CDC Ebola Response Oral History Project

The Reminiscences of

Charles Alpren

David J. Sencer CDC Museum

Centers for Disease Control and Prevention

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Charles Alpren
Interviewed by Sam Robson
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Interview 1 of 1

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Q: This is Sam Robson with Dr. Charles Alpren. This is Tuesday, October 18th, 2016, and we're here in the CDC [United States Centers for Disease Control and Prevention] audio recording studio at the Roybal Campus in Atlanta, Georgia. I'm interviewing Dr. Alpren today about his experiences with the Ebola epidemic. This is going to be a really neat interview. Different from most of ours, because Charles isn't one of your typical CDC epidemiologists going over there. I'll let him explain. Charles, can you start off by just pronouncing your full name for me?

Alpren: Charles Alpren.

Q: Great. Thank you. And what is your current position in the world? What's your current occupation?

Alpren: My current main occupation is that I work as a consultant for the CDC Sierra Leone country office. Within the country office in Sierra Leone, I have a responsibility for giving technical advice on Ebola survivor care, on transition of treatment and healthcare into mainstream health facilities that was delivered in Ebola facilities, and on emergency preparedness.

Q: Great. Thank you. As succinctly as possible, if you were to give someone a two to three-sentence description of what you did during the epidemic, what would you say?

Alpren: I started as a doctor in a treatment center, and then I went more into public health coordination and case management, and then towards what I'm doing now.

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

Alpren: I was born in North London in the UK [United Kingdom] on the 18th of April, 1974.

Q: Did you grow up there?

Alpren: Grew up in North London, then went to school right in the middle of the city of London. Went to university. I should say, I use the word "school" and "university" like the British do, so school until eighteen and then university from eighteen to twenty-three, medical school up in Leeds in the north of England, then came back down to the southeast to work as a doctor.

Q: What was your household like? Who was in your household when you were growing up?

Alpren: Both my parents, and I've got a brother and a sister, both younger. My sister's three years younger, my brother's seven years younger. Northwest London, Jewish family. We were really lucky that the three of us all got fantastic educations, lots of opportunity to go overseas. We went to France most years. We were encouraged to learn in whatever we wanted to learn in. I was musical at school. We had to make sure we did our homework and did our exams. Then I got off to medical school, and then yeah.

Q: Yeah. What did your parents do?

Alpren: My dad was a lawyer, and then shortly after I went to medical school, he actually changed his job. My mom was a secretary within various, different firms when I was growing up, and a mom.

Q: When did you know that you wanted to go to medical school?

Alpren: Probably it was around fifteen, sixteen. There was a clichéd answer as to why that you always give at a medical school interview that you've always been a scientist, but you thought that—which is kind of true, but my best friend, his older brother, was getting into medical school. I was good at the medical school subjects at school, and it seemed like a good job. My dad, as a lawyer, had what looked to me as the worst job in the world, just piles of paperwork everywhere and not seeing people, and not having guaranteed—there was a recession at the time, and he didn't have guaranteed work, and doctors do. So I went to medical school.

Q: How was medical school?

Alpren: Amazing. Incredible. Loved it. Socially, it was the time of my life, where I worked out who I was to more—you know, within those five years, more than any other five years of my life. And became me more than I ever had before. I think at school, I was far more staying within the lines and doing what I needed to do, whereas university, I was given some freedom, which meant the first year, I failed everything, [laughs] because I was having far too much fun. I managed to pass re-sits in the summer and got on with it. But yeah, school, university medical school was tremendous fun, and once I'd got through the first two years of the preclinical work—it was an undergraduate degree that I did, a five-year medical undergraduate degree. The first two years were preclinical, which were desperately boring and academic, and I hated it. That's why I failed. Once I got into the third year, the clinical bit, I loved it. I loved it. It was what I wanted to do. Seeing patients, learning about disease, talking to people, working out what was wrong. It was great.

Q: So it was the interactions with people and the kind of investigative side of things that drew you?

Alpren: The interactions with people, especially. And the investigative diagnostics, to a certain extent, but for me, interactions with people, chatting, getting to know people,

understanding people's lives, priorities, stories, agendas, understanding of their illness, all that kind of stuff.

Q: Was there a specific area of medicine that attracted you?

Alpren: At medical school, probably not so much. I really enjoyed psychiatry. I enjoyed the talking ones. I enjoyed general practice. When I started to work with a doctor, it was very clear to me early on that I wanted to know about people. I also felt that for myself and my own sanity, I wanted a job where I didn't define myself by my job. I wanted there to be time to be someone else as well as a doctor. So I went—very quickly, I went into general practice training after my intern jobs.

Q: What happened then?

Alpren: I did some hospital work, worked in a hospital in Northwest London, which was hideous. Really busy. Really stressful. Not particularly well supported in a couple of jobs. Halfway through my general pra—that was all part of structured general practice training—I saw a job in the British Medical Journal saying, do you want to come work in Sydney, Australia, for a year? And you get it accredited to your UK training? I was like, yes, yes I do. I want to be in Sydney in 2000, the Olympic year. Off I went to Sydney for 2000, where I worked in emergency and psychiatry. Had a lot of fun. That was great. Went back to the UK, finished my GP [general practice] training with GP registrar jobs, etcetera. Pretty soon after getting back from Sydney, I thought—I think that life could be

better in Australia. I think I want to live there permanently. Having finished my UK GP exams, in 2003, I moved out with my wife to rural New South Wales in Australia.

Q: I think we're going to have to pause for just a second.

Alpren: Sure.

[break]

Alpren: So we got to Australia.

Q: Australia, 2003. Is that right?

Alpren: Yeah. In order to move out to Australia and work full time wherever I wanted to, the rules at that point—and they're pretty similar now—is that as a GP, you had to work for five years in an inland, rural area before the bureaucracy allowed you the relevant number to work anywhere you wanted. I went to a small town called Mudgee, which is about three and a half, four hours' drive from Sydney. Wine country, agricultural, coal mining. Worked as a rural GP obstetrician, where we did the general family medicine. We also did emergency and obstetrics for five years, which was fantastic for my work, and for my experience. I'd done my general practice training in London, and my GP registrar jobs in London. This was far broader. We were doing much more of the—we were taking things much further before referring, because we didn't have the specialists

and resources to refer to. We were doing emergency work, we were doing the obstetrics, delivering little babies. I learned a huge amount. I was in a good practice with supportive doctors. I was very lucky in that respect.

However, I'm not a rural boy, I'm a city boy. So pretty much on the dot of five years, I moved to Melbourne, where I worked as a GP, as a family physician in a suburb of Melbourne called Hampton, which is on the bay by the sea—just out about ten kilometers, fifteen kilometers out of town.

Q: Can I stop you for just a second?

Alpren: Yeah.

Q: Up to this point, when you look back, can you think of an interaction with a patient—or a few, even—that kind of shaped your work, that was especially memorable to you?

Alpren: Well, I can think of—so from Mudgee, I had one near miss of a woman who nearly died in childbirth, which shook me up a bit. She was a most lovely woman. First thing when she got back to town, the first thing she said was, "Where's Charles? Is he okay?" I was like, are you kidding me? [laughs] I still remember her name and her daughter's name, who was delivered just before she tried to die on me. That, I remember. I remember, obviously, the emergency, and I remember getting everybody in to help. The story was that there was a meeting going on at a local school, a parents' meeting at a

local school. When this emergency happened at the hospital, I turned around to the nurse behind me and said, “Call everyone.” She started by calling the people on call, and then she went—she literally went down the list in this—and people came a lot quicker than we thought they would, because what had happened at this meeting was that the first person’s phone had gone off, and then the second person’s phone, and then the third, and then they said, okay, something’s happening, let’s stop this meeting, everybody go. Oh my God.

