

This is an interview with Dr. Christopher D'Amanda about his experiences in the West African Smallpox Eradication Project. The interview is being conducted at the Centers for Disease Control and Prevention in Atlanta, Georgia, on July 13, 2006. This is a part of the activities for the 40th reunion of the West Africa Smallpox Eradication Project. The interviewer is Victoria Harden.

Harden: Dr. D'Amanda, you were born on July 14, Bastille Day, in 1934. I would like you to describe briefly your childhood, pre-college education, influential family and friends, if you would be so kind.

D'Amanda: May I begin by saying I prefer, if it's all right with the project, to just call me Chris, or Christopher.

Harden: That is fine.

D'Amanda: Yes, July 14 was the day that my mother described as her day of liberation, so it wasn't only the Bastille that was taken care of. And that was in Rochester, New York. I was in school there, at a co-ed country day school, until the 7th grade, when my parents decided I should go to Exeter. So I went to Phillips Exeter Academy for 4 years. And then, in those years it was very easy—in fact, the Exeter senior classes were told this—that if you wanted to go to any college in the country, even if you were not in the top 75%, you could go to any college without applying to more than one. So Exeter seemed to be a precursor, in my mind, to Harvard. Then I went to Harvard for 4 years, where I majored in English.

Harden: I'm fascinated by how somebody majoring in English literature then decided to go

to medical school, so can you slow down and tell me here?

D'Amanda: Well, the sequence really began in my father's family, where we would repair every Sunday for supper or luncheon cooked by his mother, and her 5 children, one of whom was my father. Her other son was a doctor. And her daughters had married doctors. So I grew up in a family of physicians, even though my father was a lawyer. And my older brother had already claimed, as the older (as I've learned later in my role as a family therapist), he'd already claimed law as his future. So I declared for medicine, following in some ways Papa's injunction that D'Amandas never worked for anybody. They were their own bosses. Little did I know that that was a little bit illusory. We all have bosses, one way or another, even in medicine. But anyway, we all have bosses.

Harden: Indeed.

D'Amanda: So as far as I was concerned, I was destined to be a physician. My choosing English, and all the humanities I could at Harvard, was in full recognition that once I got to medical school I'd have no time—or at least, I didn't know that I would have time—to read history, enjoy music.

I started playing the piano when I was at Harvard. I took 6 courses every semester, even though we were only required to take 4, just because I wanted to get my fill of everything I could. And then, after that, after Harvard, I went to medical school at the State University of New York in Buffalo.

Harden: And would you comment on any influential teachers at Harvard or in medical school that helped direct you towards thoughts of public health?

D'Amanda: Well, we'll get to why I got here, but it was totally serendipitous, if you will, or fortuitous. Both of them were very positive moments, but not by design. When I first arrived at the medical school, my dean told me that I needed to work very differently at the University of Buffalo School of Medicine than I had at Harvard, in the sense that, it was very clear, looking at my transcript, that I could get As when I wanted to, but if I wasn't interested in a class, I would get a C. And he said, "Here, you have to do all the work we tell you to do because we want everybody to excel, and we want everybody to pass the medical boards." So a large part of their teaching was designed toward *doing*. The testing, anyway, was designed to replicate a large part of the medical boards which consisted of multiple-choice questions, which I've never enjoyed, and still don't. I prefer essays, and thinking a little bit, rather than having a thought done for me. In any event, that was the medical school experience. There were some wonderful professors there, particularly one in pathology, Kornel Terplan.

Back at Harvard. Oh, I guess the tutor at Elliott House, where I lived, was a seminal person in my experience there, in retrospect, as he told me that Harvard was a molecular society. Now, I didn't quite know what that meant, but then he explained. Everybody at Harvard is, at least in those days and probably still (I just came from my 50th reunion there, a couple of months ago) is so busy doing their own world. They're like atoms, spinning in their own spaces, and they bump up against each other from time to time. But don't expect enduring friendships or things to grow out of the Harvard experience, was his way of defining it. And that

wasn't particularly true for me because I did find friends there, but actually, in retrospect, the friends whom I still have are the friends that I made at Exeter, 3 or 4 years before I got to Harvard.

