CDC Ebola Response Oral History Project

The Reminiscences of

Denise R. Allen

David J. Sencer CDC Museum

Centers for Disease Control and Prevention

2017

Denise R. Allen

Interviewed by Samuel Robson
March 7th, 2017
Monrovia, Liberia
Interview 1 of 1

CDC Ebola Response Oral History Project

Q: This is Sam Robson here at the CDC [United States Centers for Disease Control and Prevention] EOC [Emergency Operations Center] in Monrovia, Liberia. Today's date is March 7th, 2017, and I have the pleasure of sitting with Dr. Denise Roth Allen today to talk about her experiences as part of CDC's Ebola response for our CDC Ebola Response Oral History Project at the David J. Sencer CDC Museum. So thank you, Dr. Allen, for being here.

Allen: Thank you.

Q: Do you mind if I just start out by asking, would you mind saying, "my name is," and then pronouncing your full name?

Allen: Ok. My name is Denise Roth Allen, last name Allen.

Q: Thank you, perfect. And can you tell me what your current position is with CDC?

Allen: So right now, I am an anthropologist by training, my official position with the CDC is behavioral scientist. I work for the CDC in Monrovia, CDC office in Monrovia. It was established with the Ebola outbreak, so it's been in for a couple of years now.

Q: And if you were to give someone just a two- to three-sentence, capsule description of what your part was in the Ebola response, what would you say?

Allen: During the response, I was here for a very short period, about a two-month period, and during that time we did a rapid anthropological assessment of why people were dying at home. So it was to get an understanding from community perceptions of why people, if they were sick, would not go to an Ebola treatment unit. Why they wouldn't want to interact with the burial teams. We did that at the end of December of 2014. That was actually the decline of the—the epidemic started to decline. But that ended up—my contribution, I guess, was that.

[break]

Q: So you were working on malaria, and at one point, I guess, started hearing about Ebola going on in West Africa?

Allen: So when CDC set up the Emergency Operations Center, I think it was in July of 2014, then they put out a call through—there's a lot of Peace Corps volunteers, returned Peace Corps volunteers at CD—so they put out a call for social scientists through the

CDC listserv for returned Peace Corps volunteers. They also put it out through something that's—the acronym is BSWG, it's the Behavioral Sciences Working Group. CDC recognized pretty early on, we need social scientists here, and so they put out a call. Some people were restricted by work projects that they were currently working on, so I wasn't able at the initial call to go because I had other work obligations. But in September then, I said that I could, I would be available to work in November.

They sent me in November, and luckily, just by chance, another person that they sent was Romel Lacson, another PhD anthropologist at CDC. It was the first time in my history of working at CDC that I got to work with another anthropologist, like in day-to-day work, and it was so wonderful because when you're working around epidemiologists, you really have to constantly explain what you're doing. For us [anthropologists], small samples of people—that's a lot of data for us, where epidemiologists are working on big-scale studies, and so when you tell them you have a sample size of maybe even eighty people if you add all of your focus groups and individuals, that's like peanuts [to epidemiologists]. But it was really good to be able to—I worked daily with Romel while I was there, and it was just so great to be able to speak the same language with somebody and bounce ideas off [of] and think about—like, we actually worked on developing the, the rapid assessment, together, that was eventually conducted in December. Romel was there for twenty-nine days, and then I stayed on, I extended to carry out the study, so I carried that out in December. But we were doing participant observations, we were sitting in on the contact tracer meetings [during the time we worked on the Liberia Ebola response together].

