



INNOVATIONS FOR SUCCESSFUL SOCIETIES

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Interviewee: Raphael Frankfurter

Interviewer: Jennifer Widner & David Paterson

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WIDNER: Our guest today is Raphael Frankfurter, who worked with the Wellbody Alliance in Kono, Sierra Leone prior to the West African Ebola outbreak of 2014 as well as during the Ebola response, welcome.

Wellbody Alliance ran a clinic in Kono and assisted in the Ebola outbreak response in a number of ways. So we'd like to walk you through these stories—

FRANKFURTER: OK.

WIDNER: —paying a lot of attention to the very specific steps that Wellbody took to serve residents. I think it might be helpful to begin by talking about the healthcare in the Kono community before the outbreak. In other forums you said Sierra Leone's Free Health Care Initiative overwhelmed the system a little bit, created a sense that maybe they weren't always able to provide healthcare. You also observed that local facilities in Sierra Leone were perhaps relatively stronger or had their own organization and less communication with the center than they might have.

I wondered if you would expand on these comments and just talk about the strengths and weaknesses of the healthcare system in this area just prior to the outbreak.

FRANKFURTER: *Yeah, sure. The healthcare system in Kono was set up with one government hospital that probably could be about a hundred-bed hospital, I would say. It is considered very large for a district-level hospital. Eighty-four is the official number I believe right now, peripheral health units. Peripheral health units are structured into three different levels: community-health center, which is basically intended to be a fully-functioning community-level hospital with a couple of in-patient beds and capacity for basic C-sections basically.*

Then there are maternal and child health centers, which are one degree lower, and then maternal and child health posts, which are the simplest. It's somewhat interesting that there are relatively nice buildings built essentially where you'd want them to be throughout an incredibly remote district. So in some sense the infrastructure is there. In reality, almost every single one of them are staffed only by maternal and child health aides which they have about a two-year degree and are only supposed to be assisting nurses with deliveries, nothing else. Almost entirely stocked out of drugs all the time. No reliable communication with the government hospital. There's a radio system that doesn't work which is supposed to be used to call for ambulances.

The government hospital changes from time to time but most recently had only two doctors. They were basically only tied up in doing C-sections and hernia surgeries. I mean, there's basically no possibility of seeing a doctor if you're an average poor adult Sierra Leonean. We had the most functional health center in a village right outside of the city, which was pretty quickly growing with routine primary care for the folks on maternal/child health. Before the outbreak we were serving about 50 patients a day at most, but had our own drug problems from time to time just because of the cost of what it cost to run. We were serving—around 70% of people received free care.

We had one doctor all the time and a team of nurses. We were the only clinic in the district with ultrasound and functional labs, CD4 counter and other more advanced diagnostics. I think—we ran it as a private clinic, but because we were very open to collaboration with the government and because we became known as a reliable place where the doctors could send people for ultrasound and stuff,

we essentially—I think we were pretty well-integrated into the public healthcare system.

WIDNER: So what would happen to somebody who thought he or she had malaria?

FRANKFURTER: If they were in a rural community they would probably go to the local clinic, where potentially they would get a Rapid Malaria test. Very frequently, there would not be drugs available at the clinic, but there are all sorts of informal markets run by the nurses to get drugs out into the rural areas so if they could pay for it they would. Malaria is endemic there to a degree. It's just really not an emergency, I think, for most people in their experience. So very frequently children would come to our clinic or to the government hospital in very, very late stage, like cerebral malaria. If they went to the government hospital directly, they would have a higher chance of getting all the different steps of treatment. If they went to our clinic, they would have a very high chance of getting all the different steps of treatment, from a blood smear to malaria medications.

WIDNER: Thanks, that helps put this in context. How did the virus or the news of the virus first make itself known in Kono and how was it first felt at the clinic?

FRANKFURTER: I remember getting an e-mail from a volunteer that had just left, an emergency room doctor, with a link to a Huffington Post article that mentioned that Ebola had just been discovered in Guinea. I mean Huffington Post isn't where I typically get my public health news, but it was right over the border from Kono. Very quickly after that, pretty substantive radio reports were spreading throughout the entire country. I went on this very remote hiking trip to this village, very far away, about a week after I read the article. There were a bunch of very old men sitting around speaking only in the local dialect, the tribal language, Kono, and talking in very specific terms about how it spread, that it probably originated from bush meat, that you shouldn't touch people, that it manifests with bleeding, that it kills most people. My stance has always been that actual information about how it spread and how to contain it was known at a very wide scale within a matter of weeks.

