CDC Ebola Response Oral History Project

The Reminiscences of

Desmond E. Williams

David J. Sencer CDC Museum

Centers for Disease Control and Prevention

2016

Desmond E. Williams

Interviewed by Samuel Robson
April 1st, 2016
Atlanta, Georgia
Interview 1 of 2

CDC Ebola Response Oral History Project

Q: This is Sam Robson, here with Dr. Desmond Williams. Today's date is April 1st, 2016, and we are here in the audio recording studio at CDC's [United States Centers for Disease Control and Prevention] Roybal Campus in Atlanta, Georgia. I'm interviewing Desmond as part of our CDC Ebola [Response] Oral History Project. Desmond, thank you for being here with me.

Williams: Thank you for having me.

Q: Of course. For the record, could you please state your full name and your current position with CDC?

Williams: My name is Dr. Desmond Williams, and I'm currently the CDC country director for Liberia.

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

Williams: I was born in Freetown, Sierra Leone.

Q: And where did you grow up?

Williams: I grew up in Sierra Leone.

Q: Tell me about that.

Williams: I was born to a middle-class family. My dad is a judge, my mom a banker. I grew up in Sierra Leone at a time when Sierra Leone was very different from what it is today. We had just had our independence from the British, and most of the systems that were in place were still working. Went to some very good schools in Sierra Leone then, and then I think at the age of about four, I had this realization that I had to become a doctor when I grew up. Since then I haven't wavered, and today I am.

Q: You just had this realization that you wanted to be a doctor.

Williams: Yes, at four.

Q: At four. And you can't trace it to anything?

Williams: I can't trace it to anything. I think what happened was my uncle is a doctor, and I remember one time I was at his clinic and somebody was screaming, and I thought to myself, I wish I could help them do something about that. And it just hit me, you know what? When I grow up I'm going to be a doctor, too, because I want to help with the

suffering and save some lives when I grow up. I thought it was just the coolest thing in the world, and I never changed.

Q: Tell me about going to school.

Williams: I went to the international school in Sierra Leone, and that was a school kind of like the American schools you have that the embassy folks usually send their kids to. That's the school that I went to, to start off with. Got a very good education from that school, met a lot of international friends from all over the world who were kids from the diplomatic corps, etcetera. When I finished that, I went to the Prince of Wales School in Freetown, which was the best secondary school for science. Again, pursuing my dream to become a doctor. Then, interestingly, in the third form—the way it works in Sierra Leone is in the third form, you are separated into either the art stream, the science stream, or a general stream. Because I was a generalist, they put me in the art stream. I was really upset because it kind of went against my dream to become a doctor, but there was no way for me to change it. I actually went through school as an art student doing government, history, and all the other good stuff, and then as soon as I finished school, I went back to school and did my science subjects so that I could continue my career. I got some good grades in all the science subjects, and I was able to make the sixth form, and I went to the sixth form and got some good grades there. Then I went to Fourah Bay College at the University of Sierra Leone. The year after I went there, simultaneously I won a scholarship to go overseas to study medicine, and at the same time they decided at that time that they were going to open up the medical school in Sierra Leone, the College of

Medicine and Allied Health Sciences, COMAHS, which incidentally became an instrumental part of the Ebola response in Sierra Leone. I was part of the founding class for the College of Medicine and Allied Health Sciences. I was the student representative at that time. The government of Sierra Leone had banned student unions, so we couldn't really be called the "student president." I had to negotiate with the government with the other student representatives from the other university colleges to lift the ban on student unions, which we got I think around 1989, '90, and then the student unions were allowed to come back into play.

Q: Why was that something you were interested in?

Williams: You mean student leadership?

Q: Yeah.

Williams: It wasn't something I was interested in. It was something that I grew into. I didn't go into it saying I wanted to be a student leader, but it just grew around me. We started having meetings with the government, and my other peers from the other universities allowed me to be one of the spokesmen for the group, and we just went into that. It wasn't something I actually started off thinking I was going to be a student leader, but it just happened over time.

Q: What were some of the issues that—

Williams: The main issue there was that one of the most vocal voices against the establishment of a one-party state at that time were the student unions. There were many protests and stuff organized by the students unions, so for the government to control that piece of public disquiet, what they did was they just banned the establishment of students unions across the universities. It took a long time for us to get to the point where the government was even willing to listen to the possibility of reopening or reestablishing the students unions in the universities.

Q: Tell me about medical school.