We were going out with the Liberian Red Cross burial teams when they would go to pick up a body because unlike Guinea and Sierra Leone, in Liberia, for the big part of the first wave of the epidemic, people who died were cremated. That was just so against cultural practices in Liberia. But in August of 2014, there were bodies on the ground, there was no place to bury—I mean at certain times, they would take—you'd do mass burials in some communities, one of them was Johnsonville. One day, I don't know who it was, showed up with these bodies to do this mass burial at the gravesite without even contacting the community before. There was a huge, huge uproar [in the community], and they had to do something because [community mass burials] just wasn't sustainable. The Indian community in Liberia offered—there's a small Indian community, and they offered their crematorium in Marshall, right outside of Monrovia, on kind of the offshoot road on the way to the airport. And it was a very traumatic thing for people. In Liberia, Decoration Day, the second Wednesday of every March, is a national holiday and it is a day that you remember the dead, so you go to your deceased relative's gravesite, you clean the gravesite, you know, you're just remembering the dead. A big source of stress and anxiety was that we won't have any—if you take and cremate my family member, I won't have anybody's gravesite to visit, you know, that connection with my ancestor is broken. So that was a real source of conflict. It emerged—I think I didn't realize to what extent there was that opposition [to cremation]. Well, we did realize what extent there was opposition to cremation because we were going out with the burial teams, but when I first came into Liberia on like November 8th, I think we came, just getting a sense of what was happening. Over time, as we were going out with the burial teams—because what

would happen is the burial team would come, they'd get a report that there was a dead body in such and such community location, somebody in the community would report that or a family member who would report somebody had died. At that time, they were cremating [everybody], every single person who died no matter if they died of a heart attack or they died of Ebola, they were cremated. Then the burial team would show up to transport the corpse to the crematorium, and sometimes family members knew and sometimes the family members did not know the burial team was going to show up because they may not have called, it might have been a neighbor [who reported the death]. There was a lot of health education around if you see something, call 4455, which was their equivalent of the 911 call system. If somebody thought that a neighbor was sick and had a fever and possibly Ebola, they might call the 4455, and then what might happen is a health team would show up and strongly try to convince this person to go the ETU [Ebola treatment unit]. They would show up with an ambulance, sometimes with the sirens blaring, and show up at this house and take the person to the ETU. Initially, there was no communication between family members and their loved ones [in the ETU]. I mean you know, things were in chaos, they were just setting up these ETUs. So if your family member got taken away to an ETU, you never heard from them again. There was no way to call. I think it was MSF [that] ended up giving phones to people [who] were taken to the ETUs so they were able to be in contact with their family members. But the stage had been set, people's experiences, the narratives about what was happening at the ETU had already—people had had some experiences of seeing neighbors being taken away to the ETU and never returning. So that reinforced this narrative at the community

level that if you get sick and you get taken to the ETU or your child gets sick, you may never see them again. So there was a lot of pushback from the community level.

You know if you do see somebody sick, that is how they bring people in—they take them to the ETU to stop the transmission, and then a team of contact tracers will come in and interview those contacts [living in the community] and monitor these contacts twice a day for fever, to see how they are feeling, so they can stop the transmission in its tracks. But the flip side of this is that there was a lot of distrust in the communities, it was kind of neighbors informing on neighbors, right?. It was this environment of [informants]…How do you, you know, how do you get around that, because there was a real need, it was a crisis, you really did need to stop the transmission, but how it played out—so when we did this, the reason we did this rapid assessment was—and for me, it was that perfect marrying of epidemiology and anthropology. The numbers showed—epidemiologists from CDC came to Romel and I and said look, this is what we're seeing with some of the preliminary data from the Red Cross burial teams. And in November, they started to see a peak [uptick] in the number of dead bodies being picked up in communities and the number of those that were testing positive for Ebola. That's not a good thing, right? In the midst of an Ebola epidemic, you don't want people dying at home because that's how the transmission chain [continues]. So they wanted to know, why are people dying at home? Why are people not taking their loved ones to an ETU?

So then we did a series of focus groups. We did focus groups in two of the communities that were hardest hit in—

[interruption]

Q: Okay, you were saying that you did interviews in two of the hardest hit communities.

Allen: Yes, we did it in West Point and New Kru Town. And then we also wanted to get perspectives from a Muslim community, and so we went to a Muslim community within Sinkor and interviewed them because there was a lot of issues also, transmission through washing of dead bodies [among] people [who] were practicing Muslims because you bury within twenty-four hours—or not within twenty-four hours, by that night, and all the washing that goes on, the dead body washing that goes on there. We wanted just to get that perspective. That's the report that you said you read.

