. It's actually unique, in the way that most countries, including our own—we're not completely integrated across that. When you look at the process of HMIS [Health Management Information Systems], which USAID has done with a lot of countries around routine surveillance, that's only one piece. When they have done some integration components, it's really just focused on that one component, not across all these. To work with a country to integrate their entire structure, it's pretty unique. I think it will be interesting to show that CDC can contribute to something like this, and something that supports our mission.

Q: Are there any countries that have a comparable system?

Kinkade: Parts. When you look at the open HIE [health information exchange] process, which is an open system—if we're doing health data exchange, Rwanda is the one that always comes up, is talked about a little bit, Rwanda's done this. They're a bragging point, but that's only one sliver. It's just healthcare delivery and healthcare surveillance. It's not all the other stuff. This is a much bigger, broader vision than that, and most systems. Most countries, I mean. Like I said, even ours. I know our surveillance systems have already been integrated with each other. I had heard a number of years ago that CDC has about one hundred fifty surveillance systems. Because each program has their own, which aren't talking to each other. So we're not—it's harder. Again, think of them

as a state, a small state. You can start to do stuff that you couldn't otherwise do in a big state, or country that's this large. We do have that opportunity, and I think that in the long run, the hope, at least, if my couple years I'll be there are as productive as I hope they will be, is that when I leave, they will have that in place. They won't because of me—I mean, it will be because we at least kept that conversation going and we find funds. That's the hard part, right? When Ebola ends, and the worry gets shifted off to Zika and everything else, then the funding follows that, and then stuff like this stops being a priority. How do we keep that as a priority? I think we keep that by saying that this is something—we can show how this can work for other countries. How can this work? The stuff we're doing there, how can that support the global health security activities across these thirty countries that we're now working on? It won't be exactly like that, but it will show how it can, what can we leverage from this opportunity for those? How can the work in Vietnam that we did before leverage—how can Liberia leverage that effort? How can Sierra Leone leverage the stuff in Liberia, or vice versa? I think that's our opportunity.

Q: Absolutely, serving as a model for the future. That's really cool. Well, looking back, we—I've kept you talking for a long time. [laughter] Sorry about that. But are there any other memories or reflections you wanted to share for our historical record here?

Kinkade: It's hard. It's hard to think off-the-cuff of things that have happened over the time period. When you first show up for the Ebola—when I was packing for the Ebola response, because I've responded to a number of things, right? I wasn't really worried.

Ah, it is what it is. You just sort of go. But once you get on the ground, you're realizing, this is kind of serious, and you can die, even though you're not—you don't have direct access to patients. You see it. You drive by ELWA [Eternal Love Winning Africa Hospital] and you see the people outside. People are being found dead on the street and the beach. We had a person, an adviser to the minister of health, who came down with Ebola and ultimately died, who was at the Ministry of Health. Which, of course, they had to go back to the Ministry of Health, and they decided to Clorox the building, which, that was interesting. But the point is that you realize it is pretty serious. It makes you more nervous. My job is to be there to help them. Can you do well enough to help them through this? You think about that a lot—at least I did.

Then we returned home. The first time I returned home, the quarantine process wasn't—the screening process wasn't in place yet. I literally came home, I flew into Atlanta and came straight home. There was not one question about West Africa. [laughter] This is first part of October. Height of the outbreak in West Africa. I literally came home, went through security, not a question. Got home, e-mailed my division director, and said, "Just as an FYI [for your information], I just came through the Atlanta airport and there was no question from them about West Africa." My next trip, there was. [laughter] Process had changed, which—it was interesting. As I went through this process multiple times, I would see how the process kept changing. As we're tweaking and redefining the system. Later, of course, I was screened, and you're yanked out. They yell your name—here you are with all these people, I just came on the flight with them from Brussels, and they're all staying in the passport area waiting to come through, and the guy just yells, "Marion

Kinkade." You raise your hand, and then they come pull you out of line and put a mask on you, and they put a mask on, and the border control person, he puts a mask on, and the whole crowd stands there watching you. These people are all going, what just happened? [laughter] Then they pull you off and of course go through the interview process. So yeah. It's been interesting to watch how that process has evolved from nothing back to nothing. Now, I've come back and there is no more screening you anymore. You don't have to—[unclear] coming from Liberia, but I've watched it go from nothing back to nothing, and a lot of stuff in between. It's been an interesting two years. You think about, it's a year right now. This is August 2016, so this month is my two-year anniversary of supporting Liberia for the Ebola response, which, a lot of people are that way, but not everyone has gone back and forth to Liberia. A lot of people supported it from Atlanta for that period of time, or gone once and then supported the EOC or whatever. We have a lot of folks who have also worked that long. But going back and forth, back and forth as many times as I have, you see the changes in the mood in the people. You see more relaxation. Early on the response, of course, there's tension with everyone. Then later, no touching. You don't touch anybody. You don't shake hands. You consciously think about not touching your own face. You don't think about how much you touch your face until you think about not touching your face, which is interesting in itself. Try that for a day. Tell yourself you're not going to touch your face. You catch yourself trying to touch your face without thinking about it. The whole response, don't touch your face, and you're Cloroxing—I dyed holes in all my pants and everything from all the Clorox. Every building you walk in with—they have chlorine wash stations out front, and our hotel had one for your feet, so you would step in this bin that had a big sponge in there.

