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Transcription 1

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MH: *So I was just explaining to Armand that this is for an oral history project so I'm going to hopefully take a slightly more detailed interview and conversation, but that what I want to start with is simply if you could describe who you are and a little bit about your background … you're a medical doctor as well as …*

AS: Yes

MH: *… right, so if you could go ahead …*

AS: I'll try and be as [?synthetic 00:48] as I can and you can tell me to expand if I don't get any of the better parts. So I am a physician, by training an emergency physician. I got my training in emergency medicine in the United States. I finished that up in 1997 and immediately … and actually worked for the International Medical Corps in Bosnia while I was in the last year of my emergency medicine training.

MH: *Where were you trained?*

AS: I was trained at the University of Missouri, Kansas City, at Truman Medical Center and the Medical Director there sat on the board of the International Medical Corps and had worked in Afghanistan for them during the Russian Afghan War in the 80s. And so they ran an emergency medicine project in Zenica, Bosnia during the conflict there and so I took some time out and worked for the IMC in Bosnia and the Medical Director there said, "Well if you like this kind of the work the IMC is good and MSF is also good" because he'd worked for both and…

MH: *And this was in the early 90s?*

AS: This was in '96-'97 I was there, and so I finished up my training in '97 and several months after that went into the field with MSF for my first mission with them. So I was in Sri Lanka in '97 with MSF France at the time it was … anyway, so went through the usual into the field a couple of times with different MSF sections, ending up in Gulu, Uganda in 2000 for the … what was then the biggest Ebola outbreak … well, what was up until 2014 the biggest Ebola outbreak on record with 425 cases. And that was back when Ebola was a much smaller affair with fewer people involved and what not. And …

MH: *I might just dwell on that a little bit …*

AS: Sure.

MH: *Just tell me what happened there from your point of view …*

AS: Well so at that point I was working as an isolation ward physician – we called it an isolation ward back then. So I was doing patient management. I met my wife there; she's a project coordinator for MSF Belgium and working as an epidemiologist. And I guess it was at that point that again you learn to care for Ebola patients, but you also learn that outbreak management is much more than caring for the patients. And very shortly after that I went and got a degree in Public Health at Johns Hopkins.

MH: *Before we go on, could you tell me what you knew about Ebola … can you remember what did you know about Ebola in 2000 before …*

AS: Nothing. Before going? Almost nothing. Just that it was this infrequent disease that happened in Central Africa that the media and certain authors had made bigger than life and rather colourful.

MH: *So you had read The Hot Zone? Or you had heard about it?*

AS: No I knew of The Hot Zone. I think I'd seen one of the various movies that used Ebola as a villain or something …

MH: *Outbreak.*

AS: Yes Outbreak I think it was. So I had all of the same images that most people had at that point with the understanding that they were probably overblown to a certain extent but I don't think it … when I called up MSF and said "What have you got?" they said "Would you like to go to Uganda and work on an Ebola outbreak?" That I found it threatening or, you know, my next line was not "What else have you got?" It was "Sure, I'll do that". And …

MH: *So basically you arrived there in Gulu and were you immediately thrust onto the ward and treating patients or…*

AS: Yes almost. I mean I think the next day after arriving, well the day arriving in Gulu I met my predecessor, the person I was replacing who's now working for PAHO, and who I crossed paths with again in Monrovia this outbreak. She said, "This is how you put on the gear. This how we're taking care of the patients". I think we had an overlap of a day or two. She showed me the ropes and then I kept going.

MH: *Okay so what was that like, your first encounter with the clinical manifestation of the …*

AS: Well, I guess I had the same impression that comes up every outbreak. You know, every outbreak people go to field and they come back and they say, "Wow, I expected there to be more blood" you know. That's, I think, a recurring theme that we hear. Ebola patients just look very very ill to the point where they almost have a characteristic weakness to them. You can see people come out of the car and sort of walk over to the screening area and what not and you can look at them and say "That person's got Ebola" just by the way that they move and the way that they hold themselves. So one of those Gestalt impressions that clinicians get after seeing a disease a few times.

