CDC Ebola Response Oral History Project

The Reminiscences of

Lise Martel

David J. Sencer CDC Museum

Centers for Disease Control and Prevention

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Lise Martel
Interviewed by Sam Robson
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Interview 1 of 1

CDC Ebola Response Oral History Project

Q: This is Sam Robson here today with Dr. Lise Martel. Today's date is June 9th, 2016, and we're in the audio recording studio here at CDC's [Centers for Disease Control and Prevention] Roybal Campus.in Atlanta, Georgia. I'm interviewing Dr. Martel today as part of our CDC Ebola [Response] Oral History Project. So Dr. Martel, thank you so much for being here with me.

Martel: Glad to be here.

Q: For the record, would you mind stating your full name and your current position with CDC?

Martel: My name is Lise Martel, and I'm the country director for Guinea.

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

Martel: I was born in Canada, in Quebec City, in 1964.

Q: Did you grow up in Quebec City?

Martel: Yes, I grew up there and then moved to the [United] States about twenty-five years ago.

Q: What was it like growing up in Quebec City?

Martel: It was wonderful, but it was all French, you know. So moving to the States was a big adjustment in learning English.

Q: What did you parents do?

Martel: My dad was a factory worker. Worked in a paper mill. My mom was staying home with the kids, and we had quite a traditional life in those days in a fairly small suburb of Quebec City.

Q: What kinds of things were you interested in growing up?

Martel: Always travel. From the time I was young, from the time I went to school, any time a teacher would talk about traveling and about different places, I would perk up and I would be interested in learning everything about it. It was one of my major interests.

Q: Did you have an area in particular that you were like, I really want to go there?

Martel: No, I just wanted to see everything and everywhere. Anything that was a little out of the ordinary was of great interest to me. As soon as I could afford it, I started traveling. I first traveled overseas when I was nineteen.

Q: To?

Martel: My first trip was to Europe. I did a trip, five countries of Europe. But my second trip, which was more in line with what made me discover passion, was actually in South America. I went to British Guyana and I thought, this is it. This is what I'm truly interested in. It was so—it was a poorer country, underdeveloped, but beautiful scenery and nature, and a hot humid country, and I just loved it. I thought, okay, I found something here.

Q: Up through high school, what did you imagine for your future? What did you want to go out and do?

Martel: I really didn't know, because—I loved school, and I loved so many different things. I loved anything related to science. I liked anything that had to do with the way people think, so later on I found out, okay, that's psychology. I was interested in education because I loved school so much. I had no clue what I was going to do, and I had a wide variety of passions. That kind of is reflected in my career, too, because I switched fields quite a few times before arriving here.

Q: Gotcha. So tell me what happens going into higher education.

Martel: I left Quebec to go learn English, and I went to Nova Scotia. I arrived there and I thought I'm going to go to school, but I didn't know what to study. I lived in a small town and the only thing there was a teachers college. So I went to teachers college and became a teacher. [I had the summers off, so I decided to do volunteer work in developing countries.] Every summer I would be going to a country, so either British Guyana, then I went to Haiti many times, Peru. I went to many different places. I did all the countries of Central America. So I was fascinated by that. Then after having taught for ten years, I thought, you know, I need a break. And I thought, I'm going to go and take two years off. What am I going to do? What do I prefer to do? I'm going to study. I'm going to take two years off and do a master's in something different from education. And then I'll go back teaching. I thought, well, what am I going to do? I want to go somewhere very beautiful. I registered to the University of Hawaii, and I went to do what I thought was a two-year program in Hawaii. I took the field of social psychology because I was just interested in how people think and how people react to things. In the process of being there, I attended a few classes of fields related to emergency management and humanitarian aid. Then I realized that really fit well in my liking of traveling. Then I met someone who was doing public health. They were looking for volunteers to help them with a conference that was with ministers of health of the Pacific Islands. They needed someone who spoke French, so I said, "I'll be glad to volunteer." I took some time off from my classes to go volunteer, and I was blown away. This was my first exposure to public health, and I was like, this is just unbelievable what they're doing.

Helping these people save lives in the Pacific Islands. And so I said to them, "Any time you need help, let me know. I'll be here for a little while longer." They called me back the following year and they said, "We're coming back for another conference. Could you volunteer?" And I said, "I sure can." And then they said, "We'd like to offer you a job." I didn't know CDC. I didn't know what CDC did. I had no more awareness of public health than what I had seen in those two workshops. And I said to them, "But you know, I'm in the middle of a PhD." I said, "I still have quite a bit to do with my PhD." They said, "How long?" And I said, "Another year." And they said, "We'll wait for you." So that's how I came to the field of public health, which is kind of unusual. I think most people's path is much more straightforward. People are either going in medicine or in public health from the start.

Then so when that happened, I remember my dad's reaction. I said to my dad, "Dad, I'm going to be working at the CDC." And he said, "What's that?" Then he went and looked it up on the internet, and he said, "Where are you going to work, exactly?" I said, "I'm going to travel the world. They're telling me I'm going to be going to all these countries." And he said, "Oh, don't tell me finally you're going to get paid to do what you love to do." Because for all these years, I'd been traveling on my own penny, and he was like, "You'll never make any money if you spend all your money going helping people." So then it was like, that's it. My parents were very happy for me. Then I moved to Atlanta, and then I did my MPH [Master of Public Health] at Emory [University] so that I would have a stronger background in public health. Then I realized what a great opportunity it was to work at CDC, and how lucky I was to have gotten in that way, because a lot of

people dream of coming to work at CDC and never can. For me, that realization came afterwards. From then on at CDC, for the first ten years that I was here, I was doing mostly emergency response and emergency management work. CDC would send me to a country where there had been a disaster or that was very prone to disasters. If I was going to a country prone to disasters, it was to help them plan. If it was a country that had just had a disaster, it was to be part of the response. I did a lot of very interesting work. I went to Haiti after the earthquake. I went to Pakistan after the floods for the cholera outbreak, I did South Sudan measles immunization campaign, I've been to Southeast Asia, I've been to Kazakhstan, I've been to all kinds of very interesting places. In fact, I've traveled to forty-eight countries for CDC. And the last one was Guinea. [laughs] And Guinea, it was for the Ebola response.