As a complete side note, I made the mistake once of—I love—my attire, if I had my way, is flip-flops, shorts, and T-shirt. That's how I live. If even flip-flops. Just barefoot, running around. Shorts and T-shirts. Love it. I need to be on a beach somewhere. So I get back to the hotel after one of these days, and I change immediately to shorts, T-shirt, flip-flops, and then I run to the staff meeting at the old embassy compound, not remembering on my way back they're going to make me step in this bin. [laughter] As we're in a line, the CDC people, waiting to come back in the hotel, I realize, oh, no, I gotta step in this stupid bucket. With my flip-flops. [laughter] There's this big, thick, probably a two-inch sponge or a three-inch sponge, and there was—it has whatever on it. So I did these little, really quick hop in and out, and my colleagues were laughing at me because it—they're like, "I'm not even sure you touched down." [laughter] Just sort of flew through it. [laughter] But you go from that process of not shaking hands, and not making physical contact with people, and washing continually—I mean, I don't know how many times I Cloroxed my hands and etcetera. Like I said, my pants—I had clothes, they had holes in all of them from the Clorox. Then later in the response, once the main response ended, and you had maybe the wind-down of clusters, all of a sudden you're shaking hands again. The chlorine wash stations are still there in some places—Ministry of Health still has theirs—they still do temp [temperature] checks outside their front door. Hotel does, but they're less stringent about actually using them. We don't, the CDC office. We had signs in the CDC office in the main room—well, sort of all over, not just the main room—that said, "If you have any of these symptoms, tell us immediately." Now those signs are gone, so now it's like an office space, like a normal office space. You're

thinking back about how when we're there, you're sitting there in the team meeting, and then you see these old signs all over, just making sure everyone's aware—if you're not feeling well, you need to let us know. Don't hide it. If you have a fever, don't care if you think it's food-related, just tell us. Isolate yourself in your room. It's been an interesting emotional transition out of the response and back into normal life for them. For me to be going there for two years, and to see that change—you know, I didn't see them before that. It would have been probably more interesting to have been there before that to see the change into the response and then back out of the response, but my experience is only from their response and then to non-response. It's interesting. Liberians like to touch. I think that the response was probably very hard on them from that perspective. They shake hands, they pat you on the shoulder, they hug you. Colleagues' wives, like Luke's wife, when I see her I kiss her on the cheek. You have these contacts with people. During the response, you didn't. I'm sure for the Liberians it was extremely hard. It's just not part of their culture to not touch. Culturally, they touch. They wash the bodies of the dead, which of course we had to work with them on not doing.

It's been an interesting process, and hopefully we don't have another one like this. Zika, maybe. But I'm just saying, not like Ebola. I think the agency, we found out, struggled to support it. We saw our weaknesses, our policy weaknesses. We see that international agencies, like USAID and the State Department, their people are hired and they get the training they need—that's part of their onboarding process. They get State Department medical clearances because they're going to be posted abroad. So they don't have the same limitations. WHO doesn't have the same limitations. We saw our limitations. A lot

of our staff aren't internationally focused, they're domestically focused, and that's why they don't. They don't have the official passport. They don't have medical clearance. They don't have the training classes needed. They don't have FACT training. I think that lesson came out, which of course we changed. Now everyone gets FACT—the GRRT [Global Rapid Response Team], the "gurt," has now stood up to get people available to respond internationally. More than twenty-eight days. I think that was probably one of the big lessons that got learned, is we've got to have a bigger cadre of staff available for longer deployments. Because twenty-eight days—it's hard to be gone from your family. But it's also hard to get a lot of work done in only twenty-eight days. But then, continually sending back the same staff becomes hard, too. Because that becomes taxing on their family. It gets hard. It gets hard. And we don't always see that from a family perspective—CDC sees me or you or they see our staff. They don't see our spouse or our kids, and the importance of missing that band concert or that date or that anniversary or that birthday, those little things you miss, and they're just gone. You do the best you can to make up for it when you're in-country—that's what I always do. I had a division director early on when I started—became an FTE at CDC, and—Terry Boyd. I initially started traveling—I've always liked to travel, so every time there's been an opportunity, I've volunteered, "I'll go." I'm like Mikey. If you know the reference. For the Life cereal people of the eighties, I guess. [laughter] "Mikey'll eat it." I would always raise my hand to go do it, if they needed something. But I didn't always do the other stuff. I wouldn't put down—I wouldn't log, like, the travel comp hours that you could put in your account to use later because you're away from home or you're traveling or didn't put credit time down or whatever. Just figure that's part of my job. This is my job. So you go do it. It's

