CDC Ebola Response Oral History Project

The Reminiscences of

Negar Aliabadi

David J. Sencer CDC Museum

Centers for Disease Control and Prevention

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Negar Aliabadi

Interviewed by Samuel Robson
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Interview 1 of 1

CDC Ebola Response Oral History Project

Q: This is Sam Robson here today with Dr. Negar Aliabadi. Today's date is July 6th, 2016, and we are in the audio recording studio at CDC's [United States Centers for Disease Control and Prevention] Roybal Campus in Atlanta, Georgia. I'm interviewing Negar today about her participation in CDC's Ebola response in West Africa, 2014 to 2016 epidemic. Negar, thank you so much for being here with me today. Can I ask you first if you could tell me your full name and your current position with CDC?

Aliabadi: Sure. Thank you for inviting me.

Q: Of course.

Aliabadi: My full name is Negar Aliabadi and I am a medical officer in the Division of Viral Diseases.

Q: Thank you.

Aliabadi: I just finished EIS [Epidemic Intelligence Service].

Q: Right. When was just?

Aliabadi: My new position started on the 26th of June.

Q: Okay, very much just. Got you. Well, welcome back to CDC in a new capacity, I guess. Can you tell me when and where you were born?

Aliabadi: I was born in Boston in February of 1978.

Q: Did you grow up in Boston?

Aliabadi: No. Well, yes and no. We left when I was a couple months old and lived in Iran, which is where we're from, and then in 1983 we left Iran, briefly lived in Switzerland, and then moved back to Boston, and I stayed there until I went to college.

Q: What did your parents do?

Aliabadi: They're doctors.

Q: What fields?

Aliabadi: At the time, my dad was a radiologist and my mom was a dermatologist, and now they're both radiologists. Complicated lives. [laughter]

Q: What was it like spending your time growing up in Boston?

Aliabadi: I think when we moved to Boston, it was a difficult time to be not just a minority, but also Iranian and Muslim, given the hostage crisis which was fresh in people's minds, so it wasn't an easy place to grow up. I think it's better now, I'm assuming, but I don't live there anymore. So, it wasn't the most pleasant experience.

Q: What kinds of things were you interested in as a kid?

Aliabadi: I was always into reading and was like a voracious reader. I was also into, for some reason, French culture, literature. Or I should say Francophone, not necessarily French, so I was always reading French books and watching French movies.

Q: You spoke French from a young age then?

Aliabadi: From about eighth grade onwards. That's when I started taking classes. I had a cousin who lived in France and would visit her so it just sort of—

Q: Any books that were really important to you?

Aliabadi: I'm sure there are, but I'm blanking. I can't think on the spot. I always liked *The Little Prince.* It's sort of a children's book. I have to think about that one. Oh, I

always like *The Stranger*. I liked that book a lot. I feel like it's still relevant. I can't think of any other ones right now.

Q: Was your interest in French also like academic, or in school what were you drawn to?

Aliabadi: In college?

Q: I mean in high school.

Aliabadi: In high school—we had to pick languages when we in middle school and high school, and I always just continued taking French. I did take French classes in high school. I guess I don't really understand the question.

Q: When I was in school, I was definitely an English kid and a literature kid more than a math kid, for instance. I loved that, I loved [William C.] Faulkner.

Aliabadi: Oh. I was always a science nerd. Yeah, always good at math and sciences, and the French thing was just like a side thing.

Q: So when you graduated high school, what did you think you were going to do?

Aliabadi: Honestly, I wasn't sure. I was just excited to go to college, I think. I know my parents really wanted me to go to medical school, so in the back of my mind, I was like

I'll probably go to medical school. But I really hadn't thought about it. When I got to college, I went to Brown [University] which is a very liberal place and there's so much different stuff going on. I ended up majoring in art history and thinking I would pursue that as a career and worked on an archeological site and was going to work in an art gallery. Then I sort of came to this realization while I was working on this archeological site in France, it was a really neat—it was a medieval abbey in northeastern France and we were there for the summer working on a dig and it was cool and I was like oh, this will be fun as a career. But then the more I was there, the more I was like, as fun as this is, this is such an isolated world and there's maybe twenty other people in the world that this work is relevant to [laughs] who care about this, who want to know what I'm doing. It just started to seem a little bit like an isolated world. I decided not to pursue that and had to think about what I wanted to do with my life.

I moved back to Boston and kind of randomly started working in HIV [human immunodeficiency virus] research because I just needed a job and through connections someone was like oh, this might be fun for you to do for a little while. I had amazing mentors who basically became my role models. I wanted to be an infectious disease doctor and treat HIV patients, and then really wanted to go to medical school at that point. So then I had to do all the work involved in taking classes and exams to get into medical school.