But other than that, I don't think that the management of the disease is, aside from the infection control, is significantly different from how one would go about other severe diseases. If you've worked in emergency medicine or intensive care, you're familiar with people with critical illness and I think the principles are the same and the management is the same. Despite all of the fuss internally and in the media and what not, the management principles are not outside of how you would manage somebody with a severe bacterial illness, which you would find in a hospital here in Europe or North America.

MH: *At that time, and I'm thinking back to my understanding of the first Ebola outbreaks that occurred in Sudan and Zaire, was it framed as something that was of a great danger in hospital settings because of the risk of spread, rather than communities?*

AS: Right, actually the hospital dangers were probably the … I mean that's the hallmark of the disease, what's the first alarm bell that makes people think there's an Ebola outbreak is when you hear about healthcare workers dying. And that was true in 1976; the Yambuku outbreak was very much a hospital-associated outbreak. Less so the one in Sudan that year. And then in '95 the next really big outbreak in Kikwit was very much hospital associated … and I think that's what you need to have a really big outbreak, you need to have healthcare structures involved because they are extraordinarily efficient amplifiers of disease, so that you don't have big outbreaks without having a hospital involved. It was true in the 2005 Marburg outbreak in Uige, Angola.

MH: *So I suppose if you could just continue and cover … so that was your experience then, it was a self-limiting outbreak right?*

AS: They all are.

MH: *Okay, well, you tell me what was different about that as oppose to the current because it was self-limiting in a different way clearly*.

AS: Well this one isn't self-limiting until it ends, but it will. The question is not "What makes an outbreak end?" because they've all ended and this one will end. The

question is “Why is the scale of any one outbreak different from another one?” And what has made this one exceptional of course obviously has been the numbers, the large number of cases. But in order to have that large number of cases, it has to have significant geographic extension and that’s what’s made this one different and that is almost entirely linked to the mobility of the populations involved in West Africa.

If you look at the other outbreaks they are reasonably contained because the populations don’t move about so much. I mean the people in Yambuku hung around Yambuku. They didn’t get up one morning and say “You know, I’m going to go to Kinshasa today”. And it was the same in Kikwit. Same in Kumbungo. It has been true to a lesser extent in Uganda. The folk in Uganda move about a bit more, so if you look at the outbreaks in Uganda there have been some satellite outbreaks. So in the Gulu outbreak there was a significant satellite outbreak in Masindi and there have been small one or two case satellite outbreaks in other Ugandan outbreaks. But they generally … they extinguish very quickly after they get away from the source and it may be because these people are moving outside of their social networks. So if you’re a dude on the road with Ebola and you get sick in a town where nobody knows who you are, the odds of the outbreak propagating from there are rather small.

What the West Africans are very good at is going to visit family in other villages, or most notably, in nearby capital cities. So I don’t know Guinée as well as many who have been there, but what they tell me is this outbreak started in Guinée forestière where you have a bunch of villages in this area that sort of extends beyond the borders into Sierra Leone and Liberia. And the people that live there all have relatives in Conakry, and you know, so cousin Bob who went to Conakry to open a bakery, you know, people get in the car and go and visit Uncle Bob and Uncle Bob sends money home, and what not, and there is a mapping in Conakry that corresponds to Guinée forestière. So this village tends to have a cluster of people that hang out in Conakry here and what not, and there is a lot of movement back and forth. And the ability for people to move from village to village is, despite their limited means, is rather good. So if you have a funeral in Village A, people come from Village B, Village C, Village D because your family or your extended family exists in a relatively extended geographic area, and so when they come to the funeral and they get infected and when they go home they take the disease with them.

MH: *Could I just interrupt you a second? This is all very good, but I wanted to actually try and…*

AS: You take me down the road you want to take me!

MH: *So, I want to get clear the chronology, from your point of view, of this outbreak and the emergency response. The kind of the how, what and when. But as far as possible from your point of view. So rather than second hand ... what you actually knew about Ebola at what point, so if we can take it through … I mean if you think back to … I mean as I understand it first blinks on Médecins Sans Frontières’ radar in February 2014 is that right?*

AS: Well … this outbreak is in March, although maybe the people locally knew a bit more about it, but the “What the heck’s going on here?” alert got set off in mid-March of 2014.