Q: When you look back at all of those response activities, are there some that you feel you drew especially on when you were in Guinea doing the Ebola response?

Martel: I would say Haiti because—I mean, it's a total different response. Haiti was infrastructure. It was an earthquake, so there was a lot of different problems, but the two countries share a lot of similarities. They're both very poor countries with very low infrastructure before the disaster hit. So a lot of the things that I had learned to deal with, bad roads, challenges with communication, different things, were in fact very similar.

Q: Can you just tell me a bit about the work that you did in Haiti?

Martel: In Haiti, I was part of a team that would go by helicopter or by road to different areas of the country to assess the damage and see if people needed help for any area related to public health. It could be for water, sanitation, medical attention, food, shelter, anything that affected the health of people. Because the country had such poor communication, a lot of areas we didn't receive any message from, so we didn't know if people were okay or if there was nobody left. We didn't know what the situation was. The only way was to go and see for ourselves. In areas that were very remote, we went by helicopter. They would drop us the closest possible to a village or to a displaced population camp. We would walk there and then we would talk to the elderly and to the leaders of the community, and we would try to figure out how they were affected. That was very interesting because some areas were so separated from the capital that they didn't even know what had happened. They didn't realize there had been such a big earthquake that everything was destroyed in the capital. They would say things like, "My son hasn't come. Normally he comes every two weeks and he brings money. He didn't show up. I hope he's okay. Could you check for me when you go back to Port-au-Prince?" Not knowing that the whole city had been totally destroyed. We compiled, we put that in a table to show where were the areas of biggest need, and then we could communicate that to partners, and then the partners could decide where to prioritize the services.

Q: Were you also involved in the subsequent cholera outbreak in Haiti? I know you did it in Pakistan.

Martel: No, I was gone by then.

Q: Thank you. I should probably make sure I'm paying attention to chronology here. Do you remember what year it was that you earned your doctorate?

Martel: I think it's 2007.

Q: Oh-seven. And what was your thesis about?

Martel: It was on the factors that influence people's willingness to prepare for emergencies. You know how people always say you should have a safety kit in your car, and you should have extra food and water in your home? Well, do you do it?

Q: No, I don't.

Martel: Aha. See? So then you look at why, and what happens to people that make that they're more likely to do it, and what are the factors that influence your thinking? Probably not necessary, I can probably go without it, even if you have the means to do it.

Q: Wow. Did you find anything that was really interesting?

Martel: Yeah, actually one of—the key finding was that one of the reasons why we don't prepare is because for us in North America, for most of us, we live in an environment

where whenever there is an interruption of services, doesn't matter if it's electricity or water, it's usually fixed very rapidly. You might have an ice storm somewhere, and you don't have any electricity for what, five, six hours, a day maybe if it's really bad. Then the service is reestablished. So it's hard for us to envision a situation where you wouldn't have electricity for a month. If you're missing electricity only for eight hours, well, okay, things are going to thaw a little bit in your freezer, but you're not going to lose your food. That's not a big deal, right? A lot of things we do in society—like you look at hotels, hotels don't advertise that they have an emergency plan, that they have an evacuation plan, that they have a storm plan, because they don't want to scare tourism. So everybody—all these factors play into the fact that you end up thinking, eh, that's not necessary. I'm not going to prepare that much. I'll be able to go to the store, or I always have water. I have a water bottle. I'll be okay. Only the people that have actually experienced it—have had an opportunity to either live in the countryside, so they're used to having a generator, or have snowstorms where they're buried for like five days, then these people are more in tune with, I can be without services for a week. But city people, totally unprepared.

Q: I'm one of them, I'm one of them. I can see now the path of your expertise in the emergency response, and how that's really playing in here. Was there an area that you focused on at Rollins when you got the master's in public health?

Martel: The master of public health was in prevention. So again it kind of matches with my interest in helping people prepare for emergencies.

Q: Neat. What year would it have been, ’07, ’08, when you got to CDC?

Martel: Yes. Let’s see. Perhaps I graduated in 2004, because I was at CDC—you’re right. 2005. So I would have graduated in 2004.

Q: Do you remember what you were doing immediately before the Ebola outbreak in West Africa?

Martel: I went to Ivory Coast first. I was asked to go there because at that time there was rumors of Ebola cases, and the Ivory Coast wanted to prepare themselves in case there was cases that would come close to their borders. While I was there, somebody said, “We just got the first cases of Ebola in the capital, in Conakry,” and they said, “You’re right there, could you go?” So I went directly from Ivory Coast there, and I said to Ivory Coast, “Well, as soon as I’m done there—I shouldn’t be here too long. I’m there just to make an assessment, so a week or two, I could come back.” And they said, “No thank you. Don’t come back.” [laughs] “You’re going to a place where there’s Ebola. We’re not allowing you back in the country.” They had put some rules that you had to be out of the country for so many days, so I could never go back to Ivory Coast. So then I said, well, I’m already out here, might as well stay, and I stayed longer in Guinea to help with the response.

Q: This is going to be totally off-topic, actually, but I know that you're somebody who thinks a lot about preparedness and prevention. When I look at maps of West Africa and I see—people plot it out, what areas are most likely to see cases, a lot of those areas were often in Ivory Coast. But I don't think in this outbreak, there ever was any cases in Ivory Coast. Do you know much about why that happened?