irrelevant whether you worked twelve hours, or you worked eight hours, or you worked eighteen hours. It's your job. You just do it. That's kind of how I grew up. On the farm, if it needs to be done, you do it. You work. My dad didn't care how tired I was. [laughter] I could tell him I'm falling down cramping, he'd say, "I don't care, drink some water and get up and work," and so you did it. But he [note: Terry Boyd] told me, he said, "There are people who work eight to four thirty. And they're going home to their families and they're having dinner. And they're going to that band concert. They're going to that school event. They're going to a movie. They're doing whatever. You are leaving your family to go somewhere far to work. So you log the hours. If you have a twenty-hour trip, you're going to follow policy of what it's supposed to be, but you log those and then you come back home and you use those hours to make that up for your family." So I did. And I've done that since then. I know a lot of our staff don't. But I think that when you have a family, it's fair. Log them, then use them. Take your family—go to a park. Do a cruise. Whatever it's going to be, but find a way to make up for it, and that's what I've tried to do. Every time I get abroad, I try to come back and then do something to make up for it with my family, because I know I'm going to go again, so I've got to keep bribing my wife. [laughter] She may leave me. She has her US citizenship now—she doesn't need me anymore.

Q: Oh, no. [laughter]

Kinkade: That was always the ongoing joke, that she was just using me for a visa. [laughter] Of course, she just reminded me that she's a nurse. She said, "I don't need you for a visa."

Q: Right. Yeah, that's pretty good. Well, hopefully you two have become somewhat accustomed over the years.

Kinkade: She's actually excited about moving. This part right now is kind of dragging for her at the moment because you're trying to sell the house, you're trying to box, you don't know your dates yet. The school stuff—we hadn't even bought school supplies for the school here, we bought school supplies for Liberia. Now we're realizing we're going to have to be a month here before we leave, so we should go back and buy more school supplies. All that stuff's going on. But I think she's excited about the adventure. She's excited about something to do. There's not a lot to do in Monrovia. I like the city, I like the people, but there's not much to do. There's no movie theaters, there's no malls, there's no parks. From that perspective, I think from an adult perspective, you find things to do. But from a kid perspective, I don't know what we're going to do, exactly. There are just not. There's not parks, there's not a sport—I mean, there's soccer. But there's not other activities like that, and so I'm not one hundred percent sure what my son's going to do in his free time. We'll have to figure that out. There is R&R [rest and relaxation] opportunities. We'll just make sure we go somewhere that does have it, so we can do R&R, do whatever we're going to do.

Q: I look forward to talking with you maybe a year from now and seeing how that all falls into place.

Kinkade: I think it'll all work out well. It would be different if I had never been there. Having spent almost two years there, back and forth for two years, I know it's there and I can tell my wife what's there and what's not there and we can plan for that. If I didn't know it, you're walking in cold turkey to someplace you'd never been to, I think it would be a lot harder. But I'm excited about moving. Get in there, get the house sold—somebody needs to go buy my house. [laughter]

Q: Come on, people. Alrighty. Thank you so much, Carl, for being here. Learned a lot. Appreciate you being here.

Kinkade: Thank you.

Q: Alrighty.

Kinkade: It's been fun.

[break]

Kinkade: Early in the response, my first team leads were Pierre and Frank. They sort of split the team-lead roles. They both have fun personalities, and they're both a hoot to

work with. Every night, we would have these team meetings, and they could drag on. Just dependent on who all wanted to keep talking, and everyone got a turn. Put a bunch of CDC people in a room, tell them to talk, and you're going to be there forever. But Frank would come in, and he usually had a ball cap on. He would take his ball cap off and he'd set it on the counter, and he usually had his hiking shoes on, or boots. He would take those off and he'd put them where the—would sit them on the side. He's sitting there in his socks in the meeting. Everyone's talking—we're talking. And when the meeting would end, he would put his shoes back on, and he'd put his hat back on, and then that would end the meeting. Then one day, we had whatever meeting—you know, the normal meeting, and Frank would put his shoes back on, and he'd put his hat on, and he was getting up, and somebody'd come, raise their hand to ask him a question. And Frank was like, "But I've got my hat on." [laughter]

Q: That's pretty great.