Williams: Medical school was good. Because we started medical school, and at the time, we had a lot of support from international agencies, the UN [United Nations], WHO [World Health Organization], UNICEF [United Nations Children's Fund], University of Cambridge in the UK [United Kingdom], University of Ibadan and Lagos from Nigeria. There was a lot of goodwill coming in to help establish a medical school in Sierra Leone, and we were given an excellent education. It was really interesting to see. The class sizes were extremely small. The foundation class itself was made of eight people including myself. Just eight. In some situations, the faculty was even larger than the first class. But we were given unprecedented access. We were given the opportunity to do stuff that residents were doing, and stuff like that, very early on in our career, and I think that actually enabled us to succeed later on.

Part of the course for the initial class was an intercalated research degree that you had to do midway through the six-year course of the medical school, and when I did that, I did mine on low-birth-weight infants in Sierra Leone. I got hooked on research, and I decided then that I didn't just want to be a doctor, but I wanted to be a doctor who had research components to his work as well. So we continued. During the fifth year, we were allowed to go to the provinces, to the periphery, and actually work in the provinces. I worked in Bo and Kambia [Districts], and that was an excellent experience. You were put there, you'd been given all the skills, and you had to address all the primary care issues for that community. It was a wonderful experience for us. There, I developed a deep understanding of the primary care system and the importance of that system and the difficulties that populations face in actually getting to a doctor, because in some situations, people had to travel days to come and see me. We finished that, and I graduated from medical school as the valedictorian for the school, and I did my—what you guys call "residency" here—we call it "house jobs" there. Then I got a scholarship from the University of Cambridge to go and study and do epidemiology.

Q: It sounds like you were already thinking about population health even while going through medical school.

Williams: Yeah, because it was very clear to us that in Sierra Leone, you have very few doctors to a very large population, so it was clear to us that we had to do what we had to

do to impact the larger group and not just concentrate on the patients we were seeing in front of us. That was always the orientation that we had in our minds.

Q: Makes sense. Tell me about going on the scholarship.

Williams: It was great. It was sudden. [laughs] I had applied for the scholarship, and it goes into this black hole where people are making all the decisions. Then suddenly in August, I got a call saying that you need to come over to the British Embassy, we have a packet for you. I went over there and I signed a few things. The next thing I knew I had a FedEx package at my house with all the details saying I had won a scholarship to the University of Cambridge. Within three weeks, I was on a plane and went to the University of Cambridge. Got there, went to the Institute of Public Health, excellent epidemiology school in the University of Cambridge, and I was matriculated into the Churchill [College] in the University of Cambridge. I have to come back and say that part of the medical training, we had to go on and do our electives. I chose to go to the University of Cambridge to do my elective, so I was already there before. It wasn't the first time I was going after I won the scholarship. I spent about a month there working with the diabetes units at the Addenbrooke's Hospital in Cambridge. It was an excellent experience. I had a good time there. It was good to interact with other medical students from the University of Cambridge system and it was good to compare my skills that I had with theirs to see whether or not I was up to par or not, and I think I fared well.

Q: Was that time that you had gone your first time out of Sierra Leone?

Williams: That was my first time outside Africa.

Q: What were your travels like before then?

Williams: Before then, I had been to some African countries. I'd been to the Gambia a number of times. My father's sister is married to a Gambian, so we used to make trips over there. I had gone to Liberia once very briefly with my mom, who had a friend in Liberia, and we went to visit them. That was the extent of my travel up to that time.

Q: Thank you. Continue telling me a bit about the scholarship.

Williams: It was a one-year scholarship to do a master's in epidemiology at the Institute of Public Health at the University of Cambridge. I went over there and started the course, and it was one of the most interesting things to me. Of course, I had to deal with the culture shock, and I had to deal with the temperature change. In Cambridge, everybody rides a bicycle, and I got myself a bicycle and taught myself how to ride. My trip was about three miles every day. But by the time I would get to the office, it was so cold that my face was all frozen, so it was always difficult to hear what I would say within the first thirty minutes when I got to the Institute. [laughter] It was a good experience. I chose to do my dissertation—because it was both a taught course and a dissertation requirement at the end. I chose to do my dissertation on diabetes, and I was working with a population a

few miles outside Cambridge in a small town called Ely, E-L-Y. I was looking at glucose intolerance in that population. I started working on that, working with Nick [Nicholas J.] Wareham and Nick [Nicholas E.] Day, who is an excellent professor of biostatistics. He is actually one of the authors of the Breslow-Day statistical technique that is referenced for matched case control studies everywhere in the world. Anyway, he was an excellent mentor for me. Midway through my master's, they approached me and asked me whether I wanted to do a PhD in epidemiology. I was like, wow. That was one of the most difficult decisions I had to make in my life because I knew that if I chose to do a PhD, it would take me farther away from clinical medicine, and what I really wanted to do was to do a mix of clinical medicine and research. But then, at the end of the day, I spoke to my mentors, both back in Sierra Leone and in Cambridge, and it was very clear what the answer had to be and the answer was yes. So I stayed on.

