CDC Ebola Response Oral History Project

The Reminiscences of

Daphne B. Moffett

David J. Sencer CDC Museum

Centers for Disease Control and Prevention

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Daphne B. Moffett

Interviewed by Samuel Robson
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Interview 1 of 1

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Q: This is Sam Robson, here with Daphne Moffett in the audio recording booth at CDC's [United States Centers for Disease Control and Prevention] Clifton, Roybal Campus. It is February 12th, 2016, and we're here to talk a bit about Daphne's experience with the Ebola response, but starting a little bit before that, her path to CDC, before we focus in on that. Daphne, if you could please give me where and when you were born?

Moffett: Sure. I was born in Canton, Ohio, on October 23rd, 1966.

Q: Can you just tell me a little bit about your youth?

Moffett: Sure. I probably had a pretty typical Midwestern upbringing. I have one brother who's two years younger, and my father and mother have been together for fifty-some years now. We lived in a middle-class neighborhood. I liked school very much, so I studied a lot. [laughs] We had a very happy home life from everything I can remember. We had many cousins, so we would always see cousins a lot, family. My dad thought it was also very important that we travel around the US, so probably the reason why I have an interest in travel is because he was always making sure that every year we went on

some type of vacation to see something. We were thrown in the back of a station wagon and driven across the States to see either family or some sort of historical site. [laughter]

Q: What did your parents do?

Moffett: My mother stayed at home for quite a while, she was a part-time banker. My dad worked for the City of Canton in the water department as a filter operator. Neither one of them finished—actually, my father went to college for a little while thinking he was going to play football, and when he realized that that was not in the cards, he quit college. My mother did not go to college, so I'm first-generation college. So I decided to go all the way to a terminal degree.

Q: You mentioned that you liked school and you studied a lot. What specifically got your attention?

Moffett: In school?

Q: Yeah.

Moffett: Pretty much—and this is probably—just everything. I always find just about everything interesting, which I know I've been told in the past—I remember I had a division director once who told me, "You know Daphne, you're going to have to focus on something." I completely ignored his advice, and that was the right decision because it's

actually not true—you don't have to. [laughs] You can do just about anything you want to do. I really enjoyed languages. I happen to be lucky, I was put into a program early on where they taught us French. From the fourth grade on, I was able to have French classes. It was a unique program that they had in Canton—it's where they did IQ [intelligence quotient] testing on a bunch of kids and then put them in—it was a test program for a little while. I always found—math, I don't know that I really liked math, but I was good at it, so I was always put in some higher-level math classes. I liked writing and English as well, and then I always liked the extracurricular activities that went along with being at school.

Q: At the time of high school graduation, what were you thinking you wanted to go forward and do?

Moffett: When I graduated high school—so I spent a year abroad as an exchange student, I should maybe mention that. I was a Rotary [International] exchange student my junior year of high school, which was a fabulous experience—one that I would recommend for any kid. It's really enlightening. I spent one year in Australia, and then came back. When I graduated, I had a whole new perspective on the world. Still pretty naïve, but a very different one than I had before I left. I thought probably I was going to go to school and study medicine originally, is what I thought I was going to do, but then I went to university and I really liked chemistry. I ended up deciding that okay, chemistry was my thing, so I have a bachelor's degree in chemistry and then a PhD in biochemistry. I finished my undergraduate and then decided that I didn't want to stay in Ohio any longer,

so I went on to do graduate school in Montana, where I could learn to ski and rock climb and maybe have a little bit of an outdoor life out of the lab. [laughter]

Q: So what focused—

Moffett: How did I get to CDC? [laughter]

Q: Well, there's that, there's that, but I'm moving slightly slower than that, sorry. [laughter] How did biochemistry become that focus for you?

Moffett: I was fascinated in how the body functioned, but then I was fascinated on a very molecular level. When I graduated from undergrad [undergraduate school], I had a major in chemistry and a minor in biology, so I decided to combine the two, and I found an advisor at Montana State [University] who'd just come from Cornell [University] and was interested in doing some HIV [human immunodeficiency virus] work. At that time, there's a lot not known, and I thought that would be great. My background is really—I studied for several years and tried to design peptidomimetics that would interfere with the binding of the virus with the CD4 [cluster of differentiation 4] cells. That was my goal. I did everything from designing peptides, looking at the interactions between the virus and the T cells, to designing a peptide that you could flood a system with to actually prevent the binding. I did great kinetic studies. I did molecular dynamic studies. I did a lot of things I don't do anymore. [laughs] I think I might have been smarter then.

Q: What years would have this been?

Moffett: Let's see. I graduated high school in '85, so right around '91 to '95, '96.

Q: Upon conferral of your doctorate degree, what were you thinking at that point?

Moffett: My husband also has a PhD, and his was in neurobiology, so between the two of us we were completely unemployable in Montana. [laughter] We realized afterwards that if we wanted to stay there, we should have been wildlife and fisheries biologists or something like that. We both had the option of—we could have gone to NIH [National Institutes of Health] for post-docs [postdoctoral research], but we looked at how much salary they were going to pay us and neither one of us could really believe it, so we decided no, that was not the path for us. Not that we were going to make a lot of money, but we at least wanted to be able to live off of the salary. We moved to Cleveland, and my husband did some research at the Cleveland Clinic. Our daughter then was also very young, she was one at that time. I was a stay-at-home mom for a little while, while I was trying to figure out the next steps. He was doing research at the Cleveland Clinic.

Then there were some fellowship opportunities that came up at CDC, and I thought, this sounds fascinating. I applied, and I decided to change gears a little bit. I had been doing infectious disease and HIV work for a while, and thought environmental health was interesting. I had actually done some work in water quality before, so I thought I'd give this a try. I took a post-doc here at CDC and worked in environmental health for a while.

I convinced my husband this was the place to be, so we moved from Cleveland Heights to Atlanta, and he started teaching in the public school system, and then I started here.

Q: Can we back up for just a second?

Moffett: Yes, absolutely.

Q: Can I ask how you met your husband?

Moffett: Sure. My husband and I met in undergraduate. Well, if you ask him, I'm sure he has a different story to go with this. [laughs] We met in—oh, this is so not glamorous—in an analytical chemistry course. [laughter] We had this great Greek professor, we will never forget him, Dr. [Chrys] Wesdemiotis, and probably I should thank him because he's probably the reason why we are together. At that point, there weren't many women in those classes. I think it was myself and maybe one other woman. My husband went to see the professor at one point, and he suggested that he and I should study together. I think my husband is pretty brave, and he just sort of walked up one day and said, "Okay, so what are you doing?" It was very funny. I think I had plans just about every time he asked me, and I wasn't really getting the gist of where this was headed. I think finally he said, "Let me cook you dinner. I know we've got to study for a class." I think he cooked me dinner, and I think we went skydiving or something crazy like that right together. After that I thought, okay, this is a lot of fun and this is going to be perfect. He and I have been going on adventures ever since.

Q: Yeah, I was going to say, you sound—skydiving, moving to Montana to do skiing and everything. You have that adventurous streak.

Moffett: There you go, just a small one, yes. [laughter]

Q: Can I ask, is there anyone at this point up through the post-doc at CDC that you would consider a mentor?

Moffett: That's a great question. I have probably since—I think I learned a lot about what to do, how to do certain things, how to approach certain things, from a variety of people at CDC after I started my career. Probably a little bit later on, there were several people I now consider in retrospect mentors. Up to that point of course, my thesis advisor at Montana State was a mentor. He was always very calm and methodical and supportive, and so that was very helpful. At that point in time, it was very funny—in graduate school, the last year of graduate school, I got pregnant. My thesis advisor had said something, "You better wait until your post-doc and then start a family." Timing doesn't always—you don't always get to decide when that happens. He was very supportive. I was working in the lab—I was doing cell culture—and he was very supportive of me being able to work sort of a schedule for the family, so that was good.

There was also a woman in the molecular department there who I looked up to quite a bit because she is quite brilliant, but also didn't seem like she had—she wasn't

uncomfortable with—again, the department I went to, there were no women professors initially in the chemistry department. For me, I don't think any of that ever really registered, or it wasn't of concern to me. But I didn't really pay much attention to it until I was putting my committee together and realized, I have no women on this committee and maybe it would be helpful. But I chose her for a couple of reasons. One was she had a great deal of knowledge in another area that was important to me, and also sort of that gender balance—I realized later on it was really helpful. I'm not sure at the time I knew for sure that it was, but yes.

Q: It sounds like maybe that goes along with the adventurous streak is willing to break new ground in careers.

Moffett: Yes, yes.

Q: So you get to CDC, and tell me what happens now.

Moffett: I came to CDC. I was doing a post-doc in the laboratories. I was looking at metabolites and the National Health and Nutrition Examination Survey, the NHANES survey. What the environmental health laboratory at CDC does is develop biomarkers for chemical exposures, and so we were developing biomarkers for exposures to polyaromatic hydrocarbons. We were coming up with some new methods and then testing samples to validate methods. Although I found it interesting, I realized that I'd started to come in contact with a lot of epis [epidemiologists]. There were all these

epidemiologists running around collecting this information, and I realized that what I wanted to know was—although I enjoyed the laboratory, I really wanted to know both sides of the story. I wasn't just interested in, could I make the limit of detection for 1-hydroxypyrene lower and lower and lower? That was not my interest. Although it was important, there wasn't passion for me. So I realized that I wanted to be—I really wanted to learn a little bit more about public health because public health wasn't really my background. Although my research was in HIV, it wasn't necessarily public health. So I decided that I needed to broaden my perspectives a little bit.

There was a position available in the Agency for Toxic Substances and Disease Registry, ATSDR, in the Office of Tribal Affairs. A friend of mine had been working there and she was moving on and told me that this position was available. I decided I was going to apply. I applied, I met the director for the division during the application process, who is a retired admiral in the [United States Public Health Service Commissioned] Corps, Admiral Bob [Robert C.] Williams, and I remember distinctly—so I'm a US Public Health Service officer. I remember distinctly sitting across the desk from him and saying—he had the authority to offer the position. He says, "You can take this job and here are your options. You can either come in as a civil service," and he had paperwork in one hand, and then he said, "or you can come in as a commissioned officer," and had paperwork in another hand. He took the civil service paperwork away and handed me the paperwork for the PHS [Public Health Service] officer. He said, "Here you go." [laughter] He was a very smart man in that regard. It was also a very great decision—coming to CDC was a fantastic decision, but also coming in through the US Public

Health Service was an equally wonderful opportunity. I didn't really know much about PHS at that point. I saw people walking around in uniforms. I didn't understand why some people wore them and others did not. He took the time to sit down and explain to me what it meant, how it had been good for him in his career, what the opportunities were, and I thought, this seems like a good opportunity and a way to serve. So I came in through the PHS route as a commissioned officer and haven't looked back since.