Let's see—after that, I mean, I had obviously no experience managing a clinic where there's a threat of Ebola. We reached out to a number of other NGOs (non-governmental organizations) and just began a dialogue with other Partners In Health partner projects. There was one in Liberia that we were speaking with. Then the district under the direction of the Ministry of Health (and Sanitation) formed an Ebola response taskforce, where they invited—this was a big, frightening meeting where everyone was all tensed and psyched up, representatives from the media and the youth student league and the motorbike riders and the district medical officer, et cetera—to this big forum where, as I mentioned today, it very quickly descended into—you could just see people falling back on these tropes of public health that had been fed to them for decades. This behavior change stuff.

There were people saying we should record every Guinean living in Kono, we should record their names so that we can kick them out if it spreads to Kono. We need to educate these rural people to start taking care of themselves; they're going to bring it on us. They're going to—we need to erect checkpoints everywhere.

In my mind at the time, which sort of turned into our organizational stance, was basically, you have an incredible number of—like everyone knowing how horrific this disease is and everyone knowing that at that point almost everyone who had it would die, so our focus needs to be on how to engage people who may have

Ebola who know that it's a terminal illness. Essentially, how do you talk to someone—how do you build systems to encourage people with a terminal illness to accept that they have a terminal illness? How can we institutionalize empathy in a proactive way within the healthcare system, so that when this does come, we will be able to be quite effective in encouraging people to come to isolation centers?

WIDNER: So this was on your mind when this meeting took place?

FRANKFURTER: Yes.

WIDNER: Roughly how long after those initial weeks or months?

FRANKFURTER: *Probably two weeks. So the other thing that happened at that meeting was that we had heard for a long time—well, the story that was told was that someone in the Guinean Ministry of Health called the Freetown Ministry of Health and said that there was potentially a contact of a patient, or a corpse, brought across the border into a place called Buedu Village, or Boidu Village, or something like that. They assumed that it was in Kenema District, which is to the south of Kono, because they had no grounds for knowing. About, I think, maybe five days later, the people in Kenema realized that they didn't have anything with that name, Boidu Village, in it. So they called the Kono district medical officer who found a Buedu Village, and the story is that they sent a Landrover out there—and there are very intense pictures of them jumping out with space suits and everything—that they interviewed and did indeed find people admitted that they had buried a boy who had been bleeding out of his eyes the week before.*

I'm a bit—I think some of this might be mythology; I'm not really sure. Officially, the first case of Ebola in Sierra Leone was thought, at that time, to have come into Kono District, which definitely amped up the urgency. That was only a matter of weeks after the first reports were confirmed. Everyone was tested in the village and the village was quarantined and no one else showed symptoms. So that really triggered people to get anxious about this in Kono.

WIDNER: What steps did the Wellbody clinic begin to take?

FRANKFURTER: *We basically began to utilize—very quickly after that the Ministry of Health, with this King's College (London) partnership in Freetown, published this pretty sophisticated document with a very clear step-by-step plan of screening criteria, hotline to call, where designated Ebola ambulances would be located in the country, mandating that if you have a patient you have to keep him or her at your facility until an ambulance comes, picks up the patient and brings him or her to a hemorrhagic fever hospital in Kenema District.*

So we did our best to follow that. We bought a bunch of bleach and supplies and began to do screening at the door for patients, asking them travel history and basically a series of other questions which probably would not have caught an Ebola patient, in retrospect.

We also tried calling the hotline a couple of times and it was always disconnected. So we were trying to stick by this procedure that had been given to us, aware that—just actually, really with fingers crossed that an Ebola patient didn't come.

PATERSON: If I could jump in quickly. How did you anticipate how much of the supplies you would need, like bleach and that sort of thing, based on the people you would be seeing?

FRANKFURTER: *That's a good question. I'm not really sure, our clinic manager handled that. But our infection-control systems really were not adequate until end of August, when one of the founders of Wellbody named Dan Kelly, who is an infectious disease doctor and was briefly trained at UCSF (University of California, San Francisco) where he was a Fellow, an Infection Control Officer there on kind of what the basic standards of infection control are, came. Then we began to be very particular about re-setting up the clinic so that patient flow would happen in such a way that you really could have a clear green zone, red zone, et cetera.*

Everyone has their temperature taken before they get on the grounds of the clinic. Anyone with a temperature is then screened by a pretty knowledgeable healthcare provider. Anyone who meets case definition is sent to a holding area that we built, which is also very carefully set up so that someone can don PPE (Personal Protective Equipment), walk through it, take care of the person and then doff. We made it so that absolutely no one was allowed in the clinic who wasn't a health worker in PPE. We trained all of the health staff on how to properly don and doff.

I think what made us feel most comfortable was this very rigid screening at the clinic grounds. We had a lot of Ebola patients come through our facility and not a single health worker infection. Elsewhere in Kono, where they didn't have that same attention, maybe about fifteen nurses, I would guess, got Ebola because they didn't have that same screening infrastructure set up.

WIDNER: So when the person takes the temperature right up front, before they get on the grounds, is that person wearing protective gear?