Martel: Yeah, that's a big question. The people working in public health in Ivory Coast will tell you that it's because they were very good at monitoring and that they did a great job of preparing the population. I think that is part of the answer. I mean, they definitely spent a lot of efforts to do the right thing in Ivory Coast, and they were very proactive from the beginning, taking measures, even they had measures of not touching people, not shaking hands when they didn't have a single case, which I thought was pretty remarkable. But there's also a little bit of luck, you know. People in that part of the world tend to travel a lot from one country to the other. It's kind of luck of, do they have a family member that suddenly is from Guinea that ends up traveling to Ivory Coast instead of Sierra Leone? So some of it is just luck, and some of it is preparedness, the two factors that always influence response.

Q: Tell me about what happens when you arrive in Conak—Conakry immediately?

Martel: Mm-hmm. Yeah. So I'd never been to Conakry before. When I arrived I had many concerns because people had said, there's a lot of cases there and it's in the city. I guess I had expected to see more horrible things, like tangible, very visible. I thought I

would see—because CDC, they had prepared us by making us wear suits and look at how can we take the suit off without getting infected. You put syrup on your hands and you're pulling all the equipment off. So I thought I would be in situations where I might have to put my mask on. And I arrived there and I thought, no, in fact, I'm never in the presence of sick patients. I'm really doing the public health side. So my fear before I got there was way more than—as soon as I arrived there, I realized that of course there is some danger, but I was much more at risk of getting malaria than I was of getting Ebola because I was not treating patients or working in an institution that did treat patients.

But there was really a sense of urgency, and there was a lot of people on the ground. There was a little bit of chaos because we didn't have, for example, a place where everybody could meet and strategize together. It was just because in Conakry there was not a very good meeting room with good microphones and air conditioning where you could put a hundred people to talk about Ebola. There was a lot of little meetings happening. Everybody was volunteering their offices, so you would have somebody volunteering at WHO [World Health Organization], they would volunteer their little meeting room. And then you would go to UNICEF [United Nations Children's Fund], and then you would be bouncing around and at the hotel. People would be e-mailing each other the location and time of meetings and you'd be running from one place to the other. And the roads are bad and there's a lot of traffic. It was just very difficult just to coordinate things. I remember when, a few months later, that problem was resolved by—it was through a request from CDC, through the CDC Foundation, to help the government by setting up an emergency operations center. In the process of doing that, they ended up

funding the renovation of the sixth floor of a building that became the EOC [emergency operations center] and that had this huge meeting room where you could accommodate seventy-five, eighty people with a good sound system, with air conditioning, with electricity, with presentations and PowerPoint. You could actually now plan. This coincided with—they had, the Ministry of Health [and Public Hygiene], the government of Guinea had selected someone to be the lead for Ebola, Dr. Sakoba [Keita], who is really a great leader. Dr. Sakoba started to run the meetings from that room, and once that happened, it became the place where all the partners would meet. It really changed everything. It changed his capability of rallying all the partners together, just because of that location. It was suddenly, okay, we can all talk. The response was handled that way till the end, so that was a key success. I think that partners contributed, international contributed to the response.

Q: Do you remember what—even what day it was when you arrived in Guinea, or what month?

Martel: I started working in Guinea September 2014.

Q: September 2014, gotcha. And do you know how long it was until that EOC was really established and everybody was able to come together?

Martel: It was progressive. In the beginning, they started with just having one room, and then it evolved into more space. At first partners said, oh, I don't think people are going

to go there. Then finally when everything was going very well, everybody wanted an office there. Then the need kept growing. I think it took about six months for the whole EOC thing to really get into order, but anyway, that's where we were meeting. They're still meeting there and the offices of coordination is still there today.

Q: What are some things that you were doing immediately?

Martel: At the beginning when I went there, I was doing emergency management. They had sent to see how we could maximize the use of emergency management principles. The word was there was a lot of problem with communication and coordination of activities. A lot of partners were arriving on the ground, and it wasn't clear who was doing what, who was in control, who should be leading, how the funds would be used, how the funds would arrive, who would handle the funds. They had said, if you could go and try to assess what's needed.

The first two deployments that I did there were deployments of about three months long, and I would go there and I would just try to help. One of the first things that I did to try to understand what was happening is I thought, Dr. Sakoba's the lead. I'm going to stick close to him. They said to me, you're CDC. Would you like an office? And I said no, actually, if you don't mind, I'm going to sit right here. I sat with my computer at the corner of his secretary's desk. She was very happy. I was bringing her chocolate and we would talk. I just sat there, and people would say, do you want a desk? And I would say, no, not at all, I'm good here. That way I was seeing everybody coming in. I was hearing

all the concerns of people. I was hearing all the conversations going on. Also I was very available to Dr. Sakoba. He started—after a few days that I started doing that, he would say—he would scream across from inside his office, he would say, "CDC! Come here!" And I would just know that's me. I would just come in and he would say, "What do you think about this?" or "Do you know a partner who could help us with that?" He would kind of just start asking for ideas. After a few weeks of that, he said, "What's your name?" [laughter] But very early on, CDC had a very good relationship with the lead for Ebola, and he really relied on us a lot. We were there with WHO. We were the two main partners that were there very early on, working on the response for epidemiology surveillance with Dr. Sakoba. So I started like this, and at first I managed things as simple as schedule of people coming in to try to see him, taking notes during meetings, doing kind of practical things that I thought might help them. Try to establish a contact list. Helping with any projects. Sometimes he would say, "Here, I received this letter in English. Can you read it and summarize it for me?" "Can you read this and tell me if this medication is good for Ebola?" Then I would bounce that back to headquarters and ask the specialists, "Can you tell me about this?" And get an answer back for him. I was doing a lot of things like that the first couple of deployments. Then one day I was with some of my colleagues from CDC, and I said, "You know, I've been to so many countries. But Guinea speaks to me." I like Guinea. I like the way Guineans interact. I like what they're about. I like the way they're receiving us, they're collaborating with us, they're communicating with us. I like it here. I know it's a difficult country. The roads were flooded. It was the rainy season, and they have all these problems, these public health issues. But in terms of the people, I felt welcome and I felt safe and I felt valued. I