Q: Why was the answer yes?

Williams: The answer was yes for a number of reasons. First of all, the University of Cambridge is a very prestigious university. Somebody doesn't offer you the possibility of doing a PhD from that university and you walk away from such an opportunity. I think that would've been difficult to me to do. Secondly, I had an interest in this area. It's something I really wanted to do. I really didn't know what my career path would be when I go back to Sierra Leone with a PhD in epidemiology, but I really wasn't thinking about it. I want to note that, because I actually came back to that thought when I was on the

plane leaving to go and respond to Ebola in Sierra Leone. But I will come back to that thought—I hope you will remind me about that later in the interview.

Q: Of course.

Williams: I really didn't know what my career path would be after that, but I knew that this was a good opportunity for me to do a PhD, and I decided that I was going to go for it after consulting with both my clinical and research mentors and they said, yeah. There was only one person who really didn't want me to do it, and that was my uncle who was the doctor that I told you about. Since I had started my interest in becoming a doctor, he had kind of taken me under his wing, and I was shadowing him all the time, and he had this idea that I would come back to Sierra Leone and take over his clinic because I wanted to become an obstetrics and gynecologist, which he was. He was kind of a bit disturbed that I had changed that plan. [laughs] But I think sometimes you feel like fate has a way of determining what you have to do in life, and I feel like sometimes your life has been planned out and certain doors open to you to guide you in the right direction. I think that was one door that actually guided me to where we are today. I did stay, and I did a PhD with the University of Cambridge.

As part of that, I had to do a number of international presentations at meetings and stuff like that, and I met some folks from the NIH, the National Institutes of Health. I remember one time I was giving this presentation, and this person stood up and started asking me very difficult questions, and I think I handled them well because afterwards

they came up and spoke to me and asked me who I was, what I was doing, took an interest in my career. On subsequent meetings, they offered me a job, around the same time that I had to make this decision about whether or not I want to continue on and do a PhD or whether or not I wanted to do a master's—or, a PhD in epidemiology, or whether or not I wanted to come back and join the NIH. After I made up my mind to do the PhD, I wrote them back and said thank you very much for the offer, but I've decided that I want to pursue a PhD at the University of Cambridge. They wrote back and said correct decision, [laughter] why don't you get back in touch with us towards the end of your PhD. I said, okay. We still continued to meet at international meetings, and it was clear that they had an interest in me, and I started developing a relationship with them. The month before I defended my PhD, I sent them a note saying, by the way, I'm almost done, and I'm about to defend my PhD and just wanted you guys to know. They were like, fantastic, let us know as soon as you're done. I'm like, okay. I defended my PhD, I think it was probably in mid-August 1999. I let them know, and in a month's time I was working for the NIH.

Q: Can you remind me, was your PhD dissertation also diabetes?

Williams: Yes, it was.

Q: What did you find?

Williams: We were looking at a number of things. We were looking at glucose intolerance because we wanted to understand how and why people develop diabetes. We looked at a number of issues. I was looking mainly at dietary determinants of glucose intolerance. One of the things we found, we did a very nice study where we modified the diets of people into either low carbohydrates/high fats, low carbohydrates/low fat, or high fat/high carbohydrates diet, and see how they progressed over time. Over just a very short window, how their insulin resistance changed. As you can predict, the group that had the low carbohydrates and low fat had the best performance in their glucose intolerance, and those that had the high fats, high carbohydrates had the worst performance. At that time, this was all new. We're talking over twenty years ago. It was cutting edge at that time, so that was one of the things we found. The other thing we found was that dietary patterns were more important—at least in my mind—were more important than the individual nutrients themselves, and that's because people do not eat individual nutrients. They eat food, and each food has a composition in it that includes multiple nutrients and interacts with each other in multiple different ways. One of the things I did a lot of work on was coming up with techniques to quantify dietary patterns in food and try to see whether or not those dietary patterns were related to metabolic abnormalities, and we did find that as well. Again, at that time twenty years ago, this was all new, and since then there have been multiple papers looking at the same issue and confirming what we found early in that time. It was an interesting time.

Q: So you go to NIH.