FRANKFURTER: *Yes, there are guidelines for every person. You really have to keep in mind that when people are up and walking, they're basically not contagious unless you very intimately contact them even if they have Ebola. So there are certain questions that are asked. The patient always sits perpendicular to the person doing the screening so that if they vomit that won't get on them. The person doing the screening has a facemask and face shield and a gown on and certain materials they change after certain types of patients.*

Someone arbitrarily made the guidelines, but the guidelines were out there and we just figured out how to really strictly follow them and it worked.

WIDNER: Did you already have the personal protective gear or did you have to suddenly get hold of it?

FRANKFURTER: *After this began a number of our supply partners that collect surplus material in the US—well, there is such a sort of economy of available money that basically every health-related NGO wanted a piece of that. We were fortunate to basically receive—I don't think we paid for much PPE at all, it was all donated. The really expensive PPE is the full space suits that you use when dealing with confirmed Ebola patients. Those we did not have a good store of early on, and fortunately didn't need to use that much because we weren't doing Ebola treatment at that time.*

WIDNER: So at that time if you determined somebody had Ebola, they would go to another facility?

FRANKFURTER: *Right.*

WIDNER: But then later on you began to—

FRANKFURTER: *Yes, later we began working with Partners in Health closely, we began to actually do the Ebola treatment. The plan basically was, someone waits at our clinic, we'll call for an ambulance so either, say, bring them to the government hospital isolation center which turned into a horrible, horrific, corpse-filled mess, or going back very chronologically, there is Lassa fever which is a similar hemorrhagic fever. It's endemic in Sierra Leone, so Tulane University and the CDC (Centers for Disease Control) and Department of Defense and some other partners had built and were helping staff this hemorrhagic fever hospital in Kenema, which they thought could have been easily transformed into an Ebola center. So that was a designated receiving site. There also, things totally fell apart and the main doctor in charge died, which I'm sure you both probably know.*

The idea was basically, there is a pretty good system set up. You screen. You isolate from the facility. You call for an Ebola ambulance. They send them over there.

WIDNER: Wellbody was involved in contact tracing too, and I hadn't realized that initially. I wondered if we could talk a little bit about that, and then gradually move into some of the efforts to create a more empathetic--

FRANKFURTER: *--immune system, yeah. We had been doing community health work sort of modeled after Partners in Health since about 2009, in that we were primarily focused on HIV (human immunodeficiency virus) patients and mothers basically and children and had small groups of community health workers that in a very accompaniment-focused way would provide home-based care for these patients. So we were known in the community. These people were known parts of the Wellbody system and I think we were known, the district and national level, at doing community health work in a different way than the other NGOs, which were much more focused. You know, World Vision and IRC (International Rescue Committee) and UNICEF (United Nations Children's Fund) and the district health management team all had their own groups of community health workers and they were all volunteers. In my opinion, some were poorly supervised and focused much more on either handwashing, hygiene education stuff or actual delivery of medication in the community, community-based drug distribution.*

We were always of the mindset that 1) we want them to be full-time people, like take this job seriously, so we're going to pay them and 2) they are going to be with the patients every day, they're going to walk with them to clinic appointments, they're going to understand their social context and form a more substantive link between the facility and the community. So we really jumped at the opportunity to help the district health management team build out the community-based arm of the response, which at the time was being improvised at the local level. There was very little instruction about how to do this from the Ministry of Health. I wasn't there for a good portion of this early period; I was back in Boston.

We made our community health workers—we gave them training on Ebola and contact tracing and made them available to the district health management team, so that when the first live patient came through Kono, we really said, "Let us handle this, we will have our community health workers go out, do some contact

tracing and then sit with these people and convince them to go for proactive testing." Every contact that we found went for testing which had not really happened elsewhere in the country.

Then things—I don't know how much farther I should go, but things got very complicated as the international response ramped up and different organizations were given very strict mandates to handle different aspects of the community-based response. One way in which, when things were a total mess, the various coordinating bodies at the top divvied up the responsibilities to different pillars as a way of being able to better do command and control, is the term that they always use.

Contact tracing was separate from social mobilization, which was separate from clinical care, which was separate from all these other things. So we were told very, very specifically, "You are not allowed to do contact tracing. That is UNFPA's (United Nations Population Fund) mandate, and you can do social mobilization." As if those two things can actually be detached, and as if clinical care can actually be detached from community mobilization either.

So what we helped them do was train and set up management systems for the contact tracers, who over time—they used, I believe, more and more medical and nursing students, rather than local people, which comes with a certain set of advantages and disadvantages. So we helped them structure the program, and then, I'd say by November and December, we were no longer allowed to do contact tracing, but we worked closely with contact tracers and did this empathetic, broad, community engagement work.

WIDNER: So that's part of the social mobilization pillar.