Then I did that. Went to medical school. Thought I was going to be an infectious disease doctor. Spent a lot of medical school abroad working in tropical medicine. I worked in

India and Nicaragua and Gabon in Central Africa, so that strengthened those interests. And also traveling a lot back and forth to home in Iran, seeing sort of—that's not tropical medicine there, but I don't know what you'd call it, just medicine in the Third World or infectious diseases that pop up there. I just continued my interests. When I finished medical school, I did residency in New York City at Bellevue Hospital, and that was the first time I really heard about EIS and CDC. Well, I knew what CDC was, but sort of public health, what it means, what doctors can do in public health, and I really was like, maybe I should think about this versus doing something like infectious disease. But I wasn't sure, so I finished residency, stayed on as a chief, and then I was an attending [physician] because I wanted to make sure that if I did move on to the world of public health, I'd given clinical medicine a fair shot, one hundred percent of my effort. And I did. I worked as a full-time attending and it was great, but it wasn't what I wanted to do for the rest of my life, and I think there were a lot of frustrations. Maybe it's a New York City thing, maybe it's American healthcare, but there was a lot of—I just felt like I wasn't really treating patients anymore. It was a lot of nonsense and bureaucracy and paperwork and not actual patient care, so I thought public health would be a better fit, and so far it has been.

Q: Rewinding just a little bit in your travels to Nicaragua and India and Iran practicing medicine, are there some memories of particular instances that kind of float up to the top of your mind?

Aliabadi: I never practiced medicine in Iran—I just went there to visit family.

Q: Oh, I'm sorry.

Aliabadi: But there is an instance that stands out from when I was fourteen and we went back, or fifteen. It had been ten years since we had left. That was the first time we had gone back, and in that period of time, the country changed a lot because it was post-revolution, post-war, and the economy had tanked. There had been a lot of changes. My family's lives had changed a lot. We had a nanny basically raised most of my family members, my aunts, uncles, cousins, and my sister and I, and so we went to see her. She was no longer employed by the family just because circumstances had changed. We went to find her and we were in Shiraz, which is where we're from, southern Iran. And in Shiraz—it's a big city—not the biggest city, but it's a big city. It's very crowded. But on the outskirts built into the hills, there's where it's more like low-income where poorer people live, and she was living up there. You know, the kind of places with winding roads that don't have street names and people are friendly and invite you in for tea everywhere. We asked around and finally found her, and when we went to her house, there was no door. She was just standing—well, she wasn't standing there, she was sitting there and we were like oh, why isn't she getting up? She invited us into have some tea and she was walking on her hands and we were like—my sister and I were like, what happened to this woman who had taken care of us? She had no healthcare. Nobody knows. I think that's one of the things that really stuck with me in terms of access to healthcare and just injustices in the world. That's one of the things that really drove me to pursue a career in medicine. I was in high school then.

Q: Thank you for sharing that. Were there other times when you started to travel the world and I don't know, witnessed healthcare disparities or things like that that kind of confirmed, this is what I need to do?

Aliabadi: Yeah. Seeing that kind of confirmation, it's pretty easy when you travel to the Third World, because things that we take so much for granted and the care that we give out like candy in the US and, again, take for granted there, is lifesaving and just valued a lot more. In Gabon, I remember—and this was when I was a third-year medical student. I was there for three months and I was working in the adult medicine clinic, so internal medicine, and I thought I was just going to be like medical student, shadowing doctors, whatever. Well, there weren't really—there were two doctors there and one was on vacation, [laughs] so they were like, this is your office, see all the patients that you want. I was like okay, which was fine. So I had a lot of responsibility and I just remember, there's a lot of run-of-the-mill medicine like there is everywhere—hypertension, diabetes, etcetera, but there was also a lot of HIV in the community and this was in 2006. So there wasn't access to antiretrovirals readily. There was a government program to sort of give it out to certain people, but they had to qualify and it wasn't straightforward. I just remember the amount of HIV-positive diagnoses I gave out week after week was just—I mean, at the time and in the setting, it was basically a death sentence for a lot of people. That again confirmed that hey, I want to go out there and do something to actually help people.

Q: Thank you for sharing that. You come to EIS in—what year was it?

Aliabadi: Two thousand fourteen.

Q: In 2014. What month was it in 2014 when you got to EIS?

Aliabadi: In July they have a one-month intro [introduction] course orientation-type thing, and then they start us working in our positions in August.

Q: What was your position supposed to be?

Aliabadi: I was in the Division of Viral Diseases in the team that I'm in now, that I stayed on with, working with the viral gastroenteritis team that works with rotavirus and norovirus. I predominately worked with the rotavirus side of the team. Because it's a virus for which there is a vaccine available and that vaccine is recently in the last couple of years being widely introduced abroad, we spend a lot of time going abroad to the places where it's being introduced to make sure that the vaccine works and is safe and effective the way it is in places where the clinical trials happened and it's been in use for a lot longer.