Williams: So I went to the National Institutes of Health. I was sent to Arizona, where they have the second largest campus for the National Institutes of Diabetes and Digestive and Kidney Diseases, and they've been working with the American Indian population in Arizona for many years. They have a population-based survey, which at that time had been going on for over thirty years. They had a wealth of data including dietary data, including clinical parameters that were available to us to use. It was just a wealth of data. Then as part of that, we had to do clinical consultation with the population once a week down in the Indian reservations in Sacaton. It was a good experience I think for me. I went down there, and there I developed an interest in not only diabetes, but also kidney disease as well. I was with them for about two and a half years.

Then an opening opened up at CDC, and Vanket [Narayan], who was the epidemiology team lead at that time in the Division of Diabetes Translation here at CDC, contacted my boss in Arizona to check whether or not they had any aspiring candidates there. That landed on my desk. I gave Vanket a call, and the next thing I knew, I was on a flight to Atlanta to do an interview with a group. I came over, met the group, and it was just a wonderful group. I noticed that the orientation for CDC was slightly different from the orientation for NIH. NIH was mainly bench research work, whereas CDC was public health-oriented work with a lot of engagement with the population. If you go back to what I had said previously, to my interest, that was really my interest. I really wanted to see how as a doctor you can impact a large group of people and not just the patient who is sitting in front of you. It was clearly a fit for me, and apparently they were interested in

me as well, so we started the long process of onboarding me to CDC. It took a few months, but I started working at CDC in March in 2002.

Q: Can you tell me which group it was? I forgot.

Williams: The Division of Diabetes Translation in the National Center for Chronic Disease [Prevention] and Health Promotion.

Q: Thanks. So you come here.

Williams: Yes, so I came here. I came here, I started working as a medical epidemiologist. I think it was March 3rd. One of the first jobs I was given was to work with a community-based intervention program in North Carolina called Project DIRECT [Diabetes Interventions Reaching and Educating Communities Together], in which the community was engaged in developing different intervention strategies to reduce the prevalence of diabetes in their community, including dietary measures, physical activity measures, etcetera. I was given the opportunity to develop an evaluation plan for that project to try to document the successes—first of all, find out either if the program was successful, and then to develop techniques to quantify how successful the program was. I spent some time doing that, and we got some really nice results on that that actually showed that dietary intervention at a population level had—it didn't quite reach a level of statistical significance that you would like to see, but you could clearly see a crossover in the population risk for diabetes within this population. Some of the work that came from

Project DIRECT actually fed into a number of other programs here at CDC, including the REACH [Racial and Ethnic Approaches to Community Health] Project and some of the other community-based chronic programs that we've had at CDC. It was a very good way to introduce me to the work that CDC did and how effective and how powerful that work could be at a population level.

Q: So after Project DIRECT?

Williams: After Project DIRECT, we started working on developing a completely new area of work for CDC, and that was kidney disease. Kidney disease is one of the most expensive and devastating complications of diabetes. The Division of Diabetes started looking not just at diabetes itself, looking at primary prevention of diabetes, but also looking at tertiary prevention of diabetes and trying to reduce the burden of diabetes in the population, and the development of the most damaging complications of diabetes, which is either vision loss or kidney disease. We developed a vision health initiative and we developed a kidney initiative in the Division of Diabetes Translation. We had to do a lot of developmental work to get that program going. Congress looked at the work we were doing and liked it, and in 2006, decided to give us an appropriation, an earmark to develop that work even further. I was given the task of developing a brand new area of work for CDC, and that was one of the most exciting things that I had to do in my career. We started off by, first of all, trying to document, what's the burden of disease in this population? We set up a surveillance project with the University of Michigan and the University of San Francisco. Initially, the PI [principal investigator] used to be at Johns

Hopkins [University], but then he moved to the University of San Francisco. We developed a very robust surveillance system that is still in existence today and providing valuable information to the population about kidney disease, about the capacity to respond to kidney disease, etcetera. I did that for quite a while.

In 2010, I noticed an email for a detail opportunity to be the acting country director for Ghana, because they were trying to set up a DGHA [Division of Global HIV/AIDS] GAP [Global AIDS Program] country office in Ghana. I applied, and I was fortunate enough to be given the opportunity to go and spend four months in Ghana to establish the country office in Ghana. It was very, very, very difficult work. It was very tiring. Most nights I would come home, I would be so exhausted I would eat my dinner and fall asleep right there, because it was a very small team at that time and I was the only person who was in-country. But we had people coming in on TDY [temporary duty assignment] to help support the work we were doing in Ghana.

Q: What did the work consist of?