What else? What other things would you appreciate from my practice? Of course. I was interested in and involved in mental health work, psychiatry. There was a psychiatrist who would visit town every few weeks, but they were very overworked. I remember one day in the corridor, the head of the mental health team, community mental health team nurse said to me, “You should really come up to the community center and do some work up there. We’d love you seeing all these psychiatry patients.” And I’m like, “I can’t. The rules say I have to work from this building—but you could come down here.” From that, we built this clinic where every few weeks, you would just put me up for a day, and I would see the patients that she wanted me seeing and would work together in the same room. It worked so well. It was phenomenally good. It freed up the psychiatrists to do what they—it was fantastic. That was really the big thing that I did there clinically, set up that practice. It continued, and one of my colleagues took on that clinic after I left and then built it up. They set up a community garden for the people with severe mental illness to be working in. It’s just kind of developed and blossomed, and that’s a really cool project that I was involved in.

Q: Wow, wow. That last one was in Melbourne, or back in—

Alpren: That was in Mudgee.

Q: Oh, that was back in Mudgee?

Alpren: It was all in Mudgee. And then going into Melbourne, the thing that—Melbourne was a—the practice I had in Melbourne was many young families. That meant a lot of vaccination work, and a lot of vaccination communication work. Something that has actually followed my career, in that it started during my intern year, is the measles-mumps-rubella vaccine scare, MMR scare. That started with a press conference that I think was in February ’98, which was just in the beginning of my second six-month job as an intern. It’s kind of followed me through. The Royal Free Hospital, where that press conference was, was the local teaching hospital where I grew up in North London. The big bit of initial vaccine hesitation that came from that was in North London, where I was doing my GP registrar work. I was struck when I was doing my GP registrar work about how we were taught to communicate with patients who were hesitant about vaccines by referencing the official body advice, the Royal College of GPs, whatever they’d say. The Royal College of GPs say this, the Royal College says this. And it wasn’t ringing true for me. I remember doing it, I had my spiel that I was taught, and we would say, “This is what you do.” If you have an exam, then you have to say what you would do, this is how you say it. But it wasn’t ringing true for me.

When I was in Melbourne, I was speaking to another friend, and she said, “Own it.” And I found that when I owned it, when I said, “Look, this has followed me through my career. I have read the research, I have looked at the papers, I have looked at the product information and the papers that have been published behind that product information. The more and more I learn about this, the more I know, the more confident I am. Not the more hesitant I am, the more impressed I am about what these things do. These are extremely valuable, extremely safe, and extremely important parts of healthcare, vaccines. I strongly recommend them to you. They’re not risk-free, nothing is, but there is a far higher risk of not doing this than doing this.” And when I owned it, the change in the effect of the communication was massive. That inspired more of an interest in vaccination, which developed into more of an interest in public health. Now, I can start to see where the whole public health thing is starting to come into it.

Q: Yeah. Tell me about that.

Alpren: I did a lot of teaching, and I did a lot of vaccination work. Got to work with young families, and was just more and more interested in vaccinations. Eventually, I thought, you know what? Actually, I think I want to change from—so I’ve been in general practice. I think I want to work in some kind of vaccine program delivery or something to do with larger-scale public health programs. I spoke to a few people about what to do, and they all said, yeah, that’s great, love to have you on the team—you need an MPH. You need a master’s in public health degree. You’re an experienced clinician,

and you clearly got it, and you can do it. But there are some hoops you've got to jump through. Which was fair enough.

What I decided to do, rather than enroll in an MPH in Melbourne that I would have done in four years or whatever, and then at the end of it, I'd have had an MPH, I'd have had a practice. It would have been very easy to just kind of roll on in the same thing and be on this committee or that committee, not really force my hand. I thought, no, I'm going to force my hand, I'm going to leave my practice. I'm going to pay the bills by doing rural, locum work, because I had this experience from Mudgee which meant that I could do emergency medicine as well as the more standard suburban family medicine. That's well paid, so I could go for a few weeks into the countryside, be the solo doctor for a town of one thousand people, and then come home, do some study for a few weeks, and then go away again.

Right. Brilliant idea. Set it all up, it was all systems go. Went away. That was in July 2014. I'm going to backtrack a little bit to the 18th of April, 2014, which for those paying attention from the first thing I said will know that was my fortieth birthday. That was the first conversation I had with a friend about Ebola. I remember, because it was my birthday party, my dinner that I had. It happened to be Good Friday, so everybody had a four-day weekend. We had a party. We were talking about this—it was one of the biggest outbreaks of Ebola that I'd known. There were about sixty cases. I think there might have been forty or sixty cases at that point, middle of April. They weren't totally sure what countries it was in. They were pretty sure it was in—they knew it was in Guinea. I'm

pretty sure they thought it was in Liberia as well, and they thought it might be in Sierra Leone, or they were scared it might be. It certainly wasn't officially in Sierra Leone. Then we had that conversation, and it's like, yeah, yeah.

Then in July, there was more—it was definitely—it was growing when I left my practice. One of the reasons I left was I really wanted to go out. I felt that I had an interest and expertise in infectious disease that I'd got from the vaccination interest that I had. I had experience in emergencies, I had experience working in rural remote areas, I had the social and financial setup that allowed me to kind of, if I really wanted to, drop everything and go somewhere. No kids. I really wanted to. But I couldn't. Because MSF [Médecins Sans Frontières], who were the only people really doing big response at the time, you had to have an MPH to go anywhere near them. They wanted you to do a nine-month tour the first time you joined MSF, and they wanted people with MSF experience at least, and preferably Ebola experience, to go out to the level of the response as it was at that point. I couldn't get in, it was very frustrating. Then about a week after I left my practice, the outbreak exploded. It became clear that Ebola was heading towards Freetown. I threw my CV [curriculum vitae] at anyone who would catch it to try and go and work as a doctor in West Africa. That gets us to Ebola. [laughs]

Q: That gets us to Ebola. So who got it?

Alpren: One fateful Wednesday morning—this is the storytelling. [laughs] I find things happen two days after you've decided they're just not going to happen, and you need to

get used to this life when what you really wanted to happen hasn't happened. Sure enough, two days before, I'd had a conversation with my wife about how my whole experience of really wanting to go to West Africa but not being able to get there had really crystalized in my mind that I wanted to do it, and so I wanted to be in a position where if it ever happened again, I could do it. Two days later, I was sitting on my sofa in the middle of the afternoon—I should have probably been studying—with my iPad next to me, when the notification chime chimed, and the notification—I looked down at the screen and it said "West Africa ops" [operations] selection thing, and I was like, hello, what's happening here? It was an email from an organization called Aspen Medical saying they are going to be providing an Ebola response on behalf of the Australian government, and they wanted me in Canberra for training in three days' time. So I sort of got up and I got to Canberra. [laughter] And I had a locum starting in three days' time. I think that email came through on a Wednesday or a Thursday, and I had to go up to my next locum on the Sunday, and I needed to go down to Canberra on Tuesday. It was crazy, but my locum agency was really—they knew that I wanted to do it, and they were really accommodating. They were fantastic. They really didn't need to be.

So I went up to the northern New South Wales on the Sunday; worked on the Monday, which was the busiest day of the week; drove from northern New South Wales down to Canberra, which is about a nine-hour drive on a Tuesday; we had training Wednesday, Thursday, a bit of Friday; and then I drove back up on Friday night. That training was—we were told that the Australian government had decided that they were going to provide an Ebola response through this private company. And had paid commission—

Q: Through Aspen Medical?

Alpren: —through Aspen Medical, who they had commissioned to run an Ebola treatment center. It was one that was being built as a part of something called Operation Gritrock, which was the UK military word for what they were doing, and building a few ETCs [Ebola treatment centers] around Freetown and Port Loko. One of the ETCs that was being built was going to be run by Aspen. The first deployers went out that Friday immediately after the training, and they went out to set up the ETC. As far as I can tell, the UK, the Royal Engineers from the UK Army built these massive tents, which you see in the photos of Ebola treatment centers. They put the concrete slabs down, built tents, laid it out, did the fencing, put the plumbing in and the wiring and everything. Then there were some shipping containers full of the first stores. The first deployers went out, employed the local staff who were employed, selected them, trained them, did some training themselves at one of the MSF things—ETCs, and they then set up the hospital effectively. I went out a couple of weeks later, just before we were ready to take on our first patients.

When I got there, we hadn't got any patients yet, did a couple of days of training on PPE, personal protective equipment, how to put it on, take it off, walkthroughs. It was interesting then, because of course, we didn't have any patients. You could do a walkthrough of the red zone, which you could never normally do. You could take your camera into the red zone, you could really walk through and understand it with no PPE.