Q: What happens next?

Moffett: I worked in the Office of Tribal Affairs, which was a great opportunity. I worked with tribes all across the United States on their concerns in environmental contamination. We worked with communities that are located or co-located with Superfund sites, or areas that have been contaminated due to industrial accidents, or maybe it's not an accident, but maybe they live some place where there's just fuel tank farms and concerns of leakage into the ground water and things like that. That was a fascinating job. I learned a lot about people's fears and what people's perceptions are about what impacts our health. We worked so closely. That particular agency worked very, very closely with communities, and we had community meetings all the time. We also had a lot of congressional inquiries, so I learned how to respond to FOIA [Freedom of Information Act] requests, how to respond to our legislators, and how it's important to keep people apprised of situations, and the power the public has in being able to reach out to their congressmen. I think we don't always believe that you have that touch, but you do. It was interesting to be able to see that dynamic.

After that, I moved out of Tribal Affairs and went to Toxicology and Environmental Medicine. I was the agency liaison to EPA [United States Environmental Protection Agency]. I sat on several committees with EPA and with colleagues from the National Cancer Institute. I started working on chemical-specific documents with WHO [World Health Organization] and looking at studies and the impact of—we would take a lot of data from animal studies and look at studies that were done with chemicals with animals and what that translated into potential impact for humans. These aren't studies that CDC does, but they are studies that are done by multiple universities and industry. We also worked with industry to try to obtain study data from them, so that we could actually come up with protective measures for the public.

I went to Injury Prevention after that. I had worked there for probably five years. I really liked my work, but I also felt like again, I wanted a broad understanding of CDC. CDC's so much more than any one particular area, and I really wanted to understand the agency better, so I had an opportunity to go to Injury. They were looking for somebody to come and be within the Division of Unintentional Injury [Prevention] to be their deputy associate director for science. I had an interview with a detail. I'll never forget, this was Dr. David [A.] Sleet, who is a giant among public health people, particularly in injury prevention, and somebody I do regard as a mentor. He was very funny. I went to the interview and I brought examples of all the work that I had done. At the end he said, "I don't understand. You don't have a background in injury, so how do you think you're qualified for the job?" He wasn't being mean, he was just curious. I said, "Look, a good

scientist is a good scientist. I should be able to pick up pretty much any topic, and if I'm good as a scientist, I can then transfer what I know. That ability to take data and synthesize it, it doesn't really matter what topic it is." I think that must have been the right answer because he said "Okay, I'll take you." [laughter]

I really enjoyed working with him. That division does motor vehicle injuries, motorcycle helmet laws. We looked at those. Fall prevention among older adults. It's very different. I had gone from HIV to working in environmental health and emergency medicine to working in injury prevention. I stayed there for a couple years. The detail turned into a job offer rather quickly. I stayed there for a couple years and enjoyed that very much. Maybe missed a little bit—ATSDR, there was always a lot of conflict, and mainly that was driven by the public outrage over contamination or perceived health impacts from contamination, so there were always congressional inquiries or public health inquiries. Things that required attention that were probably contentious. I actually liked that work. The injury work I enjoyed very much, but it was quiet. [laughs] I received a phone call from an old boss of mine at the Division of Health Assessment and Consultations in ATSDR at one point. He was looking for an associate director for science, and they had a job. He called and said, "Would you consider coming back?" I obviously had to apply, although as a commissioned officer actually you can just be ordered. They can cut your orders for—it's called a 1662, and as long as both programs agree, they can just transfer you. That's one of the beauties of the public health system.

I went back to ATSDR and served as the associate director for science for a couple of years. While I was there—ah, I got called up for—I had worked a couple of emergencies before the anthrax scare, 9/11 [September 11th, 2001], and then while I was the ADS [associate director for science] in the Division of Health Assessment and Consultation, I got called up and sent to Haiti basically because I had the right skills. I could also speak French. Those two things together, and they basically put me on the plane and I went to Haiti. I came back, and I thought, and that was an amazing experience. Then they were looking for—Jordan [W. Tappero] had been tapped to head up basically the response in the EOC [Emergency Operations Center].

Q: This is in 2010?

Moffett: Yes, this is in 2010, because the earthquake happened in January. When I came back, there was an opportunity to continue this work. I told my boss, I went in and talked to him and I said, "I'd really like an opportunity to be able to see what happens after." I had been on the deployment, but I would kind of like to see how this plays out. This was Captain Bill [William] Cibulas, who was also a great, really good mentor of mine and supportive of my career. He said, "I think it would be a good opportunity for you, so yes, we'll see how this works." So I went over, became the deputy for Jordan. We were basically working, living out of the EOC because we were working very, very long hours and weekends. There was a lot of work to be done. We pulled together a team and did everything from trying to support the CDC office that was already in Haiti in Port-au-Prince, supporting them to be able to get back on their feet. That was mostly PEPFAR

[President's Emergency Fund for AIDS Relief]-funded work, so it was a lot of HIV work. We wanted to get that surveillance back up and running, and then build off of that surveillance for many other diseases that we expected to see.

This was just before the cholera outbreak. Because we had decided that we really needed disease surveillance to be strengthened—that was actually one of the reasons why we were able to see the cholera so quickly, was because we were collecting data in advance of it. When the first few cases—we saw this spike in a number of cases. We had a report from one of our staff, who was Nick [Nicolas D.] Schaad, who was out in one of the districts and he called back and said, "This hospital is seeing an outrageous number of diarrhea cases, dehydration." He said, "I think we need to send a team out and take a look at it." That was when cholera hit. We set up teams, set up rotational schedules, made sure that we got [unclear] involved in all of this and our cholera experts at CDC, and then the response went from earthquake to now earthquake and cholera. It was quite fascinating. We had them rotating staff in and out of—we were trying to get people in and out of Haiti, and because you really do need French to be able to communicate—trying to find enough staff with an agency who spoke French was also a challenge. We learned a lot of lessons in that response.

I was there on a detail, and then again was offered a job, so I went back to my boss, who had really sort of let me go on the condition that I would return. I returned and talked to him and said, "Bill, I have a job offer and I'd like to take the job." Of course, he wasn't going to prevent me from it, but he said, "I knew if you left, you were not going to come

back!" [laughs] It was very good of him. I took the job with the Health Systems Reconstruction Office and worked there for three years.

Q: Can you talk a little bit about some of those lessons that you think came out of the experience in Haiti?

Moffett: Sure, absolutely. We learned that probably our bench depth at CDC for languages is not very deep, which is unfortunate. We did have conversations about, maybe when we do recruitments, that should be something that we think about. Do people already come with that language? Or if they don't come with that language, how can we make sure they get the training they need? We did actually send a few people to FSI. That's the Foreign Service Institute that basically trains all of the State Department in the languages that they need. We tried to mitigate the language issues by supplementing some of what people already had and improving their skills, and then also, some folks really hadn't had much of any French, and so we took them from ground zero. We did have conversations about, as this agency expands to—this was very much a domestic agency for many years, but we've become very much a global. Global health is a very large portion of the work that we do now, and a very important one too. I think sort of thinking about, you need to make sure that people have the skills they need because when you go to a country and the working language is not English, you need to be able to converse, and easily.

That was one, and I think another lesson that we learned was the staff that we deployed—we had some great people on deployment. We hadn't really worked a lot with people or seen a lot of people coming back from emergency responses with any sort of PTSD [post-traumatic stress disorder]. We did in this instance. I think we learned a lot about putting people in those types of situations, they also need support when they return, and there were some changes made in what deployers and responders, what sort of services they're able to access when they come back. We can talk about it too—we can talk about Sierra Leone because a similar issue came up there—but it's hard to tell when you're getting ready to deploy people how strong they're going to be able to be. Resiliency is really, really important, and we had a few people that—I think also we learned that you have to be able to pull those people back if you need to, for their good and for the good of the response. I think we learned some lessons. It's hard to identify who those folks will be. I do think that's one of the reasons too that it's not uncommon for the EOC, even though we have these teams, to maybe reach out to people that they already know. One of the reasons several of us have deployed so many times is because they know that if they deploy person Y, that that person can handle it. I think we learned that lesson. Who was going to be able—and they may be a subject matter expert, but there's a little bit of a difference when you put a person in a situation where there's political strife. We were locked down in the embassy for about five days at one point because of riots, because of the elections. You get to know your co-workers very well and their characters, but then you also see that there are some folks who probably, deploying to crisis in emergency situations is not a good idea. Knowing that beforehand is very helpful.

Q: Are there things that you think you learned about yourself and your interests?

Moffett: Yes. I would say I learned how much I really like global work. The Haiti work was really sort of a first taste of that, and I realized that this was just fascinating to me. How other countries, how their systems function or not, and then also it caused me to reflect a little bit about how our system functions and what are some efficiencies that we could see as well. I don't think I've ever really been terribly concerned about my own resiliency. I'm pretty level-headed in most cases, and I think that maybe it hadn't been tested quite like this before, but other than being really tired, I think for me, I enjoy my work and so just being immersed in it non-stop for weeks on end was okay. We did though sort of push people to take a break, it's good. It's always good. I think accepting that and realizing okay, it would be best to step back, just for a day, so you could kind of reflect on how things are progressing or not, was also very useful. Forcing yourself to take a break for a little while.

