CDC Ebola Response Oral History Project

The Reminiscences of

Colin A. Basler

David J. Sencer CDC Museum

Centers for Disease Control and Prevention

2016

Colin A. Basler

Interviewed by Samuel Robson
April 22nd, 2016
Atlanta, Georgia
Interview 1 of 1

CDC Ebola Response Oral History Project

Q: This is Sam Robson, here today with Colin Basler. Today's date is April 22nd, 2016, and we're here in the audio recording studio at CDC's [United States Centers for Disease Control and Prevention] Atlanta campus, Roybal Campus in Atlanta, Georgia. I'm interviewing Colin as part of our CDC Ebola [Response] Oral History Project. Colin, thanks so much for being here with me for this. For the record, can you state your full name and your current position with CDC?

Basler: Sure, and thanks for having me. My name is Colin Basler, and I am a veterinary epidemiologist with the Outbreak Response and Prevention Branch of the Division of Foodborne, Waterborne, and Environmental Diseases in NCEZID [National Center for Emerging and Zoonotic Infectious Diseases]. I don't want to go the full—there's a lot of letters in that. [laughter]

Q: That's okay. The cool thing is, in the transcript, we can use brackets and put the full thing.

Basler: Wonderful.

Q: Can you tell me when and where you were born?

Basler: I was born in Boston, Massachusetts, in October 1985. I grew up in Easton, Mass, and ever since I was little had a really strong interest in animals, working with animals. From a really young age, wanted to be a veterinarian, so that was always sort of my life goal. As much as a six-year-old can have a life goal. But grew up with a big backyard and took—pretty much any stray animals that found their way into that backyard, I had as pets at one point or another, which was a lot of fun. Grew up with parents, only child, tried not to get too, too spoiled during that timeframe. Lived in Massachusetts for my entire childhood, went to Cornell [University] for undergrad [undergraduate studies], was an animal science major. I really put all of my eggs in one basket—if I didn't get into vet [veterinary] school, I would have had to be a dairy nutritionist in upstate New York, and I had absolutely no interest in that, so it worked out well for me. [laughter]

Q: Can you tell me what your parents did?

Basler: Sure. When I was younger, my mom worked as a secretary at Mass Eye and Ear up in Boston, and then went to a master's school for library science, and is now the director of a town library in the town next to us. Lots of free books growing up. My dad was a paramedic, went back to school, and is now doing human resources for another town nearby. So, both local-government-type things.

Q: Tell me more about Cornell.

Basler: Oh, sure. I had a very good experience up in the frozen wastelands of upstate New York. Winters were long—the other seasons were short but beautiful. Was an animal science major, and then after four years up there, I came back to Massachusetts for vet school. I went to Tufts [University] for vet school, which is out about an hour outside of Boston, and I was able to get a—they had a great dual-degree program, so I got my veterinary degree as well as a master's in public health at the same time. That's when I really started to get interested in the potential career of veterinary public health. Beforehand, I had really wanted to be a zoo veterinarian. I had worked at the Franklin Park Zoo in Boston for a couple of summers, and I loved the more exotic animals. I did a study abroad program in southern Kenya, so I really liked the large wildlife. But then, looking at the career path for zoo veterinarians would've been two internships, a residency, and then waiting for a veterinarian in rural Idaho to die before I could ever get a job as a zoo vet. So then I found public health, and have been really happy with that transition.

Q: How exactly did you find public health?

Basler: At an accepted students' day at Tufts, they had presentations on some of the dual-degree programs, some of the nontraditional paths that they offered. It sounded like a really great opportunity, and I really got hooked in my first epidemiology class. My professor for that particular class spent a lot of time talking about some of the outbreak investigations done through CDC, and that's when I first learned about the Epidemic

Intelligence Service fellowship program. He was actually telling stories about how EIS officers in the 1970s were dropped out of the back of planes and into the Congo [then Zaire] and to Uganda, to go investigate Ebola outbreaks. That was something that I found really interesting and terrifying. I was like, oh, I like the outbreak response. I don't know if I need to do that portion of it. [laughs] But a potential career at CDC sounds really interesting. Then, when I was in vet school, I was able to take advantage of some other opportunities to learn more about CDC and learn more about public health. The CDC down here in Atlanta had a great students' day for veterinary students, where we learned more about what the EIS officers did and what type of opportunities were here. I then was lucky enough to get a CDC-Hubert Global Health Fellowship. It was an eight-week fellowship in vet school where I got to go to Kenya and work on an influenza surveillance project. While I was there, there was a rabies outbreak in both humans and dogs, and I was able to work with our team from the [Poxvirus and] Rabies Branch and an EIS officer that they had in-country at that point. Which was a really great experience to see what type of work EIS officers could do and what type of opportunities were out there. After that, I did an epidemiology elective here in Atlanta, and that was when I was like, alright, yes, I like this. This seems like a good potential career for me.

After vet school, I worked in private practice up in Boston for a year at a Banfield [Pet Hospital] clinic doing cat, dog, preventative medicine, working with small, apartment-sized pets up there. Applied to EIS and got accepted, and so moved down to Atlanta almost three years ago now. Started in July 2013, moved down. For EIS, I matched with the food and water division [Division of Foodborne, Waterborne, and Environmental

Diseases]. I did my EIS experience as a One Health officer. So, there was a new position. One Health is looking at human health, animal health, and environmental health together, instead of looking at them in siloed, different areas. It was a useful position to have in the foodborne division because a number of the enteric bacterial outbreaks that we investigate were zoonotic in nature. We were seeing a lot of *Salmonella* outbreaks that were caused by contact with baby poultry, because that's becoming really popular in suburban areas. *E. coli* outbreaks associated with petting zoos, or working farms, or some things of that nature. I was working there for about a year before Ebola happened.

Q: Up to the point that you had Ebola, would you name anyone specifically—a professor, or someone who you were a research assistant for—who you would say was a mentor, or somebody who really shaped your thinking?

Basler: Yeah. When I was at Tufts, our MPH [master of public health degree] advisor was Dr. Joann [M.] Lindenmayer, and she was a great mentor who had done EIS as a state officer in New Hampshire about twenty years previously and had really great things to say about that. She really helped guide me along the public health track. Then my primary supervisor here in Atlanta for my first year was Casey [E.] Barton Behravesh, and she was another fantastic mentor to have once I was stationed down here in Atlanta.

Q: Can you tell me a little more—it sounds like in doing EIS and in going full-bore public health, you might be abandoning working with individual animals a little bit to working with populations. Can you talk about that a little more?

Basler: When I was in vet school, my main focus was never individual, small-animal medicine. I initially appreciated zoo medicine, which is a whole different beast. Going into public health, I was really interested in more of the population-based medicine. Looking at either a population of animals or looking at a herd health level. I really enjoyed doing the small animal, individual patient work for a year. I've been away from it for about three years now, so I'm starting to miss it. But after doing it for a year, I was really happy to move over into the public health field. I'm actually looking to see if I can figure out a way to do some sort of volunteer or side work to just stay doing a little bit of the individual patient work. I miss it a little bit, but I'm much happier doing the public health stuff than I was when I was in private practice.

Q: Okay, right on. Up to the point when you were getting involved in Ebola, you'd done some international work before. You said you'd been to Kenya a couple times—had you been elsewhere in Africa?

Basler: No. I lucked out, and I had been to Kenya a fair number of times. I was there for an undergrad program for a semester, which was a wildlife management program in southern Kenya, which was a great experience. Then in vet school, I was able to go back for the Hubert fellowship. I also did a summer doing a rabies research project in rural Nepal, so it was another low-resource setting, but definitely not sub-Saharan Africa. And I was able to do a little bit of travel to Morocco. But no, I had never been pretty much

anywhere else in Africa, and had definitely never been to West Africa. West Africa was not on my list of places to—[laughs] to go to, before all of this happened.

Q: Okay. But you said you had some knowledge of Ebola, from school, etcetera.

Basler: Yeah. We learned a bit about it in school, as a disease that has a lot of zoonotic overlay. That's something that we learned a lot about, and that was something that was really interesting for me to study beforehand. And to hear the really, really amazing stories of the EIS officers back in the seventies and what they had done, and what sort of very interesting positions they had been put in, early on.

Q: Okay, so, when do you get involved in Ebola, and how does that happen?