Williams: Establishing an office. That was the first thing. Secondly was to work with the embassy, with USAID [United States Agency for International Development], to develop a country operating plan for Ghana and to establish the office so that we can start working as a DGHA office in Ghana itself. It included a lot of stuff, including not only developing the country operating plan, but also finding space for co-location with the Ministry, working and advising, suggesting the way the Ministry of Health is set up in

Ghana. You have the Ministry of Health and then you have the Ghana Health Service. All the technical and operational things that are done for the Ministry are actually conducted by the Ghana Health Service, which is a semi-autonomous body from the Ministry itself. It also meant that I had to be the primary advisor to the director-general of the Ghana Health Service as well. That was the first time I got exposed to outbreak response. I remember one time we were there having this meeting with the other directors from the Ghana Health Service, and the public health director was reporting that they were seeing an unusual spike in the number of meningitis cases in northern and northwestern parts of Ghana, and that they were seeing for the first time a different type of meningitis strain—one that the vaccines that they had in-country were not covering. Within a very short time, this became an epidemic, primarily among students and young age school-going kids in Ghana. That's the first time I saw how quickly CDC can respond to a public health emergency and how efficient the emergency operating centers are. I came back to the office after that meeting, it was a Thursday. I sent an email to my country manager and the country team supporting me back in Atlanta, and they connected me to the EOC [Emergency Operations Center] [in Atlanta]. Later that same evening, I was on the phone with the EOC, and we were talking about the problem. We were put in contact with the SMEs [subject matter experts], and before we knew it, in seven days we had a team of five CDC employees—medical epidemiologists, laboratorians, etcetera—landing in Accra, Ghana, with all the vaccines that they needed to control the outbreak. We dispatched that group up to the northern parts of Ghana, and within two weeks the outbreak was over. That really opened my eyes to the potential that CDC has to impact health not only here in the United States but all over the world. From that moment on, I

knew that I wanted to continue to do some international work. But at that time, I felt that I had to go back and finish developing the kidney portfolio that I had in front of me. I came back in 2010 and continued doing that work with the idea of applying for an international job at some point in time, but not immediately. And then Ebola happened.

Q: And then Ebola happened.

[break]

Q: We're back. What, Desmond, exactly, were you up to when you learned about Ebola?

Williams: When I learned about Ebola? I was working in the Division of Diabetes Translation, as I said before, and we started hearing briefs about this new disease in West Africa, in Guinea. And the next thing we knew, we got confirmation, lab [laboratory] confirmation that it was Ebola, and it quickly spread to Sierra Leone and Liberia. It was like, wow, this is really serious, and it was moving so fast it was really amazing at that time. But at the time, it was still confined to that border area between Guinea, Liberia, and Sierra Leone.

A few weeks after that happened, unfortunately, my dad passed away, and he used to live in Sierra Leone, so I had to arrange to go down to Sierra Leone for the funeral. I went down to Sierra Leone in the end of June, early July, and had the funeral for my dad, and we were waiting for the fortieth day celebration to happen before we came back. I was

there with my daughter. I remember one day we went to town in Freetown, and on the way back, we had the radio on, and they started announcing public service announcements that they are looking for a woman. They were calling the woman's name, her age, her description on the radio, who has Ebola, who has just entered Freetown and has Ebola, and they want to find this woman immediately. They need to find her, anybody who sees her should call the police. The police for Ebola response? I was like, wow, these guys are going about this the wrong way. And this thing just exploded in Freetown. It was pandemonium. They even had people walking around villages with a loud speaker saying, "If you have this woman, please bring her out. We need this woman now," and all that kind of stuff. I told my daughter, I said, "They're doing it the wrong way. They're going to drive this woman underground, and if they drive this woman underground, it's just going to increase the chances that she's going to infect other people with the disease. They should not criminalize this. This is not the woman's fault she is sick." My daughter was like, "Yeah, why are they doing that? They're making her look like she's a criminal." That's when I knew. I told her, I said, "You know what? I'm going to have to bring you back to America, and then I'm going to have to come back and help fix this." About a week later, we left, and before we left, by that time the news had spread to America that now we had Ebola in Freetown. You have to understand, Freetown is the densely populated capital city of Sierra Leone, two million plus people live there, or just around. If Ebola came into Freetown and entered into some of the slums and highly congested areas, you can imagine what it would do there. It was a very scary time in Sierra Leone. Everybody was panicking. People were running to schools and taking their kids out. It was almost like it was unreal to me that people were responding like this.

Anyway, I told my daughter, "I have to be back to the [United] States, and then I'll have to come back and see what I can do to help with this because they're going about this the wrong way."