One of the other things I think I knew, but I also hadn't seen before, was the value of animals, in particular furry animals. [laughs] If I could change things, if I had the power to change things, I would recommend we take dogs on every deployment. Right after the earthquake when I was deployed and we were working out of tents, and then also a little bit out of the—the military had come in and sort of took over the CDC office. [laughs] There was a street dog, he was a very cute Labrador who had been rescued by one of the military vets [veterinarians]. He had an injury, and so they had done a little bit of microsurgery for him, and he was healing, and the general who was there said, "I'm

taking that dog back with me." Of course, they were like okay, whatever you would like to do, that dog is yours. What would you like to name the dog? The dog had a handler while we were there. There was always somebody with the dog because the general said. But what was great was the other thing, people got rather stressed out because there were so many things happening all the time, and people tripping over one another, we were all camped out all over the embassy grounds. There were search and rescue teams. There were teams from FEMA [Federal Emergency Management Agency]—they were everywhere, everybody was everywhere. What we would do is when people were beginning to get a little frazzled or on edge, we would say okay, you're going to get dog time. You would send them to have ten, fifteen, twenty minutes with the dog. Just go, play with the dog, sit with the dog, pet the dog, and it was absolutely incredible when people came back from that. You're like, okay! They were centered again. I think they were ready to go again. I know it's not something that we embrace, and people are worried about people who might have allergies and whatnot, but I think there is a reason why we have service animals and I think that we would do well to consider that going forward, the benefits of having—again, I think it's furry animals, although I know fish tanks are good for some people, but having those animals that you can just spend a little bit of time with is really—was great, really good.

Q: I swear we're going to get to Ebola at some point, but you just have a fascinating career. It's not anyone's fault. [laughter] When you're describing a lot of your different, previous positions like in environmental health where you're having to go through these congressional inquiries and learning how to work with FOIA [Freedom of Information

Act]—learning how to communicate health messages to the public. How did those lessons, how did that manifest in Haiti when the political environment there, needing to communicate health messages to Haitian people in what was probably sometimes a pretty politically fraught time—I mean, you mentioned the riots.

Moffett: Yes. No, that's a great question. I think one of the things that we had to consider too, having worked closely with communities in the past, I realized that our messages had to be clear. It wasn't necessarily that they needed to be basic or not technical, as long as you would explain it to people. That was really the key. I've gone to several technical meetings and I've gone to several community meetings and I know I was really surprised at one of my community meetings when a local person stood up—didn't necessarily have any training or background, and basically wanted to talk about the mechanism of dioxin toxicity. And he already knew a lot of it. I wasn't really telling him a lot he didn't know. I think we always have to be careful about presuming that maybe the lay public doesn't have this expertise because particularly what I learned and what I appreciate now is that if a person believes something is negatively impacting them, they can become their own expert on this and learn more than I think a lot of people might give them credit for. Particularly, if it might impact their health or the health of their children in particular, people become very protective. But in the US, we have less of the literacy issues, whereas in Haiti, so many of the people were just not literate, and then even if they spoke—French was sort of the working language of the government of the educated, but then Creole was the local language. I think we got better and better at realizing that putting everything in writing everywhere was really not helpful. We tried to pick pictures

about what they should do, particularly for cholera. You show a picture of a person who might be sick and then a picture of what they needed to do, who they should talk to. Then also, previous to that, show—if you've got water, put it on fire so that it boils it or make sure it's clean or those types of things. Also, to make sure, I remember the communications department here was great. They worked really hard to make sure that all of those graphics and materials that we had looked like the Haitian—so we weren't giving them health communications documents that looked like it was somebody from the US, or somebody from Germany, or somebody from—that it actually looked like them, so they could see that okay, this message is for me and I get this.

All these sorts of aspects that I think either people (a) take for granted or (b) maybe never think about—usually it's one of the two—become very important, especially when you're trying to get a population to do something. It's very hard to give somebody a message and then say, use soap and water, wash your hands. What if that person doesn't have soap, what do you want them to do? Trying to make sure our messages match what's possible, I think, was also very critical. If we were telling them that they needed to wash their hands frequently, then we better make sure that they have soap in order to do this. I know it seems very basic, but I think it was sometimes surprising how we would tell people things and then say okay, so if you tell them this, where are they going to get whatever it is that they need to have?

Q: Are you located in Haiti for the next three years, then?

Moffett: Our staffing footprint had to remain small in the embassy. They didn't want to hire a bunch of—have a lot of US direct hires coming in and overwhelming the embassy because they were not going to be able to expand. The embassy had already expanded with a lot of staff, so what we did was we made sure that our CDC footprint—I think we added a few additional what we call NSDD-38 [National Security Decision Directive 38] staff, so US direct hire staff. We did add a few, but then the rest of us were located here in Atlanta. What we would do was travel frequently to support the staff who were there, or if they needed a break—so I served as acting country director a few times, I served as the cholera lead a few times. Trying to rotate and make sure that the staff there could have a break, but that we would also be able to support them without sort of overwhelming that office and building that office out to a non-sustainable size. That was really our goal. We were there quite a bit on long—could be short, but usually longer TDYs [temporary duty assignments] is what we would do.

Q: So then what happens with you?

Moffett: [laughs] So three years, I'm working with the Health Systems Reconstruction Office. Jordan is the director and I'm the deputy. We have a team that we've built out. It was a great team, very effective at their job. Then Jordan gets a call by Admiral [Anne] Schuchat to go up to be the ADS [associate director for science] for the Center [for Global Health]. He tells me what's going to happen, so okay. He goes, and then I'm asked to be the acting director of the [Health Systems Reconstruction] Office. I said okay.

During that time again, enjoying the work very much, but then I'm beginning to think, okay, maybe I should accept an overseas position. I've been working sort of in this quasi-overseas job, and wouldn't it be great to actually go to the field and work in the field for a while? I spoke to my husband and said, "What do you think?" He said, "I'm ready, let's give it a try." So, I applied to a couple of positions, and it was very funny. My husband originally said, "I don't know if I want to move to Africa and have the kids move to Africa." Well, then you've just sort of obliterated a good three-quarters of the options. [laughs] So I said, "I'm going to apply to a few positions anyway." I had a call from Tanzania, a call from Thailand, and I gave him the choices of which do you like. He said, "[gasps] I think I want to go to Tanzania." I said, "I know you know, and you're smart enough to know Tanzania is in Africa. I thought that was off the table." He said, "No, I know." He said, "I've been doing some research and I think this will be really fascinating."

We decided, made the decision, and then told our kids, who—maybe in my communication skills with the agency they've been pretty good, but maybe with my children that was probably—maybe I should have prepared them a little better for this. [laughs] They both sort of looked at me like, what are you talking about? We've been living in this same house pretty much, and since my son was born they've been living in this house for ten years. My daughter was a junior, and so she was just livid that we were going to move to Africa for her senior year. What were we thinking? She wasn't going with us. That was the end. She stormed off and went to a friend's house. My son just sort

of broke down for a moment and then it was like, "Okay. When are we going, and is our dog coming too?" That was his big concern. Of course, the dog's coming too.

When I received the job offer from Tanzania, we accepted the job offer. I think that was in February. We decided that a good way for us to do this was to sell pretty much everything we own and become a nomad sort of clan of people. We decided it would be easier to shed everything and start over, which was great. My husband loves not to have material things, so he was ready for this. I think his idea of bliss is living in one of those Ikea apartments that are like the ones you see—everything you own in one small space. So we did that.

I will say that, that was a little bit—there might have been a lot of stressors, probably more stressors in all of that than any of the deployments I've ever been on. You're selling your house, selling all your cars, figuring out what you're going to do next. Our kids sort of got over the whole, we're moving and that's the end of it, and moved to Tanzania. This would have been 2013, and got there, and they loved it. Then our daughter in particular, she was adamant she was going to hate this and thought it was absolutely—took a little while to warm up, but really enjoyed it. Again, I had moved over to the Division of Global HIV—it's now HIV and TB [tuberculosis]—working with PEPFAR as their associate director for science for the country office. It's a large country office of about seventy employees there, and a lot of programs and a lot of studies. Moved to Dar es Salaam, and I was there when Ebola hit.

Q: Why don't we take a quick break and let's come back to it.

Moffett: Okay, great.

Q: Cool.

[break]

Q: We are back, Sam Robson here with Daphne Moffett. We left off at, you're in Tanzania, and then you got a call about Ebola.

Moffett: Yeah, yes. It was very funny. Again, it seems serendipity or right place, right time, or something like that. I had two fellows working for me at the time, ASPPH [Associations of Schools and Programs of Public Health] fellows. The Ebola response had stood up, and in Tanzania, we were already dealing with some of the concerns about well, what if it spread all the way through Africa? At that point, when it first—this would have been—started having discussions about this in July of 2014. All these cases are starting to explode. People are starting to become more and more and more concerned because even though there were many cases earlier in the year, there wasn't as much attention around it. It seemed like either people thought it would be localized, and then as more cases were seen and there was this growing concern that all of Africa was going to become—I think there was this *Time* magazine cover where it showed Africa with a giant X through it because of Ebola. It was pretty horrible. Tanzania was worried. Especially

the African countries were all trying to get prepared and have procedures in place in the event that they would start seeing cases, which is really challenging in countries that really don't have infrastructure basically to address pretty routine health issues. Ebola is a whole 'nother level of challenge.

Q: What kind of steps were you taking in Tanzania?

Moffett: In Tanzania, they were reviewing all of their—they already had some preparedness documents, and they already had some SOPs [standard operating procedures] because they had had an Ebola scare a few years prior to this. They had at that point realized that they needed to have a plan in place for—for example, for transport. How would they get the patient from wherever this person was, and what hospital would they take them to? They identified a clinic that they would go to, they identified a place that would be sort of the isolation ward. They identified an ambulance that would be able to move this patient. So they had sort of started to work this a little bit, in terms of—and then, who would take the call and how would they activate the system? Because they didn't have the capacity to actually run the blood test, who would they send the sample to? And making sure that the export/import issues. There had been a decision to send it to Kenya—they had the capacity to test for Ebola. But having that discussion between the two governments to ensure that there was an agreement, because if it happened, it needed to be done quickly so that Tanzania would be able to export, Kenya would accept. That in particular was the concern. Okay, everybody has said yes, but

when it happens, will it really work like this? So Tanzania was sort of gearing up for this, and then one of my—

[interruption]

Moffett: The agency had started requesting deployers. They were requesting people to go. It was a big, broad catchment. We need people to go, we need people to go to West Africa, and in particular, for Guinea, they wanted French speakers. When they sent the request out, one of my fellows—I had an ASPPH fellow who could speak French. She came to me and said, "I speak French, I'd really like to go. Would you agree and support this?" I said, "Absolutely. I'm not sure what the policy is on sending fellows, so let's find out whether or not we can do this," because there were no specifics in the first request. Could contractors go? I had a contractor who also had worked in Liberia before and actually knew the Ministry of Health [and Social Welfare] quite well, and he was also interested. Fine, let me make some calls to the EOC and find out. I called the EOC and got a hold of some people that I knew and had worked with before. I said, "I've got a fellow who would like to help. She can speak French. I know you guys are looking for folks, you could send her to Guinea, I think she would be really good." And it was so funny. The woman on the other end said, "Daphne, we have been looking for you." Of course I work for CDC, it's not like you can't find me. I said, "Stephanie, I'm not sure why you couldn't—" It's like, "I've been trying to find you for the last two weeks. We'd like for you to deploy." I said, "I'm not calling for me, I was calling because I've got staff who I think should go." She said, "No, no, no. How fast can you be ready to go?" I

said, “Okay, I need to go talk to my country director first about this issue,” because that was not the plan. Then I followed up with the contractor and the fellow issue. They said at this point, they weren’t taking contractors and fellows. They were going to see if they could—for a variety of reasons, there are legal issues, medical concerns. What kind of authority do we have to basically extract people at that point? She said, “We’re not doing that at the moment. We want FTEs [full-time equivalent staff] and we’d like for you to get on a plane shortly.” I said, “I probably need to go have some conversations first with my boss and I’ll get back to you.”