MH: *So were you here then?*

AS: Here in Brussels? I think I was in one of our training programmes where I give some talks on epidemiology; I think I was in Spain for three days you know? So I got the email, you know, they said, "We're sending the samples off, it looks suspicious." Hilda De Klerk who was in Bo has moved to Guinée, she's one of our hemorrhagic fever reverends as well, and Michel who's the other one here is packing his bags to leave. So already two of three of us were already on their way so I didn't have to do anything special.

MH: *Is that the core [? 13:51] outbreak … so you, sorry just talk me through them …*

AS: So there are two of us here in the medical department who maintain a view on the technical matters related to Ebola. That's different from the operations and what not. So in terms of the medical reference for Ebola that would be Michel and myself. Hilda is …

MH: *Michel?*

AS: Van Herp [spells name]. And it's a he so it's Michel with one L no E. And then Hilda De Klerk is the hemorrhagic fever mobile implementing officer so she's the one who is single and has no kids and can spend lots of time in the field so she gets to go off to … she was spending a lot of her time in Sierra Leone dealing with Lassa up until that point. So she was under a contract basically, spend sometime here with Michel and I, but spending a lot of her time in Sierra Leone because that is where our normal everyday hemorrhagic fever issues stem from. So she was …

MH: *That's in Kenema?*

AS: No she was in Bo so that's not far from Kenema. So Bo was where our project is, it's about 40 minutes down the road from Kenema, which is where the government of Sierra Leone maintains their centre. So she was in there … that area helping out our Bo project, deal with their loss issues when the alarm bells were ringing in Guéckédou which is I guess, is an eight hour drive or whatever, so she grabbed some stuff and headed with some people to Guéckédou to be the experienced hemorrhagic fever person that provides some support for them. And at the time we weren't sure if it was going to be Lassa or Ebola or whatever.

MH: *So they're en route and you come back first and then…*

AS: Yes, I came back here and just sort of [?followed out 16:00] and the test came back positive for Ebola that Friday, and Monday they identified it as Ebola-Zaire,

which we don't call Zaire anymore but who cares. If you're going to be a historian you should get a history of the taxonomy of this disease.

MH: *Yes I have read parts of it. It's all been written up in numerous papers.*

AS: Yes I know Chen's the guy at the heart of all that. Driving some people crazy [laughs] but anyway, it is what it is.

So then things … I guess it got … the extension to … so it was in Guéckédou, it's in Macenta. It's sort of in a couple of villages regionally; nothing surprised anybody at that point.

MH: *Just to bring it to you – your experience, at what point do you head out … do you …*

AS: Mostly it's what operations says. I can go at any given moment but it doesn't make sense for me to be there while Michel and Hilda are there so I say "I'm available" and you start clearing your schedule and making sure that when they're … and I think I went in early April or mid-April, just sort of figuring "All right, they're going to rotate out, I'll go to there" and I didn't know where that would be at the time because they very quickly started unrolling the extension across the border. There was a case in Sierra Leone and there were a couple of cases in Liberia then it becomes a question of …

MH: *I suppose what I'm trying to get as much as possible is your own experience, your point of view.*

AS: Sure sure. I mean I'm just watching this unfold and so you follow the extension from the field, "Okay, where are the cases?" and the most significant next event was the appearance of cases in Conakry which was a week and a half later or something like that. So it was not surprising when operations said, "Right, we need you to go to Conakry." You know, rather than going into the interior and Guéckédou and what not. So my first field deployment during that outbreak was to Conakry and I was there for the second half of April.

MH: *So can you just talk through what you saw, what the situation was like, maybe how it was different or similar from previous outbreaks you'd seen in Uganda?*

AS: So what had been … so I skipped a part probably between Uganda in 2000, I also went to Angola in 2005 for the Marburg outbreak there and I also went to Kumbungu in the DRC in 2007 for the Ebola outbreak there. And I have provided regular support to the field for the other outbreaks so over the course of whatever it's been … fourteen years, I've been to the field a few times. And amongst the things as I said I do here is to stay up to date in all the developments in Ebola which are few and far between, because this doesn't happen every year, but you stay on top of the research, you get to know the people that work in the labs and what not.