Basler: When the outbreak started, they really weren't calling for much additional support. It was looking like a traditional Ebola outbreak in a rural part of Africa. A different region, so that was new, but besides that, everyone assumed that it was going to burn itself out in a short period of time. We started to hear about it, and then hearing more about it, and more about it. A number of friends of mine who were other EIS officers were the first cohort to go to Liberia. I had a couple of friends who had gone to Guinea previously for different-length deployments, and in Guinea, it looked like the outbreak had peaked, had gone down, and then was coming back again. When they started to find cases in Liberia, they sent a team of EIS officers there. I was going to volunteer for that deployment, but I had a previously scheduled other trip to Kenya for a

water project, a safe drinking water project. So I was sitting in a hotel in Kenya waiting for our—all the paperwork to go through so we could start doing the research project, while I had friends who were working on the Ebola response. I thought I had missed my chance. I thought at that point, it was going to be a short trip. That was back in August of 2014. We thought, it's going to be over soon. At that point, no one was really thinking how bad it was going to be and how prolonged of a response was going to be needed.

When I got back from that, I volunteered for a call list, because as cases continued to increase in West Africa, they started to put lists together of EIS officers who'd be willing to respond in case there were introduced cases in the United States. When the first case came in in Texas, they were looking predominantly for more clinical and more human doctors, so I wasn't on the first list for that. Which I was fine with. But I had put my name in, so when more cases—when the situation continued, and when the two nurses first got sick—or when the first nurse got sick, I got called to see if I was interested in going to Dallas. It was over the Columbus Day weekend, and I was actually in the panhandle of Florida for a vacation, so I got in my car and sped-drove back to Georgia. About an hour outside of Atlanta, I got a call saying nope, just kidding, false alarm, we have a full docket, we don't need you anymore. That was a bit of a letdown. But then, only a couple days later, the second nurse tested positive, and it was found out that she had been in Ohio for a large portion of her incubation period. I remember, I was at my desk, and it was about five thirty in the evening, and I got a phone call saying, are you still interested in being part of the Ebola response? Can you be at the smaller Atlanta

airport at around eight thirty tonight? Because we're flying people to Ohio. The governor has hired a private jet, so we're sending the team out this evening.

That was a really fast turnaround time for any sort of Epi-Aids [epidemiologic assistance] or projects I had worked on in the past. I spent a good hour and a half frantically trying to find someone to watch my cat and my leopard geckos, and then packing and finishing up some loose ends at the office, and then making it to the airport. There were five of us who flew out. The plane was delayed, and we landed in Ohio around two or three o'clock in the morning, and then had to be at the Ohio Department of Health emergency operating center bright and early the following morning.

We got debriefed in Ohio very briefly at the state health department, and then we drove out to [Summit] County, which was the county health department where the nurse had been staying for most of her time in Ohio. As an EIS officer, that was a really intense, really interesting learning experience while we were there. About the health department, they're great people to work with. They had recently moved facilities, so we walked in and there were boxes. Some of the rooms hadn't been unpacked, boxes were all over the place, we sort of didn't know where we were going in places. Initially, things were a little bit tense, just because the request of the Epi-Aid didn't go through normal channels, so we were already in the air before the local health department was made aware that we were coming to provide support. When we first arrived, there was a little bit of, why are you here? What could you possibly help with? I think that we were able to provide

support, and by the time we were leaving, we had a really good working relationship with the local health department, which was great. But initially, it was a little tense.

We had to find pretty much any person that the nurse had come in contact with while she was in Ohio. There were a number of individuals who had been placed under home quarantine, and that's something that really hasn't happened in the US previously, before the Dallas and Ohio cases. We had to try and find any other person she may have had contact with, and at that point there was a lot of fear about what level of contact counted as contact, if that makes sense. She had gone to a bridal store for the afternoon. The reason why she had gone to it was a sort of a sad story—she had gone to Ohio to plan for her wedding and get bridesmaid dresses for her wedding party. They were in this sort of small, boutique bridal shop. It was also a couple weeks before homecoming for a lot of schools, so the shop was packed with teenage girls and their mothers, and it was a small store, and so no one knew if there was more casual contact, if they had brushed up against her. There were a lot of really concerned people, and a lot of people who we had to contact and follow up with and make sure that they didn't have a lot of really close contact with the nurse.

We were really lucky because besides me and another EIS officer, we had a communications specialist come with us; we had someone from the CDC leadership who was there to help liaise with the higher levels of the public health department, and to help deal with some of the more political aspects of what was going on. We also had one of the Ebola specialists. It was a really great team to have out there.

We were working fourteen, sixteen hours a day, for about ten days, to help the local health department and the state health department get a full list of all of the people that she had visited, had contact with, all the people who had been at the store. Then it was decided that we also had to contact all the people who had been on both of her plane—the flight to Ohio and the flight back down to Texas. It was a lot of coordination, and a lot of coordination with other health departments—both in other states, and then also in other counties in Ohio who were tasked with following up with residents in their jurisdictions. But I think the counties and the state of Ohio did a really great job for managing a really intense situation that really hadn't happened before.

There was a lot of questions that were being asked that we just didn't have answers to because we had never had Ebola cases in the US. There were a lot of really interesting issues with patient confidentiality. For one great example, a lot of the first responders wanted a list of every single person that was being followed up, or that was being monitored, or was under quarantine. In case they got sick, they wanted to make sure the first responders were able to have the appropriate personal protective equipment so that they wouldn't be at risk when transporting that ill person to a healthcare facility. Which is great. Which makes sense from the healthcare provider's point of view. But from the patient point of view, the vast majority of those people that were being followed up were at low, low risk categories. But a lot of them had other health conditions. So the concern was that, what if someone has a heart attack? What if someone has a diabetic crisis? What if someone has an issue associated with the stress of being in this situation? And

their access to care gets delayed because of concerns from the first responder side? Trying to walk that line and provide enough information without compromising privacy was really interesting to get to be a part of.

There was also a dog in one of the quarantined homes. So, trying to figure out what to do with the dog. Because at that point, it was up in the air whether or not dogs could contract Ebola from humans, and how would you treat the dog. And the other nurse's cocker spaniel—or King Charles Cavalier down in Texas, ended up costing the Texas health department a lot of money because they put it under quarantine and had a full slate of—I think they were Texas A&M [University] veterinarians who were caring for that dog during a twenty-one-day timeframe. Because we assume if the human—[laughs] if the human timeframe is twenty-one days, then sure! The dog's timeframe is twenty-one days too. Why not? So that was my—and then they flew us back on Southwest [Airlines]. We arrived in a private jet and then flew home in economy-class Southwest, which was a fun, nice bookends to that experience.

Q: I have a few follow-up questions now, just going back to—just reflecting on Ohio. I'm organizing my thoughts here, sorry. You mentioned that it wasn't like the normal protocol through which you were invited to come and help in Ohio. What was the protocol that got you to Ohio in the first place?

Basler: As far as I know, it was the fact that the governor said CDC is going, please—the governor asked for support directly. Normally, the ask for support from CDC comes from

state or local health departments, depending on who has the jurisdiction on the issue. When we get asked to a state for an *E. coli* outbreak or *Salmonella*, it's a fair bit of paperwork, it takes a little while, and it's done with everyone involved making sure that we're going in as support. And then this was done in a very different—[laughs] very different way.

Q: I hear you when you're saying, we got there, and people are asking us, "What are you doing here?" Can you give me an example of a time when you saw that tension kind of coming to the fore?

Basler: When we had our initial meeting with the local health department, which was, again, late in the evening. They had been working pretty much flat out for two or three days at this point. They were overwhelmed. My assumption is that they were feeling like the Feds are coming in to take over the show, and to push them to the sidelines, and to tell them that they're not doing their job appropriately. None of those things are what we were wanting to do. We were like, whew. We approached it as, we are here to provide support. We have a little expertise, just because some of our team had literally just done this two weeks previously in Dallas. We had some sort of lessons learned from that, and had some potential pitfalls that we could hopefully help the local health department avoid this time around, but we had no interest in taking control away from them or taking over the show. In that initial meeting, there were some blunt questions of, what exactly is CDC's role here? We tried to calm the waters there. We had a fairly quick turnaround, because that meeting—I don't know if it was that meeting or another meeting that

evening, but we ended up staying at the health department until one or two in the morning. We went through the list of known—we went through sort of a timeline with the county of the ill person's movements throughout her entire time in Ohio, and the list of people that we had known she had contact with. We had gone through with the health department to say, what do we know about these people? Who's been contacted? Is anyone symptomatic at this point? Who are we following up on? Are there any people that we feel like should be classified as potentially being kept under home quarantine, or closer observation, versus, this person seems like they were just in the same building so have them check their temperature and report in to us, versus, do we need to have someone physically find them? Helping them walk through those decisions. It helped them realize how much needed to be done, and where we could provide some additional support. I think it was a fairly quick turnaround, but [laughs] it was a little rough when we first landed.

Q: One thing that you mentioned—and this is going off on a bit of a tangent, sorry—was there one specific city that you spent most of your time in?

Basler: Akron, Ohio.

Q: Akron. Do you happen to remember how many contacts eventually that were traced in Ohio?