I've got a photo of the people taking off their PPE, because they were drilling, they were going in and doing it properly, but just knowing there was no Ebola in there—from behind, which you'd never normally take that photo, of what it actually looks like. It was kind of—looking back on it now—kind of cool, because you'd certainly never be able to do that.

Q: And this is—

Alpren: That was middle of December, 2014. Now, we started to open—we open pretty slowly, just taking a few extra patients each day. But our senior medical officer knew—she had been working in Liberia, in an ETC for MSF, before coming out with Aspen. And she had been working with someone who is now the senior medical officer at an MSF Ebola treatment center in the middle of Freetown, at a place called Prince of Wales School. They'd been open for two weeks. They'd opened very quickly, in a very MSF, aggressive style. They were understaffed, and very, very busy. She said to me, "Will you be interested in going to the MSF place for a while?" I was like, "Are you kidding me? That would be amazing." And so basically, my first contact with—no, strictly speaking, it wasn't my first contact. We got our first patients in Aspen, we had three patients. I did go into the red zone there with the SMO [senior medical officer], and saw treatment and understood, and took my PPE off carefully and knew how to do that. And then the next day, me and one of my colleagues went to the MSF facility in the middle of Freetown, which was heaving. I mean, it was—it was what everybody thinks of when you think

Ebola treatment center. It was very busy. I'm not even sure where to start describing it. I was there for a week over Christmas, 2014. Then I went back to Aspen.

Q: When you think back on it, are there images that rise to your consciousness?

Alpren: Yeah. For the MSF place, there were certainly a few. There's eight people piling out of the back of one ambulance who had all been triaged at the hospital as potentially having Ebola, put into the back of one ambulance and sent down to the Ebola treatment center for isolation and testing, when probably only one of them had Ebola. But they'd all been sitting in the back of the ambulance for an hour or so. That was resources. They were not in any way negligent or anything. That was resources, and numbers of people who were sick. I remember very clearly, we had a sick child come in, febrile, child with a fever and dehydration, was very sick, who needed admission, potentially had Ebola. He didn't, he had malaria. But he had honest parents who took him down. He was really sick, and I remember us trying to hydrate him. We weren't able to get a line in, and just basically syringing oral rehydration solution to the side of his cheek, just kind of two mils [milliliters] at a time, and getting it in and giving him malaria treatment. And he got better. He got better treatment than he would have done at many of the hospitals. But his parents had to leave him at the gate. It was like, yes, your son probably has Ebola. You can't come in. You don't have Ebola, you are potentially a contact, but your son does, he's got to come in. You can't come in.

Yeah, of course, the memories are coming back now. A girl, a nine-year-old girl was brought in by a man wearing gloves, wearing surgical gloves, saying he was her uncle. And something didn't ring true. It just didn't work out. He didn't have the right information about her name, about her age, about—you know, it just wasn't—there was something dodgy going on, and we couldn't work it out. He was worried about her. He said she'd vomited. She looked all right, she didn't have a temperature, but there was something weird. Then I remember, I was—I would have been twenty meters or so down this long row that we had, a row of fencing which we would talk across to the people who were in the triage area. I was about halfway down that. About twenty meters up, our district surveillance officer was just standing there, and I was kind of talking quite loudly to this guy. I said, "What's the address?" He told me the address, and the district surveillance officer shouted down, he's like—I can't remember what the address was, but he shouted down that road, "She's coming in." We'd had—the whole family had worried that was a hotspot. That was a hotspot household, and it turns out one of her siblings and her mother were in the Ebola treatment center already. This was a community member who knew that this girl was from a hotspot household and had seen her vomit, and put on gloves, and walked her down. And didn't really know anything about her, but kind of knew—and he didn't want to say it like that. I think he probably didn't want to be a contact himself. He disappeared, she came in, she survived. Yeah, that really kind of brought it home to me.

Q: Can I ask—that conversation with those parents of the kid who ended up having malaria. Is that a conversation that you had to have with him?

Alpren: Mm-hmm. Yeah. And it was really—it was quite—there was a rule. There was no negotiation. This is how it is. Like, not only do you have to leave your son—not only can you not come in, rather, but you got to leave your son. Like, I'm sorry, but now we've opened this Ebola box. And once you've opened it, you only shut it in one way. You shut it with testing. You don't shut it by saying, you know what? It's all right, we'll take him home. Now, we couldn't force that on people in reality, but had they gone, we would have notified the District Ebola Response Center and said that there was this family, there's a suspect case in the community, and they would have gone to their home. It was bad. Leaving your kids at the gate. Crazy. It was, like—and I didn't—I didn't appreciate that about Ebola until I got there, that that kind of more personal aspect of what isolation really—the implications of isolation of cases. There are those. And I remember going into the treatment, you know, the red zone. And normalizing it. Putting in IV [intravenous] lines, breaking the spell of it.

There's a big—people are talking. Should we be putting intravenous lines up? My opinion on it was definitely yes, no question about it. You give the treatment that you can give to these patients. That's going to make a difference, that's what you're there for, you're a doctor, you're a nurse. You've gone in to do that. You've accepted the risk. There is a risk. You get a needle stick, a dirty needle stick from Ebola is an extremely, extremely bad thing. But you've accepted that risk by deciding to work at the ETC. If you're not happy with that risk, then that work isn't for you. Another opinion is no, you're there to do what you can, but does intravenous resuscitation make that big a

difference? At this stage, this is 2014, that was the debate going on. To me, I was like, of course it does. Like every other condition, aggressive rehydration—if it has anything to do with dehydration, aggressive rehydration is good. So yeah. So putting the first IV lines in that I did was good. It just felt like, this is another condition to treat. And that's [unclear]. Yeah. That was the MSF place.

The other thing I remember from the MSF place is it was on this big playing field by a school. Huge place. The MSF places, they put a load of gravel down on the floors rather than putting concrete slabs down, and laid the gravel on the ground. Then they put the tents up. They had the kind of administrative tents quite a long walk away, probably about one hundred meters, over gravel that you were wearing gumboots to walk, quite a trudge in the bloody hot to get to triage. On Christmas Day, I was walking back. It was a quiet day, while I was walking back across the field from triage to the administrative tent. You could hear Christmas carols being sung at the church across the road. It was really quiet, and you could just hear this Christmas carol music wafting over the whole ETC. That was really the noise, was this dim, distant Christmas carols. It was kind of profound. It was a beautiful moment.

Q: Did the patients notice?

Alpren: I'm sure they did. I'm sure they did. Yeah, they were—I wasn't around them at the time. I was just kind of on my own. But yeah. I remember that.

Q: All of that is so vivid. Thank you. So you're at MSF for about a week, is that right?

Alpren: Yeah, a week. It was a training week. It was kind of, hey, MSF, we can give you a couple of doctors if you can give them training. It was certainly working, definitely. And then back to Aspen, by which time it was getting busy. We were getting a full red zone—full confirmed ward, rather. I think at the maximum, we had thirty-five-ish patients at any one time. The one thing, the thing that I think I would want to—the message I would want to convey most of all about what it was like working in the red zone, is not how impersonal the PPE made it, but actually how personal it made it. Because Ebola is very isolating illness. The moment the Ebola box is opened, you leave your kids. You don't touch your children. You don't touch a dead body. You cannot touch, you cannot go near a sick person. One of the most instinctive things is to care for someone who's really sick. Just to even hold the hand, or to mop their brow, all that, you cannot do. Someone's got Ebola, you cannot go near them. And PPE, the only people in the world who could crouch down and clean up someone who was having profuse, like, ten liters of diarrhea every day, uncontrollable water coming out of them, the only people who could crouch down and clean the sheets and change their clothes and wipe them down and wipe their brow and give them a sip of water were the people wearing the PPE. So actually, it felt really privileged, and it felt really close. It was the most intimate patient care experience I've ever had. It was crouching down with a—this fantastic Sierra Leonean hygienist called Princess who—she did not take any shit. [laughter] If she wanted to spray your shoes, even if someone's like, "Why are you spraying my shoes here, Princess?" She's like, "No, Charles, stop! Shoes!" It's like, okay, whatever,