MH: *And my understanding is…*

AS: Work on the guidelines …

MH: *… it's a sort of disease that didn't have sustained research funding if I can put it that way …*

AS: Well it did and it didn't. The bio-terrorism fantasy or whatever you want to call it that drives a certain amount of funding from the bio-defence community has fed into Ebola research, mostly in terms of development of medical counter measures. So we came into this outbreak and others with a certain amount of stuff that works in the lab, in the non-human primates, but not a whole heck of a lot of understanding about the naturally occurring disease and how rather ordinary things might work.

You know, so if you said "Well, I can name five different drugs that if you give them to a monkey at or about the time you give them Ebola how they will affect their survival." But if you wanted to say, "Well what happens when you just give them IV fluids?" the laboratory data is much thinner. And you would think, "Well, you know, well why don't we have that information?" Well because nobody's funding that information. And what people want is something that's specifically directed against the virus, so that you can say "Okay world, don't even think of deploying Ebola as a bio-weapon, because we've already got the answer right here." You know, take that off the table by being prepared in advance. Which I think most of the people in the world didn't know about until two people from Samaritan's Purse got these things and then the world suddenly realised that what everyone else in the very small Ebola community knew was that these things had been cooking in the labs for quite some time.

MH: *Okay we're jumping ahead; I want to come onto all that…*

AS: Okay you direct traffic here because I'm all over the place!

MH: *Let's go back. I asked you originally about how when you arrive in Conakry in April what was similar and what was different?*

AS: So what was very similar was the … all things that usually happen when you have an outbreak. There are various task force meetings that are set up. People from the Ministry of Health and the WHO and the usual response agencies – CDC, MSF, WHO – sit about the table, and discuss, you know, some of the usually painful things, like you know, "Those three motorcycles that we received funding for two weeks ago are where?" And "Is it time yet to talk about how we will obtain funding for gas for these motorcycles?" You know which in retrospect seems kind of ridiculous that the fate of three motorcycles was going to make no difference whatsoever at that point. But that's what these meetings inevitably come to.

MH: *So who's in Conakry at this point? The World Health Organisation…?*

AS: Yes, MSF, CDC, WHO and the Ministry of Health. Those are the usual … there are a couple of others. I think I saw somebody from the French Ministry of Foreign Affairs has a medical wing that I think they sent somebody there to see what they could do to help out. But basically it's the same old players.

MH: *Right. One question people might have in the future … they might have been surprised by this, why is it that Médecins Sans Frontières is the one to identify and diagnose Ebola first?*

AS: We happened to be there.

MH: *It was just chance?*

AS: It was chance yes.

MH: *Because you had a malaria treatment centre right?*

AS: Right. MSF Geneva was running operations in that area and I think the Ministry of Health had received word and … you know, it's a question of I think different people do different things at different times, even the local MSF people had heard there was something bad going on but it was a specific cluster I think of nine cases and four deaths that really got everyone's attention. And it was at that point that MSF arranged the sampling and shipment of blood from Guéckédou to … as it turns out it was … it ended up being Lyon because DHL didn't want to handle it and Air France did, so it went to Lyon instead of Hamburg.

MH: *I'd be interested because I know Sophie at one point we spoke about a chronology that MSF has…*

Sophie: Yes I do, a timeline.

MH: *I still haven't got a firm idea of when exactly this was; I know it was some time in February I think…*

AS: I think it was like the week of the 18th March or something was when I heard about it, and I think that's when the samples got shipped around that time.

MH: *But I read some other piece in Time that someone called Ella Watson Stryker was flying out from New York and I'm pretty sure that was in February …*

AS: Maybe …

MH: *According to that article ... anyway, it would just be useful to get …*

AS: Anyway, before that third week in March I can't tell you much that was going on there.

MH: *So at this round table you've got the usual suspects.*

AS: Right.

MH: *Now can you tell me a little bit about the attitude of the Guinée Ministry of Health?*

AS: It was typical. I mean I guess part of the problem is in order to control an Ebola outbreak you, have to do a lot of different things. You have to find the cases; you have to transport the cases that you find safely to a place to care for them; you have to operate a place that you can care for them which involves operating a lab that can tell you who's got the disease definitively and who doesn't. You have to identify all the people who are in contact with those cases in the community. You have to visit these people everyday for 21 days. You have to go out and tell people who don't have the disease how not to get it. And then all of this stuff is inter-dependent and has to be coordinated. The coordination role falls usually to either the Ministry of Health or the WHO or sometimes both. And both these organisations have different pieces. So you have the local Ministry of Health people in the Guéckédou area for example or in Conakry. But then you have the national level people. How the local and national people inter-operate is different from country to country.