The experience for me at Harvard was probably, at least in my mind, better encapsulated by the excitement, the intellectual stimulation, and the fact that I was taking a graduate course in my first year because I could do it. I mean, I was allowed to do it, put it that way. It was just endlessly enthralling. But it was also sufficiently intellectual that by the time I got to my senior year I knew damn well I had to leave because it just didn't seem like a real world to me. I had an instinct that there was something else besides Harvard out there, but there was no way to enjoy it at Harvard. I have always been the second child, the explorer, the traveler (which is also part of family therapy: tradition of birth order). Anyway, I left very gladly. I left Cambridge and I left Boston, and went back to upstate New York.

Harden: When you finished medical school, in 1966, obviously the Vietnam War was going on, and the military always needs physicians. But you joined the Public Health Service and came to CDC. Now, you said it was a serendipitous experience. You want to walk me through this?

D'Amanda: I stayed in Buffalo to do my internship in medicine, and then chose to do a full medical residency with 2 years, and then stayed on a third year as chief resident. And during those years, I had a hand in teaching and being aware of research activities, journal articles, and so on. I envisaged myself becoming a full-time academic researcher in some ivory tower someplace.

However, the draft still loomed. So I had a good friend who knew about the Centers for Disease Control, and I was interested in statistics as a way of sort of separating the wheat from the chaff in so much of the stuff that was being published in journals. Too much of it was anecdotal and not enough well-designed so that you could produce some kind of conclusion that might bear benefit in the practice of medicine. In any event, I came down to CDC to see if I could enroll in the EIS [Epidemic Intelligence Service] program.

But when I got here, I was older than most of the people who were being recruited, having finished not only my internship, but my residency. A lot of the other doctors, my peers in the program, had just finished an internship. Secondly, I was bilingual in French and... from earlier travels I'd done in Europe, and training I'd had as a schoolboy in Rochester. So somehow that word got to D.A. [Donald A. Henderson], and D.A. came over and basically hijacked me out of EIS, and put me in the smallpox program.

And I thought, what a wonderful opportunity. Here it is, I'm going to get to Africa, where I've never been, much as I had traveled before in other parts of the world. I was going to get to really perfect my French because it was clearly destined that I was going to a francophone country. And thirdly, I was not serving in the military, except in this wonderful sort of almost Gilbert and Sullivan way. My title was Lieutenant Commander, JG. But clearly I never had a uniform, never learned to salute. But because the Public Health Service had started with the Navy, taking care of the sailors who were getting sick on their early transatlantic

voyages, the Public Health has always used naval military designations. So that was the serendipity. That was chance.

Harden: So this is 1966, and you were taken out of the full EIS program, but they were training...

D'Amanda: Oh, yeah, we still did the biostatistics course, we did all the other things. But then, one of the things that amazed me, we had a special program that went on for some time, learning how to take apart a Dodge truck and put it together again. Not part of the usual epidemiologic training, I'm sure. And I learned to do that. I'm not a mechanical genius, by any means, but in one of the letters I wrote at the time, I was describing that we all had to learn how to take the Ped-O-Jet apart and put that together. That was a piece of cake compared to a large motor vehicle. But it was stuff that I learned to do, and in fact was able to train people to do before my operations officer got to Ouagadougou in Africa. And it certainly helped me in when we had *une panne*, which means to have an accident, a breakdown.

Harden: But you did have an operations officer supporting you? You didn't have to do both roles by yourself?

D'Amanda: No. That was the design. It's one of the designs I'd hoped would follow me when I came back to work in America 4 years later: the balance between an administrative person and a physician, a medical person. But it doesn't work outside of this environment.

Harden: Why is that?

D'Amanda: I think it's because the administrators are too hungry. They don't want to share the

glory. Put it this way: When I went to work in Philadelphia, after I'd come back here, I had talked to the director of the program that I was being hired into as the Chief Medical Officer for Drug and Alcohol Services in Philadelphia. And I described this. He had been a Peace Corps director. And he assured me that, yes, we would be a team, and so on and so forth. Well, that wasn't the way it worked out. He clearly wanted to be the major person, and it was a major administrative job, just like smallpox was. But there were clearly a lot of clinical, medical issues to be addressed, in terms of providing service. Philadelphia at that time was the 4th largest city in the country. We had 14 different treatment programs; we had 10 methadone programs. I mean, addiction is a medical disability or a medical problem.

In any event, I made do by inventing things for myself. That's how I got to do a lot research for the people in Washington. But this model that exists here is very special. And I don't know whether you saw it at the NIH [National Institutes of Health], but it's a wonderful give-and-take because clearly the administrator has his or her areas of expertise and implementation and experience, just as a good doctor does.

Harden: No, I did not see it at NIH, and that's why I have found it so interesting, the 2 working together . . .