Q: How did you get pulled into Ebola then?

Aliabadi: The first day we sat in EIS orientation, Doug [Douglas H.] Hamilton came in and was like, "We need volunteers, please let us know your availability, especially if you speak French." I thought about it and I was like, this is a public health emergency, of course I want to help if I can, and I speak French. I put my name on a list, and then I think on August 3rd or 5th, we left for Guinea. [laughs] It was pretty quick turnaround time.

Q: Did you have much training beforehand on what to expect and what you were going to be doing?

Aliabadi: They did have a couple of sessions with some of the people who had just come back from Guinea to talk about the kind of work that we may be doing there and PPE [personal protective equipment] and how to stay safe. They did provide that kind of training. I think it was fine. It was still relatively early in terms of the huge response from CDC, so roles weren't as defined as they were in later deployments. We all sort of ended up doing a little bit of everything. The team was really small but great, so we sort of figured stuff out on the ground.

Q: Who was on the team?

Aliabadi: Mike [Michael H.] Kinzer was the team lead. He's current the CDC director in Senegal. Ben [Benjamin A.] Dahl also was on the team. Lisa Moorhouse was on the team. And three other EIS officers, Jennie [Jennifer B.] Harris, who is now in GID

[Global Immunization Division] and Rupa Narra who is in I think NCEZID and Max [Maximilian P.] Nerlander—I'm not sure where he is. It was just us from CDC.

Q: From CDC, right. What were the first few days like in Guinea?

Aliabadi: I think given all the media hype around it, all of us were a little bit expecting to walk into something that was a lot crazier than it actually was. Not to downplay the epidemic, it was insane, but in Conakry it was just a city that was—there was still life going on. There were still people everywhere and it wasn't—I'm not sure what I was expecting, but it was like a normal sort of city. People going on about their business, going to markets and taxis, busses everywhere. We were really cautious and weren't interacting with locals the way that all of us normally would because we've all worked abroad and we've all worked clinically abroad. Not all of us—I think most of us had worked clinically abroad and were used to interacting with people in a different way. So this was different because we were more dealing with the partners who were actually doing the actual patient care and the WHO [World Health Organization] and other agencies. For me, it felt a little bit removed in a way that I wasn't used to.

Q: Who were some of those partners?

Aliabadi: We worked at WHO, MSF [Médecins Sans Frontières] was there, Jhpiego [Johns Hopkins Program for International Education in Gynecology and Obstetrics] was there. And these people are all still there.

Q: What's Jhpiego?

Aliabadi: Oh, sorry. It's Johns Hopkins—I don't know what the rest of it stands for.

Q: That's okay.

Aliabadi: But they're a big NGO [nongovernmental organization] and in Guinea they had been working on trying to improve infection prevention and control measures before Ebola happened, and then when Ebola happened, they just switched gears and focused on that still, but in the setting of Ebola. Who else was there? Catholic Relief Services, CRS, who I actually hadn't known about until I was in Guinea. They have a pretty large network and they were there helping doing trainings for healthcare workers. Peace Corps was also there, although I think for a time they pulled all their volunteers out, but then they went back. There are so many more. Other NGOs, European ones like Terre des hommes. I can't remember the rest of them.

Q: Which were the ones that you worked mostly with?

Aliabadi: That first deployment, MSF and WHO. MSF, what would happen is that they would provide the clinical care for patients, but we would hear about new cases from them, and then with WHO we would go out and do investigations and contact tracing to

try to not let the epidemic get out of control. Oh, and I forgot, of course, the Ministry of Health [and Public Hygiene], obviously. Local health departments and—

Q: Right. Can you tell me about anything in the first couple of weeks that really stands out when you look back?

Aliabadi: Yeah. The first couple of weeks we were there, I remember me and one of the other EIS officers were working with our counterpart in WHO, and there had been a death in the community that hadn't been explained. This woman had died and then someone suspected that it may have been Ebola because of the symptomatology, etcetera. We went to the place where her body had been prepared and where she had lived before she had died to conduct an investigation. It was a home of I want to say about thirty people. It wasn't one house, it was a group of homes in a courtyard. Sort of the typical way homes are organized. We went with the local department of health, the WHO, and all we wanted to do was just, we know that the woman died there, we suspect she had Ebola, so we want to write everyone's names down and keep an eye on people and make sure nobody got sick. We get there and there's maybe like fifteen of the family members around and they're willing to talk to us with, of course, local—I think it was like the neighborhood chef. I don't know how you say that in English—like community leader.

Q: The chief?

Aliabadi: Yeah, something like.

Q: Community leader, mayor kind of person?