That was actually how I got called up for that response. Again, I think one of the beautiful things of CDC is the people that you know and you get to work with, and you get to know them well. Stephanie was running the response and said, “How fast can you be ready to go? We’re going to get you out the door, and we’ll probably send you to Guinea.” Because they knew I had the French skills, and I had deployed a lot before. “Fine, okay.” I talked to my country director, Michelle [Roland], and she said, “Sure, whatever needs to happen. If they want you to go, you can go.” Then I told my family. You’ve seen all the scary things in the news, but my husband is a very laid back guy. He’s like, “I’m not worried about you.” He said, “I am, however, worried about some of the other people who may be around you, so you just need to keep an eye on them.” I said, “Okay, that’s fair enough.” And then I talked to my son a little bit about it. He’d seen me deploy so much for Haiti that he was kind of used to it, but he was still a little bit nervous. So we sat down and talked about okay, here’s where I’m going, I’m not really sure what I’m doing yet. Actually, at that point, I wasn’t even sure exactly where I was

going. I was told Guinea originally. He'd seen me come and go a lot over the years for different deployments, so he wasn't really worried. But he'd heard things at school, too, and so I think that had made him a little bit nervous.

As I was prepping to deploy, I had several phone calls that had to be taken care of and then figuring out the route. Kenya Air [Airways] had decided that they were no longer doing—they'd shut down all flights to West Africa. They were no longer interested in putting their crews at risk. We were trying to find out the best way to get me from one place to another. It changed, I didn't go to Guinea—so that was the other thing, you have to be a little flexible. They said, "You're not going to Guinea, we're sending you to Sierra Leone." Okay, that's fine. Whatever you need. "Here's the dates and you are going to go as the epi [epidemiology] team." Okay, fine.

I deployed—this was in August, and I got to Sierra Leone. We were on a Moroccan air, which was Royal Moroccan Air [Royal Air Maroc], which was a little bit exciting. [laughs] They didn't necessarily tell you when you were landing, so it was a little surprising when we stopped, but everything worked out fine. My luggage was lost for like a week. I had nothing with me. I had my backpack, which had my paperwork was all there, my flash drives. All those types of things—my computer. I could do my job, I just didn't really have any clean clothes. We got there, and I remember we had to take a boat. You land in the airport, you take a boat, go across the bay, and then they had a driver come pick you up, and then we were all staying at the Radisson Blu [Mammy Yoko] Hotel.

[interruption]

Moffett: We get off the plane, get on a boat. There's a car that picks us up at the dock and takes us to the Radisson Blu. The Radisson Blu Hotel has done a—they weren't supposed to be open yet. They had done this sort of soft open in order to accommodate all of the deployers who were coming in. We get to the Radisson Blu, and it's sort of, here's all your things, here's your people, here's your—actually, Leisha Nolen and I, she was the acting epi team lead before I got there. At that point, she was an EIS [Epidemic Intelligence Service] officer, and I think one of the concerns when I got there that I had was we had all these great EIS officers and no mid-level, senior-level epis [epidemiologists] who could supervise or provide support. When I stepped in, Leisha had been doing a great job, and that wasn't an issue. But what I was worried about was the fact that we had sent all of these epidemiologists—and again, many of whom were either EIS officers or very young in their careers—to districts on their own. We put them in districts, and I talked to sort of the leadership team there and mentioned that it's Ebola. Probably if it was something other than a viral hemorrhagic fever, maybe we could get away this, but at that point, we'd already seen WHO having to extract a couple of their staff because they ended up basically becoming infected. They had seen some patients, and we think maybe the PPE [personal protective equipment] wasn't used appropriately. We had staff that were co-located with them in a facility in one of the farthest districts, and so now we had staff that we were concerned about. So this practice of keeping all of

our deployers safe and ensuring that they knew what to do if they started to feel ill—it was of concern to me.

In addition to, you're already there trying to make sure you understand, how many cases are we really seeing? Do we have facilities to treat these people? How would we get people from one facility to another? Health messaging—all of those issues are all swirling around at the same time, and the epis that are in the districts. At least we'd made sure—because the other issue I had when we came in, I said, nobody goes to a district by themselves. There's too much risk. We need to have two people. If you want to send two people to a district, I would be more comfortable if we at least had a mid-level or a senior-level person going with an EIS officer, but if not, there must be two. Nobody can be out by themselves. We put into place some sort of safety and checks, because as we typically do when there is an outbreak, we sort of rush to the scene because that's the thing. Get in there, find out what's going on, report back, and then figure out what you need. I think that's sort of where we were. Plus, we had the response being run sort of—there was a DART [Disaster Assistance Response Team]—so USAID [United States Agency for International Development] DART and OFDA [Office of U.S. Foreign Disaster Assistance] teams, then also CDC sort of co-leading these teams, and then we had OFDA there as well as CDC there. We had this USG [United States government] presence that was also trying to—you know, you've always got to feel your way.

The personal relationships actually do determine the success of—I was going to say the response, but how about anything? [laughs] Maybe that's a big lesson that I've learned

over time, is you can have all the credentials, all the years of experience, but it's that personal relationship and connection that you can make, either with the ministry or with your colleagues in other government agencies or the community, that's going to determine how things go.

We had a great team of epis. They were great. They were working with all of the district health department types and trying to make sure that they were getting the cases identified, making sure that people weren't then moving around after they were sick, so that they weren't contaminating others, and then also trying to figure out, where are we sending folks? This was in August, and September was my first deployment. This was sort of the height of—the Kenema [Government] Hospital had basically, like the only hospital in the country that was taking Ebola patients at that time.

Q: Can I ask actually—

Moffett: Sure.

Q: —when you emphasize the importance of the relationships, and you had CDC there, we have OFDA and DART there, can you be a little more specific about where that came into play?

Moffett: Sure, absolutely. There was a lot of information coming in to different partners, so the epis are getting some information, and mostly our information is—we were trying

to deploy a system to capture all the cases, to then also try to get a tighter case definition. We were trying to identify, what signs and symptoms are we really looking for, and is there anything that we can separate out? Because of course, there, you also have Lassa fever, you have malaria. They all look the same, pretty much, initially. Is there something that we can say, alright, other than taking a history and saying well, this person was exposed to somebody who's now been identified as a positive Ebola patient? Trying to collect all that data and tighten down that case definition so that we can say—and hiccups ended up being something that was unique to the Ebola cases, but not everyone would have hiccups. I think also the public has this view of Ebola as well, it's a hemorrhagic fever, so there must be bleeding from the eyes and the ears. You didn't even see anything like that until—it was a small percentage of cases where we saw any of that, the actual hemorrhaging. That occurs so much later in the disease progression that unfortunately, by that point, it's usually too late. So there isn't this ability to differentiate up front.

In terms of the communications and the personal relationships and why it became really important was the OFDA guys, basically, they had the access to and were sort of driving this, what sort of supplies do we need in-country? Who has what kind of supplies? Everything from PPE to ambulances and cars—they were also providing, people needed blankets and shelter, those types of things. Ensuring that we had a discussion and that people knew who they could go to. Because even though we had epis in the district, the epis and—they were doing the surveillance work, they were really doing everything because they were the eyes and the ears in the district and the only representation that we had in the district. They were the ones who were collecting information on okay, the

hospitals now need more PPE, or we don't have an ambulance, or we don't have drivers, or we need some health communication staff to be able to come out and explain to the public, and how are we going to re-integrate those who have been sick and they've convalesced and now they're ready to go back to the community to prevent the stigma?

Being able to understand who had access to the different either interventions or pieces of information was really key. We would have a meeting every morning to go around the table and update on, how many cases are we seeing? Are there new chains of transmission? At the same time, we were using the only system that we really had to use, which had only been tested in Uganda, this VHF [viral hemorrhagic fever] system that had really been utilized for a much smaller outbreak.

Q: This is Epi Info?

Moffett: Yes. It was VHF that was sort of built on the back of this Epi Info system. It was specifically designed for hemorrhagic fevers because it did have a whole module on contact tracing. We were using this in sort of a big scale, and you're using this basically in districts where, okay, maybe we have electricity for a few hours, maybe we don't. There isn't good internet activity, so we're asking people to collect data and then e-mail it to us, but they don't have a way to e-mail anything, or the database is so huge it can't go over e-mail. We had lots and lots of challenges on that front. Then also, making sure that we're working with the Ministry of Health [and Sanitation], and that we are coordinating all of our activities with them. So we're having meetings with them, and then I'm having

phone calls with all of the districts, pretty much every night. How are you doing? Checking in, just to ensure people are also being safe. It was a very fast-paced time, and really pretty incredible. We were trying to get reporting out. We had colleagues from WHO there, but at that point, they didn't have quite the large presence that they had later when I came back for my second tour. They were still pretty skeleton in staff, but we were collaborating with everyone.

We had some amazing leadership. There were a couple of people in particular within the government and within the ministry that there is no way we could have done what we did without their support.

Q: Anyone in particular comes to mind?