D'Amanda: None of us can know as much as we need to know. No single person.

Harden: Yes.

D'Amanda: But when you get into a complex project or major issues of administrative health

programs... One of the things I did in Philadelphia was to start an Employee Assistance Program for the City of Philadelphia employees. I figured if we were taking care of the citizens of the city, we ought to try and figure out how to take care of our own because the statistics were clearly the same: 10%–15% of the people in any work force are involved, either actively or just recovering from, some form of addictive disorder. So anyway, I started this program.

I had the city administrator working with me, as well as the union person. Because city employees, of course, were all union, and it was very clear from the model that I'd learned employee assistance from, that if you didn't involve the union, they would never cooperate with administration, and vice versa. So I got to be the middle person as the doctor, saying, "Look. This man has just driven a truck of hundreds of thousands of dollars worth of equipment, nearly off a bridge"—which was one of the headlines that occurred at one point when I was doing this—because he was drunk. But he was also a member of the union. So if the administration had tried to fire him, the union would have put up a battle. And if the union tried to brush it under the carpet, the city would have said, this doesn't work.

So anyway, employee assistance was a beautiful way to give everybody a piece of the pie. And my job was, first of all, to train administrators to not be diagnosticians, just to pay attention to the job that needed to be done, and if somebody wasn't doing their job, they just had to report that, period. And then to get the union people to trust me enough to say that, even though I belong to

administration, I'm not selling you out. I'm here to keep your voting member alive and well. So it worked, very well. The model is a tremendous model. It came out of the Cornell School of Labor and Management. A guy named Harrison Trice.

Harden: Let's transport that back to Niger, now. Tell me how you conceptualized what you had to do and worked with your operations officer to do it.

D'Amanda: Niger was a special project that we all shared, doing an assessment of neighboring countries. My countries were Ivory Coast and Upper Volta (now Burkina Faso). My home was in Ouagadougou, which is the capital of Burkina Faso.

Harden: So perhaps we should start with Upper Volta and Ivory Coast? Okay. Sorry.

D'Amanda: No problem. Well, one of the things I learned very quickly was, because I'm blue-eyed and white-skinned but happened to be bilingual, I was frequently taken to be a French person. And I learned very quickly that all the French carried a very significant and generally pejorative aura because they were the colonial powers. And they were still interfering with the local African people too much with their autonomy or their hoped for or desired autonomy in whatever francophone countries that I went to. So I learned very quickly to identify myself as an American, and of course that was very popular because Kennedy was President, and everybody loved Kennedy and loved the Americans.

The second thing I learned very quickly was I had access with my OOs [operations officers]—a brilliant guy named Bill White [William J. White, Jr.], in Upper Volta, and then Tom Leonard [Thomas A. Leonard], and then Bob Hogan [Robert C. Hogan]. They were just special, wonderful human beings, as well as

highly skilled technical people.

I had to learn to be patient. Because even if I declared myself an American, it didn't mean that that would work all the time, and it didn't mean that it worked right away. So for the first year in Ouagadougou, I can remember still having to learn to wait for 3 hours to get to see the Minister of Health, whom I needed to see to discuss the program. And so I used to bring books and I used to read, and I used to get restless. But I also reminded myself that I was a guest; this was *their* country. They could treat me any way they wished. But after about a year of what I now think of as eating humble pie, so to speak, then I got to be able to get in ahead of people.

I used to say to the Ivorians, as well as to the Voltans, "You know, I'm being paid by America, but I'm not working for America. I'm working for your country." And that was the way we felt. That's the way I felt. And it was important as I see the practice of medicine now, and certainly family therapy, you don't tell people what to do. You ask the questions, you learn the ways, and then help them make decisions. So it was not in any way dictatorial, "we know better than you."

The difficult part was, in some ways, working with the French, especially the man I worked with in Ouagadougou. There was a fair amount of disregard between the French and the Americans anyway, at least the French didn't like the Americans very much in those days. I'm not sure they're that much more comfortable with us now. But in any event, Colonel Sansarricq's first words to me

were, “You know, D’Amanda, I don’t know why you Americans think you can get rid of smallpox in 5 years. You know, we French have been here for 30 years, and this disease is not going to go away just because you came here.”