Aliabadi: Yeah. He was super nice and I mean, I don't know what they were thinking in terms of is this a real risk or not, but they were receptive to us talking to them—the chief was. He helped us communicate with the family. We wrote everyone's names down and I was like well, let's also—since we're here, may as well just eyeball everyone and ask them the screening questions for contacts, and we have thermometers, which Dr. Sakoba [Keita] had provided for us, and so let's take everyone's temperatures. We were going around and there were a couple of people missing and I'm like, "Where is this person?" And they were like, "She's sitting over there." I look over and this woman is lying on a bench clearly ill, about to throw up. I'm like, "She doesn't look good, guys,[1] are we concerned about this at all?" Let's take her temperature. It was elevated. I don't remember what, but it was clearly elevated. I remember one of the local [health officials] was like, "Let's just come back later and re-examine her tomorrow," and I was like, "That's not how this works." And then the second person was that woman's younger brother—I think it was brother, cousin, brother. Same thing. He looked really ill. Face was all swollen, fever. Fast forward to three hours later when we're still trying to convince them to let these—to admit those family members to the ETU [Ebola treatment unit] because their suspicion was pretty high. We called in MSF. They spent two or three hours talking to them and eventually they put them in their ambulance—not ambulance, but it looks like an ambulance—this white van, and all the PPE and took them off and the

[1] Note from N. Aliabadi, July 2018: "Guys" referring to local health officials

family was screaming. I remember one of the sisters of the woman who had been put in the car, she was like nine months pregnant, crying like crazy. I think they just—I don't know if they just assumed they would never see them again because they recently had had their—I don't remember what kind of relative—it was like grandmother had died, and they were imagining the same thing would happen. I don't know. But three days later, both of those people were dead and I was like, I can't believe that. I've seen a lot of people die in medicine, working in ICUs [intensive care units] or in residency anywhere. I've seen a lot of people die, but to see two healthy—they were less than twenty-five years old, both of these people—just die that quickly was something that stayed with me and made me want to go back and made me want to try to help stop this epidemic. A few more people in that family ended up dying after that.

It just sort of highlighted the importance of what we were doing because sometimes it's easy to forget if you're not doing direct patient care, at least for me. If I'm not doing direct patient care, sometimes it's [easy] to forget, what are we actually doing? But that sort of reminded me why this is so important and not easy. That was just one family and it took altogether probably five or six hours of that day, and then for the next several weeks of that family being monitored, it was the same thing. There was anger and resistance and all the things that you would expect and that was seen in other communities for the rest of the epidemic.

Q: Were you involved in that continued monitoring and that continued contact with that family?

Aliabadi: Yeah. For that first deployment, that was predominantly what I worked on was contact tracing and specifically, yeah, with that family.

Q: Anyone else from that family who stands out? Maybe someone who didn't get sick, or at least not immediately, who you spent more time with than others?

Aliabadi: Not from that family.

Q: Okay. Others?

Aliabadi: In my last deployment, which was a little over a year after that first one, I was also on the epi [epidemiology]-slash-investigation, contact tracing team, but in another district of Conakry, and it was a district that had the last handful of cases of Ebola for the whole epidemic at that time. We were just trying to make sure to keep tabs on all of those contacts so that people could eventually say yes, we're Ebola-free. There were a couple of families that we saw pretty much every single day, and one in particular stands out because it was a woman whose infant had died and subsequently tested positive for Ebola. So then the whole family was being monitored and traced. She was probably ten years younger than me. I think she was in her late twenties. Just the way that she was very matter-of-fact and—not friendly, but perfectly cordial with us and her husband as well and we would visit them every day, it just seemed like very normal, polite chit-chat. And then one day I sat with her with one of our Ministry of Health—or sorry, one of the

WHO consultants, but who was from that area and spoke that woman's language, and we just sort of sat with her and talked about her baby and what had happened. She opened up to us and showed us photos of the baby like two days before it died, and it had had a very fast progression, so it was the baby smiling and laughing and playing. She never broke down and cried. The WHO person and I were tearing up and everything, but she was just really like, I don't know, stoic or accepting of it, and I just remember thinking, this kind of strength is unusual. I don't know if it's just like—I don't know, people are just stronger there. They've dealt with more, I have no idea. But she sticks out in my mind. She was someone that I would've liked to stay in touch with, but—

Q: Yeah. Thank you for sharing that. Going back to that first family, was that early on in your first deployment?

Aliabadi: I don't remember. I think so. I think it was like a week into it.

Q: Like a week into it? Wow.

Aliabadi: I mean, the deployments aren't that long, right? They're four weeks.

Q: That's true.

Aliabadi: So things happen. A lot of things happen in that small period of time.

Q: Right. They're very intense periods.

Aliabadi: Yeah.

Q: Did you say you went in July or August?

Aliabadi: I think it was August 5th and came back a month later.

Q: In September?