FRANKFURTER: *Right.*

WIDNER: I want to talk a lot about that but while we're on the subject of contact tracing, if you're right in the clinic obviously it is very helpful to know what the dynamics of this are locally, how many cases you're likely to get. So you really want some of that information to come back in. Was it coming back in?

FRANKFURTER: *In terms of—*

WIDNER: The results of the contact tracing so you could make an estimate of how many people you were likely to see.

FRANKFURTER: *Things were a real mess until November I'd say. I think numbers would come back in but it was unclear what was going on. Quarantine systems didn't really get set up well until November, December I would say. There was a lot of—this whole thing has been—we were just talking about this downstairs—layered. There were so many layers of performance in the ways in which the Ministry of Health performed action, the district health management team performed actions. At every level. I feel like a lot of times I just didn't know what was real and what was not real.*

Information was not good. It was also very unclear how many positive cases there were. It was unclear where patients were. The government hospital became totally overwhelmed with Ebola patients. I have some photographs of people just walking in and out of it. I think eight nurses died in the hospital. It was completely disorganized, very difficult to plan. We were able to—and at the same time our clinic attendance rates went way down because people were justifiably

so afraid of going to any health facilities. We were seeing about ten patients a day, which was much easier to manage but also unfortunate.

WIDNER: Let's talk about the Social Mobilization Dimension and the approach you all took to this. Maybe you can talk us through not only the lens you brought to this, or the beliefs you brought to it, but also some specific examples of things that worried you that you addressed and some adaptations that you made as you went forward.

FRANKFURTER: *I very much, and I think the rest of our staff, felt like what was unfolding was very much a product of and in line with what we dealt with for a long time, which was marginalized people who have no faith in the healthcare system and have been actively excluded from it not intuitively seeking care from it when they're sick. We dealt with this with HIV patients. There is an enormous amount of good you can do in assigning a community health worker to just build a relationship and bring them to appointments and watch them take their medication. It's basic accompaniment. We anticipated that that same type of thing would happen in Sierra Leone.*

At the same time, as I said, word was spreading very fast that these isolation centers and hospitals were completely horrific. Everyone was dying inside and very frequently people would see their relatives go, had no idea where they went, if they were alive or dead, where they were buried. That continued for a very long time. So we were kind of dealing, before we got into the Ebola care, with one aspect of a totally dysfunctional system, trying to figure out what we could do at the community level. That was basically a soft, slow approach of training large numbers of community health workers to go do screening in the community with a certain template that had been given to us, house to house, and then if there is a suspect or a probable case, to spend the time to be with them and walk them through the steps that are about to happen, and call the hotline with them, and in our trainings, in our conversations, bring a culture of empathy, I guess, to the program.

At the same time we also had excellent local—excellent community health worker managers that we had trained and utilized for a long time before this, who we really knew had a great deal of critical thinking capacity and experience and we would entrust to be the ones to really stay grounded in what was happening in the stories of people. So the structure of the program, it was divided into chieftom levels. There was a district manager and then chieftain managers and then supervisors and then community health workers. And we worked to bring these different levels together to discuss problems, et cetera, but to allow for a certain level of autonomy and groundedness within the actual structure of the program, if that makes sense.

WIDNER: How would that work? Can you just give an example?

FRANKFURTER: *Ten community health workers would be supervised by one community health worker supervisor who would go around and collect the forms and talk to them every day. The community health worker supervisor would then talk to a manager who was relatively well paid and we really knew could synthesize the information. The various community health managers would come together weekly to discuss problems. There was just a lot of dialogue at every level and substantive dialogue beyond these tropes of culture and behavior change.*

It wasn't complicated. It's not technically complicated to do effective, empathetic community health work I think. It was something about the ethos of the program, if that makes sense.

WIDNER: So about how many people is this?

FRANKFURTER: We originally had fifty and then through January we scaled up to 390, and were working in five chiefdoms. Then we increasingly segmented the community health workers into those that were working in facilities, those that were doing—tagged with people who had family members in the facilities, and those who were doing screening, house-to-house sensitization was the term that they used.

WIDNER: Did great ideas bubble up from this? Can you offer some ideas that emerged from this or some things people said, that said, “Hey, the approach you’re taking is really helpful here”?

FRANKFURTER: There are a couple of stories of an Ebola suspect running away from a quarantined home and five days later them being found and then convinced to come back in a very remote village, just because we had so many community health workers, I think. In about November, December—and I don't really understand the formal politics of it but the military began playing a much greater role in the response, along with the British military. The logical interpretation is that basically no one had—we were incredibly resourced strapped and no experience dealing with an epidemic like this, so they fell on what they knew how to do, which they learned to do during the war, which is inconvenience people and treat them incredibly brusquely. So it became checkpoints everywhere, restriction in movement, some violence actually, et cetera.