Q: So your daughter—sorry to pause a bit. Your daughter was in Sierra Leone while you were in the United States?

Williams: No, my daughter was in Sierra Leone with me for the funeral for my dad.

Q: She came with you—

Williams: She came with me for the funeral.

Q: For the funeral, got you. We skipped over a little bit of it, but can you tell me about having your daughter?

Williams: Having my daughter?

Q: Yeah, the personal life part of it.

Williams: Oh, okay. Well, it was very interesting, actually. My daughter was born two weeks after I came and started working at CDC. She is what I use to measure how long I've been at CDC. [laughter] I started off with a child who was born premature, the whole

child head to toe would fit just my forearm. It was amazing. I actually have a picture holding her like that just outside the incubator. She spent a month in the incubator. And now, having a child who is almost as tall as I am. I'm like, wow, I've been at CDC for a very long time. [laughs] But yeah, she was born a few days after I started working at CDC, and we're very close.

Q: What's her name?

Williams: Deslyn. Her name is Deslyn. She was actually interviewed during the family appreciation night here at CDC, so she has an AP [Associated Press] interview already on YouTube.

Q: I should look it up.

Williams: We lived in Smyrna, and I worked at CDC here, so we enrolled her at the CDC childcare center. We used to drive the distance down every day, and we had a long—with the long commute times in Atlanta, we had ample opportunity to discuss everything under the sun. It was just a wonderful opportunity to bond with my daughter and stuff like that. We're very close. We're very, very close. She basically is with me—if I'm around, she's always with me. Very, very close, and we have a very deep relationship. She also had a very deep relationship with her grandparents because my parents would come often to spend some time with us here in America. As a matter of fact, when she was born, my mom came and stayed for an extended period of about six months just to

help out that initial phase, and my dad stayed for about three months as well. She has a very good relationship with them. When I was in Ghana, my dad and mom came to help out at home while I was in Ghana for that four months. She was very distraught when my dad died and insisted that she wanted to come home for the funeral and pay her respects as well, so that's the reason why she was in Sierra Leone with me.

Q: And I wasn't clear, was your dad in Sierra Leone when he passed away?

Williams: Yeah, my dad was in Sierra Leone when he passed away, yes. He died at ninety-two. He went to bed one day and never woke up.

Q: Wow. So that happening concurrently with the Ebola epidemic.

Williams: Yes. As I said, it was in early July when the first case entered Freetown, and the public response to it and the government's response to it being, they more or less criminalized the event and drove the woman underground. They only found her after she died. And you know, if somebody dies from Ebola, they've had ample opportunity to spread the disease to others, and that was the start of the outbreak in Freetown.

Q: So you decide this is your mission now.

Williams: Yeah, this is my mission now. I came back, and by that time CDC had sent out this message asking for volunteers and stuff. I thought I had the right skills, and I had the

cultural background, and I had a deep sense of the languages and the people in Sierra Leone. So I sent an email documenting this to the box, and I waited. I was preparing everything in my personal life to be ready to go and made sure I had all my prescription medications already, everything ready, family was prepared, etcetera. I waited, and that was in August. I waited and nobody contacted me. Took a while. Nobody was contacting anyone. It wasn't just me that had volunteered. A number of other people had volunteered and nobody was hearing from anyone, so what's going on? They don't need us? Anyway, they did a brown bag session at our center, I think it was in September, and I went to that brown bag session and Barbara Knust was there. She is from the Viral Special Pathogens Branch, and Barbara had just returned from Sierra Leone, so she was describing her experience in Sierra Leone and what had transpired there. There were a lot of questions that people were asking, and some of them Barbara could not answer, and so I answered because I had the background. After that brown bag was finished, I walked up to introduce myself to Barbara and to thank her for going down and volunteering to help out in Sierra Leone, and she said, "Do we have your name?" [laughter] It was funny. I said, "Oh yeah, I sent you an email almost a month ago, I still haven't heard anything from you guys." And she's like, "Oh, I wonder why? Give me your user ID [identification]." I gave her my user ID. In a few weeks, I was on my way to Sierra Leone. That's how I got pulled in.

I told you that I wanted you to remind me again about that thing that I'd said. I remember after being prepared, it was quite rushed, but still I remember sitting on the tarmac at the Atlanta airport just getting ready to take off and it suddenly hit me that, wow, I didn't

know why I made a decision to do epidemiology. I didn't know why I made a decision to move away from clinical medicine. But in a way, all of what I've done up to that point was preparing me to go and respond to this Ebola outbreak in Sierra Leone. It was a very surreal moment for me. I was like, wow, it's amazing, you can't plan this. It was a very powerful moment for me, and I was like, wow, this was what the plan was all the time. Then I had to be prepared to be able to respond to a public health emergency in my neighborhood.