Aliabadi: Yeah, it was early September. I could be wrong about those exact dates, but something like that.

Q: Okay. Was contact tracing something you'd had experience in before?

Aliabadi: No.

Q: What was that like then—just starting to pick that up?

Aliabadi: It's a pretty straightforward concept, but it's not necessarily easy to execute because, again, there's people letting you talk to them, people being suspicious, and all that stuff plays into it. The theory is simple, but the execution isn't. I always, just for me, especially with that first appointment, when we'd be out talking to people in the field it

would just be really hard for me not to immediately try to assume a doctor-patient relationship with people just because that's my training and where I'd been from. It's hard to push that away and not want to examine someone or like—you know.

There was an incident in that first deployment as well when I was with the same WHO person who was doing contact tracing with me where he was like oh, there's been a death in a prison and it's unexplained and we need to go investigate. We went up to the prison, and this was not in Conakry, this was in the next prefecture a couple of hours away. We go there, and talking to the prison warden or whatever they're called, I'm like, who did the person share a cell with? Can we examine them—or I wasn't asking, can we examine them. I'm like, "Who's the doctor or the nurse here?" They brought that person in, and I'm like, "Tell me the symptoms, give me some history that I can say yeah, this person probably had Ebola versus they didn't." The story was all over the place. It was hard to understand what really had happened, but I was like, "Did you examine the people around this person?" He was like no, they hadn't. My instinct at that moment was like, bring them in. Someone needs to examine them. I want to do it, but we're not supposed to do that. They told us no exceptions, we're not supposed to handle patients and touch patients and care for them in a clinical way. That was hard for me to let go of. But when I saw that it wasn't being done, it was just frustrating. What ended up happening is we just called MSF and were like, just please come, somebody needs to actually lay hands on these patients. [laughs] Not lay hands, but look at them, observe them, examine them. They did, and it ended up being fine.

Q: But when you look back, how do you feel about that? The prohibition on having that more doctor-patient relationship?

Aliabadi: I think it's probably appropriate. We're there as epidemiologists, not as physicians. I think if there was a mechanism for us to have been able to provide direct care, I think a lot of us—some of the EIS officers that I know I'm sure would've taken on that role. But I can also understand that CDC wouldn't want to get involved in potential exposure of its staff to Ebola. I can understand.

Q: You mentioned something also about when you're doing this kind of outreach in communities and contact tracing about community resistance popping up—not something unique to Ebola, by any means, but can you describe some of that and some instances where you saw that?

Aliabadi: Yeah. That first family that we went to with the two people that I mentioned that ended up dying three days later, the neighborhood chief called me after they found out that those people had died and there was contact tracing still going on in that family and more people were getting pulled in for observation or to the Ebola treatment units. He was like, "Can you come back? We really need help." I think what he wanted was supplies like bleach and specifically, he wanted gloves. But I was like, "We'd love to come back and do a training," just basic hygiene things or how to recognize symptoms. Sort of the standard training that was given to communities. So we organized something, but the day that we were going to go, there was a protest in that neighborhood and I

honestly don't know what that protest was in relation to—whether it was the community angry about what was going on with Ebola or something else, but we weren't able to do it. So that was very frustrating. I thought that with time those kind of things would decrease, but I'm not sure that they did. I was there in August of 2014, and then again at the end of December, January, February, and March of 2015, and then back September of 2015. In September of 2015, when we went out to do door-to-door contact tracing in the whole community, the community specifically told me, you shouldn't go because you have white skin and people are going to be very resistant. I was like, that's fine, I'm glad you told me that because I don't want to get hurt, but more importantly, this isn't about me, this is about this community, so I'm fine to hang back. But I was just surprised that a year and a half into this there was still such a distrust of foreigners. It wasn't even just me with white skin, it was also our fabulous Congolese FETPs [Field Epidemiology Training Program epidemiologists] who were there with us, and they were also wary because of language concordance issues and they're also foreigners, so some of us couldn't go into certain neighborhoods. I found that surprising. Because we had had such a presence in the country for so long.

Q: How do things develop during that first deployment through September? Are they staying pretty much the same throughout or do you see any changes going on?

Aliabadi: In terms of?

Q: In any respect, really.

Aliabadi: It was a really much better organized response in that time, obviously. It's sad if it wasn't. Teams were really well organized. I thought that the WHO and the CDC teams that were the epis were working really well together. I think our little infrastructure was working well. I don't know about things like communications. I just feel like there's something that we must have missed out on if a year and a half after all this had started and there was still so much community resistance, it just makes me wonder what could have been improved in the communication with the community side. I think that's probably for me the biggest question that remains after all of this. I'm not sure we have a good appreciation of what some of the people in Guinea actually—what their perceptions of us were and what their fears were and what we could have done that was culturally competent in connecting with them. I think there are different belief systems, maybe that plays into it. But I'm not sure we ever actually addressed those. That sticks out for me.