A challenge that we dealt with was how do we interact—how do we convince the military that we can handle community mobilizations and engagement. There were basically two really—or three really hot spot villages in Kono during the height of the outbreak. I think there were up to 27 cases per day. The first one, the military began doing what they called a “mop-up campaign” where they came in at five in the morning and basically barged into houses and took everyone's temperature.

I wasn't there for the first one but my colleagues said it was surprisingly un-tense for some reason. It was like people were so resigned that this was going to happen and were so used to this type of treatment by the military that they didn't actually resist. But it wasn't terribly effective.

For the next two, we managed to convince the military—with a lot of support from the British soldiers who were there, who could understand why going in with the softer approach, is what they called it—to allow us to manage the mop-ups. So we went in, they insisted at five in the morning with this big convoy with a bunch of Army trucks. We split up the community health workers into teams of three with one community health worker supervisor. We transported them in from all regions of the district. They went house-to-house. In that first mop-up, we got I think about seven Ebola patients who were in their homes. Very quickly things stopped after that.

Then we had the justification for taking a greater role in community mobilization after that. So those would be a couple--

WIDNER: In other forums you talked a little bit about the way in which you managed the treatment center once you had established this treatment center, so letting

people know what the status of a relative was. Could you talk a little bit about how that evolved and specifically what you did?

FRANKFURTER: With Partners in Health we originally wanted to run a 50-bed Ebola treatment unit. For a number of complicated local political reasons, the [International Federation of Red Cross and Red Crescent Societies] was given the mandate to run this huge Ebola treatment unit. We were tasked by UNICEF with running four community care centers. They were twelve-bed units, six beds for what they called dry beds for patients that did not have fluids coming out of them and six beds wet.

We actually felt that this was an opportunity to be quite innovative and creative about thinking how these more decentralized—we could structure programs around these more decentralized community care centers in a way that would somehow be more transparent and collaborative. Communities would really capitalize on the fact that patients are being kept closer to home. In terms of these frightening optics of people being lost in this massive 50-bed units, we thought, that's a real opportunity.

We really spent a lot of time as these things were being constructed doing pretty touching dialogue with local leaders and people surrounding the community care centers in a non-performative way. It is not easy to describe how that happened but it was pretty clear the communities knew that they needed the help, and we knew that we actually needed them to feel like they knew what was happening in these centers.

We asked the chief of each community to choose twice the number of community health workers we wanted to hire, split of male and female, geographically distributed. We then interviewed them with a questionnaire that particularly tested their critical thinking/empathetic communication skills and then also had them trained and take a test and we hired half of them. We split them into three different cohorts, as I said. One were facility-based community health workers who were within the facility, talking to patients, assisting with sort of auxiliary tasks. Many of them were Ebola survivors actually, so they said, "This is what is going to happen to you, this is where you're going to go from here," et cetera.

We had a cohort of psychosocial, we called them, community health workers who did empathetic, I guess, grief counseling in a way, and also informed families what was happening to their relatives once they entered the Ebola facility. Then we had this group of what we called social mobilizers who would do house-to-house screening every day. When they found an Ebola patient or a suspect, they would both call the hotline. We also had people embedded in the dispatch system so that they could 1) advocate for an ambulance to be sent quickly, and 2) also notify community health workers when ambulances were being sent elsewhere so the community health workers could arrive prior to the ambulance.

Then when the ambulance came, they would wait with the family after the ambulance left to kind of emotionally clean up the horrible thing that just happened. That was actually—having the sort of second link into the dispatch center ended up being a very, very helpful source of information flow back and forth, in that I was there and a community health worker would say, "There has been a body on the stoop for the past 24 hours, someone needs to come pick it up." Then we would have someone able to really push, push, push, advocate for them to dispatch a burial team, et cetera. Does that make sense?

WIDNER: So there are a whole lot of questions. Just on that point, earlier you'd mentioned that the radio system hadn't been working. This is a regional network that you're talking about now or had somebody managed to get up?

FRANKFURTER: *We used cell phones.*

PATERSON: Was this a radio cell phone?

FRANKFURTER: *No, there was coverage in a good deal of Kono but if not, they would have to climb a hill or go somewhere where there was coverage.*

WIDNER: So they're communicating too with the families of those who are in the centers through cell phones?

FRANKFURTER: *Yes.*

WIDNER: In the sensitization activities and also with the social mobilization group, what kinds of things do they talk about with people? What kinds of things do people want to know, and what kinds of things did you feel they needed to know so you found a way to package this in a good way?