just enjoyed being there. I said, "You know, I've never considered going and living in another country. I've always done traveling back and forth." I used to travel about twenty-four to twenty-six weeks a year for CDC. But I said, "It's the first time I'm thinking actually, I could live here." And somebody said, "You know, they're probably going to put an office here. Why don't you apply for the country director's position?" So somebody else kind of proposed that idea to me. And then I thought, well that could be interesting. So I applied and was selected. Then the next time that I went, it wasn't as emergency management specialist, it was to be the country director and try to establish a permanent office in country.

Q: Do you remember when it was that you applied?

Martel: Yes, actually. My interview was in December. I was in Canada for Christmas vacation, so it was in December 2014. Then I was officially hired for that position in January 2015.

Q: In January 2015. And that was after the first couple deployments?

Martel: Yes.

Q: So you're there like September, October, and then did you go back to Canada?

Martel: Yes, then I came back again.

Q: Wow. This is all remarkable. I love hearing about that role of facilitating and trying to make the whole system work better. This is kind of a strange question, but is there a specific example you could give me of a time you saw a problem and how the system was working or how the partners were interacting, and how you were able to work on that?

Martel: What would be an example? I think that one of the roles that I played that I enjoyed playing that was kind of a unique opportunity for me was to often explain to Guineans how the world of international help and Americans work. Because Guinea, up until Ebola, had received very little international help. You think of a country like Haiti. They receive help all the time. They get a hurricane, there's help. They get the earthquake, there's help. Cholera, there's help. Or you look at some of the countries where a lot of international people always work. But Guinea was kind of, from my perspective, a forgotten country. Guinea does its little things. It's not a country that went to war. There's not something that puts them on the news. So things were pretty quiet there. And also it's a Francophone country, so not a lot of agencies have French-speaking staff that they can send there. It was very quiet, you know, not too many people. Even CDC didn't have an office there. We had a malaria advisor that was working there under USAID [United States Agency for International Development]. That was the only CDC staff on the ground. The Guineans didn't quite know how to handle—when a partner would come and say, we're going to bring a million dollars, ten million dollars to do this, they thought, oh wow, we're receiving ten million dollars, not realizing that that's going

to be used for traveling people, hotels, insurance, this, a lot of other things. They had a little bit of naiveté, if you want, about what was going to happen, why people were doing things, how fast things would move, how different partners would interact with one another. Often something would happen and they just couldn't understand exactly what's going on. They would say, can you explain to me this? And then we would explain. I did so many diagrams. For example with us, with CDC, they used to confuse the difference between CDC and CDC Foundation. I remember one time I was in a meeting with the previous minister of health. It was the minister of health, and Dr. Sakoba, and all kinds of partners from the ministry. One of the ministry persons said, "We're glad to have our partner here from the NGO [non-governmental organization], CDC." And I said, "First, let me clarify. CDC is part of the federal US government." He said, "No, it's not." Then somebody else said, "I think she knows who she works for." It was kind of funny. But there was a lot of things like that that we needed to explain again and again. There was confusion, they thought CDC and USAID is the same because we're both working for the US government. Many things like that, by explaining and preparing—trying to prepare them. Trying to prepare them for high-level meetings, when we had people from HHS [The US Department of Health and Human Services] that came for a visit. Why were they coming? Who are these people? Why is it important to talk with them and receive them and explain to them what's going on and being candid with them about the problems we're experiencing on the ground? I would do a lot of that work. I think today, their view, after two years of international help, their view has totally changed.

Q: Now as you're saying, CDC, there weren't as many of you in Guinea as there were, as there would be in Sierra Leone and even in Liberia. Can you talk about that and how that affected your experience?

Martel: Yes. That was actually one of the biggest difficulties. In the whole response, for two years that we did the response for Ebola in Guinea, we were always understaffed. We get on conference call and I would hear, oh, in Liberia they have ninety people. And in Guinea we were thirteen. I was like, how is that possible? The problem was really that it was very difficult to identify French-speaking people. In Guinea, it's not the kind of country where you can get by with a translator, for example, or if you say, well, some people will speak English. Nobody does. You're really not able to function if you don't speak French. So our crew was always very, very small. We had to wear many hats and work very, very long hours. Even now, we're still struggling to identify staff that can come over. Now people are focused on other things. There's Zika, there's all kinds of other public health concerns, so now the focus is not so much on Ebola. It's very difficult to still get people qualified. It's hard to find people that have the language skill, the technical skills, and also some work experience in Africa or in a very poor country where infrastructure and the commodity, the things, the comfort of everyday life is not available. Very difficult.

Q: How about the people you did have, though? Can you describe some of them?

Martel: To me, they fell kind of in two different categories. You had the hardcore people who've deployed many times. Many of us were repeaters. We would go deploy four, five, or six times to Guinea. Sometimes more senior people that have done a lot of emergency response that, you know, very seasoned and able to manage. And then there's young people that they spoke some French, and this was a perfect opportunity for a first deployment, or for finally experiencing going into the field and doing something exciting like Ebola. It was very tragic, but also a very unique event in the field of public health. So you had a little bit of the two. You had the crew that was fairly experienced, seasoned responders, and then you had people that have had no previous deployment experience, or very little, or in very, you know, places where things were quite a bit easier than Guinea. It was an interesting mix.