[break]

Aliabadi: We never got there. We never got to the point where we really—I don't think from what I saw—connected with people in a way that they felt comfortable sharing those things with us. Yeah, maybe some of it was ludicrous-sounding conspiracy theories and I think they were, but there are real fears that people have that could've been addressed. We always had anthropologists. On the last deployment that I was there they had anthropologists there, but I just don't know. One or two anthropologists, I'm not sure they could have—I think you needed a whole army of them.

[break]

Q: On that first deployment, when you're with—you said those three other EIS officers, Rupa and the others, did you have a lot of contact with them? Were you—I don't know—relating to them as fellow EIS officers in the field for the first time?

Aliabadi: We had all just met, so we didn't really know each other pretty much at all. But I think we got along. We had all had experience in the field in some way. I told you about my experience, Jennie had had a ton of experience through her previous work and she'd already been at CDC for a year. Rupa also had been with MSF and had had experience in the field, and the third one, I think he'd had field experience, but I'm not sure where. I think we were all comfortable being there. And we all wanted to be there and we all wanted to do the work, so that made it easy. Personality-wise, I think everyone got along. I think. But eventually they split us up because they needed people to go out to the frontier, the Forest Region that shares the frontier with Sierra Leone, and Jennie went out there and Rupa went out there.

Q: Right. And you stayed in Conakry the entire time for the first deployment?

Aliabadi: Yes.

Q: When you go back in—was it December of 2014?

Aliabadi: It was like the end of December, yeah.

Q: End of December, and was that second deployment through March or was that two different deployments?

Aliabadi: It was two different deployments. I went I think through February, maybe early, mid-February, and then I came home for two weeks, and by "home" I mean I went to Zimbabwe for my regular work job and then went back after that until mid-March. So it was split up by a couple of weeks.

Q: What were you doing in the second deployment?

Aliabadi: I was working with the infection prevention and control team. I mentioned that group Jhpiego. They were working with WHO and with MSF and with us and some other smaller partners to do trainings for healthcare workers at all levels for basic infection prevention and control in the setting of Ebola. For that deployment, I focused mainly on going to healthcare structures and either doing assessments to see what their practices were and where they were lacking or giving trainings.

Q: What did your assessments find?

Aliabadi: There's no compliance of any—I mean, have you ever visited any Third World country?

Q: I've never been to West Africa, but yes, I have.

Aliabadi: Have you ever had—well, where have you been?

Q: Let's see, I've been in Tanzania. I mean, it's not—Tanzania is more developed than some, but I've had at least one wild medical interaction in Tanzania but otherwise, just Central America and elsewhere in East Africa.

Aliabadi: Okay. I don't know what your Tanzanian medical experience was, but I feel like in a lot of places I've been in West and Central Africa, the clinics—I'm not talking about big, fancy hospitals, but smaller clinics and medium-sized medical structures and then even university hospitals that are public, don't have the greatest hand hygiene, use of clean surfaces, safe disposal of needles, safe transport of specimens or laboratories that don't have vials of whatever or smears from malaria just sitting out. Basically, stuff like that. If you're worried about someone coming in with suspected malaria, well, was that malaria or was it Ebola? Who knows? But let's just say you drew blood from that patient. You didn't wear gloves, you put a smear on a slide and it's just sitting there in the laboratory. Already, that's however many potential areas of exposure of staff. Things like that we saw all over the place and so we would do these trainings to hopefully try to change that behavior.

Q: So trainings on just typical, basic infection prevention and control?

Aliabadi: It was more geared towards Ebola, and Jhpiego—this is a huge project for them. They're in-country and they've been working on this. I think they had a general module, which is a pretty intense training that they were trying to do, but then in the setting of Ebola, it was more focused on Ebola I think. Since then they've probably expanded to just generic—not generic but general infection prevention and control.

Q: Right. Were there people you worked with from Jhpiego who especially stand out to you?

Aliabadi: Yeah, the woman who was the director. Basically, she's a woman from Guinea named Yolande [Hyjazi] who was just such—she was maybe in her sixties, I'm guessing. An OB/GYN [obstetrics and gynecology] by training who is just a badass. She was not afraid of being a woman and having an opinion and getting stuff done and I think she's just one of these admirable people that I aspire to be like. Through her agency, she had organized five-day trainings that were being done throughout the country by the time I was leaving.

Q: Any memories that stand out from that second deployment just generally?