Q: Yeah, and it was a fascinating read. I have a couple of questions going back to the beginning. Did you originally come to Liberia before they requested that rapid assessment or as a result of it?

Allen: Yeah, I had actually done a study in Liberia right before Ebola, that February of 2014, as part of the—right before Ebola broke out—we did a, for the Malaria Branch, we did a qualitative study to do an assessment of mosquito net use. There had been a lot of, since 2008, there had been like four million nets distributed, but the recent survey was showing only fifty percent use of those nets. And when you think Liberia has a population of about four million, it's like the key question is what happened to those

nets? So we did a study in two of the rural communities, looking at what were some of the factors people weren't using [the mosquito nets]. That was my first research experience in Liberia, in the rural area. But I had been coming—the first time I came to Liberia was in '99. My husband is from Liberia, and he was doing his dissertation research. We weren't married at the time, but I came to visit him, and then we started coming regularly in 2009. So I've been, I had had some experience in Liberia already.

Q: What did you find in that earlier study about the mosquito nets?

Allen: It was interesting because there were—a lot of times—so, the big question was, are people not using the nets because they didn't get the nets? Or do they have the nets and they are not using the nets? Those are two completely different issues, and it was a combination of both, that there were a lot of communities that were missed, I think, during the distribution. There was a lot of misuse of nets. You would go and you would see classic misuses of the nets, but people said that those would be the misuses of nets from mostly with the old nets; I don't know if that's true. But it really, it shed a light on that whole distribution process. It's that the people that came and distributed the nets, they brought them [the net distributors] from Montserrado County from Monrovia, and there wasn't always a lot of interaction with the county health team or in the preparation part of it, so people weren't working together in the distribution thing, so I think that pointed out some of those issues.

Q: I appreciated hearing about how great it was to finally work with another CDC anthropologist after all these years. Can you describe, was it Romel?

Allen: Romel.

Q: Romel, can you describe him a little bit?

Allen: Yeah, he has done a lot of work around—he's currently now in Vietnam; he is working for DGHT, Division of Global AIDS—I think that's the acronym, DGHT.

Q: Division of—

Allen: of HIV, Global HIV and Tuberculosis, DGHT. He worked before in the TB [tuberculosis] Division, and he had done a lot of work with a project called Photovoice. It's a Photovoice project where you have people with TB taking pictures of their lives and issues, [then] talk about the experience of what it means to have TB through photos. So he worked a lot on that. I think that was actually before—you probably should interview him, he worked on that, and I think he was at CDC and then left CDC for a while and then worked on the Photovoice project and came back. But when he was here, he actually spoke with the Carter Center about the possibility of doing a Photovoice project for Ebola survivors. So he did a short training with the Carter Center here, and then I think from there on they carried the project on. There was some version of a Photovoice project among survivors in Liberia, but I haven't heard much about it.

Q: Interesting.

Allen: I don't know how far that got, actually.

Q: And there's also a third person listed as an author on the report, or a contributor, another contributor?

Allen: Oh, there's several. Amos Gborie, he is the manager of Liberia's National Emergency Operations Center. His life pre-Ebola was deputy director of environmental health. He actually just finished a fellowship at CDC in emergency operations center management, or the Public Health Emergency Management Fellows Program, PHEM, I think it is. He was manager of the operations center throughout the—he currently still is, but he was also the lead for—it's a horrible name, but the Dead Body Management Team, overlooking, you know, how do you manage the dead bodies. They need to be tested before they're buried, once they opened the national—there was cremation from August 4th to December 24th, and then they opened the national cemetery, so it was also these issues around safe burials, swabbing the dead bodies. Well, even during the cremation phase, they would swab the dead bodies and then test them, but he was the lead on that, one of the leads on that group as well.

Q: I'm hoping to hear a little more about your visits with the Red Cross burial teams. Did you go out with them on any trips?