Q: Are there individuals who stand out in your memory?

Martel: I think, yes, there's a few people that always touch you in a special way. One of the most senior people, repeated deployers was Ben [Benjamin A.] Dahl. Ben Dahl came many times, and he served many different roles. He would adjust to whatever needed to be—he could serve as the lead for Ebola, but he could also go in the field and do an investigation. He could serve as an advocate with the minister or the president, and he could work with the deployers in the field and worry about their health. He had this whole range, and he came—I think Ben deployed five or six times to Guinea over the epidemic. Then there's some people that to me showed so much growth and so much adaptability. For example, right now in Guinea, the person that is pretty much leading all

activities is Mary Claire Worrell, and Mary Claire is a young epidemiologist, pretty much fresh out of school, in her twenties. Very enthusiastic, very adaptable, speaks French, and is just a problem-solver, and has great leadership skills. And all this was kind of revealed in her coming. We thought, oh, this junior person coming, and then suddenly it's like, wow, she can do a lot. So there are people like that that just strike you as pretty unique.

Then there are also—and that's not so much by name, but now it's a category, it's all the FETP [Field Epidemiology Training Program] graduates. FETP graduates from DR [Democratic Republic of the] Congo and FETP graduates from Haiti, for example. They came in large numbers, and they were so adaptable. They went and they did some of the toughest assignments. They went to the communities where there was a lot of resistance, slept in very rough areas with very little communication, rough roads, being on the roads for a long time, very long days, being dusty and dirty and hot day after day, working communities where people are resistant to their interventions. We've had—for example, I remember one group, when we had one of our Congolese that was in a convoy going to do an investigation on a death that had happened, and they were supposed to go and investigate if it was Ebola. When they arrived near the village, the villagers had put a barricade on the road. We had told them that when something like that happens, just turn around. And they did. They turned around, but then about a mile later, there was another barricade. So they were kind of stuck in between two barricades. Then the villagers put the field on fire on both sides. And the only way that they escaped, the driver had the presence of mind to cut across the field, across the river, and take a road on the other side. That was a pretty traumatic experience. But you know, they came back—we

brought them back to Conakry. We were kind of hoping that they were okay and worried about how that would impact them. I remember the deployer from DR Congo, he was just ready to go back to the field. He was like, yes, well, it happens, but we need to explain to people. He had a very positive attitude about it all, even if he was shaken up a little bit. I remember thinking, wow, these are hardcore people that are perfect for this kind of experience. They had the technical skills, and in fact, they had a huge impact on us deciding to start an FETP program in Guinea. They are still the ones, to a large extent, that are in Guinea right now and helping the ministry and establishing their capacity in emergency management for the epidemiology, field epidemiology, collecting data. Not just for Ebola now, but also for other diseases like measles and polio, malaria, yellow fever, and all that.

Q: Do you happen to remember that one individual's name from DR Congo who had to flee?

Martel: I don't, but I'm sure we can find it.

Q: We'll look it up. We'll put it in the transcript.

Martel: That sounds good. [note: his name is Six Moke]

Q: Great, thank you. Actually, so I had the opportunity to interview Dr. [Thomas R.] Frieden a couple months ago, and he also said in addition to the Congolese, people from Canada. There were a lot of Canadians that came over.

Martel: Yes, that's right.

Q: Did you work a lot with them?

Martel: I did. Public Health [Agency of] Canada has been a strong collaborator, especially in the first year of the response. For example, in emergency management, CDC did not have staff that were specialists in emergency management that speak French. They didn't have any. So we contacted Public Health Canada and see if they could help us. And they did send quite a few people that work in emergency operations centers in Canada for public health that deployed and helped coordinate the response and worked with CDC staff very closely. More recently, Public Health Canada has sent also a lot of epidemiologists. Of course, the advantage they have is in a lot of them come from Ottawa, Montreal, French-speaking part of Canada. People that work for the federal government in Canada have to be bilingual. So people come and they speak fluent French and English, and it's kind of very helpful in Guinea. So yes, that has been a very good collaboration. Unfortunately in more recent months, it has been hard for them, just like for us, because of Zika but also because in Canada they're dealing also with refugees from Syria. Their attention has to be diverted to other public health emergencies, so the

number of people they've been able to send in recent months has gone down some. But yes, very strong collaboration there.

Q: Thank you. I know you told a funny story about Dr. Sakoba, and how he called you CDC for a while before he knew your name. Can you describe him as a person a little more, and some of the interactions with him that stand out to you?

Martel: Dr. Sakoba I liked right away. When I met him, I liked him. He's very solid. He's one of the most senior epidemiologists that is in Guinea. He's done a lot of training, and he's been responsible for part of the government there that handles epidemics. He was the lead. He's well known mostly for cholera and how he handled in the past, in a very creative and very assertive way, the crisis with cholera. So he was already known as an authority for epidemics and for infectious diseases. But he's also a very modest man. Dr. Sakoba would say that all he's after, really, is to do good, serve his country in whatever capacity. When he was asked to take this position, he was nominated directly by the president. The president just appointed him to this position. And his goal was just to do the best that he could to help stop Ebola. He's a very introspective and very insightful person, and I find he has a very good balance in navigating the scientific side of things. He understands totally the science of epidemics. But also he can navigate the political side. How to say it, who to say it to, how to manage partners, how to be—he has a gentle side to him, but he also has a very strong, practical side to him. I think he was actually—he was the perfect candidate for leading this, and a big part of the success we had as partners is that he was able to show the leadership that he did. And that's pretty

remarkable. The country was always in the leadership position. This was not led by foreigners. This was not led by military. This was not led by CDC. It was not led by WHO. It was not led by another country, France, England, whatever. It was led truly by the government of Guinea, and I think they should be very proud of that.