Basler: I should. I don't remember the exact number, but I think it was 127. We were actually really lucky in that she had a lot of contact with her parents, her mother and stepfather, and some members of her wedding party and the bridal shop, but that there weren't that many other places besides the airplanes and the airport. It wasn't as extensive as it could've been. But just trying to come up with a standardized way to keep track of and make sure everyone's getting followed up, and making sure all that information was being reported up the chain on a daily or twice-daily basis. We were giving reports to the head of the [Summit] health department, we were reporting to the state health department, we were having regular calls with the other health departments—the other local health departments that also had cases—because we needed them to follow up. We were having calls with CDC. We were having calls with the governor's office. And we actually had one really amazing conference call with President Obama, who did a joint call with the team in Ohio, the team in Dallas, and then the three teams in Liberia, Guinea, and Sierra Leone at that point. Which was an amazing experience. But it was a lot of follow-up calls across the board. [laughs]

Q: Were you hearing what the people in Dallas and in West Africa were saying, too?

Basler: Yep. Not on a regular basis. For that conference call, we had an opportunity—well, specific people from the different teams had an opportunity to ask questions to see what the overarching plan was, and what the response was. That was really nice, to sort of get the idea of what the picture was in the West African countries and how things were progressing in Dallas. While we were in Ohio, the other EIS officer who I was with had

previously worked in Dallas, and he was really excited because the man who died in Dallas, he had been sick at his home and had been staying with his extended family for a couple of days. There was a real concern that they were high-risk contacts and had a chance to potentially get sick. But they passed their twenty-one-day quarantine period while we were in Ohio. That was a really happy day, to see like, no one that we have in Ohio had anywhere close to the level of exposure that some people in Dallas had. That was really good to hear.

While we were in Ohio, we were also helping with community events. Because there was such a high number of contacts in the Akron area, there was a lot of fear, and there was a lot of fear of letting children of contacts go to school. We were able to help with a couple of events where parents could come in and ask questions to the health department, and we could say—we were trying to help ease some of their fears. To say, "We can't ostracize these kids." These kids weren't at risk of getting sick. "Here's what we're doing to follow up on the people who were at risk. But we're not putting children who are a high risk of getting ill in the general population. They're not in school with your kids." There's really a zero percent chance of this happening. The flip side is that any side of messaging we were having, we were having a really hard time—even though we knew that the risk for a lot of things was utterly miniscule, saying that there is a ze—as an epidemiologist, a zero percent chance of something happening is really painful to say. Because you don't want to be that guy who has the horrible luck of one in a million, when something actually happens. It was interesting to try and come up with public communications that both got

our points across in a coherent way, without straying too far from what was scientific fact at that point in time.

Q: I'm glad you went into that, because I was thinking throughout this, you're having this conference call, you're listening to people in West Africa who are dealing with an ongoing, devastating epidemic, and in Ohio it's a different situation. Different risk.

Basler: It was a dramatically different situation. For the US, I think it was a much—it was very political, as well. There was a lot of political pressure, and there was a lot of media attention. It was in the middle of a series of events that led to a lot of almost hysteria in the media and the general public about what was happening. The dominoes were the first case in Texas, and then after publically saying that this is fine, this was one case, we're not going to have more, then having one nurse get sick, then having a second nurse get sick. And while we were in Ohio, Kaci Hickox, I believe her name was, was the nurse who was coming back from West Africa who had been forcibly quarantined in New Jersey. And then there was a returning physician in New York who also got sick. It was really interesting because I think the political pressure was very, very high for the health departments and for public health in general. There was a lot of push to make decisions and to take actions that didn't necessarily have a lot of scientific backing to it, but looked good. Like, it looked like you were taking a strong—you were being tough on Ebola, and quarantining everybody, and everything's fine.

Q: What's an example of one of those things?

Basler: I think the great example of that was the attempt to do a forced quarantine of every returnee from West Africa. I think at that point, CDC was just starting to get a monitoring program up and running with the states for returning deployers, and for just returning nurses and doctors who'd been working overseas, so that wasn't in full place yet. I understand why states were a little concerned about that. But it seems like a lot of the media coverage was focused on the fact that "we can't trust doctors and nurses," specifically, to take appropriate action and protect themselves. Because "we all know that doctors make the worst patients, and that they would not seek care if they got sick." Which, I think, is just the complete opposite of what the case was. I think any person, the moment they spiked a fever, would want to contact public health and take the appropriate actions. Which is what happened for the nurse in Ohio, and what happened for the doctor in New York. Once they hit a fever, they started contacting and took appropriate action. But that's not what was portrayed in the media. What was portrayed in the media was, "these people are doing bad things and are putting the general public at risk! We don't want Ebola here, so we're just going to put everyone in a tent outside of a hospital in New Jersey, and that'll be a way to solve the problem." It was really bad, predominantly because there were only five entry points for returnees from West Africa at that time. It really didn't matter what the public opinion was, or what the politics were in every state. It only mattered what the politics were in [Washington] DC, Georgia, Chicago, New York, and New Jersey. It was really scary when New York and New Jersey said, we are going to quarantine everyone. Then it was like, alright, how is this going to affect the ability for doctors and nurses and other volunteers from the US or from Canada to get

over there, and then to get back? If you're threatening to lock someone up for a month after they've been gone for one or two months, working in a really difficult situation, that is going to dramatically decrease the amount of people who can volunteer when there's a huge, huge need for help in those countries. I think that was the biggest thing, was the treating of returnees who were volunteers and were doing amazing work, treating them more like criminals. I think that was the best example of decisions that were made because they looked good, but didn't really have scientific backing.

Q: There are a couple of questions I want to make sure I wrap up. Sorry, I'm being a little scatterbrained.

Basler: Oh, no worries.

Q: One was—so there were a little over one hundred contacts eventually in Ohio. You mentioned that it was lucky that the second nurse hadn't gone to too many places. Were the contacts pretty centrally located in Akron? Or was it across Ohio? What was the geographic dispersal?

Basler: The majority of them were in Akron, but there were contacts in other—who lived in other jurisdictions, and most of those were low-risk contacts from the airplanes, or low-risk contacts from the bridal store. Basically, the health department used social media to reach out to the general public to say, if you shopped here on this day between

these hours, we would like to talk to you, just to cover our bases and make sure we're not missing anybody.

Q: Can you tell me about the conversations that you had with people who were contacts?

Basler: I was helping out more in the health department. I was doing more of the phone calls, so the other EIS officers were going out and helping with some of the visits, the quarantine site visits, and dealing with making sure that the people who were forced to stay at home were having their needs met. But for the calls, a lot of what we were trying to do was to provide information but not scare the crap out of people. Because Ebola's a really scary thing. Like I was saying, especially back in October of 2014, it was utterly terrifying by how the media was portraying it. To say, just making people know what to look for. To take their temperature twice daily, what numbers to call if anything happened, but that everything that we're doing right now is due to an overabundance of caution. We are at very low risk, but we just want to make sure you're going to be okay. We were trying to provide as much information as we could to help keep people from having a very stressful twenty-one days.

Q: Thank you. We're probably good on Ohio for now. Tell me about what happens after Ohio.

Basler: After Ohio, I had actually—well, before Ohio, I had gotten permission to do a longer-term deployment in West Africa. I had volunteered for that, and had volunteered

for about a thirty-day deployment for the month of November. I figured I could miss Thanksgiving but make it back in time to go up and visit my family up in Massachusetts for Christmas. They were trying to match people with the teams and with countries, and I think there was a lot of moving pieces in our Emergency Operations Center here in Atlanta. But the initial responses that I got were like, you're on the list, you are going to West Africa starting in early November. I was like, great. Which country am I going to in West Africa? And the response is, you are going to West Africa in early November. [laughter]

Eventually, I found out that I was going to be deployed to Sierra Leone. And then eventually, I found out that I was going to be—like, the day before I left, I found out that I was going to be part of the epidemiology team in Sierra Leone. The CDC response was really ramping up in Sierra Leone. The CDC had set up a mobile lab in one of the areas where there was a hotspot of illnesses. They had set up a satellite emergency operating center in a giant ballroom in the Radisson Blu [Mammy Yoko] Hotel in Freetown. Then they had a social mobilization team which was more on communications side, they had an infection prevention and control team, and then they had an epi [epidemiology] support team. I was on the epi team, and the training before we got there was fairly basic. It was pretty much, you're going to try and provide standardization and support to the Ministry of Health [and Sanitation] and the local district health departments on case investigation, contact tracing, helping them with the database system that's up and running. Because this was a ton of information and not a lot of people had a lot of technical expertise in-country. And then, helping wherever else we could.