Moffett: Yes, Dr. Amara Jambai. He has been and continues to be pivotal to this response being successful. He understood what needed to happen in terms of the collaboration. He understood the reporting needs. He's just also very warm, very friendly. He was—the first meeting that I had with the government, we sat next to one another and talked about okay, here are the cases. Here's what we need to do in order to increase case reporting. Here's what we'd like to work with your epis in the field to improve reporting. And he got to be a good friend and colleague, and I think that was really—again, these relationships.

CDC Foundation was there coming into play as well. There are so many things, infrastructure-wise, that Sierra Leone needed in order to make this response work. We needed generators in order to be able to have the electricity in order for us to be able to do the work that needed to be done. The Foundation was incredible. I remember getting a call—I got an e-mail I think from Charlie [Charles] Stokes, one of his assistants, asking if I could be on a phone call one evening. He said, "I just need to talk to you for ten or fifteen minutes." I had been in meetings with Charlie Stokes before in Haiti because the CDC Foundation was very important then too. He called and said, "Daphne, if I can get you two million dollars, what are you going to do with it?" Okay. [laughs] I was a little bit tired at that point, and it was probably late at night, but I said, "We need generators. We need vehicles. We need PPE. We need—more than anything, if we have no place to put people who are sick, we are dead in the water. We have no place." The Kenema Hospital basically had shut its doors a couple of times while I was there. They were the hospital that had been identified as taking the patients, and of course the hospital director had become irate because it had put so many healthcare workers who died—it put all of his staff at risk. He'd come to Freetown from Kenema and was basically having meetings with as high level of government as he could to say, "I'm done. We are closing the gates." But then we'd have ambulances who would [unclear], they closed the gates, they would just drive up and then they would just leave the people. We had some epis who were stationed there, and that was hard on them—that was very hard on them. We tried to bring people then back to Freetown, and so that was the other piece of this, for their own well-being and to reconnect. And people would say, "I just can't. We've got so many things going on." We would do it on a case-by-case basis, but it was like, you would need

to come back to Freetown. It's only a couple hours' drive. Come back, get a nice hotel room with a decent meal, and just sleep for a little while, reconnect with the team. Then you can go back. We had so many really dedicated people that—they wanted to do so much. Everybody knows you're there for just a short amount of time in the scheme of things, you want to get as much done as possible, you really want to make a difference. I think that's also the beauty of most of the people I worked with at CDC are very compassionate and very dedicated.

I think the Foundation, so when Charlie called and asked about the different things they could do, we had a list of things, and then I asked all the epis, what is it that you need in your districts that would be useful? We compiled a list, and of course, I went to the government and said to Dr. Jambai, "Look, what do you need that's going to help you?" He also had a list of things. The idea that we were able to deliver on those, that was big for them and it was very helpful. We were able to get them generators. We were able to get them vehicles that they needed because they did have some vehicles, but half of them were sitting in a vehicle graveyard. They were missing tires, maybe engines, half the things didn't work. We did have and still have a very good relationship with that government because we made good on the promises that we made, and also we were able to give them the technical support and expertise that they needed for this.

What was hard on them was the constant rotation of staff because they would have—okay, so you're the epi lead for how long? They were like, can you just stay, because we don't want to have new people all the time. We tried to explain to them that—we tried to

come and stay for longer periods of time, but you can't always do that. They understood, but I think that was hard on them because they had new people rotating in all the time. At some point, it was a little bit wearing. They were always very gracious.

Q: Was it frustrating for you that we had these limited deployments and then had to cycle people back in and out?

Moffett: I had been through this already with the Haiti response, so I had already had experience in this. With the Haiti response, what we had tried to do, after we had sort of gone through that deployer fatigue and all of that. We had tried to identify teams and get agreements with them and with their center supervisors that would say, these are going to be the teams that we will work with to deploy out for—whether it was water, sanitation, hygiene. Whether it was for reproductive health. Whether it was for TB. That way, at least for Haiti, there got to be a relationship between people and although again, that person might not be sitting in-country permanently, that they would be a known person that the Haitian government could count on. So we'd seen this before, knew what this looked like, and made this recommendation. We made the recommendation for Ebola too that if it was possible—I think again, because as you mentioned, this Ebola response is the largest in our history and we had so many people that we needed basically to have on deck for this, it became hard. Also, we had people who understandably were scared and did not want to deploy. There were people who might have deployed to other situations, but were not going to deploy to Ebola.

Q: Can I clarify, you made a recommendation to—is this a recommendation to have a team of people who were there longer-term who were dedicated?

Moffett: Yes we did. We did. We made a recommendation that if it was at all possible to have people who could come for—well for one, they were originally deploying people for thirty days or less, and I don't really know where that came from, but they said, okay—I think it became obvious quite soon that (a), it wasn't enough time to get it, because most of the people that were flying were flying from the US to Africa. It's not a short flight, and then you get into country. You have to figure out who the partners and the players are. You have to figure out your team. There's always those dynamics, even if you're there and you all understand you're there for a short amount of time and you need to go, go, go. We also have to recognize that there are people involved, and those initial relationships, they do determine what happens throughout that response. Whether it happens within your tour of the response or the next person's or the next person's, you set that tone. There was a recommendation that if we could get people to come out—and then the agency took that, and they did try to get deployers afterwards for—I think they were asking for people to come for—they wanted people for ninety days, sixty days at a minimum. It just took us awhile I think to get to that point. It is hard, and people have other jobs, and everybody understands that they have other jobs, that their primary job is not emergency response. Asking a program to let somebody that they have hired go for three months to do something maybe completely unrelated, I think is a little bit difficult, but I think everybody understands that is our mission.

Q: Do you have a sense of when in the timeline this change took place?

Moffett: My first deployment was August through September. Wait—I was still there at the beginning of October. I think it actually changed probably during my second deployment, which started in February. Because I was there February, March, and part of April. I think that was the time—so it was pretty quick that they started making these recommendations that if we could get people for longer periods of time, that that was actually better. It was really better for everybody.

Q: Who would you make the recommendation to?

Moffett: I happened to know who was running the response because I had worked with him before. [laughs] So I sort of called some people I knew who were also friends and said, "What I think would work better," and they also had worked with me in Haiti and said, "Yeah, we know." I think it wasn't necessarily something that they didn't know, it was sort of getting this surge capacity out the door. It was hard enough getting people to commit to sixty days. And then also sometimes, I think the flip side to that is, but what if you get somebody out there for sixty days and that person is a disaster? However, you can send people home, and we have done it. It's for the good of everybody at that point.

One of the other policies that changed too—it was interesting. We had all of these people who deployed, and because so many healthcare workers had gotten sick, and then there had been the WHO workers who were in basically an office setting who then also ended

up getting sick and getting extracted. There were really heightened concerns about the deployers' safety, and we had a couple of us who ended up with some pretty bad head colds. Of course, then that turned into—we were all issued thermometers and told to take our temperatures, but you had to use some judgment too about okay, what are you going to do? What are you going to tell people? Are you going to put people in a hotel room because they're spiking a fever, but it looks everything like a sinus infection? We had a couple times that were—I had one of our epis out in one of the districts. I got a phone call from him saying, "I'm calling in just to let you know I'm sick, and I'm not really sure what's wrong." But he had some symptoms that they were on the list for Ebola—although, there are many symptoms on the list for Ebola. [laughs] He had checked off a few, and we had decided okay, the best course of action was you need to stay in your room. The other epi who's there will make sure you've got water and bring you some food and you just need to keep in contact, monitor your temperature, and let us know if things start to get worse. But at the moment, we are going to watch this. There is a lot of judgment also when you're deployed to a situation like this. You don't want to unnecessarily have people medevacked, but you also don't want to put people at risk, so you have to decide, what call are you going to make? I think that just comes with experience and how comfortable you are with things. We had a few of us who ended up with head colds, and you had to sort of explain to people, no, no, I know exactly what this is, it's a sinus infection, or it's a whatever. But there was that concern for the deployers and the safety.

I think there was not a policy in place for the significant amount of monitoring that was going on. The amount of monitoring for deployers who were returning home changed after my first deployment. One reason may have been, I know I got very sick when I returned back to Tanzania, and I think there may have been a policy shift after that. I don't know that I was the impetus for it, but I know my case is well known. [laughs] When I came back from my first deployment, I got home, felt fine, went to work, and then probably four hours into work, I started to feel bad, very bad. I realized I was starting to spike a temperature. I left and went home, and then progressively got sicker and sicker over that day. I started to tick off several of the symptoms. So, I called the Emergency Operation Center, as we were told to do, and also I had told—obviously, my husband is there and my son is there. We also have staff who worked in the house. I sent all the staff home. I stayed away from everybody and then told the staff that they should take the next few days off. My son, we kept him home from school, and we kept my husband in the house. We basically quarantined ourselves for a few days because we weren't exactly sure. I couldn't think of any situation I had been in, in Sierra Leone, where I was at risk. We were very careful about that. But again, because of all of these incidences that had happened in-country, you just didn't know for sure. Although I had been vigilant, I didn't know for sure. And again, I was spiking a fever and then having the shakes and the sweats and the whole sore throat. I was sort of walking down that list of, okay. All your early symptoms look like so many things, it was kind of hard to know. I was ninety-nine percent sure that I had nothing more than a terrible, painful infection—probably some sort of respiratory infection, coupled with I think maybe a sinus infection.

I called CDC and told them what was going on, and headquarters was very receptive and very good about—so we did a consult over the phone. I said, I've been taking my temperature, here's where I am, here are all the symptoms that I have, and here's what I've done. This is what I've done to ensure that hopefully my family is safe, the people that I've come into contact are safe. They said, okay. We're going to go with your plan, it seems like the right one, and then we're going to monitor. Call us if things start to progress, and then also if you need anything, let us know. But the staff at the CDC office I think were like, where is she and why is she not coming in? One of the guys who had also deployed with me, Steve [Steven] Wiersma, called. He realized that something wasn't quite right, so he said, "Do I need to come get a blood sample? Maybe it's malaria. Do you need a rapid malaria test?" I said, "No, I don't think so." I'd given myself a timeline that if things hadn't improved by day three, we were going to do something different. Everything was fine, but it sort of also exercised the system at headquarters. I don't know how many other people they had call as a potential case, especially a returning deployer. But I noticed that after that, there were a few policies that were changed in terms of closer monitoring, and also not just monitoring temperature, but also symptomology. I think also they paired people up with buddies who were returning into country. And then also, trying to determine—some of the countries where we had deployers go, they wouldn't allow deployers from West Africa to return immediately. They basically told them they had to go someplace else for thirty days, and then they let them back in. It was interesting.