Aliabadi: This isn't particularly unique, but we were in a neighboring prefecture close to Conakry, because we'd gone up there to investigate not a clinic, but a health post, a smaller, one-man-show kind of health structure where I believe it was a nurse that was working there or a nurse's aide, I'm not sure, had died from Ebola. We weren't doing the contact tracing and case investigations, but we wanted to sort of see the health post and do an evaluation of that facility. But when we went up there, I remember the WHO person who was the surveillance coordinator in the field there was like, we just drove up there and the villagers were throwing rocks at us so we're not allowed to go there. We weren't allowed to go there, and I was like well, that's a shame because that small health post, small as it was, was servicing a good catchment area of people that weren't as close to the capital of that prefecture and maybe couldn't easily come in if they had something that could easily be treated with an IV [intravenous therapy] or whatever they were able to offer. It was just shut down, and it was shut down for the rest of the time I was there. That just was sad in my mind.

Q: Yeah. What was it like traveling around more that second deployment?

Aliabadi: That second deployment I traveled a lot to that neighboring prefecture. I was still based in Conakry, it's like a two-hour drive. And I liked it. I loved getting out of the city. It's a very—it's a beautiful country. The landscape is pretty. I don't know, it was nice going out in the field. I wish I'd been able to go really out in the field, but by the time I had gone back, I think there was more focus on Conakry, especially at the end of last year for my last deployment.

Q: So doing all of this infection prevention and control, these trainings, were you able to see any results of your work? I know that's always hard to actually see it in front of you.

Aliabadi: No, I didn't see any results, but you have to remember that the things that we were trying to get changed is behavior change. It's like asking a physician, please wash your hands between patients, please wash your hand between patients. I don't think you're going to see change in that kind of thing in a three-month period. We would do assessments. With the trainers that we had trained, their role was to go out to some of the structures and do monthly assessments so that eventually we could go back and see hey, was there any change made? But I don't think it's realistic to expect anything even in a year. I remember when I was a resident, even in New York, getting people to wash their hands for some reason is really hard to do, and that's in our system. Behavior change is hard, but even outside of that, when you're in these clinics that yeah, you can tell somebody to wash their hands, but if it doesn't have running water. You have a second problem. Maybe they ran out of hand sanitizer because they had one delivery donated to them, but maybe they can't afford to buy more on their own or whatever. There's just so many other problems or other issues that I don't think we were going to be able to see a change in that short a span of time. But the team that I mentioned, Jhpiego, they were doing facility assessments as well I think every three months or something, so I think hopefully eventually, there'll be some report that they come out with or some indicators that show improvement. But during the time that I was there, I can pretty much say that no.

Q: I think that's an excellent point. Just because it's a response and you're trying to make as quick an impact in something that's catastrophic as you can doesn't mean that these issues aren't systemic and long-term. In fact, they most likely are. Yeah, I hear that. So at the end of your second deployment, you go to Zimbabwe, is that right?

Aliabadi: Yeah. I went to Zimbabwe for a rotavirus-related meeting.

Q: What's it like just spending time in viral diseases?

Aliabadi: I love my team. I love my job.

Q: Yeah?

Aliabadi: Yeah. It's fantastic. It's been really good, and most of my work has involved working with West African countries, Central African countries and Haiti, who are introducing this vaccine or who want to make sure that it's safe and that it's impactful, etcetera. So a lot of it is doing trainings and then working with countries on looking at their data and seeing if any of those things impact safety, etcetera, or how that's going.

Q: Any of the same West African countries that were most affected by Ebola?

Aliabadi: No, not the—

Q: Not the three?

Aliabadi: Well, I know that—I want to say it's Sierra Leone. I can't remember if it's Sierra Leone or Liberia, but one of them if not both have introduced the vaccine, but I haven't been working there. I usually go to the French-speaking places, just because our team is small so we sort of divvy up based on language. If possible, concordance. And Guinea hasn't yet introduced that vaccine. But if it does, and I hope it does, I would love to go back there and work in that.

Q: You would?

Aliabadi: In capacity—of course, yeah.

Q: Why would you love to go back?

Aliabadi: I don't know. I feel like it would be nice to see them trying to make a—it's real public health infrastructure, right? A vaccine program. It would be nice to see investment in that in this country that's come out of this crazy tragedy, and where their vaccine program probably suffered a lot. Because when I would talk to that woman from my last deployment whose baby had died and I was talking to her and she was like, we don't—she was like, I never took my baby to the hospital. It was I think nine months old when it died. She was like, it never got any vaccines. Not because she was an anti-vaccine person

but she was like—nobody did. Nobody wanted to go to the hospital or wanted to go to a clinic because we didn't want to get Ebola there. I think that they suffered a massive hit. So it would be nice to work on improving that infrastructure.

Q: Sorry, I took us in a bit of a digression in our timeline, but what did your third deployment focus on?

Aliabadi: Infection prevention and control, same thing. I went back that time as a team lead for that same team, but it was the same activities, the trainings and healthcare facility evaluations.

Q: Did being a team lead mean any practical difference for you?