I had about a—I think it was a ten to fifteen-day gap of being in Atlanta, coming back from Ohio, and then we flew out for Sierra Leone. We flew to Brussels, and during the layover, I had a fun conversation with a friend of mine who's another EIS officer. [note: Jessica Adam] She's an MD [doctor of medicine] by training, and really hates flying because her big concern is, what if there's a medical emergency? Because she hasn't done ER [emergency room] medicine for a while, she did her residency in internal medicine and is now in public health. She's like, I haven't done that in a while. That was a conversation that happened in Brussels. We changed flights and got on our Air Brussels [Brussels Airlines] flight. It was pretty much the West African local bus route. We stopped in Senegal to take on the high-risk flight crew that was specifically servicing the West African region, and then we stopped in Guinea, then in Liberia, and then in Freetown. At this point, there were only two airlines that were still flying to the Ebola-affected countries, and there were only two flights a week. So there were limited opportunities to get in and limited opportunities to get out.

Freetown, it's built sort of like San Francisco. It's on the ocean, but sort of built on the sides of very large hills and mountains. There's no real place for a nice airport in Freetown. The airport is across the bay, in another part of Sierra Leone. We landed, and then had to get into a ferry to cross over to Freetown. While we were getting onto the ferry, our deputy—the deputy country director, I believe that was his title—slipped in between two portions of the floating dock, because this was ten o'clock at night and we couldn't really see things well. He slipped and got stuck, and ended up having his ankle

broken in three places. We had to get him out, get him onto the boat. My friend who had just been telling me about how she hates traveling because she's not good with ER medicine was in the back of a bouncing boat at 10:00 pm at night, boating across a bay in Sierra Leone, trying to assess the state of his ankle. That poor man had a very brief trip to Sierra Leone. He got x-rayed at the embassy the following day, and then got medevacked back out. But then he came back afterward. Once he healed, he went right back to Sierra Leone, so that didn't stop him from volunteering a second time, which is pretty impressive.

I stayed in Freetown for only a couple of days. When I first landed, I had received an email from an epidemiologist, Tim [Timothy] Styles, who was working out in Koinadugu District, which was one of the outlying districts in Sierra Leone. It borders Guinea. Known for their chili peppers. He emailed me, and his email was basically, "Hey, you're replacing me. Make sure you pick up a tent, sleeping bag, a week's supply of MREs"—which are the meals ready to eat, the army food—"and here's your e-ticket for the UN [United Nations] helicopter that's taking us out there on Tuesday." At that point I was sort of thinking, what the hell have I gotten myself into? [laughs] We spent a day or two sort of catching me up to speed on what the situation was out there. Koinadugu had been spared a lot of the worst, the brunt of the outbreak, because of its geography. It is a hard-to-reach, very mountainous location. There was a fairly localized outbreak happening in one chiefdom in the district, but besides that, there hadn't been any cases reported from anywhere else. We were going to help the district health department—Ministry of Health—get up and running, and make sure that cases were being identified, contacts

were being followed up, and making sure that that information was then being entered into the database and transmitted back to Freetown.

Q: What was the district where the outbreak was occurring?

Basler: The district was Koinadugu District—

Q: I'm sorry, the—

Basler: —the chiefdom was Nieni chiefdom.

Q: Nieni chiefdom. Okay.

Basler: We got a couple of good maps and realized that the chiefdom where the outbreak was happening was a border chiefdom with Kono District and Tonkolili, which were two districts that had both had a number of cases at that point. We were in the dry season, which was good, which meant that some of the roads were a little more passable. But a lot of the roads were really nothing more than goat tracks. To get from Kabala, the district capital, down and around to Kumala, the paramount chief's seat—so, the districts are split into chiefdoms, and there's a paramount chief for each chiefdom, and then each—there are subchiefs for different subregions in a chiefdom, and then below that, each village or community has their own community chief. The outbreak was happening in Kumala, which was the seat of the paramount chief for the Nieni chiefdom. That was

another sort of big political thing. Once the team before me was able to get him on board with, yes, this is a problem, yes, these mysterious deaths are due to Ebola, they were able to get WHO [World Health Organization] to come in and set up sort of a community care center.

We took the helicopter out to Kumala initially, and we met the other CDC person who was there at the time, Nick [Nicholas] Burton. He was a social mobilization person, so he's from our CDC communications team. They had driven in. I met him and we drove the six hours to get back out of the district, around through Tonkolili and back up to Kabala, the district capital. But the community care center was pretty much made by three really intense, very impressive WHO volunteers, who were all ex-MSF [Médecins Sans Frontières], and who were basically what—if you were casting for grizzled, weathered, European aid workers, these would be the three. [laughs] Chain smoking, all really tan, all a little on the leathery side. A German, a Swiss, and a Frenchman. They built this place from scratch and were trying to train some of the local nurses on appropriate PPE, and they were pretty much running it with really limited resources, which was very, very impressive. Basically, when they arrived, they'd turned a school building into the community care center, because all the schools had been closed during the Ebola crisis. But when they arrived, the community had just been putting sick individuals in a separate school building and were just sort of leaving them there to die. Which was a really rough situation. They were able to sort of get things up and running, get an opportunity to get testing happening, and to provide basic rehydration and basic care there, while we were waiting for one of the three ambulances to come back to do the

day-long drive to take patients out to one of the hospitals. Which, none of the Ebola treatment units were nearby, and especially at the beginning of my time there, a lot of those were full.

The process was, once we had a couple of sick people, we had to try and figure out where we could put them. Are they in a position where it's ethically appropriate to move them? Are they on death's door, or would they survive a day-long car ride? If so, are they going to Freetown, are they going to Bo? Where the hell do these people go? That was really interesting. In order to figure out how to move people, we had to get blood samples out to the CDC lab, so that was another logistics issue. The UN helicopter that we came in on, eventually they were able to start running a regular sort of delivery route to stop in the different districts that were outlying, pick up lab samples two, three times a week, and drop them at the Bo lab. Which was a huge time and equipment and personnel savings, across the board. Because you didn't have to devote an ambulance to try and get through some very bad roads.

I was in Koinadugu District for about three weeks. Some of the time there were two of us, for some of that time I was the only CDC staff person there, which was interesting. It was nice because we had support from Freetown. But I could sort of do what I wanted—it was not a set goal. It was sort of, help however you can, be it trying to do trainings, to update the line list, making sure contact tracers were doing their work appropriately, making sure that we could just get rubber boots for the contact tracers who hadn't been paid at all, to make sure that they would still go door to door and do their job.

One of the biggest issues that was happening, especially in a lot of the outlying districts, was that people would get sick, the scary people in the white suits would come, take them away, and they would end up being transferred from a community care center to an Ebola treatment unit. There was no good way to relay that information back to their families, and to their villages that they came from. In a lot of instances, people who were really sick, their families wouldn't want them to be taken because they're like, if they're going to die, we'd rather them die in the village—that way they can still be part of—there's some really interesting anthropologic studies in the region that had been [written] previously. Just with the history of the region, there was a lot of distrust of outsiders and distrust of government post–civil war. A lot of the communities believed that if someone died outside the village, they would not be able to be part of the village afterlife. And as a corollary to that, if someone died outside the village, they would then potentially come back and haunt and bring bad luck to their families. In that tradition, it made perfect sense that, if one person died outside of town, then all of their other f—or if you didn't do the appropriate washing of the body before burial, it made perfect sense that additional family members would start to die one by one. Because you upset the initial spirit, and so this makes total sense. Trying to explain germ theory and explain what Ebola is, when it goes completely against cultural norms, and when what we're—yeah, what we're recommending goes against cultural norms, and when the series of events that's happening is perfectly explainable by traditional cultural practices, they're like, this makes total sense that more people are dying, that more people in specific families are

dying. There were a lot of difficult beliefs to try and overcome, and a lot of difficult educational points to get across.

Q: Yeah. Because in that belief, it's actually the taking away of someone which leads to further death. It's a bad action itself.

Basler: Yes. If someone is sick enough for an ambulance to be called, and for them to say okay, maybe it's Ebola, they have gone through whatever—they've spent a couple of days doing traditional healing routes. They've probably seen at least one traditional healer in the area, and nothing has gotten better. That was something, that was another message, was that if we can get—it was tough because initially in the outbreak, all these people were coming into facilities so late in their course of illness that there was not much—that they were probably going to die. That there was not a lot that healthcare workers could do at that point. Especially in areas where they weren't able to put in IVs [intravenous lines], just because they didn't have the appropriate supplies. Versus, if we could get people to come out of their villages early, not only would we be able to better protect their families, they would have a better chance of survival. That was a really important but really difficult message to get across. Especially because—so it was a very hilly part of the country. For a lot of these villages, the contact tracers would have to hike up to the top of the hill every day to try and get cell service to call out and say, hey, we have two, we have three, we have four sick people, you need to send an ambulance. And that ambulance might not get there until the following day, depending on where it was

coming from. And you couldn't call back and ask follow-up questions, because if they weren't still on top of that hill, that wasn't helpful.

Q: Was it one of your roles to help do this kind of communicating about germ theory and all of this?