whatever. But because she cared about the people she was in there with, she cared about keeping things clean, she cared about doing things right. We did a ward round together, and we did it efficiently, we did it well, and we were going well. I think the second- or third-last patient we had was a fourteen-year-old girl who was dying, and she had just been cleaned like half an hour earlier, and she was already horrendously soiled. She was lying on her mattress on the floor, that she'd put her mattress onto the floor as many of our patients did. We saw her, we did the kind of clinical bit, and then I wanted to move on. And Princess was like, "Are you leaving her?" I was like, "No, we're going to see our next two, and then we'll come back, because we've got enough time." You're only meant to be in the red zone for an hour, but we had probably been there for forty-five minutes at that point. It's like, we've got two more people—no, it must have been one, because we would have been about the forty-five minute—we had one more person who needed a proper review. Then we had three or four people in the convalescent tent. They were all well. They were getting better, their blood tests were just still positive. I said, "What we're going to do is we're going to see this one more person, we're going to sack it off, convalescent tank can wait for another time, and then we're going to come back and clean this girl up." Princess was very happy about that. We did that, came back, and together, Princess on one side of the mattress, me the other side, we crouched down. You're wearing this big PPE with these heavy aprons and gumboots and the hood, and your goggles are steaming up, you've been there an hour. It's really, really hot. Your clothes, the scrubs you've got on under your PPE is absolutely saturated, like you have jumped in a swimming pool, saturated with water. I have one photo of me, before-and-after photos getting on scales. I'd gotten on scales before I went in, and then when I came

out, I didn't drink any water, I just went and changed my scrubs into dry scrubs and got back on the scales before I had water. I'd lost 1.3 kilos [kilograms] in an hour. And you hear stories of people losing more. Anyway, so we were crouching down, sopping wet, and got new bedsheets, got new clothes, cleaned her up, made her comfortable, gave her some water. She would have only been clean until the next people came past, I'm sure, and they would have done the same. But that was the most intimate patient care experience I've ever had in my career. No question about it. No question about it.

Q: Was the patient conscious?

Alpren: Semi-conscious.

Q: Semi-conscious.

Alpren: Yeah. She would sip through a straw. She had an IV going, but still she was dry. She was going to die. She died. When she died, I was going into the red zone for another reason, and I was pretty sure she was—I was going in to help move a body to the burial team. The body was in the morgue, and we had to get it to the burial team. But I was pretty sure she would probably have died when I went in. And so the first thing I did was went to check. I was with the hygienists who were going to help move the body bag to the burial team. And I said, "One moment, guys, we just got to go and check on this girl." We all walked up, and she was—I put the screen around the bed, went out to the front of the tent to tell the people in the green zone that she had indeed died, and we would need

to arrange to move her body to the morgue. I came back to get to the guys who were helping—the hygienists. They were standing there really solemnly, and I felt really bad, because I'd kind of just quite—not, yeah, quite matter-of-factly. It's like, I was used to it, I understood the illness, I knew where we were going with this, and that we had done everything we possibly could, and I was satisfied with that. But I don't think they understood quite my thinking, and I just kind of walked them up to a bed, said, yeah, what I thought was going to happen has happened. Walked back, told the guys in the green zone, said, "Right, come on, let's go and deal with another dead body."

I think the whole—the experience was very different for the Sierra Leoneans we were working with than it was for the expats [expatriates], and that was something that I didn't appreciate well enough early enough. I think that they—that the culture in Sierra Leone is far more collective than in Australia or America. There was more of a feeling, especially amongst the people who had volunteered, who in many times were kind of ostracized by their families for doing so, but they really felt that they were in this—not only together as a team treating, but they were in it with the patients. I would imagine, although I don't know this, but looking back now, I think these patients were from around the area where they lived. There probably—there were links, they knew.

Q: You said that you regret that you didn't appreciate that early enough. Do you think that there were consequences to expats not understanding that?

Alpren: I think that it's—well, firstly, I think it diminished the experience of the expats. I think then, it gave us—the perspective that we went into it with was very Westernized. And that was not the actual perspective of the reality and the culture that was experiencing it. So I think that diminished the experience for the expats, and the understanding of what this disease actually was in the cultural context that it existed. I think that it probably promoted more of a sense of imposition of the response, or maybe it reflected the imposition of the response. Because the response—I don't think it's particularly controversial to say it was to a large extent imposed. Perhaps it more reflected that than perpetuated it. I got on, we got on, very well with the Sierra Leonean people we worked with. We respected each other enormously. Despite differences, despite us not understanding culturally where they were coming from, or maybe spending enough time to understand it, they massively respected the fact that we had gone halfway around the world to help their country with what they saw as their country's problem. So whatever your kind of GHSA [Global Health Security Agenda] focus on whose problem it was. They felt this was Sierra Leone's problem, and here were a batch of Australians coming to help, and they did really respect that.

Q: When you talk about the Western understanding of medicine, to what do you refer?

Alpren: I suppose I mean more—in this bit, I think I mean more the difference in the cultures in Sierra Leone versus America or Australia between collectivist and individualist, which is huge. There are hardly any more individualist cultures than Australia, and there are hardly any more collectivist cultures than Sierra Leone. In that in

Sierra Leone, it's the collective, the community who act together through leaders who will say—and this community you earn together. So the leaders will earn and pass money down to other people who may or may not be working, which changes dynamics in all kinds of areas. It changes dynamics for consent, it changes dynamics for earning money, for employment, for ceasing employment, which I think was probably difficult when Ebola treatment centers decommissioned, and who would get kept on—a decision made on very much a Western, who is the best person, who is the hardest working, who is the most reliable, not who is the person in the collective who is in the position that they should continue. And that created a lot of resentment towards—I heard stories in organizations of that creating difficulties when people were let go when places were decommissioned.

In this case of what we meant, I was coming at this from the individualist, what do I need to do, what needs to be done for the individual patients in here, right now? Our job is—we always had a job going into the red zone—right now, our job is to get the body to the burial team from the morgue. I also want to check on that young girl. She's dead. Okay, I need to find out what—I need to tell the people in the green zone so that they can prepare her body bag, and they can come in and get that. And they were far more of, our experience here is that part of us has just died. There was less separation there that I probably didn't appreciate at the time.

Q: Yeah. It almost sounds like how we define patients—

Alpren: Sure. Yeah.

Q: —could be expanded a little bit to include the community at large. Okay. So you get there after about a week in MSF. How does your experience change over the course of your deployment?

Alpren: Well, the big change is that the outbreak slowed down considerably in the middle of January, because we were out and about there as part of Operation Northern—no, that's something different, sorry. The Western Surge.

Q: The Western Surge.

Alpren: Western Area Surge. Operation Northern Push came later. [laughs] The Western Area Surge, which was a surge of contact tracing, isolation capacity, which our ETC was part of. Treatment, and the whole thing. My belief is that the isolation did help tip over the epi [epidemic] curve. I think that's probably the big—the thing was getting people isolated. The big thing that changed in my deployment was it started very busy, and then in mid-January, we saw far, far, far fewer patients. And then, by the end, we had maybe two or three confirmed Ebola patients by the time I left at the end of January, beginning of February, whenever it was.

Q: So what changed, though, in how you cared for people, if anything?

Alpren: I don't think anything did later. I think it changed early, because when I went in, I didn't know—I went in thinking, shit, I'm wearing PPE, oh my God. I'm not allowed to get one tiny, little virion anywhere near. Stand back, be scared. Then the first time I went into the red zone, when we had our first three patients at Aspen, went in with our SMO, and she had had Ebola experience before. She was like, "Is this your first time in the red zone? You're watching. You're not doing anything, you're not touching, you're watching. You can write the clinical notes." But she went in and she crouched down and helped the patient drink, gave her some food, held them. She kind of provided that example not only to me, but to all the other staff there. And the Sierra Leonean staff were particularly scared. A lot of them were nurses who had come from the hospitals, and they had seen ten of their friends die of this illness that they're now being employed to treat. So they were scared.