FRANKFURTER: *Again, it's tricky because of these layers of performance in Sierra Leone to know what actually happened when I wasn't there in the engagement. One thing was, go through every single person in the household and ask a series of questions. We have that all inputted into a database and could actually see—I mean there are problems with the data, but every week the percentages of people with certain symptoms and the way the symptoms mapped onto each other was relatively stable. So we were getting some good information there and they were being screened effectively I think.*

The conversation often—people generally knew “don't bury your dead,” “send sick people to the hospital.” The most effective conversations I saw were ones around, like, “We both know this is happening, we both know this is destroying our communities and our village. These are the sacrifices we have to make in order to get this to stop.” It was like bonds of solidarity underlying the conversation. That wasn't a—I don't feel like I or our training team had a big role in that. I think that was having local, experienced managers who had dealt with accompaniment-focused community health work before, having strong relationships with the community health workers and doing on-the-job training and coaching and discussion about what types of communication and dialogue could actually help and why people might not be—what would be a reason someone would not go to a facility at this point?

At the same time, when we were able to say, “We're running with Partners in Health this community health center, this is the quality of care that is going to happen inside,” large numbers of people started showing up to get screened. Some got treatment and some didn't but had positive experiences. I don't know anyone that's had a—I can't think of any real screw-ups with the community care center. That made it much easier. At that point, I think it really was a matter of sustaining that level of trust and ensuring that the surveillance system was there and that the different components—. I guess it became much less about community engagement and more about maintaining a certain functionality of the practicalities of the system, like the ambulances and the quality of the care and the food in the community care center and making sure that the community health workers continued to do their screening every day.

WIDNER: Those are kind of basic management challenges but under very difficult circumstances. We're working on a supply chain case right now and you can think, "Well, getting that food in there at a time when people are maybe not working as much in the fields, but presumably you have to go out to a local market to get some of this—how did that work?"

FRANKFURTER: *Obviously, Partners in Health had a great deal more operational experience on a much greater scale than we did, and so I didn't play a great role in much of that sort of logistical work.*

WIDNER: But there was sharing of information about approaches within that network.

FRANKFURTER: *About approaches. And we brought, I think, local knowledge and experience in Sierra Leone. I think people were very—the degree of poverty, I think, increased substantially as a result of the movement restrictions and shutdown of businesses. So it was not hard to hire people at all. In terms of supply chain, that was complicated by—there was increasing infrastructure from the British and the UN in terms of helicopters and warehousing systems. That was helpful. I think basically, with trusted, experienced local staff and money—we got the money and had the local staff, and had really—if there's one difference about our organization, it's that it was really locally managed without much input from me or any other American for a long time. We really had a core group of people. My approach when building out a staff in Sierra Leone was like, I have a core person that I really like the way they think and I've learned a lot from and trust.*

Then I empower them to find their—to build their own team out. Their impact—it sort of spreads like that. With that approach it was not difficult to set the systems up fast. We expanded incredibly rapidly and were able to sustain all these logistical issues.

WIDNER: You've mentioned several different groups of people that you had to interact with and gather information from, that you got help from in various ways. I wonder if you could talk about a couple of those. I'd like to actually start with the local leaders, the local government leaders but also traditional leaders because I understand that you brought traditional healers into the clinics before this.

FRANKFURTER: *Yes.*

WIDNER: Then did you build on that experience?

FRANKFURTER: *Yes.*

WIDNER: Let's just talk about the people who were there in traditional or elected or appointed positions.

FRANKFURTER: *That was something I wish we had done more of or emphasized more through the outbreak. We had had a long relationship with traditional healers in that clinic attendance rates are incredibly low in Kono and were for a long time before the outbreak. Infamously, delivery rates are very low, et cetera.*

Me as an anthropology student and then our staff, intellectually, we were interested when a patient decided to go to a traditional healer rather than our clinic, what is that traditional healer doing better than we are? Rather than just again falling into this trope of behavior change, thinking about it rationally. I think some core values emerged from the type of care that I observed the traditional healers providing and that then they would help us with in our clinic, which is the

importance of empathy in a place with this degree of illness and suffering, the importance of involving family in some sort of joint healing process, the importance of delivering news or delivering a diagnosis in a language that makes sense to patients, that they can really cling to.

So those core values were what we really tried to institutionalize in our clinic and later in our Ebola response. So that is where I'd say the relationships with the traditional healers contributed to our Ebola response, less so than actually hiring them. I don't feel—you know one of my interests as now a PhD student is to go back and actually look at what this whole thing has done to traditional healing practice, and the forms of healing that revolved around touching, and intimate touching, how that all has changed.

In terms of local leaders, there are these incredibly powerful, somewhat ambiguous characters of paramount chiefs who are always needed to be publicly very included. It's a very complicated system. They can't really do anything to undermine you, but it's better to have them involved because they have a lot of money and clout. They were also very involved with the district Ebola response centers. So they came together and then the district—the leader of the district Ebola response center was a paramount chief.