Basler: Luckily, the social mobilization teams—and Nick, the other CDC person, who was more on comms—was more on the communication side. We would normally go out together, and he would make sure that if we were, as an example, going with a burial team or doing a spot check with contact tracers, he would make sure that they were providing the appropriate talking points and giving appropriate information to the quarantined homes. Saying, "We can help. Will you seek early care? This both helps you get better, but also protects your family members. If someone gets sick, let us know." And then on my side, I was trying to make sure that the contact tracers were going through and actually checking on every person and making sure that they were following up and asking appropriate questions when they were—and making sure that when there was a case, or if a dead body tested positive, that they were going back and not just putting the three family members that they saw on the list, but asking and making sure that they're like, okay, I know that he lived in the house with these three people—who else did he have contact with on a regular basis? Is he from a polygamous family? Does he have a second household? Is there a second wife involved? Does he have a girlfriend on the side? Did he travel to Freetown recently? Does he travel to any other villages recently that we have to start extending outreach to?

Q: Right. Wow. Can you tell me about a specific conversation or instance that you had interacting with a contact tracer you were training, that sticks out in your memory?

Basler: Yeah. One of the lead contact tracers for Kumala was fantastic. One of the big issues throughout the response was people not getting paid on time. A lot of these people who were volunteers to do risky jobs were not getting reimbursed for it, which was completely unacceptable. But these guys were still out, were still doing their jobs, and were like, we hope we'll get paid eventually. Philip Kamara, he would come in, and he would have his written-down list, and he would go through and be like, I saw this many people today, and this person has gotten sick, so we need to get someone out, we need to get an ambulance out to talk to him, and then we will have three more people I still need to check up on later today, and these two people have absconded from their homes, they're not there anymore and we don't know where they are. It was like, okay, we need to try and find them. But yeah, the contact tracers were doing—I mean, there was so—it really turned into, especially in the rural communities—well, I think in the cities too, but I didn't have as much experience there. There were so many people who had to be involved in these responses. It really turned into, if you didn't have buy-in from the village leadership, it was really hard to get people involved, and to get enough people that you needed. Because you needed—there had to be people who were trained to do safe burials when people died. There had to be contact tracers trained. There had to be case investigators trained. There had to be people who could go out and take swabs from people who had died. And in the rural areas, just family members or some of the local

nurses were acting as caregivers, and they had to be trained on providing PPE [personal protective equipment]. Logistically, just the amount of buy-in that was needed from communities was pretty high. Unfortunately, that amount of buy-in peaked once the outbreak reached a certain point in that particular community. Which was a little unfortunate. It would've been nicer if we'd been able to convince communities to buy in earlier on. And there were some communities that were just intransient, and that were just saying, nope, we do not want your help, we do not believe you. I think luckily that was something I never really saw firsthand. That was a bigger issue I think in some parts of Guinea, and some parts of—more rural areas, because they just didn't trust people coming in.

Q: Sure. Any other specific memories that you have of Koinadugu, anything you remember seeing or saying or—

Basler: Yeah. One of the things that really stands out for me was when we—it was early on. I think it was my first week there. We were going out to do a site visit to this village where there had been reports of some deaths, and where the burial team was not fully equipped with body bags, or with the appropriate PPE. We were concerned that they were being put at risk because of lack of equipment. Also, the fact that there were additional deaths in that village was also concerning because we hadn't really heard what was going on much from there. We went out with someone from WHO, a Sierra Leonean who was on the communications team. We went and saw the local health clinic and talked to some of the village leadership. In this community, there was a village chief, and the subsection

chief, were both in the town, and then there was the mammy queen, which is sort of like the leader of the women in the town. The village chief and the mammy queen were both under quarantine. About a third of the town, at this point, was quarantined. We were having a conversation with the village leadership and with the burial teams, and they're like, come in, stand out of this shade, come up on our porch. This house had—like, a lot of the houses set up had some very large front porch spaces. We were up on the porch, like, okay, we're in the shade. And as we're standing up there, the crowd of men grew. Because there's people in town, everyone wanted to hear what was going on. The WHO representative was saying that the entire—and he was saying this in Krio, which is a sort of—it's English, but it sounds almost—it's a patois, but it sounds like someone speaking with a really strong Jamaican accent, which is a little odd to hear for the first time. It's like, this is not what I should be hearing here. But he was talking very quickly in Krio, so we, who were also standing on the porch, we could understand bits and pieces of what he was saying, and he was saying that the entire burial team had to be quarantined. Which, the burial team were—they were using appropriate PPE, but they had run out of body bags. Which wasn't the best situation, but did not really—like, they needed to continue to do their job and do their job as safely as they could. He said that, and then the burial team got very angry, and then the village leadership got very angry. Culturally, a lot of conversations are done at shouting level, which made meetings really interesting. That was very common, just have a lot of people yelling all the time. But this—the yell, it was different, because it was definitely a little more—you could sense the frustration and the anger in the crowd. That was really the only point in Koinadugu where I felt that I was like—this was not a good situation, we have no—if this escalates, we are completely

hemmed in. We're surrounded by a house and a fence, so we can't get off this porch quickly. Even if we could get off this porch quickly, it would be sort of elbowing our way through a large crowd of angry villagers, which wouldn't be the best scenario for a number of different reasons. That was the one sort of like, okay, mental note. [laughs] We got the WHO guy to sort of take a step back and recommend, "Okay, we can get you more body bags. This doesn't require a full quarantine. Continue to do your job." Without having him lose face, which was good, and without causing more anger in the community. That was definitely the most concerning event that I was a part of there. But it turned out fine, which we were very happy about.

I think the one other one from Koinadugu was about halfway through my second week there. Nick, the comms guy, comes over and says, "We're getting a Washington Post reporter and photographer, who are flying in on the next helicopter. They're going to be staying with us for like three days. Good luck." He was like, "Don't say anything stupid." [laughs] Okay. Thank you. And they were great. They were not as scary as I—because I was just a little shell-shocked from the media circus that had been in Ohio, so I was like, I don't really want to deal with this again. But they were great. While we were there, the big—this one story that they spent a lot of time covering was that back in Sumbaria, the village where there was the angry burial team, a couple days later, one of the contact tracers had hiked up the hill and called out and said that there was a family that's sick here. The ambulance had gone out, the mother had died, and so the father was in the house with—and she had tested positive for Ebola. The father was in the house with two small children under the age of ten. The girl was sick at that point. The father and the son

weren't, but she was sick. The ambulance came out to say, we need to take your seven-year-old daughter into the community care center for testing, to see if she has Ebola. And when the team was trying to get her into the ambulance, the entire town started wailing, because they—when the ambulance came to take someone away, they started going through sort of the grief of burial because they felt like it was a lost cause, that she was going to die. She got very scared, jumped out of the ambulance, hugged her father, and her father said, "I can't send them into the ambulance." He grabbed his other child, and all three of them went running into the bush. It took two days to find them, for community members. That was something that we couldn't help with, as white foreigners. We would not be the ones to try and convince them to come back. Because a lot of villagers, they're all farmers, and so they had sort of huts by their different maize or chili fields. He was out in the bush somewhere for two days before the contact tracers—that town had some other awesome contact tracers—were able to go out and convince him to come in to the community care center with both of his kids. They came in, she tested—the girl, the baby girl, tested positive, and so she was—she had to be sent out to treatment. That was another series of conversations to convince the father that this is the best thing for your daughter, we will try and keep you in contact as much as we can. Then she was sent out, and she actually survived, which was wonderful. It was nice to have a happy story, surrounded by a lot of sadness. And the father and the little brother never got sick, which was also amazing, after they spent a lot of close time with her out in the bush. But, yeah. That was my other Koinadugu story.

Q: Thank you. As you can see, the computer has jumped up with this little box, so I'm going to take care of that, and then maybe we can continue?

Basler: Sounds good.

[break]

Q: After Koinadugu, do you go straight to Kono District, or what happens?

Basler: While I was in Koinadugu, every weekend, we would try and get back to Freetown. It was nice to be able to take a shower. For most of the time at Koinadugu—I only had to go camping once, which was nice. For most of the time, we had guest houses to stay in, and I ate more of those MREs than I ever wanted to. For my entire time in Sierra Leone, I had a fantastic driver. I'm blanking on his name right now, but I'll just try and think of it later. [note: Supaya] He was a large guy and he always wore a cowboy hat as a way to pick him out of the crowd of other drivers, which was very helpful. When we had to be stuck out in the field and were camping, or were stuck in places without easy access to restaurants or cooked food, we would eat the MREs. I'm like, "Would you like one as well?" After we did that in Kumala, the following day when we were driving out, he turned to me and goes, "Mister Colin, thank you so much for the meal last night. I had it out in front of the paramount chief's house with some of the other drivers." For the ready-to-eat meals, they have a little chemical packet inside of them, so you add water and then a chemical reaction happens, heats up the food, but steam comes out the side of

the bag, like, a white smoke. He was like, "When I was making the meal, everyone came around to look at it and said, 'What is this magic?'" And then he said, "'No!' I said, 'Don't worry about it! It's white man magic. It's okay.'" I was like, "Supaya, that's not helping the situation right now. Please. [laughs] I don't want to be known as a witch in this part of the world. Glad you appreciate it."