Allen: Yeah, so initially, so when Romel and I worked together for a month, I'm going back a little bit, but part of our first thing that we did when we first got here, to get a sense of what the issues were, Romel went out with a team of epidemiologists to Rivercess County, which had a small outbreak there, and then I went out to Sinoe County with Joe [Joseph D.] Forrester, an epidemiologist, to get a sense of what the issues were on the ground. And Joe and I went to a community in Grand Kru County that had had several cases in this community where family members had been taken away, the family elder had been taken to an Ebola treatment unit in the capital city, a day's drive away, and they never heard from them again. So when we went to go visit the community, it could've gotten really ugly because we walked in kind of unaware that this had happened and that they were quite angry because they hadn't heard from their family. So that gave me the initial clue of the tension around family members, dead or alive, being taken away.

So then when Romel and I were back in [Monrovia], in addition to sitting in on a lot of the UN [United Nations] meetings, the emergency operations meetings, the incident management system meetings, we asked the Red Cross if we could observe the [burial] teams, and so we split up and each one of us went out for two or three days, we went two or three different times. And the first day that I went, the team picked up a body and immediately took it to the crematorium. So I, for me, it was just this awful, awful, emotional thing because we were in a community in [NAME DELETED]. And this family did not want to turn their deceased relative over to the burial team. They kept

saying, “Look, he has been bedridden for ten years, this is his nurse that comes daily, she changes his Pampers. This guy did not die of Ebola.” Which everybody was saying they didn’t die of Ebola, right? But he had not been out of his house for ten years. They did not want to turn over the body, they wanted to be able to bury him and give him a befitting burial. So the burial team, they can’t take the body, right?. They just say, well, you won’t be able to bury this body. This was on the weekend, and the Ministry of Health office that you need to talk [to for permission to bury]—so the thing at the time—sorry, I’m going back. If you could get a certificate from health facilities saying that your relative did not die of Ebola, then you were allowed at this point to bury your loved ones. So obviously, people were trying to get that certificate. So this [death] had happened on a Saturday, on a Friday or Saturday, they wanted to wait with the body until that Monday or Tuesday when they could get a certificate and have somebody testify in writing that this was a bedridden person. He was bedridden with—I forget what it was, for many years. So it was all this negotiation going [on] between the burial team and the family and other community members coming in. There was a crowd of about thirty people, a very heated crowd, about not wanting this body to be turned over. They were eventually convinced by a community leader who was saying “Look it, this body is going to stay now in that house, in a very hot house, and it’s going to get rather unpleasant, and you may not get that burial certificate.” So they ended up giving the body to the burial team. It was that body that I accompanied with the team to the crematorium. Here we left this emotionally-charged setting where people wanted their family member buried with dignity, to a crematorium, where there were—it was just so awful, very sad. I went into the crematorium, there were two machines there, they had his body in a body bag and put

it in the machine, and it just seemed so alienating. It was just very alienating. Here, this person with all of these loved ones now is alone, right, and then waiting to be cremated. Yeah, it was awful. And then also there, there were several drums of ashes that were marked, like October 2014, November 2014. They would put the remains of everybody together in a big [metal drum] to keep—with the idea that they were going to memorialize them later, but it was [organized] by month. So while we were there, we were talking to one of the guys there, that was his job to do the cremation. When the two machines were full, they would also burn funeral pyres on a bunch of wood and put the bodies on there. And he talked about he had dreams at night of bodies coming after [him]—he seemed really quite—had been severely affected by them. Helene Cooper has since written an article in the *New York Times* about this group of people, he was one of those people I think she interviewed. But for me, it was going from this family environment where they didn't want to give up their loved one and seeing, you know I just felt like "Wow, if they could see how this played out, they would just be further distressed." It was distressing. It was really, really distressing.

Q: Sounds like it.

Allen: Yeah, to see that.

Q: When you were that burial team, with that family, were you there purely as a witness or were you talking with the family as well?

Allen: No, definitely purely as a witness. I just stood back. I was watching them fill out the forms, they had to fill out all their forms, take all the case investigation, all the specifics of his illness. But no, I wasn't involved at all. It was truly the observation part of participant observation. It wasn't my place to intervene so much.

Q: Were there interviews that you had with the burial team members that stand out to you even today when you look back?

Allen: We didn't do structured interviews with burial teams. The work with the burial teams was really more just talking with people in the car on the drive there.