Q: No doubt. Were there any moments, keeping that in mind, that the country was in charge, where as an advisor from somewhere else you kind of disagreed with an aspect and you had to work through some disagreements?

Martel: Yes, and I remember some very funny things, like for example, one day I received a call from Atlanta. People were saying, Lise, you need to tell Dr. Sakoba that it doesn't make sense to put ThermoFlash in all the schools. It's very costly. The kids are not at higher risk. Actually they're safer in the schools because most people being infected are people that are taking care of bodies. You need to advise him to ask the president to reopen the schools and this ThermoFlash thing, forget about that. Instead, just make sure that if a kid is sick, they go back home. Anyway, so I arrive in the meeting, and Dr. Sakoba comes in the meeting, despite having received this feedback from CDC, and he says, "We need ThermoFlash in all the schools." I'm kind of a little puzzled by it, but trusting him a lot, I said, "Dr. Sakoba, can I talk to you for a minute?" And I closed the door and said, "Dr. Sakoba, I want you to explain to me why it's important to have ThermoFlash in schools." He looked at me and he paused, like he was deciding how he was going to say that to me. And then he said, "You know, Lise, when foreigners leave Guinea and come to Guinea at the airport, we have ThermoFlash, right?

And we take the temperature of everybody, correct?" I said, "Yes." He said, "Okay, so we see on TV a lot of white people, foreigners, temperatures being taken, people are being monitored for temperature," he said. And then he said, "When you go to your country, you get monitored for temperature, and you have a proper apparatus to do that, right? So what message are we telling parents if we say, we're going to do that here, but in the schools, your children are not quite important enough to have a ThermoFlash?" He said, "The point is not that the kids need to have their temperature taken. The point is perception of the community, and if you want the buy-in of the community to help us to do activities, you need to give them what they want. And right now they're scared. They're scared for their children. Their children is the most precious thing they have, and you have to show them that you're willing to do anything to help them protect their children. If you do that, we're going to buy a lot of goodwill from the community." And I said, "Dr. Sakoba, I totally understand." I was like, "We need ThermoFlash in all the schools." [laughs] So sometimes the decision is not purely scientific. Public health involves a lot of psychology also.

Q: That's a really powerful example. Thank you for sharing that. Can I ask also how you would characterize the relationship between CDC and WHO at various times in the response?

Martel: WHO was always one of our biggest collaborators. We worked hand-in-hand, we had to. We were from the beginning managing the database, the surveillance database for Ebola, together. Typically, like in any relationship of large organizations, we have

different missions. We have overlapping activities but different missions and different ways, different cultures. At times, these things can create a conflict or a divergence of opinion on what should be done. Sometimes it's on things like case definition. What should be the trigger point to do a certain activity? Do you go by the book or do you go with the practical application on the ground, and who decides, and when do you implement it? How do you write it out? So there's a lot of, sometimes, decisions and disagreements. But I think that through these disagreements we actually also make better decisions because if you're with a group where everybody agrees with you, sometimes it's very dangerous because if you go on the wrong path, you can be reassured that you're making the right decision when you're not. So I think WHO and CDC are some of the few partners that are there to stay. WHO has a permanent office there. CDC has a permanent office there. A lot of partners right now are leaving the country. People are going back to their other activities or they're going to another emergency, but we're there to stay. The success of the future of public health in Guinea and the success of building the surveillance systems and helping the ministry will depend a lot on how we can work well together. I think right now, with the leadership that is in-country, the WHO representative that is currently in place is very collaborative and very practical. We work very well together, and we meet often and we share ideas often. Just as a recent example of that, in the past few weeks we were asked by the minister of health to help in defining now how the cellule that Dr. Sakoba leads would be reintegrated within the ministry to continue to serve a function for future epidemics, because it's a parallel structure right now. He wanted some ideas and some feedback. They had written some proposals and they wanted us to—they said, we're going to ask a few partners. The very first thing we

did is, I met with WHO and with UNICEF and we talked just candidly about our thoughts, about the difficulties and the very good points of what needed to happen, but also the difficulties and how we could best assist the ministry into the big task that they were putting in front of them. When we did go and they asked us to participate to a high-level meeting where they were discussing internally what they would do next, we came in as a single voice. We came in, the three of us, and when the WHO representative talked, he was talking on behalf of the three partners. I'm very proud of that, because that's something that we built in-country during the Ebola response and that I hope will continue on.

Q: Thank you for that. I know we have limited time. One thing I wanted to make sure that I ask, though, is when you look at the epi curves of the three countries, Guinea's seems a little more extended, right? The outbreak just kind of keeps on going for a little while. Why is that? Do you have anything—does that bring any specific memories to your mind when you think about that?