Then I think the majority of our conversations happened with local-level chiefs, particularly those in the villages and I'm sure in the community care centers who we engaged from a very early stage. Again, there was this ethos when we were building them of, "We need help, we know we need help." Our contribution to that conversation was, "We really need you to tell us what's going on, what the social dynamics are in the community, so that we can respond."

WIDNER: You created the community care center. Did that mean they thought you might be bringing in somebody from another place that might have this disease or did they see it as basically serving—

FRANKFURTER: *—themselves? I think that is what we were concerned about. There were some early flare-ups of anxiety and tension. That is why we were very proactive before we started building, saying, "This is what we're going to do. This is what's going to happen." We want—we had each community appoint a focal person, which was kind of the village bureaucrat who had probably held a bunch of different roles. That would be the one we'd call to have really quite frequent dialogue about what was going to happen.*

We also—I can say it and think about whether it should be in the transcript after—but we made probably over-extensive commitments to long-term health systems strengthening in the communities, which at the time made a huge difference. We said that we would be transitioning everything from the community care center to the village's clinic afterwards. We definitely did a good deal of that. We did not do as much as we said we would do, and hopefully in the future we will go into fully staffing and help run those as well. But I think that that contributed to a sense of—lessened some of the suspicion that a new organization that was quite clearly following the humanitarian economy and there were a bunch of those that wanted to jump in and were viewed with a great deal of suspicion. We skirted that issue.

WIDNER: That is an issue I want to get into later. It is a highly tiered system as it was everywhere, but Sierra Leone obviously pursued a slightly different policy than Liberia. So the military were involved—the British military were involved. What kind of contact did you have? You mentioned one type of contact, but if you could

talk about those two groups of people, what would your contact be on a regular basis?

FRANKFURTER: *The military and the—*

WIDNER: And the British military.

FRANKFURTER: *It would be daily. Every afternoon there was a district Ebola response center meeting. There was one in particular British guy who—there would always be a team of, in our case, Welsh soldiers who seemed incredibly bored because it wasn't quite clear what they were doing. Then one DFID (Department for International Development) ex-soldier who was now—I don't know what they were, some sort of contractor. There was just this absolutely fantastic guy who knew how to take this mess of all these different parts that weren't functioning and order things, have a vision for how all these different parts could be ordered, how to separate dispatch from ambulance control, from clinical care, so that even structurally in the room information would flow from one to the next, and over time, in a humble but persistent way, made that happen.*

So these district Ebola response center meetings were excellent by, I'd say, about February. They would be an hour long. Someone would stand up and say, "We had this number of cases, this number of alerts, this is what happened." Then someone would stand up and tell a story of a challenge that they had.

The police were responsible for securing quarantined homes with the military, and the military was also responsible for security during larger-scale exercises, whether these mop-up campaigns or other Ebola parades or whatever. In general, the Sierra Leonean military was quite disorganized and, as I said, really fell back on these modes of operating that I think probably emerged during the war, of just incredible briskness and this performance of control, and were not very good.

The British military—again, I don't think we had much sense of what was their mandate. They helped a lot with logistics in terms of getting stuff from Freetown to Kono on helicopters, with helping with supply chain. Actually, we had an Ebola lab brought in in a trailer that they helped. They accompanied it all the way in the truck. But I didn't have—I'm sure that the soldiers actually had a great deal of some sort of role but they didn't interact much with me.

WIDNER: But if you needed some supplies you could say to them, "Hey, we're really short on this," and could they help out?

FRANKFURTER: *More often we could say, "We have this satellite phone in Freetown that we want to get out here, could you handle that?"*

WIDNER: The transport. You mentioned—so there are homes that are quarantined?

FRANKFURTER: *Yeah.*

WIDNER: There is a separate issue of how you relate to those as opposed to people in the emergency centers. How did that work? Did Wellbody play a role in that?

FRANKFURTER: *Yeah, and I think a big part of it was the food and water supply was just horrible for them for a long time. So when people would run away from them or try to avoid being quarantined, we sort of tried to—we stayed very grounded in the practical realities of what quarantined people faced. That involved doing a lot*

of advocacy for them to receive food. Various partners were tasked, like Welthungerhilfe, some big NGO was tasked with supplying the quarantined homes. We received some home-based hygiene supplies that we would drop off at every quarantined home. They would be visited every day by one of our community health workers in addition to district health management team people for screening. But I think a lot of what we did was listen to their problems and then our local managers were pretty effective.

I was very impressed that they were turned on, plugged into their phones at all times, problem solving for these individual households. It was very unclear whether there was much that was systematic about who was quarantined and who was not, and how much people actually were regulated within the quarantined homes. There was supposed to be a police officer there all the time. Often it didn't seem like that was the case. They were often—I once came to one village where they just had quarantine tape around the entire village so it was a wide net they were casting. The idea that everyone in that village stayed in there for 21 days doesn't really seem possible to me, but it was a very complicated situation and there were a lot of practical problems with the system.