Then WHO is even worse because you have the WHO country office, you have the Afro office and you have the Geneva office. And all of the real competence with Ebola is in Geneva, but because of the way the WHO governance works, the authority falls to the local and the regional office. And there's an interesting history there, and you can look at it's all the fault of the Americans, and the public health service and the Surgeon Generals after the war and all that but anyway …

MH: [laughs] *Now you're doing my job!*

AS: And then the pre-existence of PAHOs, the Pan-American Sanitary Board before the UN structure was set up, but anyway … So WHO has this issue, and the problem is of course that the people who get to wear the hat don't have a lot of experience with Ebola because it's a rare disease. So generally the people who have the authority to run the show don't know what they're doing and that happens all the time.

MH: *Are you saying that that is what you saw happening?*

AS: Sure, but you've seen that happen before. It is rare unfortunately that the person who is given the role of being the coordinator of what's going on is somebody who's done this before, or done it well before. Because you have to be a leader and you have to be a manager and often you pick medical people, and you don't go to medical school to learn how to manage and be a leader unfortunately, you learn how to diagnose diseases and what not. And running an Ebola outbreak involves running a big machine with lots of different people running all around, each of whom has to do their job well and we probably need better managers doing this than … the normal thing is to find a medical person who understands the disease … this person would be better of as an advisor and you should have a manager running the shop.

MH: *I just want to remind you of something you said at a Chatham House talk where you were speaking …*

AS: I think I said this at Chatham House?

MH: *Well you did kind of because you were talking about the coordination … it was right at the end of your talk. But you used this phrase, which was rather interesting. You said "We get off on the wrong foot pretty much at every outbreak."*

AS: Yes.

MH: *So you're kind of saying there that lessons don't get learned from these outbreaks?*

AS: Well, or to the extent that the lessons that are learned there are institutional barriers to correcting the deficiencies. If you had a magic wand and said "Okay, I happen to know somebody who is well suited to coordinating an Ebola outbreak response, everybody who has the local authority, please step aside and delegate it to this person so he can get the job done." That never happens! You know? People don't step aside and delegate authority to the person because they happen to be well qualified for what they're doing. Which is interesting because you go to these meetings and you see the people that have been there a thousand times … well, okay it's Ebola, it's not a thousand … several times before, hanging out and taking notes and occasionally making pained faces when the same weak leadership manifests itself. For example if you work for the US CDC, you're a government agency, you can't say to the sovereign government of Guinée "Please step aside and let me run the show here because I know what I'm doing." And WHO can't say that either.

MH: *You can't mount a colonial style military response.*

AS: No you can't. And, you know … so whatever it is, the outbreak response is not a meritocracy and that's always been the case it's very much the case throughout this outbreak as well – you make do with what you've got and …

MH: *Right. From your point of view is it frustrating to see …*

AS: Yes, I'll give you an example; we'll run the clock forward a little bit, just for the purposes of illustration. Let's put ourselves in Monrovia in early July. So this is when nobody understood the scope of what was going to happen in Monrovia. Things were just getting underway, but it was clear that there were more cases than people had sort of expected, and we were sort of at a point where we were getting outbreak extension fatigue, so even MSF who I think we were operating out of however many half dozen treatment units, and we just weren't in a position to open up another one. We just didn't have the staff to do this. And so our job … when I turned up there were two people there ahead of me, I was the third person in Monrovia, and we were it. We were the ones that were going to advise the Liberians on how to do this themselves and also to help Samaritan's Purse. Because Samaritan's Purse, much to their credit, stepped up and said "We're uncomfortable with this, but we see it as our obligation to help these people and we're ready to do it if you can tell us how we should do it and help us out."