Q: Can you talk about the fact that it must've been so difficult knowing that it was in your neighborhood, in your backyard.

Williams: Yeah, it was very, very difficult and very disconcerting because Sierra Leone is a very vibrant place and it's a very warm culture where the default is for somebody to hug you and to touch you and stuff like that. It's a very close, communal environment. People really care about each other and people tend to take care of each other. For something like this, which actually fed on those kinds of social networks to actually spread the disease, it was just heart rending to see. I used to tell people on the radio in Sierra Leone that Ebola kills people who care about you. That is really what it does. People who want to help out, people who have what we call in Sierra Leone "*ajo*." That's a term that means people who are compassionate, people who want to help, a Good Samaritan kind of person. Those are the people that Ebola kills because they inadvertently touch you, they touch your body fluids, and they get infected themselves. It was very difficult to sit here and see this thing unfold in Freetown, and it just took off

like wildfire in Freetown because it was a heavily congested area, and before we knew it we were having hundreds of cases a month in Sierra Leone.

Q: Were you contacting home during this time?

Williams: Yeah, people were contacting me all the time because they knew I worked for CDC. [laughter] What is the news? What do we do? We're planning to go on holiday, we can't go now. There was a lot of panic within the Sierra Leonean community in the diaspora—a lot of concern for their loved ones back at home, a lot of concerns for themselves as they were trying to prepare to travel to Sierra Leone for different reasons. There was general panic all around. It was a very turbulent time. It was very difficult to focus my mind. I was already geared, I was already doing all the reading that I needed to do to prepare myself. I was already trying to learn every single thing that I could learn about Ebola. I was attending every single presentation being made by anyone at CDC. Basically, my mind was focused on Ebola. My mind and body had already moved. My body was here but my mind had already moved over to go and respond to Ebola. So, very difficult time during that month and a half that I had to wait before I had to go.

Q: When you finally get sent over, do you have specific duties?

Williams: Mm-hmm.

Q: Can you tell me about that?

Williams: I was sent over to support the epidemiology team. Let's go back to the trip, okay? I have that surreal moment on the plane, and we took off, and we landed in Brussels. When we landed in Brussels, I started noticing a few people with my backpack. The DEO [Division of Emergency Operations] and the EOC gave us equipment and stuff like that, and we had this really nice backpack that was made by [unclear]—really nice, very useful backpack. We used that backpack, and actually it was used to identify us in Sierra Leone after a while because all of us were coming in with the exact same backpack. Anyway, I started noticing a few people at the airport in Brussels with this backpack. Slowly, everybody started congregating, and we had a small group together and everybody was introducing themselves, what they were going to be doing in Sierra Leone. I met Rebecca [E.] Bunnell there. She was going to be the communication lead, and she turned to her colleagues and said, "Do you hear his voice?" [laughter] Then they found out that I was originally from Sierra Leone, and they were like, "Do you speak the local language?" I'm like, "Yes, of course I do." "Oh, my goodness."

Initially, I was sent down to support the epi work, but I ended up doing both epidemiology work and communication and health promotion as well because I spent a lot of time on the radio trying to educate the public about how to protect themselves and how to prevent themselves from developing Ebola and what to do when they developed Ebola. When I went down to Freetown, I was put in charge of the Western Area, which includes the capital city. I was working with WHO and a group of very bright EIS [Epidemic Intelligence Service] officers and recent graduates from EIS who were just

excellent. At that time, the epidemic was at its peak in Freetown. A very scary time. You're talking about a time when we're getting a thousand cases a month.

Q: That's wild.

Williams: That's crazy.

Q: Can you—what day did you arrive again?

Williams: I don't remember exactly what day it was. I think it was October 19th. I'm not too sure. Around that time.

Q: Sure, sure. No, that's good. Gives us an idea of where the epidemic was.

Williams: Mid-October. We were working with the local surveillance officers, we had a really good team led by somebody we called "the General," and that is Charles Keimbe. He was the district surveillance officer for the Western Area, a very energetic and imposing guy, and he was a great motivator for his team. And a consultant whose name was James Bangura. They were really excellent. James had been working on Lassa fever before, he had some infectious disease experience under his belt. We teamed up with them, and also with the WHO team attached to the Western Area as well. Subsequently, I was also put in charge of field operations for CDC for the whole of Sierra Leone, but initially, when I went, I was just concentrating on Western Area because that was the hot

spot at that time. It was scary, it was very scary. We realized that we were on the brink. That we either had to get it right or it was going to rage out of control, and we had one opportunity to do it.