Q: Where would that be?

Moffett: Well that's what I said. I said, "Do you get to pick a location? Can I go to Turks and Caicos [Islands] for thirty days?" [laughs] I think what they had done was they actually sent people back here to Atlanta because the countries didn't—we'll welcome you back after you've been someplace else for thirty days. So they sent them back here. So that was the first deployment.

Q: I think I have a good sense of it, but how would you describe your role in that first deployment?

Moffett: Sure. As the epi team lead, my job was to work with the governments, with the Ministry of Health, and in particular, this was the [Directorate of Disease] Prevention and Control. We worked with them in order to deploy this surveillance system—was one priority that we had to ensure that the numbers of cases that we were getting—we were capturing as many as possible. In addition to that, we had this team of epidemiologists, all of these—I'm going to say "young" because they were all young. [laughs] Young epis that were in several districts. I think we had six districts that we were in. They knew their jobs as epis, I'm not worried about that. They knew what they needed to do, and they were all very good in terms of recognizing what they needed to do on the epi and surveillance front. But then, they were also very good and clever about understanding that it goes beyond that. Particularly, because they were the only eyes and ears that we had in the districts, they were reporting on everything. They might be reporting on, okay,

there are stock-outs of PPE in these clinics. Or, we are seeing an uptick of malaria cases as well. Or we have no services, or no place to send people for services for birthing. They were sort of tracking, and people would come to them and tell them many things. They were good at that, in addition to—we had some NGOs [nongovernmental organizations] who were also getting funding to support. They had been in Sierra Leone doing many different things. UNFPA [United Nations Population Fund], UNICEF [United Nations Children's Fund], we had all of these. Their missions had also shifted towards supporting this Ebola response as well, so they were collaborating with all of them.

It was a lot of coordination, but it was also a lot of data collection, doing some analysis. Also, we had people going out and trying to do some mapping of where cases were, looking at clusters, trying to do chains of transmission. And then also, just ensuring that the epis had some support. For some of them, this was a first deployment. They would call, and basically, they might have a dilemma. I will never forget, one of our epis was working in Freetown. At that point we had holding facilities available, and some treatment facilities. Basically, the call center that he was working at basically came to him and said, we have a list of who we think are probably patients—they haven't come back with positive tests yet, but these are all very sick cases. They wanted him to prioritize who was going to get care. Exactly. He's a physician by training, assigned to a state health department, very solid skills, and he had already sort of worked through in his head, okay, I think my recommendation is that this be the flow chart that we would follow. How we might make that decision. I was very impressed. It was an unfair position for him to be put in—completely unfair—but he handled it with grace and aplomb and

very methodically. But I do think it was hard on him. Being able to work with him to say look, this isn't your responsibility, but approaching it from a scientific method will help get us through this, and that's what we need to do at this point.

There were instances like that where we had some very challenging—you know, there were some tough decisions to make. Some of these folks were put in a position that I don't think they'd ever been put in before. Part of my job then, too, was to try to make sure that they knew that I had their back and would support them in making those decisions. And if they weren't comfortable making those decisions, they needed to just say so, and I'd make the decisions and we would work through this together. I think it was a good experience for everybody involved—maybe surprising for some in what they were asked to do. It's been an unfortunate event, but we've learned a lot in terms of what can happen and what to prepare for, for the next time.

Q: In this first deployment, were you mostly stationed in Freetown?

Moffett: Yes. I was stationed in Freetown, but I actually went to the districts frequently. I was stationed in Freetown in order to work with the government because they were located there, and so I would attend—we would have epi meetings and also laboratory meetings, because the other piece of this was we were really trying to bring all the laboratories together as well. But I would also go to the districts in order to work with the epis. Some of it was, we were trying to get equipment out to them or bring things back, make sure that they had the servers that they needed to be able to run the Epi Info—the

VHF on Epi Info, to be able to collect the data and do the data analysis and do the trainings. There were all those pieces too, so I tried to spend time in the districts as well. I actually spent—maybe fifty to sixty percent of the time, I was in the different districts. Also, if we had one epi in a district and they needed some help, then I would go out and work with them to try to make sure that they had whatever backup that they needed.

The laboratories, we had a fantastic—well of course, our lab was there, which was great, and then the South Africans had brought in a lab, which was also fantastic. We had made connections with them, because that was the other thing was we were trying to make sure, do we understand if the clinics or if somebody is collecting samples, do they understand how to collect it? Do they understand how to package it? Do they understand what data needs to go to the— So, I remember going to the South African lab, and I said, we need to go have a conversation with them and find out, are they getting what they need? How are they relaying results back? I had a really great conversation with the head of that lab who had been there for a while and stood it up. They just had an outrageous volume of samples to test. I'll never forget, I came in and introduced myself, he introduced himself, we sat down and he reamed me for about the first ten minutes of the conversation. "What we were you thinking? You have sent me three pages of a form to try to fill out or that I'm supposed to do something with. I don't have time for this." I think he needed to vent. I let him go on and go on and go on for a minute, and then he said, "Okay, I'm done. How do we make this work?" He made some really great recommendations. He's like, "I'm getting these forms, I've got three pages, and to us it's like another source of contamination." So basically, they had bleached all these forms,

like spritzed them with bleach, and then let them air dry, and then they could do something with the forms. His concern was, why are you collecting all this data and then sending all of this data to us? We don't have time to put this into—we're running the analysis. I said, "Okay, I hear you." I said, "Let's see what we can do." Right after that, we went to a one-page form after that. I think he was happier, but it was one of those things where he needed an opportunity to be able to say his piece, and then we got over that and he had good suggestions, so we took them and ran with them.

Q: Are there other partners from other governments or other organizations like MSF [Médecins Sans Frontières] and WHO that you especially remember working with?

Moffett: Oh yeah. MSF was doing a great job, and they were really—of course, this is their area of expertise, too. They were participating in our epi meetings and engaged. In the first deployment I was there, it was interesting. There really weren't very many partners at that epi meeting. There was a big difference between my first deployment and my second deployment. My first deployment, it was basically CDC, sometimes WHO, sometimes not, and then the Ministry at these epi surveillance meetings. While we were there, we also tried to get the laboratory involved. I talked to Dr. Jambai a few times and said, "It would be great if we could get the laboratory to engage." For them, they were like, the laboratory is a separate group. I said, "I understand that, but we need the two to work together because we can collect all of these suspect cases, but confirmatory testing comes from the lab and we really need them to be engaged in these discussions." Also, for example, during the second deployment, we had laboratories popping up all over

Sierra Leone. We weren't sure about quality controls, and the fact is, there were some problems with a couple of the labs running tests that they would get one result and then we would run them through another lab and get a very different result and we were worried about that.

The CDC labs—not only the folks working in the hot lab, but then we brought out some other, senior laboratory staff like John [D.] Klena and some others, to basically work with the laboratory working group and to get them to understand, they really needed to get a handle on the laboratories that were coming in and they needed to understand whether or not they had quality control and assurance procedures in place. And could they trust the results that were coming out? Because if not, then—there needed to be some standardized SOPs for this.

UNFPA, who had been working on maternal and child health because Sierra Leone has one of the highest rates of maternal mortality in the world, they had been there working on that. Basically, they were fantastic. They shifted their approach. They were already working in the districts and they had all these networks, so they shifted their approach to also help with contact tracing, health communications—they were a fabulous partner in-country. There were also some other NGOs who had gotten together and formed this umbrella coalition, so that they would play off of one another's strengths and wouldn't compete for the money that was coming in. They would certainly write up, here's what we can do for the money, but then they would have different partners within this umbrella who then would go and actually do that project. They were very clever. Actually, we had

a very strong NGO community—it was a pleasure to work with them. We integrated them into the response, too. I would have meetings with them frequently, and it was great because they knew they could call. If they had questions about what was going on in a district, they would call me and okay, we would connect them. The same thing if we weren't sure, we would call and find out, did they have some connections in maybe a village someplace because we were trying to confirm maybe a new chain of transmission. We had some really strong collaborations with UNFPA, with the NGOs. Again, although WHO's presence wasn't really strong in the first deployment, the second deployment they were there in force. We had I think a really good collaboration with them. I went out on my second deployment, I went out as a contact tracing—I don't really know. I was the contact tracing person for CDC. I don't know what—[laughter]

Q: What the title would be. So you have three months off, I suppose, from that.

Moffett: I did.

Q: How did those pass?

Moffett: After I got well, [laughter] so I came back from the first deployment and got pretty sick right away. I was down for about a week, and then I was fine. We had already planned a safari. We were going on a big safari, and so I had told everyone, I'm looking forward to getting home. I'm sorry I cannot extend because we have had this booked in advance. My family is sort of knew—unfortunately, for the three years that I was in Haiti,

I missed a lot of family vacations, I missed a lot of milestones. I sort of made the decision that we had enough staff that I didn't need to do that this time. I'd planned this special safari that we were going to go on, so I did that and it was great. I got back into my job, but I was still keeping an eye on things because I was interested in what was going on. For me, I was always looking at the data to figure out okay, are the cases going up, are the numbers going down? How are we doing? Then, of course, I had so many friends in the field, they would once in a while send a note and say how things were.

I hadn't necessarily intended to go back a second time. I had not decided—it is what it is. You never know. I got a phone call—actually, I had probably gotten a few e-mails about going back, and for several reasons I couldn't do it at certain times, and then was asked to come back in February. I said okay, sure. I can do that. Again, made sure I had staff who could cover my positions. They said okay, we want you to come back, and we think we want you to do contact tracing. I said okay, fine. So I came back the second time.