So our job there was to empower, facilitate, train Samaritan's Purse. Samaritan's Purse had already been doing this up in Foya along the borders, so the idea was okay, Samaritan's Purse was doing a good job running Foya with support from MSF; we're going to try and talk them into doing it here for Monrovia; Samaritan's Purse and the government of Liberia were going to work together and provide some man power; we'll make do with what we have and things will be okay. And I think the large international agencies realised things could get bad so pledges of millions of dollars and euros were made; material was starting to show up; warehouses and stocks were filling up with boxes of stuff. Because it's a lot easier to mobilise stuff and money than it is to actually get a machine in operation.

MH: *We must be getting into August now if that's the case?*

AS: No this is already in July. It wasn't at the scale that it was but it was already … the people who were there, you know because a lot of agencies were already there doing other things and so they said "We want to … we don't want this to be horrible so we're going to pledge all of this stuff." And so every morning at these coordination meetings somebody would stand up from whatever agency and say "We've mobilised this much money and we've got people en route, we've got stuff coming here and so forth." And you would sit down with the Ministry of Health machine and we would talk about burial collection, you know, body collection by the burial teams. 50 per cent of their capacity was off line because one of their vehicles had a problem with one of its tyres. And we'd already identified the accumulation of bodies as a problem. You know, that the bodies aren't being picked up because the system to pick up the bodies is not up to the scale of what was already going on in early July. Because I think they had four teams and two vehicles, and the idea is that these two vehicles would be in operation with the two teams and they had capacity or whatever it is…

MH: *For the whole country?*

AS: No this is for Montserrado County. And they could probably do fifteen burials a day. And it was clear that many more than fifteen cases a day were accumulating.

The calls were coming in and there were frustrations that people had been calling in and the bodies weren't getting picked up and bodies were staying in place for 24, 48, 72 hours before they'd get picked up. And so this was an infection risk and this was also interfering with other people's ability to work, because it was clear that somebody would go there to investigate a case and people would say "You go away and come back when you're ready to take care of these bodies." So this was clearly an issue and people are mobilising huge amounts of resources and it doesn't materialise into a system that can remove bodies because there's a problem with a tyre. And you'd say like, "Well why is this happening?" Because it's a management issue.

MH: *I think there was some comment on how ironic … I mean because Liberia is the place where rubber comes from right? For tyres. And I think there was a comment about … there were similar problems with just getting basic surgical equipment like rubber gloves. They made the rubber, it's shipped somewhere else where they make rubber gloves, but there are no gloves there.*

AS: Yes right. Try and get a good cup of coffee in Columbia! Or a good cup of tea in Sri Lanka – that was a big disappointment because I was there for six months and couldn't find a good cup of tea.

MH: *So Liberia is a critical moment …*

AS: That was a good example of it, but it was much the same in Conakry. I think it was … I mean one of the most important things to do early on is contact tracing. You know, how do you get control of an outbreak? You get control of an outbreak where you know the … where you've identified all of the chains of transmission, and every time you identify a case it comes from a known chain of transmission. "These are the people potentially infected – I've got my eyes on all of them. Everybody who turns up infected comes from the pool of people I've already got my eyes on." And we identify quickly and we get these people out of the community as quickly as possible. That's when you have things under control.

So you need that contact tracing system. And I think it was … what was the arrangement? It had been done I think with the local Red Cross and it didn't get anywhere and it was being taken over by the Ministry Of Health but the Ministry of Health didn't have money for it, and the people that were providing technical support for it at that point was the CDC and they didn't have a budget for it. And I think MSF was basically passing money under the table to CDC to pay the contact tracers so that it would get up and running because the money that was supposed to come through WHO to the Ministry of Health was following the normal administrative pathway that everyone has to sign off on. And so the funds had been made available but hadn't actually become cash in the hands of somebody who could pay off these people to do their job …

MH: *That's extraordinary. So MSF whose expertise is in medical emergency response, you're now describing a story where you're actually having to get involved in something that's not at all in your remit right?*

AS: Well for example, we've done contact tracing before but that had been "Okay, who's going to do the" … because everyone has to say what they're going to do … and MSF … this was like, Conakry was one of these multiple places and so we were focussing on the treatment unit which is our strong point…

MH: *But your own people would do the contact tracing?*

AS: No, so for example, our people were doing the contact tracing in Guéckédou. But in Conakry, the Ministry of Health is there, they've got the people, the network of community health workers and what not, but they need to be mobilised, paid, you know, you have to just do the things that it requires to engage the human resources to do the task and this requires money and management. And the management was kind of there but the money wasn't there. So MSF basically said, "Well we've got money, we will quietly slip it to the people who have the titular administrative role here and get things going, until the money that should be doing this actually materialises."