But that was another lesson I learned. We can segue up to Niger at this point because I was involved with the actual campaign in Ivory Coast and Upper Volta, in terms of the up-front sort of dealing with the higher-ups in the health administration. I’m an internist, and trained, as we all were, to identify smallpox, to determine whether an illness really was smallpox or not. The longer we were there, smallpox was getting less and less common. I ended up seeing about a hundred people with smallpox in Upper Volta. But near the end of my stay, most of the time, people who did not know the distinguishing characteristics thought that a lot of the old, but most of the young, people who had these particular kinds of rashes had smallpox, when in fact they had chickenpox.

Harden: People have talked to me a little bit about differential diagnosis, but nobody has actually gone into detail. Can you?

D’Amanda: Sure. First of all, smallpox is what’s called an exanthem. It affects the skin. Virus affects basically lining, or squamous, cells. Squamous cells are on our skin, but they also line all our insides. They line our gut, they get modified in various specific ways. But, for instance, one of the common problems with measles patients is that they get otitis media; they lose their hearing. One of the worst things that happens to children who have measles and are nursing is that the whole lining of their mouths and their intestinal tract get these lesions on them, so they

can't swallow; they can't even nurse. They get chronic diarrhea. That's how so many of them die. Or they get bronchitis. Again, these same cells are being infected with the same virus. So the distinguishing characteristic to do the differential diagnosis is really on the skin.

And also time course of the illness. Each disease has what I call choreography, which is one of the words I use to define the withdrawal symptoms of various drugs that people take in the street. The time course, the process of smallpox, is 3 weeks long. And the lesions are in specific locations on the body.

Harden: As opposed to chicken pox.

D'Amanda: Chickenpox is sort of a flood of these same-looking lesions. On a black-skinned person, they're called taches blanches, white spots. Because as they erupt, they look like little blisters or pustules; but when they become scars, the black melanin hasn't gotten to that space; in fact, it's new tissue and it may never be replaced. In fact, that's how we do the assessment: we look for the white spots, the taches blanches. But the white spots have to be in different locations, and the patients have to have been sick for a different period of time. So that was a differential diagnosis.

Harden: Someone spoke about a different smell for smallpox. Does this mean anything to you?

D'Amanda: Not one I remember. It may have been, but I used those measures that I just described for you. I did not use my nose.

Harden: All right. You were going to talk a little more now about the Niger assessment.

Would you?

D'Amanda: Okay. Our primary job was to make sure that we vaccinated at least 94% of the people with smallpox vaccine. Smallpox, like all infectious diseases, has something called herd immunity, meaning that you don't have to really cover every individual with whatever vaccine or inoculation to get immunity for the population. The only reason smallpox was eradicable was because the virus only lived in human cells. So it was known from work done here, before we even got out to West Africa, that if we got 90% of the population immunized, the virus couldn't survive. So our job was to first of all organize people in the various *campements de marché* in whatever way we would bring them together to get them all inoculated with the Ped-O-Jet. And then going away and get the country done, within the 3-year period.

We thought we could do the same thing with measles but that was an error. We thought measles infected children who were 5 or 6, when they first went to school. We did not understand that the epidemiology is a crowding phenomenon. And the crowding phenomenon in West Africa is going to *marché*. (market). Infants are carried on their mother's back. So as soon as they are born, they're introduced to the markets of whatever region they're in. And they get exposed. So in fact, the measles virus was transmitted very, very rapidly, and there was no way we could cycle in the 3-year time to get all the new children being born.

So measles became actually a sticking point because in some of the

African countries, especially places like Ivory Coast, smallpox had virtually vanished before we even arrived. There were a few cases, but they were imported cases, usually from Upper Volta because so many of the men from Upper Volta had to come south to find work. There was very little employment in countries like Niger or Upper Volta, and they lived by subsistence farming. So they'd go south to get money. But they'd also bring disease with them.

Harden: So some of the countries were not supportive, then [of the smallpox effort]?

D'Amanda: Well, that had to do a large part with how they were beholden to the French, their *agent technique* who were French. Some of them were upset that we weren't eradicating measles. We'd set out to do that. That was part of our title: Smallpox/Measles Eradication. We did it with smallpox, but we in no way did it with measles, and so they were disappointed. There were a few slings and arrows thrown at us, but we had to do a mea culpa, or effectively so, that we didn't understand that the crowding phenomenon [that we assumed] had occurred in this country at the age of 5 or 6 and which would have given our cycle of 3 years ample time to vaccinate everybody, simply didn't work in the developing world. And so we did the best we could.