It really made me examine my own kind of fear and decision to come there. What am I there for? Of course this is what we do. I hadn't really thought that I wouldn't do that, but I hadn't realized that I would. And then seeing Cath [Catherine Deacon, the senior medical officer] do it is like, yeah, it's medicine. It's the same. It's assessment of pulse—not necessarily blood pressure because you haven't got any equipment. But it's remote, developing-world medicine where you've not got equipment, but you can do a clinical assessment of somebody. You can ask them questions to work out what's going on, you can examine them, and you can decide what to do about it. In that respect, you've got to try and make it as normal as possible. It is another illness, you know. It's just another illness.

Q: Do some of your relationships with patients stand out to you when you look back?

Alpren: Yeah. [laughs] Yes. One patient we had, she was our second or third patient who came in. I think she was the second. A teenage girl. She was paralyzed by Ebola. Literally, the Ebola must have given her some kind of strange encephalitis, brain inflammation, or something that rendered her lying down. She again, wanted to—she'd lay on the mattress on the floor, and she looked like a fossilized lizard. She had her hips externally rotated out to the side, her knees pointing outwards, her shoulders externally rotated—so that's, like, pushed back—with her arms out to the side. Her neck was extended, and her eyes would kind of flick around, or flick up. But she could talk, and she could sip water and ORS [oral rehydration solution] through a straw when we put it in her mouth. She was paralyzed for like ten days. A week into it, we're like, she's not going to do very well. And then she didn't die. And then she moved, and she straightened her legs, and she straightened her arms, and she sat up, and she got better, and she survived. I remember, when she was paralyzed, we would try and cheer her up because she was desperate. We would do dumb stuff, like dancing in PPE in front of her. She joked back. She had this lovely spirit where she would take the piss, and so she proposed to me, whilst I was wearing my PPE. So I don't think she really meant it. Yeah, so we developed a real rapport.

When she was discharged, man, there was not a dry eye in the house, because the discharges—there was a ceremony that happened. The patient would come out, they

would have to have a shower in chlorinated water, leave their clothes and everything they came in with in the red zone, have a shower, dry off with a towel that had been put in from the green zone, put new clothes on, and come out of another door from the shower into the green zone. They'd have to go through this shower system. What would happen would be, a team would go into the red zone to get the patient, and all the national staff would congregate around the green zone side of the shower and start singing. When this girl was discharged, what a celebration. It was huge. They were singing and dancing, and then she came out to more singing and dancing. She was really quite stunned by the whole thing. She had been through it. And again, it kind of sounds so selfish of the treating team at the time, that we were loving it, and we were bawling our eyes out, and so happy for her. But she had just gone through, like, two and half weeks of complete terror, and we didn't know what had happened to her family. But looking back now, I think probably, her family were affected by this, you know. They had died. She came out, and we were like, "You got to be happy, you survived!" Yeah. Maybe that wasn't the most political sensitive thing to say to her. Anyway, and she did the hand wall. I'm sure you've—

Q: Yeah. The hand wall.

Alpren: Have you heard of the hand wall? It started at an MSF facility in Liberia where there was a big, white wall that could be seen from the red zone. There happened to be a pot of paint sitting next to it one day when somebody came out, somebody survived. And some brilliant person in this MSF place in Liberia—I'm pretty sure it was MSF in

Liberia, I could be wrong on that, I'm sure it was an MSF one—said, why don't we get the patient to dip their hand in the paint and put a handprint on the wall? And then the people in the red zone can see that people are leaving. Every survivor who left that facility left a handprint. It took off like that. [snaps] In every ETC, everyone's like, that's a great idea. Every survivor, when they came out, there were—come over here, come over here, dip your hand in this paint and slap it on the wall, and then go wash your hands. This girl, she came out, and she did the whole hand wall thing, she was kind of—she was really dazed, and like, what is going on with all this fuss? And then she went out into the health promotion area, health promotion team's tent where her family were going to come and get her. And I went up there and had a chat with her there as well, and kind of said, "The guy who's been dancing and who you proposed to? This is me out of PPE." I remember asking her if I could take a photo, and she was fine with that, but she was very serious for her photo. It's almost like the kind of Victorian portraits. She would just kind of sit there, upright, and very serious. I had to make her laugh, and so I did. And I got the most beautiful—she was a stunning woman. She had this bright smile and bright eyes. She really brought life to the ETC. We all remember her because she was so sick, and she just got better. I often wonder what happened to her, especially in my work since with Ebola survivors. But yeah, so that would be one patient relationship that made an impression. The photo of her handprint on the hand wall was my Facebook photo for like ten months. [laughter] It's like, yeah. It was a special handprint.

Q: Yeah, absolutely. How about with staff? I know that you mentioned, was it Princess?

Alpren: Mm-hmm.

Q: Any others that—any conversations that you recall having, or—

Alpren: Well, the—yeah, the conversations were more—the conversations I recall happen with the local staff were more about our differences in opinion. Just like, just the differences between Sierra Leone and Australia. And jokey things, like when I say that—it didn't go like this, I can assure you, it was slightly more culturally sensitive. But basically, a conversation where you say you don't have kids, you don't want kids, and you don't believe in God. That kind of a conversation. You may as well have three heads. And just that kind of, the joke—those kind of conversations, which made the Sierra Leoneans, it actually made them—they were uncomfortable with it. They're uncomfortable with those concepts, and so they were obviously presented in a far more sensitive and careful and friendly way. But they would treat the concept with joking derision. Just, that was the way they would cope with it, would be just to laugh, "Oh, you're ridiculous, so funny, Dr. Charles." I was like, "No, no, seriously." [laughter] Those kind of conversations that really illustrated the difference between our cultures and our opinions and our ways of life. One of the hygienists—hygienists or nurses? God, I can't remember. His wife had a baby during the time we were working there, and he named the baby after the nurse who was the head of his team, the Western, the Australian nurse who was the head of his team. That was gorgeous.

Q: I typically don't do this in an interview, but I'm just having some thoughts about some connections between what you're saying, and I'm just wondering what your thoughts would be. It sounds like there's a question about who things are for. It sounds like one of the concepts that you're bringing up really is, how does the experience differ—obviously, momentously—but from the patient side and the carer side? In one aspect, the celebrations on discharge. Who is this for? Although the patient looks happy, inside, how are they actually? I think you also brought it up with the PPE. It's something that you experience as extremely intimate, and maybe patients do too, someone who can actually touch them. But on the other hand, I can imagine people being off-put and scared.

Alpren: I think initially, it would be extremely off-putting and scary. But I also—I think that there—it would be an experience, but it would also be colored by the fact that until that point, people wouldn't even go near them. And now, okay, they're wearing PPE, but if you can humanize yourself within the PPE, and people did things, we didn't do it—at least I didn't do it—like printing off a photo of themselves and sticking it to their PPE, and those kind of things. If you can humanize yourself—we all had our names written across our foreheads—and show that there's a person in there, then you really could have connections. I do think that we had genuine connections with our patients. There's no question, holding a hand, making sure you made proper eye contact, sitting there next to somebody. You could have proper connections, which could not be done without some kind of contact. I think it was better than the alternative for the patients.

In terms of who—I mean, the big "who is this for" is, who is the response for? Who are we there for—Sierra Leone, or the wider world? Why is the response done? That, when you said "who is it for," I was like oh, are we going there now? [laughs] Because to me, I think you could be there for all of it, but I also think that it was a response that really kicked in when the rest of the world realized that the problem wasn't only West Africa. It was West African, and we went out there to help West Africa. Higher up in the political chain, they were probably like, yeah, we need to help West Africa, no question about it. But we also need to make sure this doesn't go anywhere else. So yeah, that's—

Q: Yeah. I have—Dan Martin's outside right now waiting for you.

[break]

Q: I'm here again with Dr. Charles Alpren. We have just gone into detail about your experience with Aspen Medical in Freetown. How does that experience wrap up?