Aliabadi: There's more meetings [laughter], presenting to the director, which is always interesting.

Q: The CDC director?

Aliabadi: Yeah. He came during that deployment, I believe, and met with all of us. So having to brief him. It just sort of makes you—I've always kind of only worked in the field, so I know the data that I have to keep track of and what's important at a very field level, very specific, whatever. But when you have to report, you have to know how to aggregate all this information in a useful way, so that for me was a different skill set.

Q: And then the fourth deployment in September. What brought you back so much—you know, a few months later?

Aliabadi: They kept asking me because I think it was always hard to get French speakers and unfortunately, that seems to go on. I don't know. They kept asking, and I also wanted to go back and I had a chunk of time, so it worked out. My supervisor was incredibly supportive.

Q: That always helps. What was your focus on in September?

Aliabadi: I was in the contact tracing and epi team again.

Q: That's right. You mentioned that.

Aliabadi: Yeah. It was nice to see how much things had changed in a year. Just how well organized and structured the teams were. But that was the deployment—during that deployment, the last couple of cases in Conakry, their contacts were being monitored so that eventually we could say hey, we're Ebola-free. They had also rolled out the vaccine, so that was also under development by then. I think Dr. Sakoba received the vaccine the first day that it rolled out, not during that deployment but in my previous one. I don't know how many people had received it by then, but in any case, that was something new. What they had wanted to do—the WHO leadership—was to do this thing where they

canvassed the entire neighborhood where these last few cases were. Do a—I don't know how many meter perimeter around the last couple of households and just go door-to-door and screen people.

Q: Was this in Conakry?

Aliabadi: Yes. We set that up and it was launched with the community. We went out and that was when they were like, we don't want you in the community, because they didn't want foreigners, understandably. But that was an interesting experience because they were basically going door-to-door and asking people if they had symptoms of Ebola and doing rapid testing, which was also new. I don't think any cases were picked up. It was like a three-day, massive undertaking. That was the last time. They asked me to go back again in January when those new couple of cases popped up, but it's too disruptive at this point to just take four weeks off.

Q: Yeah. Anything else you remember from that last deployment that floats to the top of your brain?

Aliabadi: Really just that woman whose infant died. We spent so much time with her and her family and they were always cordial. At the beginning, they were probably distrustful, but by the end of it—I remember on the last day when we said okay, you guys are free, you don't have to be monitored anymore, they threw a party. They did prayers with us, they were Muslim, which was nice, and I don't know, it was just—finally you

could like, shake hands. Not really, but it didn't feel like—you could tell that people were very tense and were trying to stick to the no-touching rule, but everything just felt much more relaxed. You almost felt like you were friends with them.

Q: You mentioned earlier also the Congolese FETP [people].

[interruption]

Q: Can you talk about that some more?

Aliabadi: The ones that have—I think they've been there the whole time, but the ones that I worked most with in September were these three guys from DRC who had been through the FETP program already, so they were graduates. I believe they all worked at the Ministry of Health, or work at the Ministry of Health. Apart from being hilarious and fun, they knew what they were doing. They were like, we've managed Ebola before. They were very sure of themselves, not wishy-washy, is that the word? They were not waffle-y. They were just very direct with people. Maybe a little bit too direct, but they were just fun to work with. I feel like I learned from them. It's too bad they weren't there earlier on. They had been there for a while—I think they had been there like for four months, but—

Q: Do you remember any of their names?

Aliabadi: Yeah. We're Facebook friends now. [laughter]

Q: Oh, all right, right.

Aliabadi: There was Jacques Katomba and Dieudonné [Lufwa], which is a great name. It means "God-given." I don't remember the third one, actually. I don't remember the third one.

Q: In what capacity did you work with them?

Aliabadi: We were on the same team. So they were also CDC. We went out to the field, we did investigations together, so the three of us went and interviewed the last case from that part of Conakry and they were both also clinicians. But it just worked well together. They would ask questions that I wouldn't think about, I would ask questions that they didn't think about and it was all—I feel like we all learned well. And then we would do the contact tracing and then call each other frequently and fill each other in on details and write reports together. It just felt like a real team.

Q: Looking back over your deployment, is there anything that we haven't talked about that you'd like to make sure we have on the record?

Aliabadi: I don't think so.

Q: No? Well, we've covered quite a bit.

Aliabadi: Yeah, we covered a lot. For me it was a good experience and I think just getting at that communication thing that I mentioned before. I feel like it'll be interesting if the communications people that have been there, or that if there have been communications people in there long-term, hear what they have to say and what they think is going on. Or people like—I should probably sit down and talk to Monica's husband and be like, "Your family's there and lives there. What do people really think?"

Q: It's a good final thought.

Aliabadi: Yeah.

Q: Thank you for being here.

Aliabadi: Thank you.

END