At the end of November, when the president [of Sierra Leone] saw the numbers and saw the numbers were increasing exponentially over time, he panicked and he went on the radio one day and made an announcement that the government was going to do something and we're going to control the Ebola epidemic. I remember walking into the emergency response center, [unclear] at the British Council at Tower Hill, and everybody was looking at us saying, did you hear what the president said? Yeah. So what are we doing? And I'm like, I don't know. Nobody knew. The president just went and made a political pronouncement that something had to be done, this had to be corrected, and I guess he just left it up to us to decide what that was going to be. He gave us the dates to implement it, and he only gave us two weeks. [laughs] He gave us two weeks to implement something. We went into a scramble, we went into a huddle with WHO, the Ministry of Health, and CDC colleagues and started thinking about, okay, if we're going to do something different, what are we going to do? The first thing we decided was we need to start from scratch. Let's start thinking from scratch. Let's start thinking about what's going to be the best approach for us to control this outbreak. What have we already seen so far, what's the experience been, where are the bottlenecks, what do we think is holding back the response now? Trying to do a deep assessment of where we were at that time. We realized a few things. Number one, at that time we were identifying people in the community who were probable cases of Ebola, or suspect cases of Ebola,

and we were leaving them in the community because there were no beds. We didn't have enough beds. The bed capacity in Western Area was consumed. It was run over by the number of cases we were having. I think we had about four hundred beds, and for the month, we were having probably a thousand suspect cases a month. It was just scary. We were working with the British military as well who were supporting the response at that time. Andy [Garrow] was there, was kind of who was leading the response then. We all sat in a huddle and decided we had to do a Western Area surge. I think that would probably be a good place for us to stop because the Western Area Surge is a—

Q: It's a big thing.

Williams: It's a big thing.

Q: A big deal.

Williams: Yeah, it's a big deal. We'll talk about that later.

Q: Would you mind if I reviewed a little bit of where we are to this point?

Williams: Mm-hmm.

Q: Great. I'm big on vivid memories of things, like what you remember seeing and hearing, sensory kinds of things. Do you remember anything from the first like month

and a half—before the president's pronouncement—that you were there that really sticks out?

Williams: There are a number of things. First of all, when I landed—remember, I was just there a few months ago. When I landed, the difference that I saw in the population was amazing. Everybody was terrified. Everybody was terrified. This is a place where, as I said, it was a lot of hugging, touching, interacting with folks. Nobody wanted to touch anybody. Nobody wanted to be outside if they didn't have to be outside. It was a ghost town. The difference between June and July and that time when I landed was like night and day. It was like a ghost town. Everybody was scared. Everybody was so terrified about this disease. It basically consumed all the energy in the country. It was amazing. And then, of course, the economy had gone on a standstill. There was very little economic activity going on, and it was really amazing to see that happening because in Sierra Leone, every little corner has a little shop that's selling something. Everything was just quiet, and that was really scary for me.

The other thing that was very vivid around that time for me, and this is before the pronouncement, and then I'll talk about after the pronouncement. We were working very long hours. We were working sometimes sixteen hour, eighteen hour days, and we were staying at the Radisson [Blu Mammy Yoko] Hotel, and our headquarters was in the basement of the Radisson Hotel. We call it the Cave. I remember one time, we were sitting there looking at the numbers, and people were like, wow, this is scary. Because as I said, at that point in time, we realized that we either had to do something to control this

outbreak or it was going to overrun Freetown. That was a very scary moment. I remember I went to bed, and I woke up that morning and I rolled out of bed—you have to roll out of bed because every morning you wake up and you feel like somebody took a stick and beat up your body or something like that because of the long hours we were working. [laughter] I rolled out of bed and I sat down, I held my head, and I was thinking to myself, wow, are we going to lose this? That was a very scary moment for me to think about Freetown being overrun, because then by that time we were starting to see some cases in the slums. Yeah. That was very scary. I was like, wow, we've got to do something. It was a very vivid moment. I don't think I've ever felt a deeper sense of purpose than I did at that time. I realized that we've got to do something now and we had to do something dramatic for us to change the course of the disease.

Q: Thank you. It's about time for you to take off, you've got that call at twelve. I appreciate you sitting here with me. This has been fascinating and amazing, and I'm so excited to continue.

Williams: Yes, definitely, and thank you for doing this.

Q: Of course.

END