Alpren: It wraps up with going home and twenty-one days of self-monitoring to make sure that I didn't get Ebola. Which, from my perspective, was slightly—it wasn't slightly ridiculous. I understood it, and actually in Victoria, the state of Australia that I live in, the rules were sensible in that I wasn't allowed on public transport, but I was other than that allowed to do pretty much whatever I wanted, so long as I was within an hour of the Royal Melbourne Hospital, which is the hospital I'd have to go to if I got sick. I had to email in twice a day my temperature. Or email in once a day with my temperature, taken

twice in the previous twenty-four hours. I wasn't allowed on public transport. I was allowed into public gatherings, but they just asked that if I did go, I made sure that I could leave quickly if necessary. So kind of, if you're going to go to a music festival, please don't go right into the middle of the mosh pit type thing. Which was kind of sensible when you consider that other states in Australia were doing quarantine. Like, you know, twenty-one days. I can tell you now that you do not have to look hard to find—well, no one stayed in a room for twenty-one days. No one stayed in the house. Everyone went out for a coffee. Everyone went out for a coffee, okay? It was twenty-one days for healthcare workers who were not allowed to go into a healthcare facility, so we couldn't work. So yeah, it's just crazy, stupid. Though others of my friends returning from Sierra Leone had some anxiety from their families and friends—and some of them also, they made the decision that they weren't going to touch their grandkids or whatever it was. I don't—I know what my potential exposures were, and also, I know that this is an infectious disease spread by direct contact of body fluids from a symptomatic person. We have had enough freaking trouble persuading politicians that they should enact public health precautions based on that advice. For example, look at Canberra and Queensland, where people were told to stay in their houses for three weeks. Are we going to have the courage of our convictions or not? And if we're not, then what right have we got to say to other people that this is an infectious disease spread by direct contact from infectious bodily fluids of a symptomatic person? No, far from it. Own it.

But my friends were great. No one was worried at all. Everyone was fine about coming out to my place, going out. When I explained, yeah, I'm taking my temperature regularly,

and if I felt ill, even if I didn't have a temperature, I can assure you I wouldn't be—I wouldn't be going out. But I'm totally fine. I've not really had much exposure in the last three weeks anyway. Because we were quiet for those. Yeah, let's go to dinner. That's how the Aspen experience basically winds up.

Q: Right. Got you. Were you able to communicate with—you had friends who were in quarantine?

Alpren: Yeah, well, say "in quarantine," they were in other states doing the same kind of thing, and some of them were meant to stay indoors the whole time. The other thing I wasn't allowed to do was fly, so I couldn't fly interstate to see friends. I basically had to stay in Melbourne. I won't go into it in too much detail, but I promise you, we all—not we all, but many people bent those rules. We've seen it recently in Pauline Cafferkey in Scotland who got Ebola, was symptomatic when she got to Heathrow [Airport], and she was disciplined, although the case was thrown out, thank goodness. She was disciplined for hiding, or not being open about her symptoms. Now, I promise you that you do not have to look hard to find people who came back from West Africa who, half an hour before getting off the plane, took a couple of acetaminophen, so that their temperatures were low. Because they felt fine, and they didn't want to be hot after a twenty-four-hour flight and have a temperature of 37.8, whatever that is, 99 or whatever. Lots of people did that. Lots of people did that. And that was a reflection of the reaction we knew we'd get if we had a temperature of 37.5 and even—yeah, that happened. I think that happened a lot.

Q: So what happens then?

Alpren: I'm going to backtrack a little bit, and talk about one episode I had one evening in Sierra Leone sitting in the living room. Basically, I think one of my lessons from [laughs] that whole experience is, just do it. If you're wondering, I wonder if I should try and go to West Africa, I wonder if I should send my CV, I wonder if I should—the answer is just—what could possibly go wrong? What's the worst that could happen? [unclear] I was sitting on the sofa before dinner one evening, and I was on Twitter. And somebody who's very, very senior in one of the state health departments in Australia who I follow on Twitter, I've never met him, I'd never met him at that point—tweeted, "Not going to be tweeting much for the next six weeks because I'm going to Sierra Leone to help coordinate foreign medical teams for the WHO" [World Health Organization]. I thought to myself, ah, should I message him and say, do you want to meet up? He's a pretty senior guy, but I'm here too in Leone. We could have a little Australian thing, or he might want to see Team Australia where I was. I'll message him, fine, so I did. Much to my surprise, twenty minutes later, he replied, "Yes, that would be great. Let's meet up." I was very surprised, but we went out for dinner, and he said to me that the problem that WHO had and may—I don't know, maybe CDC—was that they had a whole load of really experienced, really expert public health practitioners coming out to help coordinate the public health response to Ebola, and none of them had any experience dealing with the disease. He was really excited to talk to me, because I did, and he wanted to hear what it was like. When he said that bit about not having people with Ebola experience, I

thought to myself, I've got Ebola experience. Maybe you guys have room for me in these organizations, these exciting organizations that I thought when I left my practice in general practice, one day in a decade or so, I might be able to maybe do a little bit of work for WHO, or even CDC. No—maybe. [laughter] You'd see the Land Cruisers driving around with WHO stickers on them or CDC stickers on them, and MSF France. You felt part of a big thing, a big response. You were part of something massive, even though you were just one tiny little bit of it, you knew there was something massive going on.

The day after that dinner, I was on an early shift, and I spent the afternoon on the WHO website, submitting my CV. Basically, the only job you could apply for on the WHO website in the Ebola response at that point as a doctor was his—it was the foreign medical team coordinator position. And I was horrendously underqualified for it. There was just no way I was qualified for it, but it was the only job, so I was like, fine, I'm going to apply for it, and hopefully they'll look up my CV and go, oh, this guy clearly can't do that job, but here's a deputy position or something else that his experience might be useful for.

Much to my surprise, I got the job. I went out—so three months after I got home, I went out again. It was the end of April, which—that was like two-and-a-half months-ish after I got home, I went back out to Sierra Leone via Geneva. Went to WHO headquarters. I knew nothing about the UN [United Nations], I knew nothing about WHO, I knew nothing about how it works, I knew nothing about the member state system, the

governance, the country office, the difference and the rivalries and the politics between country offices and headquarters. No, I was completely naive to all of that, but I did have Ebola experience. I went out to help coordinate the Foreign—what was called, the title of the entities were Foreign Medical Teams, FMTs. They're now, I think, called Emergency Medical Teams or Emergency Response Teams, or something like that. There's meant to be a team from each country, but it's kind of like the NGOs [nongovernmental organizations]. Coordinating the NGOs who are out there, working in the ETCs. Some of them were running an ETC, like Aspen would run an ETC. IMC [International Medical Corps] would run several ETCs. GOAL. Some of them worked with others within the ETCs, like the African Union, or the Cuban brigade, or the—there was a Danish delegation who worked with GOAL in their ETC in Port Loko. I was meant to be coordinating that. The outbreak was really diminishing by that point. There were two or three pockets that were very difficult to get on top of, and they were not diminishing, they were very difficult to get on top of. But the rest of the country didn't have it, so it was diminishing. Whilst I was there, my role expanded dramatically, and I ended up as the—not just Foreign Medical Teams, but that got merged with the case management. So I worked with a counterpart in the Ministry of Health to coordinate the overall case management of Ebola. That's isolation and treatment of Ebola. The ETCs, the isolation facilities, where the patients are, what should be closing, when it should be closing, what the SOPs [standing operating procedures] should be, what the IPC [infection prevention and control] precautions should be, how we should deal with screening at hospitals. That spilled into the—so, screening at hospitals is a big deal, because when there were cases discovered in a mainstream facility, that was a big "oh my God, how did that person get

in?" Explaining why that happened, trying to prevent it happening, trying to mitigate against the problems that would have of calling all the staff who work on an entire special care baby unit at a hospital "contacts," and closing the special care baby unit. All those kind of things was what I came into contact with at WHO. It was a steep learning curve. Very steep learning curve.

Q: What do you mean?

Alpren: Well, like I said, I had no understanding of WHO culture, the UN. Even the cluster system, I'd read about, but I'd never worked within. We didn't work—you probably know, we didn't work in the cluster system. We used the pillars instead because it was a more public health emergency rather than general humanitarian emergency. But that kind of system. Worked within [unclear] how it coordinates. I was naive, and my naiveté time and again in my life wins me the day, because I'm just like, well, why wouldn't you want to do the right—what I think is the right thing? I just didn't have any understanding of the potential differences in agendas that different jobs would give. I just thought, no, we're all in this to fight Ebola, aren't we? We were, but that means different things to different people, and—

Q: Do you have an example of a time when that kind of fresh thinking changed things?