Every weekend we would drive the six hours back to Freetown because we would have an epi team meeting every Saturday. It was a really good opportunity to get more supplies, but then also to hear what was going on in the other districts. What good things were happening, what things were problematic. For other districts that had dealt with problems that I was having, it was a nice way to get ideas on how to work through things.[1]

After three weeks in Koinadugu, the outbreak there was really settling down. There were a couple of WHO epidemiologists there, and the number of cases was really dropping off. We went from a high of a case coming in every day to one coming in every couple of days. We did a big push to do a canvassing, and it seemed like most of the cases had been identified. Because it was a holiday season, a number of the other districts were having trouble staffing shorter timeframes between longer deployments. There was a new bunch of CDC staff coming in after Christmas, but between Thanksgiving and Christmas, different districts were having a week or two-week period of having no one from CDC

[1] Note from C. Basler, August 2018: Examples include learning what were some of the best practices for re-integrating survivors back into the community or how to better coordinate burial and contact tracing teams.

present. So I started acting as sort of a stopgap epidemiologist for the short term in these districts. I spent like a week and a half in Bombali [District]. I learned what was happening from the outgoing team, tried to keep the wheels on the bus for a couple of days, and then sort of trained up the incoming team who would be there for the next six weeks. Then did the same thing in the Tonkolili District, and then moved to Kono District for three weeks after that. It was a nice—it was really interesting to see what was happening well in other districts, and what was not happening at all in other districts. They were all really different, just because they were at different points in the outbreak. Different districts had, you know, a working emergency operating center, and had British military support for longer periods of times, and so they had more of the operations and the logistics were better up and running. Versus other districts like Kono, where the British were just trying to start getting an emergency operating center off the ground, and it was very new in that outbreak there. It was a nice variety. In Bombali it was—so, in comparison to Koinadugu, which was a very small room, very small staff, not a lot of people, in Bombali, they had pretty much taken over a major hall. And that was just filled with people, and there were multiple people on every team, and there were phones and laptops for everybody, and it was one hundred degrees in there all the time. It was a much larger operation, because that was in the Makeni city, which was a much larger urban area, versus where I had been previously.

The big issue that happened right before I got there was that there had been a—a couple there in the neighboring district. Bombali and Tonkolili are right next to each other, and the CDC teams for both districts stayed in Makeni together. Before I arrived, the CDC

team in Tonkolili had been pulled out because there had been a couple of safety issues. One of the district surveillance officers, who's Sierra Leonean, after working for a couple of days, developed symptoms. He had actually been sick for a couple of days, working closely with the CDC team before he was diagnosed and sent to an ETU [Ebola treatment unit]. That was a bit of a shock. The day after he was diagnosed, one of the CDC drivers was also tested positive for Ebola. That just sort of caused a lot of issues. There were some people who were sort of medevacked home early. No CDC staff got sick, which was good, and actually, both the district surveillance officer and the driver both recovered, which was wonderful. But it meant that CDC had no presence in Tonkolili District for a number of week—for about two weeks. For Bombali, it really changed how CDC and how WHO interacted with our driver staff. Because we were renting a fleet of cars, and a fleet of drivers were driving the cars for us through car agencies in Freetown. But in some areas, it turned out that they were sleeping in their cars, and in some places, like in the hotel in Makeni that had the CDC teams, it also had all of the drivers for Bombali, Tonkolili, it had all the WHO drivers, and it had all the African Union drivers. They were all being kept in really poor conditions that none of us knew about. They were sleeping with multiple people to a room, and they only had access to one or two showers, and they had to eat at like five in the morning before the guests woke up. It was very eye-opening to see how—sort of substandard conditions our drivers were being kept in. That caused a lot of changes for how we worked in-country. Which was good. It also meant that all of the drivers who had been there, of which there were forty, had to be followed up, and made sure that they were all healthy and didn't have fevers and weren't sick. At that point, a lot of those drivers had been reassigned to other staff in other districts. So

that became a huge logistic nightmare of trying to follow up on the CDC drivers to make sure no one else got sick.

Q: How does that—I'm going to adjust your mic quickly.

Basler: Oh.

Q: Just to make sure it's—it looked like it was completely on the side. No, it's still in front of you, that's good.

Basler: Cool.

Q: How does that happen? That the drivers end up in just these really substandard conditions?

Basler: We would be staying in hotels, and the CDC would reserve rooms for us, and there would be the drivers' quarters. And we never looked to see what those were, because we assumed that they were acceptable quarters. Because we'd be getting in at ten o'clock at night, and then leaving in the morning. I felt really bad when I found out about this, because it was something that I had never really taken under consideration. When I was in Koinadugu, my driver would be staying with friends because he had friends in Kumala and he had friends in Kabala. Or if we were staying out somewhere on the road in between, we would rent four rooms and he'd have his room, and I'd have my room,

and the other guy would have his room. But in the cities, where there was less space for both NGO [nongovernmental organization] staff and drivers, the hotels were like, we got rooms for you, too. We're going to put you over there. It was eye-opening.[2]

Q: Gotcha. Okay.

Basler: So I was in Bombali for a week. Moved over to Tonkolili, helped get that office up and running again. [laughs] The British commander in Tonkolili was named Charles Dickens, which I found entertaining. I don't think he found it nearly entertaining as I did. Trying to get Tonkolili up and running again, those meetings were outside under banana thatch that they had set up. Because there was no room in any of the buildings for the group of us to meet. One of the stories I remember from Tonkolili was that there was a—oh, there was a family who was under quarantine, so they were being monitored, and their son died. The family had a burial service for him and didn't tell anybody. A day or two later, the contact tracers found—the following day, they found out that the child had died, they had buried him in the home. One of the Sierra Leonean—I think he was a police officer—stood up and was telling this story, and saying how their plans—because it was illegal to have private burials in Sierra Leone at this time. The plan was to dig up the body to test it, and then the family members were all going to be sent to jail. So, I had to try and state that the CDC's position was that there's no point to dig up this body, because it was under a quarantined home. He probably died of Ebola, but we don't want

[2] Note from C. Basler, August 2018: The spaces some of the hotels provided were cramped quarters with four to six drivers sharing a room. Drivers also sometimes slept in their cars so that they could keep the per diem that was supposed to be covering their room and board expenses.

to risk putting any of the burial team at risk by digging up this body. That's an unneeded act at this point. And it's probably a safer option to keep the quarantined family members—who've just lost a child, and are grieving—to keep them in their home, but maybe have a soldier guard the house there, so they don't go—disappear. But to not put them into an overcrowded jail, where if they do have Ebola, could then cause a lot of damage further on down the line. There was just a lot of—there would be conversations and stories, and I would just have to stop every once in a while and be like, is this really happening? Are these really the recommendations that are being made right now? How can I address this without coming across as a complete m—without just yelling? [laughs] So, that was interesting.

Finally, my last time period was in Kono District. That district had had a bit of an outbreak early on, and there had been riots in Koidu Town, which was the capital of the district. My friend Tim Styles, who was the epi [epidemiologist] that I had been replacing, he had been there previously with another CDC staff person. We never really got the entire story, but a family member—I think the mother—of someone who was a local gang leader, or potentially high up in some not really traditional workforce, who had a fair bit of local power, had sick family members. The health department and the military came in to take the person to a hospital for care. Apparently, this guy was just out in the streets shouting. Yelling that, "White people have brought Ebola here, Ebola's not real, it's all lies, we're not letting them take my family," and basically incited a riot. The military came in, confronted the protesters—I think two individuals were killed, and during the riot, the entire health infrastructure of Koidu Town fled, basically. There was a

concern that the rioters were going to start targeting the Ministry of Health officials or doctors, and so the CDC staff exited quickly, and there was pretty much a mass exodus of anyone who would be in a position to help fight the outbreak for about two, three weeks. A couple weeks later, people realized that the situation was very bad there in Kono, and that the government hospital was overrun with ill individuals that were being just sort of kept everywhere. There was no care, and there was no good separation of Ebola from other patients. They sent healthcare workers back, and I was part of the first CDC team back into Kono.