Q: Oh, okay.

Allen: We didn't structure interviews with the burial team, we did observations with the burial teams. Had we had a longer time, we would have been—that was our initial hope to also interview them, but we had to finish the data collection by a particular time because we were under an OMB [Office of Management and Budget] deadline, it just covered the research for a particular point of time, so we couldn't extend the study.

Q: Sure, but the feelings from them—

Allen: Yeah, a lot of them talked about coming home and not wanting to sleep near their—sleep separately from their family, or some family members not wanting them to

come back to the house while they're there. Not wanting them to be involved with the burial teams because they felt that they were putting them at risk. I think there's a mix of people's different experiences, some—it sounds like a lot of them slept separately, at least within the same house, but others didn't even go back to the same house. It might, would be interesting to do interviews with them.

Q: Were there other events like that, that visit with the burial team and the family, that were just especially impactful for you, especially vivid when you look back?

Allen: Yeah, they [the burial team observations] all had that level of intensity. For me, that was a striking one because it was the first one that I observed and because I followed it from the picking up of the deceased to depositing [him] at the crematorium. So that in itself. Yeah, they all—there was never not tension. There was never not tension, and it was stressful for the team themselves because you're coming into an environment, you don't know if you're going to be attacked by the family members. So their stress level coming into that was quite high. One of the teams I went with, they were really quite stressed about it, it would have been good if there had been some type of counselling for them. I think they did quote-unquote some type of counselling for them, but I think there was a high level—at least this one particular team seemed quite stressed out, arguing amongst themselves. There was one point I did actually intervene because they were all arguing amongst themselves in front of the family members and I did say something to them on the side.

Q: Be aware of their environment?

Allen: You have to be aware of your environment. Another one, we went to go pick up the corpse and they told us when we arrived there, "Oh, we were given permission to bury the body, and the burial team was on their way here." When we left, we found out that that wasn't true, that this family had gone and buried the body near a swamp. So then a burial team had to go back the next day and dig it up and then bury it someplace else. It was just all these stories that just—they're not pleasant memories. Liberia has been through a lot. It's been through civil war, all the horrible conflict there and through—it's just hard to convey what it was like to be an on-the-ground [witness] to that constant trauma that people were going through, just constant, constant trauma. And at the same time, reading a lot in the Western media about these strange African cultural practices, and it was like, "These are just human beings who've had a relative die and are traumatized by that." It was, yeah, that disjuncture was—yeah.

Q: I can imagine. By the time you were doing the focus group interviews with the community leaders and the community members, was Romel still part of it? Was he still—

Allen: No, he had left by that time. We developed the protocol together, but he had left by that time. He left, I think, mid—he left probably a week and a half before we carried out the study. He left just when we were starting to get IRB [institutional review board] clearance.

Q: That makes sense. Can you tell me a little bit about those focus groups, especially any specific memories you have?

Allen: Yeah. Yeah, I mean there is so much there that isn't even in that report. There was just so much. There was so much around people not believing Ebola is real. And it's true, people didn't believe Ebola was real. But one woman said, she said, "Those people who say Ebola isn't real is because they didn't have anybody who had died from them.[1] And we who have seen our friend human being taken away, carted away to the ETU," I'm paraphrasing now, "or carted away to the crematorium, we know that it's real." Basically, she's saying—and it is true, people started believing once they started being personally affected. So that's one thing. The distrust of the government, the level of distrust with the government was very, very high.

The other thing that I haven't—I don't think it comes out much in the report, it's kind of a separate issue, is how low paid these contact tracers were. These people were working from five in the morning to sometimes six or seven in the evening, every day, seven days a week, and they were paid one hundred twenty-five dollars a month. But they did it. They complained about the poor pay, but they still did it. They still did it. One hundred twenty-five dollars doesn't buy much in Liberia. For fifteen pounds of rice, twenty-five dollars—it just doesn't buy much. And this guy was talking about how he had to go to a

[1] Note from D. Allen, September 2018: This is Liberian English for they didn't have a relative die of Ebola. This is a quote in the report as well.

payday lender to make ends meet. He had to always get advances on his check just so his family could eat.