Martel: Well, you know, all three countries are quite different in many ways. Guinea, yes, it was more—it started there and it finished there. But we never had the number of deaths that they had in the other countries. So yes, it was longer but not as dramatic. You didn't have a huge peak where you had so many cases a day. But I think Guinea has a lot of different challenges. For example, the country's very big. If you look at the size of the country, it's humongous. And the roads are very bad, and the communications are bad. So you can have a small outbreak somewhere that simmers for a while, and you wouldn't

be aware of it. And then suddenly we had this happening in Forécariah, where we had very little reporting on deaths in Forécariah—not just Ebola deaths, but any deaths. Then when finally a team was let in, they found seven deaths that occurred that were positive for Ebola. It's like, oh wow, what do we do now? In Guinea, we had that additional challenge of distances, communication. It's to a lesser degree in the other countries, too. I think a lot of it was that communication, and then also, it's really hard to know what's what sometimes because the borders are so porous. There's a lot of people that are traveling. A lot of people have, like, family members, one house on one side of the border, and another family member on the other side. Some of these things are not as clear cut as they seem. Now, of course, we're able to define much better the chains of transmission. We've learned a lot and we're able to go back to where the case came from. But at the beginning, when things were happening very fast, it wasn't all that obvious. But I think epidemics are also very complex, and it's hard to tackle a single thing, or a method, something that had worked or didn't work. Often there's a big gray area where it worked in certain cases, it helps in some others, but it also has some negative consequences. You never quite know, and a lot of work, I'm sure, in the next couple of years is going to be spent on analyzing all this and trying to figure out what were the things that really worked well and what were the differences between the three countries, and why the epidemic was the way it was. I'm sure that's going to be fascinating information in the next few years with all the data. The size of this epidemic was a unique opportunity—that I hope never happens again—for finding vital information about Ebola. Ebola was fairly unknown. So many things, like we didn't know a lot about the consequences. We certainly didn't have a big awareness about sexual transmission from

Ebola. That was unheard of. When you look at today that Ebola can survive in the sperm of a man for over a year, it's something no one would have ever guessed that before. So this was a very unique opportunity. But I think the lessons and the reasons for things are not known yet.

Q: Thank you. Which way do I want to go? I want to ask, I know that WHO did their ring trials, for vaccine trials, in Guinea. To what extent were you and was CDC involved in coordinating with that?

Martel: CDC's always working with WHO in the field, so we always had people embedded in all the teams, and we also had at the decision-making level—often the way an initiative like that would be agreed upon is first there would be a meeting with Dr. Sakoba. He would invite key partners to discuss and make sure that this is sound, so we would always be involved in that kind of thing. Then you would decide, okay, how we're going to do it. You need to have a road map of how we're going to do this, how many you're going to send, what they're going to say, what form are they going to use, you know. So all these things would be decided together, and then WHO had a lot of staff. They had much more staff than we did on the ground. They had three-hundred-something staff deployed. But we would send people to help with the data management, to give feedback on outbreak investigation, because these are some things that we're very strong at. So always working together in the field.

Q: Sounds good. I'm going to ask just broadly, and this might be hard to answer because it's so broad, but when you look back on your experience on the response and as country director, are there any other kind of memories that are important to you that kind of surface?

Martel: I think for me, one of the big things was really how resilient Guineans are. I was puzzled by—even though I was there when they had elections, and they had the president was Alpha Condé that won the elections. In all the other countries around, whenever there's events like that, there's a lot of civil unrest and danger and it's kind of, you know. And Guinea, to me, has always been so peaceful. I mean, there's been a few incidents with resistance in the community, but for the most part, it's a very peaceful country, and it's a place where I've always felt safe. I feel safe walking on the street. I feel safe interacting with people. It's a nice place to be. I've been asking Guineans, "How can that be? You're surrounded by civil unrest and war and displaced populations. Why is Guinea so peaceful?" And they always find that question pretty funny, but the answer is always the same, so I have to believe that that's the answer. And the answer is that Guinea has many different ethnic groups and religious groups, and these groups intermarry. One person said, "One day there was this big battle between two villages that didn't agree on where the village stops and who has what." And he said, "They said, 'We're going to divide. We're not going to communicate.' And then somebody said, 'Okay, so are you going to give me back your wife, who's my sister over here? What are we going to do with the kids? Are we going to kill the kids?'" Because the kids, they kind of belong to both sides. At a certain point they realized this is a stupid argument because the families

are so intertwined that the person you're mad at is actually the brother of your friend, or it's—there's always a link, a family link, in between the different families. So he said, "We have to make it work. We have to sit and discuss and come to an agreement, because if not, it's going to affect everything, our family." So they tend to always see things as that people need to compromise and come to an agreement. They don't consider, like, I want to win. It's more like, I got to find a way to make this work, because if I win and they lose, it's not going to work. So to me that's one of the beauty of the Guineans.

I was also very touched by how everybody that is Guinean and has been working for us and with us has played such a crucial role in our success. I'm thinking of the drivers, for example. The security guards. All the people that are spending a lot of time with us that are Guineans, and they all have either family members or they know someone that was affected by Ebola. That's their environment. We come there to help them, and we ask a lot of them. We rely on them for our security, for knowing where to go, for getting us there on time, for solving a lot of little problems we have, things we don't understand, cultural things, we don't know what's happening. They serve as a little bit of everything, as a friend, as an interpreter, as a broker for whatever. And these people do that very nicely and quietly, and with grace, I find. And that's something that is very endearing that made me want to be in Guinea.

Q: Thank you. And now, as country director, what do you see on your horizon for the next few years?

Martel: The exciting thing is that for the first two years of working there, I've only worked on Ebola. Finally, a couple of weeks ago, they announced the end of Ebola. It was on the first of the month. They said, that's it. We're done with the forty-two days of monitoring, and now it's just ninety days of extra monitoring. But we're done with Ebola. Suddenly, it was the permission to shift and look at other things. Guinea has a lot of other diseases they're concerned about. Right now there's measles, there's polio, and you know the devastating effect that polio can have. It's so sad when you know how easy it is to prevent polio. It's so sad when you see children affected by polio. There's malaria, there's yellow fever, there's—the list goes on. Meningitis. Now finally we're able to not totally let go of Ebola. We're always going to be monitoring it pretty closely to make sure that we catch if there's anything coming up, but at the same time we can now focus on truly helping the ministry develop its capacity for surveillance, epidemiology, detecting diseases earlier so they can protect better their population. It's exciting. Ebola gave us the opportunity to create the trust and the relationships that we need to be doing it. It's a little bit like we did a lot of work that now's going to pay off because we have all these relationships. It will be easy to work on these other diseases now that we've done this hard work on something as dramatic as Ebola. So this is exciting. Now it's looking at the broader issues of epidemiology. We're in the process of starting a field epidemiology program on the ground. I'm very excited about that. We're doing a lot of training of people with epidemiological tools, how to collect data and how to analyze it. We do work still in emergency management. We do work in infection prevention and control. We do a little bit of communication work. We do in all kinds of areas we're able to participate in,