Harden: In the forward to your journal in Niger, you stated that after being in Africa for a while, "The stranger begins to long for the leisure that cannot be had here, and he knows, even as he does so, that he has become a devotee of the special non-leisure that is Africa." Would you comment on living in Africa?

D'Amanda: Well, it has to begin with us. It has to begin with the enthusiasm and the

excitement we felt. We've talked about it a couple of times already here, in this reunion. It was really a new adventure for all of us. It was a new program for the country. It had extraordinary benefit in the potential to think that we could be helping so many people in such a distant place live, survive. So we were all fired up. And some of us enjoyed the clique of the American, sort of ambassadorial, residence and everybody of that sort. But most of us had to be out in the field, and we got to know the countries we were in well.

I certainly got to know Upper Volta as well as anybody who was living in the capital because I was traveling all over the place. But in that process, you begin to realize that there's very little rest for these people. Subsistence farming is a cruel fate, and nature is there at every beck and call, either with too much water or not enough, either with seeds that can germinate or can't. There were very few animals in my area, so that there was no loss from predation. But it was just nature. And so people are always trying to take care of themselves, to get enough food just to survive. And then that's part of the traveling: people from Niger would travel through Upper Volta to go down to Ivory Coast, just to look for work.

And I became aware of this energy that was often physical, was certainly mental. And it's not to say that there weren't warm, wonderful family units. And the camp, the compounds that we visited and the ones that I got to know in Ouagadougou and would be invited into for evening tea, were special, warm, loving places. But the real world was much harsher.

That's what I was trying to get at: the fact that, in any developed country and certainly in America, we have the time to put punctuation marks. The time to take a break. Read a book. Watch TV. Listen to a concert. But that can't happen there.

Harden: The program obviously had a major impact on you and the rest of your life. Would you comment on this and on the idealism of the '60s?

D'Amanda: Let me deal with the first question. I never thought of myself as belonging. In fact, one of my regrets was that I was so busy in medical school that I didn't get into the idealism of the '60s. I mean, much of the Vietnam War went by me like that because I was too busy focusing.

Harden: But on the other hand, you could have just come back and gone into private practice and made lots of money, and ignored the rest of the world. This is the kind of thing I'm thinking.

D'Amanda: Oh, okay.

Harden: It sounds to me, from what I've read, that you were very much committed to these people, and that they grew on you a lot.

D'Amanda: Yes, they did. And the exposure to them. The simplicity and the dignity and the integrity. And I've learned the same with the poor people I work with now, from the inner city of Philadelphia, many of whom have not had much education. Literacy was, I thought, the way to get ahead in life. I had no idea, until I went to Africa that literacy had nothing to do with wisdom. We met lots of very wise men and women there who couldn't read, couldn't write. But they were wise in life.

Did I come out of Harvard, thinking that was possible? Not at all. In any event, it was possible, and my goal of becoming an academic doctor in some ivory tower was totally blown.

One of the things that Sencer [David J. Sencer] asked us to do [to prepare for this interview] addresses that particular question. This was my number-one response: altered career plan and life: From academic medicine in an ivory tower, to addiction medicine in the trenches with citizens victimized by poverty, racism, and bigotry. Because that's what we've got here. We don't have subsistence farming, but we have people who are diminished in their value, and certainly in their ability to lead quality lives by a lot of "isms." And so, that's what, in the largest sense, those 3 years meant for me. Working with poor people, and, certainly in the northeast part of America, working with blacks, was not anything I had any experience with. We had had a black cook in the house I grew up in, and that was about my extent.

I had read about the Black Panthers, and I had read about the freedom movements of various groups, and the "Black is beautiful" concept that was being promoted in the '60s. I knew that Stokely Carmichael had taken refuge in, or been offered asylum (I'm not sure what the proper phrase should be) in Guinea, and was a guest of the president, Sékou Touré. So I had friends in the airlines business, a wonderful... Vert Comboree, an absolutely statuesque, brilliant, and very, very intelligent and wonderful woman. And I asked her if she knew anybody who knew Stokely. Oh, she said, "I do. Because I'm a friend of the president's."

Vert was a friend of virtually every man of power, as far as I was concerned. And whether she was courtesan or not didn't make any difference. She was just a very special human being. So anyway, she set up an interview.