I was in the Amsterdam Airport [Schiphol]——wait, was that the first time? Second time? I remember being in the Amsterdam Airport—oh no, that was the first time. The funny thing about the first time when I went, and I probably should have mentioned this. I was in the Amsterdam Airport and I get this phone call from headquarters and they said, "Captain Moffett, you're going to be on this flight, right, to Freetown?" I said, "Yes." "Okay, Dr. [Thomas R.] Frieden's going to be on that flight too." Okay. [laughs] It's a commercial airline, it's fine. "We want you to know he's going to be on the plane." I said, "Okay, he's going to be on the plane, it'll be fine." I'm not really sure what the

expectation was, but anyway, it was quite funny. It was an exhausting flight, and when we stopped in Liberia on the way to—because they stopped in Liberia to pick up people and drop off people and then go on to Sierra Leone. We were stopped in Liberia, and that's where we were picking up Dr. Frieden. Dr. Frieden, who walks on the plane. I'm sitting in an aisle seat. "Hi, Dr. Frieden, how are you doing?" He looks down at me and he's like, "Oh, hi, how are you?" He ends up sitting right across the aisle from me. Then I see Tom [Thomas] Kenyon. Dr. Tom Kenyon comes on behind him. "Hey Tom, how are you?" "Daphne, what are you doing on this plane?" [laughs] He said, "Aren't you supposed to be in Tanzania?" "Well, yes." So it was an interesting group of people. Of course, Dr. Frieden, in true fashion I think, never sleeps and is awake all the time. I'm trying to wake up a little bit because the flight between Liberia and Sierra Leone is very short, so we're going to deplane not too long from now. We're sitting across the aisle, so he has questions, many questions. We talked about several things. We get off the plane and then we're waiting in line to go through the hand washing station and everything, and he's got more questions. We had a nice chat about the response and some of the interventions and what's going on, and then he was met by the entourage of people there who are taking photos and waiting to whisk him away into a car so he can go have a million meetings. That was my introduction to Sierra Leone, which was funny. It was great.

The second time after, so three months have passed, I'm asked to come back. I said yes, I can do this. I come back. I get to Sierra Leone, and things are very different, very different. There's like an army of CDC people in the Radisson Blu Hotel. We have now

taken over a giant conference room and turned it into a mini EOC. I'm like, where did all these folks come from, and where were you a few months ago? It was very funny.

It was fascinating to go back because it was so different. They've got this communications team sitting over here, and they've got the infection prevention and control team sitting over here. They've got the lab team over here and they've got the epi team over here. They've just got these swarms of people. Then they've got all of these, okay, well you now have to have four hours' worth of introduction. I was like, I was just here a couple minutes ago. Four hours' worth of introduction to what, exactly? It was funny. They were trying to get processes in place, and actually, I think it was very beneficial for people who hadn't been before, and they had the RSO [regional security officer] then addressing people and trying to say look, your safety is paramount. They had an entire fleet of cars and drivers and all of these types of things. It was a very different atmosphere at that point. It was fascinating. Oliver [W.] Morgan was there running the response, and then Sara Hersey was coming in as the new country director.

I was there, and they knew I had been the epi team lead before, so their incoming epi team lead had been delayed and so Sara says, "Do you want to be the epi team lead?" I said, "I think I'm supposed to be your contact tracing person." "Okay. Well, which one do you want to do? Do you want to be epi team lead?" [laughter] I said, "Whatever you want me to do, I'll do. That's fine." I said, "You've got a person who I think is excited to be the epi team lead coming in. How about if we do this? I know you've got a person leaving. I'll bridge the two. Having been here before, not a problem. We'll just do the

bridge." Since I already knew all the NGOs and I knew the government and I knew these people, it was easy to reconnect. Everybody was very kind. I said, okay, so I'm the contact tracing person? There's probably a lot more things to do in contact tracing than one person can do. So it was another one of those opportunities where you sort of get to decide what you're going to do, you get to make it up as you go. I said okay, I'll figure out what needs to happen.

I did the bridge for the departing epi and the incoming epi. I said okay, there are meetings that you need to attend. Let's go introduce you to people—make sure they know who you are. Great incoming person too, and there was a good hand-off. And then for contact tracing, it was interesting. I went to a couple contact tracing meetings and they were like, "CDC really hasn't been involved in contact tracing." I was like, "What are you talking about? When I left in October, we were very involved in contact tracing. We wrote the policy for contact tracing. The one you have right now, we wrote with the Ministry of Health and with WHO." They were like, "Yeah, but they didn't send anybody." I said, fine, whatever. What I've always found interesting in response is initially, it's all hands on deck and everybody's good to work together, and then people become a little, almost a little territorial about things, which is fascinating to me. I said "Okay, whatever we can help do, let's figure out what we can help do."

It was a different approach. It was very different. Before, I had a team, a big team of people, and then I had me, and then people to connect with. It was good. We worked on the contacting tracing issues a little bit with WHO, and WHO had developed trainings

while I was gone. They had hired contact tracers, UNFPA had hired. I was still working very closely with UNFPA, so we were giving some advice and guidance to them. Actually, the trainings that had been developed had sort of been developed early on by our CDC EIS officers and epis. So that's actually where a lot of this training comes from, which was good because we shouldn't be reinventing any of these things. We got to the point where we were, okay, fine, here's what we can do. And then, as with all deployments, every one I've ever been in, you plug in where you can and you should. So contact tracing, yes, I did some work with contact tracing, working with the Ministry. Also I went to the field a few times to check in with our epis and see how contact tracing was being worked and how we were handling this. As one person, it wasn't going to be possible for me to do contact tracing for the entire country. So I said, maybe I need to just focus a little bit more through the system instead of me actually going and interviewing people—although I did go on a couple of interviews to try to figure out, what are you asking people, and how are these questions being asked, and then what are you doing afterwards? Are you taking temperatures?

We had a lot of discussions about thermal scanners in the field, who should use them, how should we use them. That was a big discussion point, both in my first deployment and in my second deployment. I had a lot of concerns about the thermal scanners because I had gone through many checkpoints and in and out of the hotel, and I'd have people who would put it here, put it here, put it here, and several times they would say, "You're thirty-one degrees." I said, "Great, so I'm dead." [laugher] But for them, these poor people, they hadn't had any training—they were just given this tool and nobody

explained to them how to use it, why to use it, and what it meant. All they knew was—and I'm not even sure if they knew, well, if it was forty, maybe we should be concerned, or thirty-nine. But all they knew was I didn't have a temperature. But the fact that I had one that didn't register in any sense, it really didn't make sense, was a very foreign idea for many of them. They just sort of give you the thumbs up, okay, you're good. I thought, oh dear God, here we go. So there were things like that. Every once in a while I'd try to take a person aside and say, "Your thermal scanner, it must not be calibrated properly. This is not actually"—and then at some point you're just like, there are so many of these people taking temperatures all over the country who have no idea what they mean. You can't really—you couldn't educate everybody on that point. So I had a lot of concerns about that and the thermal scanners, and I had mentioned it. I said I had concerns about them using them in the contact tracing. Initially, when we developed the policy for contact tracing, we had said, no, we didn't want people getting close enough to people who were quarantined, that there might be—so there wasn't a consistent policy. Also, there wasn't consistency in the thermal scanners that were in-country because I said, that's the other thing. If you're going to hand them out, we need to know what's the brand; do they need to be calibrated; when they come in, are they tested; if they have to be calibrated, who's calibrating them? All those types of information, and do people understand? It's not a difficult tool to use, but if you have no training and you don't know what the numbers mean, it's not a useful tool. So there were a lot of conversations about that between Dr. Jambai and I in particular, and he understood, I think. He's like, "I agree, but what should we do?" I said, "Do you want to use fever as a determining factor?" Because that was one of the things they wanted to do with those who were in

quarantine, was take their temperatures a couple of times a day and then have somebody visit them and make sure that once they reach their twenty-one days, they are fever-free, symptom-free, and they can be out of quarantine.

There were a lot of those types of challenges, too, policy-type challenges. Quarantine was a huge, huge issue. When to implement it, how to implement it, who was responsible for implementation, who was responsible for releasing people from quarantine, were military people going to be involved? It was very, very complex, and people had different—there were some wildly varying ideas of what to do about this. I think WHO, CDC, made the same recommendation, but I think for some political reasons the government of Sierra Leone felt like they had to quarantine people. Originally, we were not keen on the quarantine idea because, again, there was no support for it. Basically, they were going to tell people they had to stay in their houses for twenty-one days, and we said, they have no water, they have no food, these people live day-to-day. You can't do this and they won't do this. Eventually, it will all break. And that was a big part of the problem. That's exactly what we saw. So that was an interesting aspect of the deployment.

Q: How did the fever thing turn out? Sorry, the—

Moffett: The thermal scanner?

Q: The thermal scanner. [laughs]

Moffett: There was a small study, CDC did a small study with some of the thermal scanners in a pocket in, I think, Freetown. I don't know that it was published. I haven't seen the paper yet. But we had a discussion with some folks. They claimed that they felt like the thermal scanners had been useful, but I think the difference was the thermal scanners in that particular mini-pilot that they had done, they were being utilized by people who had been trained. They had like the health department, the surveillance officer had been trained, and they had trained all of these people to use them, which is a very different issue than having people that you just sort of hand these out to and say, okay, here it is, just do this. Some of them, I don't think they even had any sort of, you know, "Pull the trigger," or where it was supposed to be, and it was obvious that that was the case because, again, as we went through checkpoints, sometimes you would have a person who would come up to you and they would put it right here to your temple, and then sometimes they would put it at your shoulder. Then the other issues was you had people that wanted to put it on your head, and you're like, no, you do not want to touch from person to person. Also, these folks felt like they were doing something, so they had this tool and this was going to help them, and so we had a lot of discussions and I said, yes, but that's dangerous. It's dangerous to give people a tool that they don't know how to use or that may not be actually protecting them, but doing more harm than good. Because in particular, if a person has a malfunctioning or non-calibrated thermal scanner and they're scanning all these people who go through, you've got a person profusely sweating, obviously sick, and they take their temperature and it registers as thirty-two and they say, oh, it's fine—they haven't been told what else to do. They haven't been given any other skills, but they're relying on that to make their decision for them.

Q: So were there ways that you found to resolve some of these issues?

Moffett: [laughs] I think in our health messaging, although we told people that certainly temperature was one aspect, we tried to—we also emphasized other aspects. The other symptoms that occurred—making sure if people had a headache, they had a sore throat, they ended up feeling malaise, if they touched their skin it's hot, things like that, so that they weren't relying on an instrument that may or may not have been functional. I think that was helpful. Also, if they'd come into contact with a person they knew was sick before, or gone to a funeral. Those were key triggers for all of this.

Q: Back to the quarantine, how did that evolve and resolve, to what degree?