MH: *But what I'm saying that's different is that's moving into a role of health infrastructure – you're plastering over the wound if you like, the gap …*

AS: Sure**,** we're filling the gap until the system can lurch into motion and do what it should do. And I think after I'd been there a couple of weeks that happened. The official funding stream through WHO, to the Ministry of Health took on some semblance of regularity and that we could discontinue our financing of the system.

MH: *How would you characterise the attitude of the Liberian government at this stage? Had they woken up?*

AS: In Liberia?

MH: *We're back in Liberia*.

AS: All that with the funding and stuff was in Conakry.

MH: *Oh that was Conakry right, sorry I misunderstood.*

AS: I used Liberia in July for the tyre issue.

MH: *Okay so when we were talking about this … okay I'll make that clear. To come to Liberia which is where you were talking about the logistical problems there as well. Were there other issues besides tyres on vehicles or …*

AS: Sure. All of this … it was true in all of the different aspects of outbreak control. First off it was almost entirely the Liberian Ministry of Health taking this on with very little assistance from MSF at that point. We were, again, one or two people in these meetings. You had all of these people who … their normal job was to run the Ministry of Health. And I was optimistic at that point that they had all of the pieces in place, but that they just couldn't do two things - they couldn't scale the services to meet the scale of the epidemic, and they couldn't manage the services that they had set up. So they're bright people and knew, "Okay, we need to have an alert line that people can call and tell us when somebody's sick or somebody's dead." And they did it. And the calls kept flooding in and flooding in, and at some point that system got overwhelmed. And another problem is that, sure these people can write down "Dead body in this location reported at this time" but then somebody has to go and pick it up. So the capacity of the system was under scaled for just about everything. So they did all of the right stuff that would have matched an outbreak on a scale that we'd faced in years past but … and I guess there's just a need to think …

MH: *Can we be a bit more specific because one of the key moments, as I understand it, was when the government decided to quarantine West Point So … my question is …*

AS: Why would you want to do that?

MH: *Why would you want to do that because you're just forcing people to hide cases and trying to escape and all that? But that was criticised for the reason that, people argue that, that actually exacerbated the transmission…*

AS: Sure. We said that to the President right as soon as they did it. There was a … I mean West Point is kind of a special place in Monrovia. It's a stigmatised ghetto. It has a history of unrest. And it's also a place where people have a transient lifestyle. So there are a lot of people in and out, there's a lot of commercial traffic through there. So I think the naïve assumption was, "We hear about cases that are there." Because it's an isolated community, they had developed their own response. They said, "No one's helping us, we're going to help ourselves". They set up a community containment centre there. With some help from the Ministry of Health. And there was a desire to be self-sufficient.

So it got a lot of attention, and I think when things started to go wrong, there was a need to sort of "Well we've got to clamp down. That's what you do with places where unruly sorts behave in ways that you don't like, you clamp down. And we'll seal this off and that will solve the problem." And then we said, "It only solves the problem, or helps solve the problem, if you're containing something". But if you look at where our cases in Monrovia are coming from, they're coming from all over the city. As a matter of fact, because West Point did not make use of the existing treatment units, none of the cases that were reported there came from West Point. So West Point actually was an empty spot on the map of cases because nobody's coming from West Point because they're all staying there. So you could make the argument that closing off West Point would have protected West Point from the rest of Monrovia.

MH: *Right!*

AS: So we said, “This doesn’t help contain anything. Ebola’s all over the Montserrado County and all you are doing is destroying any relationship you have with the community which is what you will need to get them to report cases and allow you to follow contacts and all of this normal stuff.”

MH: *So it destroyed trust.*

AS: Yes and we’ve learned this in every outbreak. You cannot engage in outbreak control without the willing participation … enthusiastic participation of the affected population. And anything you do that gets in the way of that causes problems. Well, we said that. This is … the reason that there is Ebola is in Monrovia was because we did not have the trust and cooperation of the population in Guinée forestière. If we’d established a working relationship with them in March and April, there would not have been any cases in Monrovia.