So I flew to Conakry and took a cab to the president's compound, a section of which he'd given over to Stokely. And I had a wonderful 3-hour talk with him. Strange, Caucasian-American, walking into this compound. . . I don't know whether he knew I was coming or not. I have no idea. In any event, one of the things he said, which was very, very special to me, was "Don't try and do things for black people in America." In other words, "Don't do a Teddy Roosevelt." He did use that phrase. Don't carry any big sticks on their behalf. He said (again, I'm having to paraphrase my own recollection, but basically, he said), "If you can open a door, that's fine. They may choose to go through it or not. But that's their business, not your business."

Harden: Bill Cosby would tell them to walk through it.

D'Amanda: Well, Bill Cosby's a newer generation.

Harden: Right.

D'Amanda: And one that has some legitimacy, I guess a lot, with the people who want to believe that they would or should. But a lot of people don't buy that.

Harden: There must be a thousand stories that you have from your experiences over there. Is there anything that just impresses you that you'd like to get on the record here?

D'Amanda: One of my difficulties, I guess, in the life I've led, is that I am enough in the moment so that even though I've got a reasonable mind, I tend to forget moments.

The memories that I could share at this moment are the friendships and the excitement of being on the move. That's why I took that little caper in Nigeria, even though I was supposed to only be working in Niger. And I loved the excitement. What stories, what stories...

Part of being bilingual in Abidjan, which was a much more sophisticated city than Ouagadougou, meant that I got to know people at the university. One friend of mine and I used to give great parties. Dominique would know various restaurants that would be available, and we would know lots of people at the various embassies, and so we had these wonderful, sort of all-night dancing, drinking, fun parties, in Abidjan.

On the work side, I would say that the most important piece for me was something I've already alluded to, which was, you don't walk with a big stick. You listen, and you are patient. You observe, and you figure out where the hook is, to use a family therapy term—how to get in. Because you've got to work on somebody else's territory, as well as your own, to influence change. And change is why I went into family therapy.

I'll share a story to give you a perspective of part of what made Africa so useful for me, and part of why it was such a powerful experience. My first day in family therapy, there were 12 of us in the class. The supervisor was going around, asking each one of us why we had come. When she got to me, I said, without even thinking, it was totally reflexive, "I want to be free." And I'd be damned if I knew what I meant.

Well, part of Africa was being free from here, my particular family of origin, the issues that my parents had, that my brother and I sort of united to be safe and separate from. There was a lot coming in, in family dynamics, that in quite significant ways, affected who I was, and I knew that. Just like I had the instinct that Harvard wasn't the real world. I didn't know what the hell it was, but I knew that I wasn't participating, and that's one of the things that Africa let me do. It's probably why I was so active.

I had another fleeting thought. . . There are wonderful raconteurs that I have listened to. One of my favorite delights listening to Bob Hogan, who unfortunately isn't here. He could tell stories beautifully. Part of the issue of being over there, especially in Abidjan, was to go to the Fourth of July ambassadorial celebrations. You just talked to people you don't know and wandered around talking. And at one of them, I got into conversation with this fellow, who wanted to know how many people I knew in the government. He dropped some names. Did I know them? Yes, I knew them because I'd had to work with them and discuss things. A long story short, he began to ask me whether I would be willing to record my conversations with these people. I said, "What would I do that for?" "Oh," he said, "Well, there are people in America who would be interested." Well, it didn't take me long to figure out that he was a CIA [Central Intelligence Agency] operative, and he was trying to recruit me. And I just sort of stood back after a couple of minutes of this conversation. He even got to the point of saying, "Well, we know what you're doing here in Abidjan, and we could make it

uncomfortable for you.” I said, “What the hell do you mean? I don’t play cops and robbers.”

And I was so fascinated by the way the system apparently works. I have heard this subsequently. There are people who collect data., conversations. And they reel them off into these recorders, and then somebody, somewhere, tries to fit them all together. I suppose that’s a large part of what our “war on terrorism” was all about. Anyway, that was a story that made me understand, again, so powerfully, as so many other things in Africa did, that I just don’t fit into any of those kinds of skullduggery cowboy stories. Cops and robbers is not my style.

Harden: Before we stop, is there anything else about the program that you would like to talk about?

D’Amanda: I guess I’d like to hope is that there are other programs like it in the future—where there’s a mission that is humanitarian, requires scientific and administrative know-how, and can move ahead and get things accomplished. I’ve not been in the public health world, other than looking at addiction sometimes as a public health process and as a behavioral disorder. But I know there’s a lot to do. And this country does have inordinate resources. I think we lack the will, too often. But this organization, 40 years ago, didn’t. And I think that that’s a tradition that could be remembered with benefit to everyone, including CDC.

Harden: Thank you so much.