WIDNER: Did you have to get chlorine into these houses as well as part of the protection supplies?

FRANKFURTER: *We did. I mean basically, we provided this home-based—what's it called again?—interim, some kind of home-based care kit that had chlorine if someone started to show symptoms. They didn't have to use—they weren't really trained on any sort of infection control and it was us doing it with support from IOM (International Organization for Migration), like we handled the home-based care kits. There was not any sort of formal—*

WIDNER: Did they provide the kits themselves, the IOM?

FRANKFURTER: *No, USAID (United States Agency for International Development) or OFDA (Office of U.S. Foreign Disaster Assistance) gave it to IOM, who then contracted us to deliver them through our community health workers.*

WIDNER: Interesting. So many questions. I don't know how much comparison you were able to make when you were on the ground. Obviously Liberia handled things differently, the military role wasn't there. Did you travel at all to Liberia? Were you able to see differences?

FRANKFURTER: *I didn't. The very frequent refrain from anthropologists is that somehow communities learn to take care of themselves in Liberia. I've heard that about people in Sierra Leone too, and I really don't believe that. I mean, maybe it's true. I think there is a real risk to romanticizing what communities could do without beds available for Ebola patients to go to. But I don't know in terms of at a policy level much about it.*

WIDNER: Thinking broadly about your organization and other organizations, I wondered if you would talk about say, three examples of a negative impact of a clinic practice or design on the behavior or attitudes or whatever, something that worsened the situation, and then three initiatives you thought had a very positive impact.

FRANKFURTER: *That worsened the situation? Of our clinic?*

WIDNER: Well, you could use your clinic as a reference, or if you think more broadly, maybe you want to draw examples from others as well.

FRANKFURTER: It's hard to think specifically. Quite concretely, the state that the government hospital in Kono was allowed to get into before there was a substantive, a substantial cleanout, that was—the legacy of that is going to continue for a long time in terms of reducing any sort of trust in the healthcare system.

I think, as I mentioned, the history of the Free Health Care act and the amount of health education that accompanied it by NGOs and the Ministry of Health, encouraging people to come to facilities, which continued—encouraging people to come to facilities that aren't able to take care of them, whether it's about maternal health or about Ebola, which there was an awful lot of, only undermines the situation and digs a hole that requires—digs a deeper hole that you have to get out of.

Then I think lastly, this issue of burials, a burial system that attended to these different needs that family members had, like wanting confirmation in a photographic form that the person had died, where they were going to be buried, some sort of participation in the ritual. That was effaced as less important than the actual mechanism and apparatus for turning through corpses in a safe way for so long that I think that's why there are still unsafe burials happening right now. If that had been dealt with early on, that could have really slowed things down. Are those specific enough?

WIDNER: Yes.

FRANKFURTER: I think that really, what turned things around in my opinion in Sierra Leone was that the number of beds reached a point where people were no longer being turned away at the door and sent home. I was there in Freetown in October, and it was like nothing—I had never felt like a place was so apocalyptic in that this endless stream of ambulances and taxis coming to the hospital, being turned away, bringing people back to their homes where they were spreading it, to the point where people were being dumped on the street. Once that happened, at the same time that there was more infrastructure, in rather public ways, people began to talk about different managers in different Ebola treatment units, and Partners in Health played a big role in this. They challenged each other to innovate and improve the quality of clinical care, in a way that I think actually filtered down to communities in a pretty impressive way.

It became known that this military-run Ebola treatment unit in this place called Hastings had brought down their fatality rate to 25% because its really charismatic directors were doing this new protocol. The EMERGENCY, the Italian NGO, built this one where they had dialysis so people knew that there you go and you have this and Partners in Health talked a lot about—they brought human rights to the conversation and that just increased the sense that this is no longer a terminal disease and that people are actually going to receive some form of care.

I also think that over the course—there is still a lot of really bad community health work happening. This education-focused stuff—I mean, there are only so many times—it's a year and a half in and every household has probably been visited 50 times by someone telling them to not wash their dead and they're still doing it. In a way, I think that there has been a recognition of the importance of taking community health work seriously beyond just that type of education.

As I mentioned earlier today, starting to deploy the term "loved ones" rather than just "family members" is an indication that, I think people, much of the healthcare

system, maybe realized that unless you in some way attend to patients as humans, they're not going to come to the healthcare system. So we've been a big advocate from the start. We were able to start scaling up in Port Loko District as well. It sounds like there are other NGOs beginning to learn from that as well.

WIDNER: Interesting.

PATERSON: I like that perspective. I don't really have questions that were not otherwise addressed.

WIDNER: Thanks very, very much. This has been really helpful. We may also come back to you with some more questions as time goes on.