Q: Was this $125 in Liberian or US dollars?

Allen: US dollars. Yeah, they weren't getting much money. So there was this sense that, people seeing a lot of money pouring in, all of these partners, a lot of aid coming from the US government or other governments, and they were really the front—they truly were the heroes in a sense. They were there every day, going to people's homes, checking up on people, doing the contact tracing. That was also initially when they were imposing the quarantine, people were being quarantined in their houses without access to food or water or medicine. So a lot of people would not stay home, so it was trying to track them down. That was one of the things that I remember. When you do a focus group, really you should try to limit it to an hour. These focus groups were going on for two hours because you just felt like people wanted to talk and it was hard to cut that off. So they were very long.

Q: Can you talk more about that, just people's desire to talk?

Allen: Yeah, I think people wanted to be heard a lot. What was also interesting is they just wanted to be heard, they wanted their perspective heard, and at the end—this was a very interesting thing. At the end of all of our focus groups, I usually include a question, "Do you have any suggestions—is there anything else you would like me to know or us

to know, or you would like the government of Liberia to know? Any suggestions or comments?" So one of the focus groups, the first focus group we actually did with community leaders in one community, they took that so seriously and each one of them passed the recorder around for each person. Stood up and said, as if they were speaking to the government, "I would like to tell"—and people getting nervous, wanting to be sure they said the—not said the right thing, but they were addressing now the government so they wanted to be sure they spoke proper. They had all of their recommendations for what the government needed to do to improve, which ended up happening down the line. This was early on, and some of the suggestions that they had ended up being implemented afterwards. When we did this study, the national cemetery opened up like halfway through our study, so people weren't really aware that cremation wasn't still happening. They might not have been aware that it stopped effectively December 24th or 25th. So these things, to open a national burial site, stop cremation, those were things; to make sure that when people are quarantined, that they're given food; that the government, in the future, needs to develop a rapid response team so next time we have an outbreak, you've trained all of these people now, developed them into a rapid response team, so now anytime another outbreak happens, these people that have been through this, have worked on this and are qualified in some sense, you can draw on them. A lot of the contract tracers really felt, look, we've been working on this. Now a lot of them aren't working, don't have jobs, but they did really good work. Those would be the type of people that you would want to draw upon in the next outbreak. So those kinds of things. Open up the schools. Schools had been closed for a certain amount of time, they really wanted their schools opened. Another thing that came up was—and this was before the

first case of documented sexual transmission of Ebola that happened on March 25th, I mean they're pretty sure it was sexual transmission—people [were] concerned about, having heard about sexual transmission. Some of them wanting survivors locked up, so until they're safe, until these three months—because at that time, people had been hearing three months, men need to practice safe sex for three months. So fears around that sexual transmission, what did it mean, how at risk are we? Things that played out over the course of the next couple of months. But a lot of fear, a lot of fear, a lot of trauma.

Q: One thought that comes to my mind is, was it at all uncomfortable when you had this project study, which you do hope is going to affect the response, but people are taking it so seriously that they were talking to the government—because in a way, it's not directly to the government, it's to you—

Allen: It's not directly to the government.

Q: —and to this study. How do you manage expectations, I guess is what I'm trying to say.

Allen: I think they're talking to the government in the sense that Amos was a co-author. Amos was—he helped with the development of the protocol, with the questions, you know, with the analysis. He is the "dead body management guy." He is hearing these things. So in that sense, the government did hear. What I would like to do is do a separate