They were able to get things set up. I never felt unsafe there, which was very nice. My strongest memory from Kono was that we were visiting a house that UNICEF was renting. Because it was becoming a chronic issue of, quarantined homes would be homes of only children, at certain points. Because if the father or if the grandmother got sick and was sent out, then the mother and father had been caring for the grandmother, then they both got sick, and then there would be a seven-year-old left in a quarantined home when her entire family was fighting for their lives to not die of Ebola. The question was, we can't leave these children in these homes. So UNICEF was trying to hire survivors as caregivers and set up sort of communal homes for kids who were under their quarantine period until they could find family members to send them out to. We were providing a sort of consultation service to try and come up with ways of how children could be kept there in safe ways, and being kept in cohorts, so they wouldn't necessarily be interacting with all the other children there. So in case one kid did get sick, it wouldn't mean that that entire group would have to start their twenty-one-day monitoring all over again. We

were going to visit this house, and we were told that there weren't children there yet. We walk in—there's a gated compound, which is very nice. We walk through the gate, and we hear laughter, and the door opens and these three adorable seven—between seven- and nine-year-olds run out. The seven-year-old runs out and immediately just hugs us around our knees. And like, ah! This was like my last week in Sierra Leone after being there for two months. I was like, I've done so good of not touching people, of not putting myself in high-risk situations, and now this adorable child—who I can't, like, kick away from me, because this kid is starved of affection, because his entire family is under quarantine—is hugging my knees. Okay. So then we're like, alright, well, we're just going to do the tour of the house while these kids are around. And then there was a two-year-old who was there as well, and we had some Plumpy'Nut, which was a high-energy peanut-butter-based nutritional supplement for kids, and so we handed those out. This little girl loved the Plumpy'Nut, and so she ate the entire thing really fast, and then ten minutes later vomited. Then we were like, we're ninety percent sure that is because you ate all the Plumpy'Nut really, really quickly, but again, ah! [laughs] That was a fun almost final experience of being in Sierra Leone. Of being like, I made it! I've done so good for so long! Dammit. [laughter]

Q: What happened with the little girl?

Basler: The little girl was fine. She never had any other symptoms after that. Actually, the four children who were in the house when we visited, none of them got sick, as far as we know. Which was good. The three that I was able to follow up on were sent to other

relatives who—like, they were able to have care. Because we weren't sure what—we were still having a hard time finding outcome information for patients. That was in general a huge problem, is that we just didn't know if people survived or not after they were sent out to ETUs. Which was really, really sad. We had sort of backup options for those kids, which was nice. There was a, I don't know, a squadron, or some unit of the British—so the British military had a really strong presence in Sierra Leone. There was this group of, like, twenty-two-year-old Scots who were helping out in Kono. A couple of them had kids, and so they had all these extra toys sent over around Christmas. We brought all of them over to the child's home, and they had tons of coloring books, and crayons, and stuffed animals and toys, so that was a fun thing to do right around Christmas. It was good.

Q: What happens then?

Basler: Then, after Christmas and New Year's in Kono, on January 3rd—or January 2nd—like, fly back to—and Kono was another outlying district, so I was commuting mostly by helicopter. Which was a Russian flight crew, and the first time we got on the helicopter, their security brief was, "Seat down. Put on seatbelt. Do not move." You're like, alright. I can do that. And they would get out and be chain smokers at every single stop on the route. They were able to get a lot of people and a lot of supplies to very remote areas. We flew back to Freetown. I loved the helicopter rides because it was beautiful to get to see Sierra Leone from above. There was some really beautiful countryside. And was able to do some sort of final debriefs in Freetown, and then get on the ferry. The last day or two

in Freetown before leaving was always a little on the stressful side. Just because you've made it this far, and had never really had any major GI [gastrointestinal] upset, I had never any fever, I had no problems my entire time, but the big concern was that, if you spiked a fever or any other symptoms and were recognized to have those symptoms in the Freetown airport, then you would be sent to an ETU. That would be a very dangerous place to be. There had been a couple of close calls, where someone had gotten seasick crossing over the—because it had been choppy waves, and she then vomited over by the airport, and then they had to fight to keep her from being sent directly to an Ebola holding center, which would've been a really bad situation. Because at that point, the outbreak in Freetown was still really, really bad. There was a lot of places where people maybe were being sent to holding centers because they only had malaria, or had—they had symptoms of Ebola, but didn't necessarily have Ebola, but were then being exposed to Ebola in those holding centers, which was a really scary concept. But we made it through screening, made it onto the plane.

I enjoyed the Brussels lounge, and then spent the following twenty-one days just doing self-monitoring. I flew back to Atlanta, was in Atlanta for about a day, and then flew up to Boston to do sort of a post-holidays visit with my family. Part of the reason why I extended was that about a couple weeks into my deployment, I had been talking to some people from some of the NGOs who were heading back for Thanksgiving. This one guy was saying, "My mother-in-law isn't letting me come to Thanksgiving because I'm just coming back from Sierra Leone." Which was something I hadn't really thought of before. I would try and talk to my parents once a week, and try and keep them from being too

stressed out about what I was doing over the holidays. But when it was leading up to Christmas, and when I was trying to decide whether or not to extend my trip or not, I brought it up with them. Initially, they were outraged that any of our family members would potentially think that—would disinvite me from holiday gatherings. I was like, no, you need to talk to them and see. Because this is something people aren't thinking about. I have a nephew and a niece who are both under a year old, and I have a couple family members who work in other healthcare professions, and so it was something that hadn't really been thought through. Once it started to become apparent that there were some family members who would be less than comfortable, I would be like, alright. I am perfectly happy. I feel like there's enough for me to do here. I can extend through Christmas, there's a need. And then I can come home and visit you guys in January and see whatever family members are willing to see me at that point. Otherwise, I'll see everyone in August. So, it was good.

The transition back was rough. Coming back to this version of the real world after that was interesting. I think the biggest issue was human contact again. It became so second nature to not shake hands, not hug people, no touching in Ebola-land. I did not realize the additional sort of—not really stress, but just the mental energy that was needed to be constantly aware of where you were and what your surroundings were. And transitioning back, to be like, oh yeah, I can hug my loved ones. I don't have to be concerned while I'm riding the subway, or in a taxi, or anything like that. It was a longer transition back to normal than I was initially anticipating. So, yep. And then I got to go back to foodborne outbreak stuff after that.

Q: How long do you spend there?

Basler: Doing foodborne outbreak stuff, or—

Q: Well, you're still in foodborne—

Basler: Yeah, I'm still there now, so I finished—

Q: —but I know you made another trip out.

Basler: Yes. Yeah, so I stayed doing foodborne stuff. That was January, all through winter and spring. After I had my job nailed down, that I was going to stay in foodborne afterwards, my supervisor was kind enough to let me volunteer again to do a secondary deployment, mid-May into mid-June. So only a month.

It was very, very different. It was for the infection prevention and control team instead. It was more of a distinct project. My goal was to set up a training for the government ho—so there were government and private hospitals in Sierra Leone—helping the government hospitals develop better infection prevention and control strategies. These were basics from providing hand sanitizer and handwashing stations to providing sharps containers so that people have a place to safely dispose of needles and other sharp instruments. And making sure that Ebola screening was happening in all of these hospitals. Each of the

government hospitals was being paired with an NGO that was interested in improving hospital access and hospital support. For some of those hospitals, there was requiring the basics of, how can we get electricity? How can we get twenty-four-hour electricity, running water access? How can we provide the appropriate amounts and types of personal protective equipment? Who needs to wear it? What are the protocols in place for pregnant women who are coming in, to make sure that the midwives and doctors aren't being put at risk in case one of the pregnant women has Ebola?

That was really interesting, but it was just a very, very different trip. I spent most of my time in Freetown. It was more meeting-based. It was really interesting to see what Freetown was like, and what Sierra Leone was like at that point. People were much—like, I walked in, and the airport when landing was totally different. There was no longer palpable fear in the airport. It was more of a relaxed environment. Answering the questionnaires and getting your temperature checked was still happening, but occasionally you'd see someone shake a hand with a colleague, and it was just a more lax environment. The outbreak in Freetown was pretty much winding down, so the CDC staff on the epi team were sort of fighting over cases to go investigate because there wasn't enough work to keep everybody busy, which was great. There were a couple of clusters that were happening up in Kambia and Port Loko, but in general, things were in a much—it was not—it was amazing to go to an epi meeting and be able to have people walk through and say, here are the four people who have gotten sick, and we can actually trace back and say that this person got sick from this person, who got sick from this person, who got sick from this person. When I was there previously, it was more just

people coming out of the woodwork and being like, we have another sick person. We have no idea if we have the full round of contacts being traced, we have no idea how this person was exposed, but they have Ebola. That's another one. Move along. So it was a really different environment, which was really nice. I got to do a quick trip up to Koinadugu, and I got to see a lot of the district medical health staff and the district medical officer who I worked with pretty closely when I was in Koinadugu the first time. Which was really nice, to reconnect with people and see how things have improved, and to see what systems were in place.