and now we're known entities. CDC, through the whole response—every agency has difficulties in any event like that, but CDC has always been praised for the work that it did. We were not criticized by the government. We didn't do like a big mistake that put us in the spotlight that they said, oh my god, the CDC did this. CDC was always a strong supporter, always seen as a key partner that was getting things done on the ground and that was very collaborative. I was telling the deployers, every time I have a new batch of deployers coming through, we have a staff meeting. I was saying to them, "You don't realize how important the role, the work that you do is for my office, because you're setting me up for success. The good work you do on the ground, the reputation you formed about CDC during the response, is what's setting me up for success in this relationship with the ministry to move on." So very exciting times.

Q: Thank you so much. I think you have another thing to run off to, but I just want to thank you from the bottom of my heart for sitting here and talking to me about your experiences. Fascinating.

Martel: It was a pleasure.

Q: Thank you.

Martel: Thank you.

[break]

Q: You said the one thing about how you came to Guinea and you thought, okay, maybe I could stay here for a little while. [laughs] It'll be a change, right? Because you're used to all the travel.

Martel: Yeah, and it's kind of nice, you know, because it's been ten years that I cannot have a steady activity like be in a club or play volleyball every Wednesday. I just can't. And now suddenly I'm like, Tuesdays I can do this. I was like, I could even have a cat. But I'm like, ah, not quite, because I still travel a little too—like I'm here now.

Q: A little too much with a cat?

Martel: I was like ah, no, I think I will hold on. I was like, maybe I could have a pet. People were like, what are you talking about? I said, I haven't had a plant or a pet in ten years because I travel too much. My house had all those fake plants. Couldn't even have a plant. I'm like, now I'm going to be in the same place most days. I could actually do something.

Q: That's hilarious.

Martel: So that's kind of a big change, a big adjustment. I even went to see cats. But then I thought, maybe that's a little bit—maybe I better hold on.

Q: Just for the moment. Not ruling it out.

[break]

Martel: This building where the EOC is, there was two fires there. We were supposed to have our CDC office in there, and our office, they had asked us permission to use it for storing gloves, latex gloves. The fire started there, and it burnt piles of gloves to the ceiling to the ground. Petroleum, right? It burned so hot it made a hole in the cement of the ceiling.

Q: The cement?

Martel: The cement. It melted the cement. They had two fires, and then this week, I receive while I'm here, I receive a message saying that there was just a fire in the new workplace and they had to work from the hotel for two days. Somebody said, "Aren't you discouraged? There's always, like, fire." And I said, "You know the way I see it, what I thought?" They said, "No, what do you think?" I said, "We're just hot. We're hot stuff." [laughter] They were like, "What?" I was like, what else are you going to say? What are you going to do? But the reason there are so many fires is because before, they didn't have regular electricity, and now they have a new dam. Now they have electricity, but the wiring is horrible. So now that there's regular electricity, the wiring can't take it. So they would have to redo all the wiring of all the buildings and all the houses.

Q: All the infrastructure.

Martel: Yeah. So right now what they do is they wait when something seems like it's burning down, they turn it off. They smell the rubber, something burning, they'll turn the thing off and wait a little bit. And the current fluctuates. Like in my house, it's 220 [volts] there. So I said, "My air conditioners, my bulbs are bursting. Something's going on." They sent somebody, an electrician, and he said, "You know what your electricity comes in in your house?" and I said "220." He said, "245." I was like—how is that possible? He said, "That's why you're burning through your lightbulbs."

Q: Too much.

Martel: So now of course in my house I have regulators for all my electronics, for my TV, so that's okay. But the lightbulbs, of course I don't have a regulator on my lightbulbs.

Q: No, that doesn't make sense. You can't put it everywhere.

Martel: So there you go. I was like, what's the solution? He was like, "Well, I don't know, change your lightbulbs."

Q: Just have a lot of lightbulbs.

[break]

Martel: For me, it's a great learning experience. I just hope I can give—my goal when I accepted country director, I used to run a small team and we were very successful in our activities. I thought, I wonder if I can magnify that and make a bigger difference. If I'm in charge of something bigger, I can kind of, you know. And I'm thinking, what if thirty years from now, when I retire, somebody would say, "Wow, look what you guys started. Now their system is stronger." I would have something. But I'm not sure it's going to happen because it's such a poor country. We've been in countries where we do interventions, and you go back five years later, and everything you've ever worked on has disappeared. It just doesn't exist.

Q: That's so sad.

Martel: So as you're doing it, you'll never know. You won't know until ten years from now. And it's to look at that and wonder, am I doing the right thing? Am I doing it for the right people with the right money with the right intensity with the right angle that this will survive? It's a humbling experience because you do stuff, sometimes you think it's the greatest thing. And then it flops. When you think of this, it's so simple. Of course it flops. We've been like, everyone's been promoting gloves, gloves, gloves. In the institution, everybody, they need to wear gloves. Sanitation is very important. Then you go to the hospital, the clinic, and they don't have running water. It's like, okay, you've got the gloves, but you can't wash your hands. I don't know, you know.

Q: So many things. Oh my goodness.

Martel: So it has been just a very humbling experience.

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