write-up on people's recommendations on what—you know, actually, I just learned there's an anthropologist who just published a book on Ebola. I haven't read the book so I don't know if it's just Sierra Leone specific or if it's for the West African epidemic in general. I just heard about the book so I'm going to get it. But he's talking, I think he's talking about people's recommendations as well. So I would imagine that he found those same kinds of things. Like people being these peasant intellectuals or scientists or these peasant epidemiologists. I'm saying it in a sense because there's a book by a historian called *Peasant Intellectuals*, it's written in Tanzania, just talking about knowledge, local knowledge. I imagine at some point—just to document it for Liberia, for their history. The other thing that came out of this for me was that it was really hard to find people, Liberians, who had been trained in doing qualitative data collection and analysis. So there's a real [need for] capacity for that so people can research their own history, right? That they can be the researchers, not have to depend on outside researchers coming in. So I'm hoping—not hoping, I'll be teaching a class at the University of Liberia next semester, spring semester, in qualitative field methods. One, it's a good skill for them to have, they can do their research. But also, just practical in terms of job opportunities. It's a skillset that they could benefit from having in terms of there are researchers coming in that produce their skillset, but they themselves can be the researchers of the issues here themselves in Liberia. I'm hoping that goes well.

Q: There was something that you said in the report that I found striking, and that was when you were talking about—you learn that people, of course, were terrified that calling

4455 and having someone come and pick up their body or their loved one, their sick one, and then they get sent away—it might be the very last time they see them, right?

Allen: Yes.

Q: Maybe it's the best thing to do for their health, but also it's this huge, huge decision.

Allen: Yes. Yes.

Q: The thing you said in the report was, and we can imagine, when we put ourselves in their shoes, that for us, that would be an impossible choice too.

Allen: Imagine, I mean, imagine somebody—I don't have children and I don't know if you have children—

Q: No.

Allen: Imagine somebody coming and taking your child away. Imagine that and know that you'll never see this, or the likelihood of you seeing this child again. Imagine. I mean look what happened in the US for the one case, look at the resistance to the one case in—well, the one initial case in—

Q: In Dallas?

Allen: Yeah, in Dallas.

Q: Yeah, you're right.

Allen: And then the nurses then got sick. Look at that, the fear. It's a fearful thing.

Q: So I guess what struck me about it was just the empathy with which you approached this subject. Would you mind just talking a bit about it, like the role of empathy in your work and specifically on the Ebola response for you?

Allen: Yeah, I guess I don't think about it, the role of empathy. I mean I don't think of empathy as a role kind of thing. At the end of the day, you're just humans. It's just really a human emotion. Anybody would feel that way in that situation. If you're there, it's like—I guess I don't think of it as a—I never thought of it in, what is the role of empathy. I see what you're saying, but—

Q: It's not like a discrete part of the study—

Allen: It's not a discrete—"Okay, now I'm going to put my empathy hat on." No, I get what you're saying, but yeah, I don't see it as something separate. I guess I do have to say though, I didn't realize going in, saying we were going to observe the work of the burial teams—Romel and I did that initially, and then I did two days of that during our

study. So by that time I had seen—by that time the tension had decreased a little bit because people were now being offered the ability to be buried, so some of the tension had decreased a little bit. But going into that first one, I didn't know really what I was—I didn't know that arena of emotion because that was the first time I had ever seen that. Other than—well, I had a piece of it actually because when we went to Grand Kru and visited that family who were quite angry. The one that I told you I went with Joe in Sinoe. We went up there, and they were quite angry, and there were a lot of youths around that were also quite angry and quite vocal. And it was starting to get a little ugly, and then Joe said, "Please have my condolences for your loss." Because their elder family member, one of their family members had died. And that dissipated things a little bit, that you were able to say "Look, I'm sorry for your loss." That kind of decreased the tension a little bit, but not a lot. So that was my only experience before going on the burial teams that oh, this is a really emotionally charged atmosphere.

Q: That makes sense. Well, is there anything about your part in the response, your study, your work since, that I haven't asked about that you'd like to have on record?

Allen: You know, all I can say is that the resiliency of people—I feel like Liberians have been through a lot and then come out of it. Live they've survived it. The civil war was horrible, the Ebola was. Moving forward, there's a resiliency there despite all of the deaths and moving on—yeah, you have to admire that resiliency. And you have to admire people working from five in the morning to seven o'clock at night, seven days a week, for one hundred twenty-five dollars a month.

[break]

Q: I just want to thank you, Dr. Allen, for your time, doing this interview, the passion that you put into your work. I appreciate it.

Allen: Good. Thank you.

END