Q: Can you describe a little bit some of those people?

Basler: Mm-hmm, sure. There's a district medical officer who was a young guy, early thirties, and had done his medical training outside of Sierra Leone, but had come back. He was interested in working in more of the national public health office. He was sort of doing a deployment out in Koinadugu District as sort of an outlying district when all of this happened. But he was very intelligent, very driven, and a really great resource for that district. It was a little concerning at one point, because early on, or about—actually, no, I think it was my third weekend—the president was supposed to come and do a site visit to the community care center in Kumala. He was flying in on his helicopter, and the day or two beforehand was just—it was all prep for that. Luckily, the outbreak was winding down, so that was okay. But during that timeframe, we started to get really concerned because the district medical officer, he was not looking very good. We had a meeting, and he was sort of ashen and was sweating profusely and had bags under his

eyes. Then, for the following two days, he was like, "Yeah, I'm—" He put himself under home quarantine because he spiked a fever, and so that was something that was like, if he is sick, and if he is sick right before or during the presidential visit, nothing about that is a good plan. He only had malaria, thank goodness. Which is also weird, to be in a situation to say, oh, it was only malaria! It's fine. That's not something anyone wants to have either. But he recovered. But that was a couple of tense days waiting for him to break a fever there. Because that would've been—besides the fact that he was a nice guy and really great to work with, it would've been a big blow to the public health infrastructure there if he had gotten sick.

Then I also worked with Alhaji, who's a Peace Corps vol—he worked in the Peace Corps office as one of the sort of cultural ambassadors. They have local staff in all Peace Corps offices to try and help the volunteers acclimate to their new surroundings and make sure that they are aware of cultural and societal norms, wherever they're going. These were all twenty, thirty-year-olds, there was five or six of them, and they were pretty much out of a job because all the Peace Corps volunteers had been evacuated. We hired them as part of our communications teams because they were great resources to have for that cultural competency, and being able to explain things to Americans on a regular basis was really helpful. Working with him was great also because his father was a subdistrict—I forget the middle term, not a paramount chief but a step below, in one of the chiefdoms that was a border-lying district with Guinea. We were actually able to go out, visit him, visit his extended family, and hear about what was happening in some of the border chiefdoms in Koinadugu. Because until that point, we really hadn't gotten a lot of information from

there. Theoretically, all dead bodies were being buried by burial teams, and every single body was being swabbed, but there had been zero reports of deaths from those chiefdoms in a three-week timeframe. So that was a little concerning to us. It was really interesting to learn how economically, culturally, and socially close those chiefdoms were with Guinea in comparison to the rest of Sierra Leone. It helped us try and plan for, how do we best reach these communities? How do we best engage with them, in case there are flare-ups or outbreaks in their areas? He was a great guy to work with, too.

Q: Sounds like it. And it sounds like a really cool resource for looking at the possibility of the trans-border transmission.

Basler: Yep. That was a really big point of concern. Especially for Koinadugu, just because two-thirds of its—it's the least populous but geographically largest district in Sierra Leone, and three-quarters of its border is just all border with rural Guinea. There's only like three roads that cross, but everyone just—there's more bike tracks and goat paths than you could possibly count.

Q: Let's see. Where are we on your second deployment now? You went out there—

Basler: Second deployment, May-June. Went out there, did the prep work, and then ran this training program on—it was more of like a reporting tool, as a way for these district hospitals—government hospitals to keep track on a regular basis of what supplies they had, what gear they had, what supplies they need, what additional support they needed.

Either from the Ministry of Health or from the local—the NGOs that were partnering with them. During that, we got to do a site visit to the district hospital in Koinadugu and talk to the NGO, Médicos del Mundo, which was partnering with them. To see sort of what was going well, what areas they still needed to work on.

I also ended up sitting in on some higher-level meetings in Sierra Leone on trying to figure out sort of the larger funding aspects, and how the infection prevention and control team—how that was going to transition from, okay, this is only Ebola, we need to stop Ebola, what can we do to improve the fight against Ebola? But transitioning from that to, alright, how can we rebuild healthcare infrastructure? How can we improve healthcare infrastructure to try and prevent this from happening in the future, but also just in general, improve it so there's a better quality of health services in the country? Some of those conversations were boring, but mostly they were interesting. It was a very different experience from being out in the field the first time around.

Q: It sounds like you also had an eye toward the future.

Basler: Yeah, and that was a nice part, being able to sit in on—there was only—it was me and Sarah [D.] Bennett, who was the infection prevention and control team lead in Sierra Leone forever, she stayed in that Radisson hotel room for the duration. If she was gone, I got to fill in for her for some things, so I was able to sit in with a lot of those types of meetings, which were really interesting to see sort of what—it was heartening to see that

there were thoughts on the future, and there were thoughts on more of the rebuilding that needed to happen. Which was really interesting.

Q: Any other memories from that deployment, from May to June?

Basler: That one, it was just being able to see Freetown a little bit more. When I was there in November and December, Christmas was canceled. I didn't know that you could cancel a holiday, but they did. And there was a curfew in place. A lot of the restaurants were closed, a lot of the bars were closed, and there just wasn't a lot to do outside of the hotel. It was really nice to get to see that the local economy was coming back, that we could take a walk down to the beach and have a beer in one of the beach restaurants, go have dinner at the Chinese restaurant casino. It was also really interesting to see how many of the roads had been paved in that timeframe. That there had been a lot of infrastructure improvements. I think the Chinese had sort of done some major roadwork infrastructure plans, and the fact that those were continuing was really nice. To just be able to walk around Freetown, and not be as concerned about everything there. The other thing that happened right after I left the first time—so in early January, there was an outbreak in sort of a slum neighborhood that was right next to the Radisson hotel that a lot of the Radisson staff walked through, that a lot of the CDC staff would go by on a daily basis to go anywhere else. It was nice to see that that had been resolved. That outbreak was over, it was no longer a risk that was literally right outside the front door. [laughs] Which was good. I'm trying to think. That one, it was more of a basic trip, that time. More meetings. I got to go to some very interesting meetings at the—a lot of the

pillar meetings for the infection prevention and control pillar, where they would bring together Ministry of Health and NGOs and WHO and CDC. They were held in the building and in the actual courtroom where—I think James Taylor? The dictator from Liberia—

Q: Charles Taylor?

Basler: Charles Taylor, yes! James Taylor's the musician. [laughter] Charles Taylor, thank you. I was like, I'm saying that, and that's not right. Where Charles Taylor was tried in the international court system. Which was really interesting, as a place. It was like, we're having a meeting in here now? Alright—wait, you're making use of the space, so that's good. [laughs] That was odd. But yeah, that was pretty much it. No major issues when leaving the second time, which was nice. I did a day layover in Brussels on my way back, so I got to have a little mini vacation, which was very nice. And then came back.

Q: Tell me what you've been up to since.

Basler: Since then, I transitioned over into working—instead of as an EIS officer, I'm now working as a doctoral-level epidemiologist in food and water. I'm now getting to supervise EIS officers and our assessment epis on foodborne outbreak investigations. We had a busy last summer with a bunch of different foodborne outbreaks, which was nice. Have gotten to do a little bit of travel for some of the longer-term Ebola response stuff. A lot of the funding has come through the Global Health Security Agenda, and so I've

gotten to go to Cameroon for a small trip for that, which was really interesting. One of their platforms, one of their focuses for the Global Health Security Agenda is One Health, so got to go help co-lead a workshop to help the different ministries sit down and come up with a prioritized list of zoonotic diseases to focus on there. That was fun. Lots of bats. And very good fish food. Like, good French food, very good fish. Which was surprising, because we were fairly inland. Yep, just a lot of outbreak investigations for foodborne. [laughs] Which has been nice to get back to things that I find interesting but way less scary than an Ebola response. It's been really nice to see that things are really starting to slow down. There have been a couple of small, sporadic, secondary outbreaks, but I'm very, very happy to see that it's not remotely in the same situation that it was a year and a half ago.

Q: Do you have anything else that you'd want to say, to have on the record? Any further reflections of your experience, or—

Basler: In general, I think that this is a fantastic project to sort of collect people's thoughts and experiences, because I think so many people had very, very different experiences in the different countries. It was a horrible thing to have happened, but for the position I was in as a second-year EIS officer in a training fellowship program, I felt like I learned so, so much in all of my Ebola-related deployments, which was a really great opportunity for me. I hopefully will never have to do anything like it again, but it was a really amazing experience. It felt like I sort of came a little full circle from first learning about EIS and public health by being told stories of EIS officers being thrown

off of planes in Uganda to fight Ebola, and then I got to go get off of a helicopter in rural Sierra Leone to do that. [laughs] I was not expecting to. It was a really intense experience.

Q: Well, thank you so much. It's been great having you here, and great listening to some of your experiences.

Basler: Thank you very much.

END