Alpren: [laughs] Yeah. [pauses] I'm wondering if I should even—I'm going to say this, but I'm also going to say that I think we should have—that we should think, once you've done the transcript, about whether we want this.

Q: Of course. Sure.

Alpren: We had an issue one Saturday morning where basically, to cut a long story short, we found that the main Ministry of Health–run Ebola treatment center in the country was failing. It was unfit for purpose. Now, my reaction when I saw the place was—and I wasn't angry or upset at the Ministry of Health. Certainly not at the individuals working there who were working incredibly hard on a ridiculously un-resourced—they'd run out of water, for God's sake. They were patching up the fence with body bags. It was just horrible. But my reaction was, right, we close it, we don't have any more admissions, we fix it, we train the staff again, we put up some fencing, we sort it out. But of course, it's—you know, Ministry of Health, international community, so this is actually the international community saying, we'll come in and help you, don't worry, we're here to help. So I understand how that was naive, but I also felt—and I still feel, and I'm actually proud of what I did. It's the thing I'm most proud of in my whole time, because I felt that we'd got to a stage—this was in July last year, July 2015—that it wasn't just about isolation. We didn't have four hundred cases a week, we had three, or whatever it was, fifteen. We were in a position where we really should be also concentrating on the quality of case management that gets delivered, the quality of care that gets delivered to people who have suspect or confirmed Ebola. And that is an issue that we can now afford to

spend time on, and we should—we should improve our standards, and we should—yeah. So that's what happened. There was a big kerfuffle because of my naiveté. And because—it was just because of my naiveté. I did genuinely try to contact the Ministry of Health when it happened. And not their fault, that were out the country, the people who I could contact. Obviously—and it came to light because five people, two of whom had confirmed Ebola, walked through gaps in the fence overnight. There was no harm came, no harm done, they came back, everyone was happy, it was fine. But yeah, my reaction was really quite definite. I kind of led it. I stepped up. I was like, right, I'm calling in my team. We're gonna do a full IPC assessment immediately. We're going to write this report right on the spot, we're going to talk to the staff in here about what we're thinking, we're going to send this up the chain. We're going to present it, we're going to talk to the Ministry, we're going to ask them if they—you know, ask, ask them if they would present it to the executive committee on Monday.

You said an example of how the naiveté changed things. It changed things. It was a blip. It was a little blip. And maybe, I don't know if it prevented it happening again. It meant that we would be alert for that kind of stuff. But it certainly made everyone stop and think about the quality of care as well as the isolation.

Q: And the facility did end up shutting down?

Alpren: No, it reopened.

Q: It did reopen?

Alpren: Yeah. Yeah. It closed for—I don't know how long, actually, because I came to the end of my contract whilst it was closed. But it closed, and then it reopened, and then it closed just after—it closed in November, after the outbreak was declared over. That was the big defining moment of that job for me. It started at seven thirty on Saturday morning, just after I'd had the thought, oh my God, I've worked solidly every day for about three weeks, and I think I've got a quiet day. It was seven thirty-two, and my phone rang, and I know exactly when it was and exactly what time it was. And it was like, five people who [escaped from an ETC]. That was the big moment in my WHO job.

I think another place my—maybe my naiveté, but this—it goes against the cultural thing that I was talking about in the ETC. Except rather than between Australia, America, and Sierra Leone, the whole world comes together in the WHO. In an emergency response, people with their own quite temporary contracts. Six weeks, three months, that kind of thing, less sometimes. People from all over the world would come into this country office, and there's no clear organizational culture. Where's your anchor point to build an organizational culture when you've got so many people from all over the world working, who know their organizational cultures in their normal jobs? And that's how they work. So the Europeans went with the Europeans, and to a lesser extent with the Americans and the Australians. And the Asians, and the Africans. People formed into their own little siloes. That created tension between those siloes, because the Europeans are like, well, of course you do it like this, and of course you communicate like that, and of course you

treat people in this way. Whereas for their perfectly good cultural reasons, people from a different culture would do things differently. But there was no cultural expectation of the organization that you could then go back to, to say—and that's where the CDC stood out, because the CDC was America. So the CDC had this kind of—mission, literally. I was amazed, quite excited when I started working for CDC to hear that the ambassador is the head of mission. There is a mission. You're part of a mission. You're there for Mission America. That makes work much easier, because you understand the cultural expectations. You understand the organizational expectations, what your framework should be. And most people, even if they're not from the States or the UK or Australia, kind of know most of the general themes of American culture, even if they don't know some of the subtleties. So you can do it. I think that's one of the reasons I—and I worked very well with my CDC counterparts when I was with WHO and became friendly with them. I thought it was just like, well, of course we do things like this. Of course we share information. Of course we ask each other for help. Of course I will phone up Sarah and ask her if she's happy enough with her epi investigation that she was doing to be confident enough that I can tell Geneva about her results. That kind of communication that was apparently new, but it was just obviously how I worked, and obviously how CDC worked within them, but not necessarily—it was harder to break into other cultures. And there are so many cultures there, that I think that was real thing, a really big deal in terms of how organizations work together.

Q: So CDC kind of provided a common space for people with similar understandings? Is that what we're kind of saying? With CDC, you get kind of a lingua franca?

Alpren: I think CDC provided a—yeah, I think CDC provided a consistent expectation. And they provided that within a response. Within a DERC, a District Ebola Response Center, or within the National Ebola Response Center, they provided a consistent expectation. So if you were working with CDC, you could work with them on a cultural level, on a cultural understanding, that then shifted the balance within the room to that being the majority, and therefore, more of an expectation. I think that a lot of people from Europe, UK, Australia, felt that working with CDC was fun, and easier. I think that was one of the big reasons. I'm sure there were resource reasons, that CDC was well resourced. But that, I think—I'm big into organizational culture and how that reflects on how easy it is to work, and what that does to the result, to the actual product. I think that was a big factor in the dynamics of the response.

Q: Thank you so much for sharing that. We have Dan Martin out here, maybe we should join him quickly for—

[break]

Alpren: We talked about WHO and about what CDC were like from WHO's perspective. Finished my WHO job after four months, and didn't extend my contract because I was exhausted. To the extent that my friends from CDC were taking the piss out of me. I got home and just slept for three days. Yeah, it was crazy. Everybody does that who comes out of a WHO job, I think. At that stage, quite frankly, every single person—and

definitely all the CDC people—were working sixteen-hour days, seven days a week. There was definitely no weekends. It was very busy.

I was really lucky, and the CDC country team who I had become friendly with and worked closely with were—kind of said to me, look, if you're interested in working with CDC, then we can see if we can work out a way for you to come out with us. I was very interested. The CDC were—you know, the impression I had of them was that it was extremely competent individuals in a well-resourced, well-supported organization. So yes. I came back in October 2015, and my job was to coordinate the technical assistance, coordination around survivor care. And also to help try and coordinate the transition of the case management from ETCs and screening facilities and triage to mainstream facilities doing the work.

The main projects I've been involved in, the main theme of my work over the last year, has been semen. [laughter] Because Ebola was found to persist in bodily fluids, particularly immune privileged sites—the sites that don't get much blood supply, much immune cell supply—for far longer than we initially thought when the outbreak started. When I was discharging men from ETC in Aspen, we would say to them, "Look, Ebola has been found in semen for longer than other bodily fluids, and we think probably about three months, so you should use condoms." That's the kind of advice, that was the basic advice. I could have probably put it in a slightly more articulate, official way, but that's kind of how it was said. It quickly became evident that it was potentially present for a lot longer than three months, but probably the chances of actually causing sexual

transmission were low. That's really where we're at now. We've had examples of sexual transmission from survivors well over a year, well over fourteen, fifteen months from the time of their infection, but they are very isolated cases and very rare. However, when you've got three, four thousand, however many survivors we've got in Sierra Leone, forty-odd percent of whom are men, most of them are men of sexually active age. They all need testing, they all need counseling, they all need to change their behavior because you don't know which one person—we don't know for sure if having cleared Ebola RNA [ribonucleic acid] from your semen, it stays away. We don't really know what negative means, what not detecting Ebola RNA in semen means. One of the things that I say when I'm teaching about Ebola is—I don't know, do you know how many people work in this campus of CDC?