Moffett: Sure. So the quarantining issue, there was a decision made—WHO and CDC really tried to step back from the quarantining issue because we were worried that there weren't support services to do this. But then also, there was a large British response that came in and sort of set up these—it was like an emergency control—they were Ebola response centers that they set up around the districts. They were also trying to centralize information and centralize things, and they started running some of the quarantine issues. I think they were trying to ensure that the partners who were involved in these—DERCs [District Ebola Response Centers], they would call them—that the responsible party for say food and water and hygiene, they were going to quarantined houses. So they had a list of the quarantined houses, how many days they had been quarantined, and if there were

people, contact tracers, that were going and actually taking temperatures and recording symptoms, and then also that people were getting food and water and hygiene items and things like that. The bottom line was, there weren't enough people to—we had thousands of people technically in quarantine, and there were not enough people to monitor that situation. And then, there wasn't a good understanding of what that monitoring meant. We visited a couple of quarantined places in one of the districts, and there was an armed—like an army officer who was supposed to be watching the houses. We went, and it was very hard to tell which one of the houses was the one under quarantine because they were outside having a game of checkers with the neighbors, with the man who was supposed to be monitoring the quarantined house. [laughter] That to me was indicative of the whole problem. I think really the main reason why we had big concerns, WHO had big concerns, about this whole idea of quarantining was because to do it properly and effectively is hugely resource and labor intensive, and we didn't have that. And then people not really understanding what it meant, and again, if you're inviting all your neighbors. Some of them understood why I can't leave my house, but "Nobody told me I couldn't have people come over." You know, let's play checkers outside under the tree. That part remained really challenging, even up to the very end. There were constant discussions at the district level and at the national level about what to do. I think the other thing is the government of Sierra Leone felt like it was important for them to do it too, so it had really turned into more of a political decision, not necessarily one that was based on the best science recommendations.

I would say the other thing while I was there for this second round was—we had been working on contact tracing, but there was the discussion of post-Ebola. What was the country going to do post-Ebola? I remember having some discussions with Dr. Jambai and some of the other Ministry people about this. "We think it's time for us to start planning." Okay, well—and they were very interested in IDSR, the Integrated Disease Surveillance Response system, which has been deployed in most African nations. Actually, Sierra Leone had been utilizing this approach pre-Ebola as well. But I think they realized they needed to reinvigorate the system because they just had this big outbreak, so what better time to take a harder look at their system and response plans than now? This is something that CDC does, and we work on IDSR in other countries, and I had worked in different types of systems, EWARN [Early Warning And Response Network] in South Sudan and in Haiti we had some other systems, and so I'd seen these different types of platforms and was familiar with IDSR. They asked, what did I think? Again, this turns into one of those relationship issues. They knew me and said, "What do you think we should do?" "Well, I think now is as good a time as any." I went back to Oliver, and we had a discussion. Some of the concerns that we had, too, was well, this is still a very active outbreak. I said, "I agree, but if the government is saying that they want to do this, probably we need to figure out what this means and whether or not—where we are and what we should do to help support and facilitate." He asked me to go ahead and run with it, so I worked with WHO and with folks back here at headquarters and with the government and we pulled together a broad meeting. Basically, brought in all of the surveillance officers and medical officers from all the districts and the senior leadership for the Ministry and said, okay, we need to strengthen systems to ensure that we're

prepared not only for this, but for whatever else comes next. We helped develop plans, trainings, got some funding to WHO to help support it and sustain it and the Ministry. I actually extended twice the last time I was there because they'd asked—the country office had asked and the government had asked if I could stay longer to help them at least get this to a point where it could be handed off. That was sort of my final—the last thing that I did while I was there. It was great to be able to say, okay, and now we're prepping systems that you need to have in place for the next time. It was very rewarding in that respect.

Q: Anything else you want to talk about related to the second deployment?

Moffett: The funny thing is, never underestimate the power of chocolate. [laughter] How about that for a title? I'd been working on contact tracing, on IDSR, working all over the place, talking to the lab folks a little bit, and I realized that it would be really, really helpful to get everybody in the same room and have a discussion about several topics. I talked to the WHO rep [representative] who was there, and she was completely in agreement. She said, can we have this meeting, and can we pull this together, and there are many things that would be helpful for us to have a very focused meeting. We're going to bring in the partners, bring in CDC, bring in WHO and the Ministry. But you never had enough time to address these at all the other meetings you had because they were already targeted to lab or surveillance or contact tracing. You had so many of these other discussions going on that we couldn't really do any broader, forward planning. There was some other staff, particularly some CDC staff, who wanted to have an opportunity to talk

about some other things. I said, I think it's a great idea. I don't know how, but somehow I got tasked with, can you make it happen? [laughs] I said, well, let me see what I can do. It was easy to get all the CDC staff together. That was simple. I went to Dr. Jambai and I ran into a couple of other people I knew in the Ministry and said, "I know you all are working all the time, and I apologize." I'm pretty sure it was Valentine's Day, yeah it was. I said, "I'm going to ask for some more of your time. I'm going to ask for like a chunk, like three to four hours, and I think it would be important for the NGO reps, CDC, WHO, and you to get together." We had an agenda, we knew what we needed to talk about, and basically sort of forward planning for the next steps. It was great. I wasn't sure how it would go off, but I said, "I promise if you all come, I will make sure there is chocolate there." [laughter] I went to the store—there weren't very many stores—I went to a store, bought pretty much all the chocolate they had, and it was great. They all showed up at the meeting at the Radisson. They gave us their time, they were very generous, and we had really good discussions, and I think had some sort of action plans for what needed to happen in a couple of areas. A couple of folks were able to get clarification on what the government wanted to do specific to their area. It ended up being good. Afterwards, Dr. Jambai thanked everybody. "This was a good meeting, Daphne, and we need to have these so we can really plan some strategies. These are good." So it was very positive. It was a great relationship, and they're wonderful people to work with. I will say chocolate does wonders. [laughter] So maybe chocolate and furry animals for deployments.

Q: Lessons learned.

Moffett: That's right. That's exactly right.

Q: Are there any other lessons learned that—I'm sure there are—that come to mind, either for yourself or about public health or West Africa or CDC?

Moffett: I think the thing that I always make sure that I remember, particularly when it comes to emergency deployments, is that these are people. I think sometimes we can get swept up into a response. For example, just having that meeting on Saturday. We were tearing these folks away from time with their families that was very precious and short lived at that point in time. So always focusing on that aspect of, yes, you have a response, and yes, there are systems to be developed and run, but making sure that the focus is on the person or the people or the population. Of course, that's what we do in public health, right? But I think making sure you keep that focus, because sometimes I think people also become—you know, you have to sort of monitor and gauge because you can become very overwhelmed. Especially when you're, say, in a response in a country like either Sierra Leone or Haiti, and they have so many people coming at them from so many different agencies or governments or organizations. And bearing in mind that you could be the hundredth person who's asked them that question in the last two hours, is something to remember. Coordinating with partners or making those sort of linkages early on so that you can work as effectively as possible, those are I think all things that I keep—they serve well, whether it's an emergency or just day-to-day working with other governments.

Q: So you wrap up the deployment. Can you bring me up to today?

Moffett: Sure. Okay, so I wrap up the deployment. I think that's April, after the second extension. I go back to Tanzania and do my monitoring. I don't get sick this time, which is a good thing. [laughs] Do my monitoring, everything is fine. Go back to my job, which I enjoy, and thank my staff profusely for stepping in and covering for me for the [laughs], because it's hard on them as well. Particularly the acting—I had to call him again and say, "John, I am extending for the second time and I apologize." "When are you coming back?" Which I guess is also a positive thing, that he wasn't staying, could you stay gone longer? [laughter] So I come back and get back into my routine. After that response and the other things that I've done, I enjoyed my ADS role, but then also thought about, maybe it's time for me to think about—I'd been asked if I wanted to be a country director before, and I had declined and said I wanted a little bit more time doing something else first and thought it would be better. I decided I was probably ready, had enough experience under my belt, although I'm not sure if there's ever enough experience to quite prepare you for—there aren't classes for this. [laughter] I had applied for the position for country director, and actually, the regional director for Central Asia became available. I was drawn to it because it's a region I had never worked in. On a personal note, my son was interested because it was a cold weather climate and he really wanted to go to someplace that was cold, and he was looking forward to skiing again. Frankly, those are hard-to-fill posts. Kazakhstan is not an easy position to fill. The State Department, USAID, they all have trouble getting people to come. There's a perception,

unfortunately, that it's a dangerous place or that it's going to be a difficult place. It's quite a lovely place, and there's fascinating history within the region. When I had applied for the job—I should back up for a moment. I came back from my deployment—actually, it was my first deployment. I had come back in October from my first deployment, and I think I had applied for the job in maybe November it came up, because I thought it sounded interesting and exciting also. Sort of drawn to that. I applied in November, and I had an interview maybe also in November, so I knew we were going after I'd gotten the acceptance letter. But I think we were excited to go to a new place also and learn some new history. We enjoyed our time very much in Tanzania and the work we were doing, and also just Africa in general is a fascinating continent. The people—although, every place, the people are different. We were privileged to be there. Then the Central Asia region, again, is fascinating. Our regional office is in Almaty, Kazakhstan, and so I have—Kazakhstan is my country, but then also I have Uzbekistan, Kyrgyzstan, Tajikistan, and Turkmenistan. I have the majority of the 'stans. [laughs] It's fascinating. This is a former Soviet, post-Soviet structure, still very aligned with Russia, and still very much engrained in that culture and the processes that come from that. It's been interesting working with the government and trying to warm the relations a little bit. Health is a great way to do that. We were excited to be able to continue the work of the programs that we've been doing there. That was in June when I arrived, and so we've been making some progress. I think it's progress that we were able to have our high-level delegation come to CDC this past week. I think they'd been working on that for almost a year. It's happened, and I think we're looking forward to, when we return, being able to

sit down with the government and develop some strategic plans for the next few years. Yeah, it's great.

Q: Great. Looking back, is there anything else you'd like to add before we end the recording?

Moffett: I can't really think of anything, but I'd just like to say thank you for doing this history. I think this is a great idea. I get asked frequently about my work at CDC and what I do. I've been very lucky to be able to do so many different things, and I think CDC does afford people that opportunity if they just kind of embrace it, and when you get the call, say yes, I will do that. [laughs]

Q: Thank you so much. It's been a privilege. Appreciate it.

Moffett: Sure.

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