Kinkade: But yeah, they were fun—they were fun to work with. I didn't know Frank before, or maybe—I might have met Frank during—I've detailed twice over to polio for the polio response. He was in GID [Global Immunization Division]. I'd kind of, maybe in meetings knew him, but didn't really know him as a person. Pierre—I've worked with Tom [Thomas G.] Ksiazek and Pierre over the years with some of the special pathogens stuff, because they were both on the special pathogens team. Matter of fact, I went to the Rift Valley fever outbreak with the special pathogens team, Tom Ksiazek. Pierre didn't. Pierre and I, we had actually talked about some of that, and that even though him and

Tom Ksiazek were the leads of special pathogens, they had never been in the field together. Because one of them was always in the office.

Q: Yup.

Kinkade: So they took turns.

Q: Yup.

Kinkade: One was in the field, one was in the office. They'd always flip. They had never been in the field together. While we were in Liberia, Tom was in Sierra Leone. He was the team lead in Sierra Leone. Even though he was retired from CDC, they pulled him back. He was in Sierra Leone, and Pierre was in Liberia. I told him, I said, "I was in Kenya with Tom and the rest of the team." Pierre wasn't there. I had never worked with Pierre in the field, only through e-mail and some other stuff had he and I interacted here in Atlanta. But he was a good person to work with. He's got a good personality, and I think that that team, those two, Frank and Pierre, would sort of bounce off each other, and it was kind of a hoot in some of the meetings. You needed that, and I think that from a leadership perspective, I think their personality types were critical for that point in the response. Because at that point in the response, I think there was a lot of stress. It was early in the response, the numbers were big, people working long hours—of course, people were away from their families, maybe they weren't used to that, etcetera. I think you need someone who can be light-hearted enough to bring some humor into the team

meetings to relax people. I think if you have someone in there who doesn't have that personality, I think it allows that stress and the other feelings of just being away from home and tired and whatever to start showing some other sides of people that isn't their normal self. Other people may not recognize that. You know how someone—I've been around many leaders throughout my responses and whatever, and you sort of—I pick up—I like what that person did or I don't like—you sort of—if I'm in a leadership role, here's how I want to approach it, because I think that worked. Having some humor involved and trying to lighten up the meetings some, I think, is a tremendous asset of a good leader. And competent, of course. And they both are. And willing to do whatever. I remember at one point we had a car stop, come to pick us up. It was a Toyota Land Cruiser, but it only had the front and back seat—or middle seats, and the back was—there was no seat, it was just open. We didn't have enough seats for people. And Pierre just hopped over the back seat and got in the flat area and sat down. [laughter] So I just hopped over with him. We were both sitting back in the flat area to get back to the office from the field. I had made some joke about that—I think it was later. It was Chris—who was it? I can't remember. I can't remember who it was. Someone else that was following rules more than we were, and they were like, "No, no, don't tell us that." [laughter] "La la la la la la la," fingers in ears. [laughter] Because you have to sit in a seat that has a seatbelt, that's the policy of the State Department and CDC, of course. But we got one vehicle and too many people.

Q: What are you going to do?

Kinkade: What are you going to do? He wasn't afraid to hop back in the flat area and sit. He's not going to say, "I'm Pierre Rollin, I'm going to sit in the front seat."

Q: Right.

Kinkade: "You, whoever you are, get in the back seat." That's not his personality. That, to me, is a good sign of leadership—you're willing to do it. I had that early in my military career, we were at a summer camp in Fort Hood, Texas, middle of the summer. Hot. You could see Lake Belton from the place we were out in this field, and it was just hotter than heck in the middle of the day. The guys had been working hard the entire day, and one of our leaders came out, and he had talked with some of the guys, and they jokingly said, "Could we go to the lake? There's lakes right over"—it was down, it wasn't near us, but we could see it. And he goes, "You know what? We'll do the rest. You guys go." The leadership jumped on the equipment and started doing all their jobs, and those guys all were released to go to the lake. You do something like that once, twice, whatever, and people remember that. Like, no, I'm going to work hard for this guy, because he's willing to do my job for me to let me go jump in the lake. You notice that leadership style, and Pierre's, where "I'm going to hop in the back and whoever can sit in the front, I don't care." It's not important to him. It was a fun—they were a good team early in the response, and I think that that was needed. But I always—I still laugh about that response from Frank, that he's got his hat on, so it—[laughter]—means the meeting's over. Meeting's over. My hat's on.

Q: Did you not see? [laughter]

Kinkade: Well, thank you.

Q: Yeah, thank you. This was beautiful.

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