Q: I have no idea. [laughs]

Alpren: No? I use the example of Melbourne University, where I teach, where there are about forty thousand undergraduate students. It's a big—it's a big—

Q: We have a large college campus next door with Emory [University], too.

Alpren: Exactly. So a big university campus, a few tens of thousands of people. Probably most of them, if not all of them—not all of them, ninety-odd percent have had chicken pox, a very common infectious disease. But everyone kind of knows it. We know a lot about chicken pox, but there's stuff we don't know, and there's problems we have with it

still. We can't treat it very well. Shingles comes along. Sorry, this is a bit of a longwinded explanation. However, before this Ebola outbreak, there had been just over two thousand recorded cases of Ebola ever. And there have now been less than thirty thousand cases of Ebola recorded. So less Ebola than there has been chicken pox at Melbourne Uni now. We know nothing about this condition. Our level of understanding is low, but accelerating very fast. And that's been reflected in—so many times, the uncertainty about the counseling, even that the politicians or the public health people should be giving the politicians early in the outbreak, and the confusion that happened, not just in West Africa but also in America, in Australia, in Europe, when there were cases. I do think we've learned a lot about communicating uncertainty. That's one thing I do think we've learned a lot about. The speed at which the information is changing, we've gone from saying to male survivors, three months, to six months, to a year, to [shrugs]. [laughs] To a year? Well, there's no RNA in your semen, and that sounds great. Keep in touch. We're not totally sure what that means, but you've had a couple of negative tests, so whoopee. Which is kind of where we're at, at the moment. I have helped to coordinate setting up a program which initially was in three districts in Sierra Leone with the most survivors, the most recent from their infection. Western Area, where Freetown is, Port Loko, and Bombali.

Q: And was that program called something specific?

Alpren: Project Shield. CDC put a lot of technical advice into that. It provides counseling, which is the important bit. Because testing shmesting. It's behavior change

that changes the chances of sexual transmission, especially if you don't really know for sure what a negative test means. I should say "not detected" test, not "negative," because we don't know it's negative, so we're saying we're not detecting the Ebola in there. We agonized for so long about how to say it. We can't say negative/positive, because it's not necessarily positive, we're just saying it's RNA. That might not be the whole virus. But it's not necessarily negative. It might just not be detected. So we'll say detected/not detected. How's that going to translate? Oh my God, what are we going to say? Then we got to the trainings, and we said to the survivor health advocates and the sexual health counselors who we were training, "Okay, this is the situation. This is very important. We're saying 'detected' and 'not detected.' We're not saying 'positive' or 'negative,' saying detected/not detected." Oh, that translates to Creole as, "We see em, we no see em." That's perfect. That's exactly what we want to say. We see em, we no see em. Right, there we go. And we're not sure if we no see em, they no there, they no there for good, they no there just today—we no see em. That has been the main thing that I've done over the last year with CDC.

Q: Has your role really strictly been in setting things up? Or have you been involved also in counseling?

Alpren: No, I haven't been involved in counseling. I was working with the people who were writing the counseling scripts. That was actually CDC's main job, was to write the counseling scripts. However, we also realize that in order to write the counseling scripts, we've got to be able to write down what the counselors have to say to the patients is

going to happen in the clinic. So you have to understand the clinic flow and the client flow. So actually, we gave a lot of technical advice on how to do this. We drew on the Viral Persistence Study, who had already written their scripts and put their clinic together. We drew on the Men's Health [Screening Program] in Liberia who were doing similar things to what Project Shield was doing in Sierra Leone. They were all very generous with their operations manuals and their scripts and everything, and we adapted, and we were [unclear] for bits. But it was also all happening at a time when the understanding about sexual transmission, and the official messaging from WHO and CDC, was also changing. It was going from this is theoretical, we've never actually seen it, we've never documented it, to yeah, it's happened, but it's rare. And deciding—of course, this is a Ministry of Health program, and so the messaging that goes out is what the Sierra Leonean Ministry of Health want to say. Not what WHO or CDC want to say, it's what the Sierra Leonean Ministry of Health want to say, and that is based on the technical advice from mainly the two main technical agencies, but other places as well. And CDC and WHO haven't been perfectly aligned on this the whole way through. We had to change the messaging subtly from we've not seen sexual transmission—really trying to push against the sexual transmission fear, because we wanted to break down stigma against survivors; to an acceptance that it was happening but it was uncommon. And that had to happen a few weeks after the scripts were written. They had to be, you know, reviewed. So writing that and developing that program, as the knowledge was changing and the advice was changing, was interesting.

Q: I should have asked you this before, but it's interesting to me. Can you tell me about somebody you really got to know at CDC and your work with them?

Alpren: Sarah. Sarah [D.] Bennett. Sarah was basically my CDC counterpart when I was at WHO. She was more involved with IPC, I think, than case management, but she was case management as well. She was doing whatever needed to be done, and she was doing epi, and she was doing response lead stuff, she was doing crazy, superhuman, everything-type things. We got on—we got on. I was scared of her when I first met her—not when I first met her, before I first met her, because I had to do something—I had to find out about IPC things going on in hospitals, and we had no data. I was finding it really difficult to work out what was going on. The boss of WHO in Sierra Leone had told me to get this information—could not get it. And I was like, CDC must know this stuff. Who do I ask at CDC? And it was like, ooh, you got to ask Sarah Bennet. I was like, who's Sarah? Is she nice? Well, she's nice, but—but don't be an idiot around her. And I was like, well, I'm a bit scared to phone up with a question that we should clearly know the answer to as WHO. So maybe I won't pick up the phone right now. I kind of tentatively introduced myself at the next meeting that we were both at.

But then we worked more together. There were clusters of cases in Freetown where we wanted to put in what's called ring IPC. So where you put intensive efforts into the healthcare facilities very close to where there are cases. And I think that because I was someone who would put organizational egos aside and say, "What needs to be done here? Okay, what can you guys do, what can we do? You do that, we do that, we meet very few

days and tell each other what's happening. Here's my data form this. Can you send me your transmission chain on that?" We worked really well together, and we've become friends. I am envious of her public health practitioner abilities. She kind of epitomizes CDC a little bit to me. I really think that there's a way of working which I try and emulate where you can actually bring out the best in a team by being good, and other people in other organizations will all step up, because it kind of brings over real quality, and I think that's something that's not just in Sarah, in many other people in CDC.

Q: Got you. I should mention that I think in forty-five minutes, you're to give a talk here at CDC.

Alpren: I am. Yeah.

Q: What are you talking about?

Alpren: On Project Shield. So thank you for making me say that. I've just said all my little vignettes about Project Shield, my detect—we see em, we no see em, all that kind of stuff that I have to have in the front of my mind, [laughter] for this presentation. Hopefully, I'll be able to be slick with the presentation.

Q: I'm very much looking forward to it. And so what are we—what's your future? What is your—[laughs]

Alpren: Good question. That's a really good question. I currently work for CDC Sierra Leone country office. The job was meant to be three months on, three months off. I was actually at home for nine weeks between October last year and September this year. That's just how these things always happen. But I'm currently in a three-month break. I'm actually doing a little bit of clinical work at home, GP work, just a little bit, just to do it again. I am hoping to work more with—I'm hoping to work with CDC. I'm going to go into public health practice one way or another. I need proper, accredited type of training. I'd like that to be with the CDC. If it can't be with CDC, then I'll probably ask CDC again, or have to go to Australia, where the training is excellent, but it's CDC. Yeah, that's the direction I'm going.

Q: Right on. No matter what, it's public health, so—

Alpren: Exactly.

Q: Thank you so much, Dr. Charles Alpren, for being here with me today. We've covered a lot. You have a unique ability to talk both about I think the larger picture and draw larger conclusions, but also explore in detail those specific memories that you have. I value that very much as an interviewer. So thank you.

Alpren: Thank you very much for the opportunity to do this. I really enjoyed it.

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