MH: *This reminds me of something else you said at Chatham House which maybe we could expand upon. You used this phrase that “We have a marketing problem” so just expand on that. What do you mean in your own words?*

AS: Well, so, what do you need to do in outbreak control? You have to identify cases, you have to identify contacts. You have to bring the cases into a place where you can confirm that they have the disease, and if so, care for them in a protected environment. And you have to identify the people that may have become infected, the contacts, and keep an eye on them. And it’s easy to see what’s in it for the greater good, but what’s in it for them? Well, for the people who are sick, you have to offer some sort of hope of a better outcome, and unfortunately most of the people that end up going - well, it’s no longer most, let’s say half-ish - of the people that go into the treatment unit don’t come out, don’t come out alive. And if the treatment units are seen as places where one goes to die, then “Crap, we’ll do that at home. In the comfort of my family and surrounded by people I know and love.” Which is exactly what you don’t want to happen with Ebola.

And then for the contacts, well what’s in it for them to sort of say how they’re doing every day? “Well, if I get sick they’re just going to haul me away to this place where I hear that they’re harvesting organs and drawing blood to sell to pharmaceutical companies and what not, and every time the people in the funny Land Cruisers knock on my door, my neighbours look at me funny. You know, and say “What’s wrong with you that these strange people come and ask you how you’re doing every day? Stay out of my yard! Don’t play with my children!”” So they would prefer not to have these visits. And this is why in Guinée forestière we just didn’t get a good handle on things and there was a very motivated subset of the population that threw rocks and makes it clear we were not welcome and “Go away”.

That’s our marketing problem. So if we come out of this outbreak with a therapeutic agent that’s approved and useful and improves outcomes, that will address part of our marketing problem. If we come out of it with a vaccine that offers protection, that will be our big carrot or carrots.

MH: *Well, shall we talk a little bit about drugs and vaccines? The ethics of all this. I don't know if you've got … we've been going already for 48 … are you okay to go…*

AS: A little bit…I mean my opportunity to eat lunch has gone but I'll…

Sophie: I've got some chocolate biscuits I brought from the UK. That was my lunch as well!

MH: *If it helps, I've also missed lunch!*

Sophie: What time is your next meeting Armand?

AS: I've been out of the office for a week so basically I'm playing catch up on all the others so I don't have another meeting, I just have stuff to catch up on.

MH: *Okay, I just want to explore a little bit, and you can do this any way you like I suppose, and I can prompt questions. So there are two key parts to it. One is in the period where there are limited supplies of drugs like ZMapp which there seems to be some anecdotal evidence can help in an emergency situation. I understand that in various MSF treatment centres there were debates about the ethics of whether you can give some patients ZMapp and not others. So I'd be interested if you could explain the decision you made around that. And then the second question will come where everyone gets together in Geneva to talk about the struc … how these vaccine trials are going to be run. There's a fierce debate about whether it's ethical to have a placebo arm … if you could just explain, there must have been lots of discussions within MSF?*

AS: Yes ... well ... there's a lot of stuff to discuss here …

MH: *We don't have to do it all!*

AS: Well, to start with, there are questions around what is the best way … you have to remember what we're starting with here. You have agents that show some promise in laboratory animals, and then other agents that have some theoretical benefit based on somebody's cousins' PhD thesis that showed that this has an anti-inflammatory effect that might have some relevance in Ebola. And then … so you have to decide okay, what works, and what's available. And what I want is stuff that works and is available. But that's … or rather stuff that I know works and is available. And getting to that point is a difficult thing. So unfortunately what we had in … go back several months … was we had drugs that we had reason to believe should work because of their efficacy in non-human primates, but these are in short supply, they're not licensed for use, they're experimental or investigational agents. And then we have some other things that had been licensed for other purposes that were available in larger quantities but for which we had less evidence of efficacy. There's sort of a spectrum there. And so the ones that had the greatest hope behind

them but that were in the shortest supply … so the poster child for this is ZMapp, the monoclonal antibodies

[There is an interruption as somebody enters the room 51:35]

END OF RECORDING