

In 2014, I was an EIS officer three months in when I deployed to southeastern Liberia to its tip called Harper. It was a three-day drive during the peak of the West Africa Ebola epidemic. I was heading out to join the local county health team as they anticipated a cluster of Ebola in their county. And in this picture, I'm showing people how to mix up the right dilutions of two different concentrations of bleach for skin and surface disinfection.

You don't want to screw that up. And I know many of you audience were there and are remembering this unprecedented epidemic. But this talk is not about Ebola. It's about trust. My experience during the Ebola epidemic shaped the way I think about trust in public health, whose trust we need, where that trust lies. And importantly, how do we navigate our new reality, where the trust in the work that we do and the ideas that we stand for feels like it's crumbling around us?

While some hospitals during the Ebola epidemic were overwhelmed with patients waiting for care, others stood eerily empty, like this one in Harper, where I was deployed either because PPE and supplies had run out or health care workers hadn't been paid, and so weren't showing up. Really emblematic of a system in complete collapse. A couple weeks into my deployment, the manager of a rubber plantation company town said, I'd like to meet with the American from CDC.

So, I went out there.

And when I got to the rubber plantation, I was stunned to visit the company hospital, which you're seeing on the screen. And it was this calm oasis of order amidst the chaotic public health response to the Ebola. It was clean. It was well equipped. And importantly, it was stocked with publicly funded PPE and supplies that the public health response desperately needed.

The contrast between this hospital and either the overwhelmed one or the completely empty one was breathtaking.

Back in the office, the manager of the plantation was direct with me. He said, okay, how can I keep Ebola out of my hospital? If one of our employees get sick, I want them transported elsewhere immediately. And for anyone in the audience who was there in West Africa during this time, you're thinking what I was, which was there is nowhere for them to go.

There was nowhere for them to go at that time. But what struck me wasn't just his question. It was that he'd apparently bypassed his local county health authority to bring the question to me. He bypassed his traditional fear. He rerouted his trust from his typical sources to the American, from CDC. The way I answered his question might get my epidemiologist card pulled but hear me out for a minute.

I approached his question through the lens of harm reduction, which is nuts. Right? The whole point of an Ebola response is to get to zero. This isn't the road to five. I get it. My instinct to push him to use his hospital for the public health response. But I recognized that his trust in me created this small opportunity to engage.

That might vanish if I pushed him too hard for the moral approach. So, I met him where he was. I said, okay, let's use your hospital for screening, triage, and temporary isolation, and then we'll figure out a transfer protocol for anyone who becomes a probable case. Today, 11 years later. I don't know if that was the right call, but it did create a path forward that used his hospital for Ebola on his terms and might still have saved lives.

Thinking back on those 11 years, I've come to think of our work in public health as something like a transportation system. And for decades, the map was pretty simple. When people needed public health, they sent their GPS to one of a few trusted destinations: CDC, state health departments, local health departments. There just aren't that many places where you can find people who do what we do with all of our training or our experience.

And let's be honest, our hearts in this traditional geography of trust, the highways were wide. They were direct. And for the most part, they were passable. Often underfunded or outdated even in the very best of times. And then came 2020 and COVID. Suddenly our highways experienced the public health equivalent of a massive traffic jam, or a typical day in Atlanta.

And people down in the traffic jam often couldn't reach us, even when they really wanted to, or they really needed to. And we learned that when the highway becomes this gridlocked, people don't just wait. They reset their G.P.S. to new, trusted destinations in order to find the answers they need. A couple of years later, in 2022, I left CDC to become one of those new trusted destinations.

When I helped to found a public health-oriented tech startup company called the Public Health Company, or PHC at the time, I left CDC to test a hypothesis. Could we build new routes to new trusted destinations that could augment the work of public health and relieve the burden when the highways were so jammed up? Here's a story from PHC.

One day we received a call from the HR director of a giant corporate bank who had a pretty classic COVID dilemma. She said, we need our stock traders back out on the floor. They can't work remotely. They can't do their jobs with masks, and they sure can't shout at each other over zoom. And to me, this dilemma required the same harm reduction approach that I used in Liberia.

This bank needed a way to translate sound public health recommendations into their specific context, without dismissing the very practical concern that stock traders just can't do their jobs while following all of the recommended guidance at the time. So, we developed a custom risk mitigation plan for this bank. That involved testing, vaccination and enhanced ventilation. And we got those traders back out on the floor.

In our traffic metaphor, the bank sought out an entirely new destination that had never existed on the public health map before. They took a massive risk heading out on a gnarly side road that hadn't even been paved yet. It was a new landmark in the geography of trust, not replacing traditional health authorities but amplifying their impact. And PHC was just one place I learned, amidst an expanding geography of trusted spaces where people can find public health information, technical support and guidance.

These other trusted spaces include other public health-oriented companies like Bluedot, Ginkgo Biloba, analytics. They include individual experts like Doctor Caitlin Jetelina, Your Local Epidemiologist; Eric Topol, who writes ground truths and collectively leads audiences out far exceeding the populations of many health jurisdictions. Trusted spaces also include long form podcasts and discussion forums like Eric, like Joe Rogan and Lex Friedman, who reach millions of people every day with health information despite no formal training.

Famously, veteran epidemiologist Michael Osterholm went on Joe Rogan in 2020, early in the pandemic and reached so many people who would never have thought to open up a public health department website. Trusted spaces also include online communities like subreddits, discord servers, telegram channels where health decisions are increasingly crowdsourced. They're made based on stories that share transformations and anecdotes and compelling emotional appeals, and not always a well-designed meta-analysis.

And these aren't isolated little spaces where people are starting to look for information. A study out of the London School of Economics showed that historically, epidemics are followed by this long term and characteristic loss of trust in leaders, especially among young people. And while businesses have historically enjoyed greater trust than government entities, that gap has widened since 2021, according to the annual Edelman Trust Barometer report.

This fundamentally reshapes our reality. All of this while most of us remain stationed along our big traditional highways. Much of that traffic has rerouted to destinations that were never built.

The landscape has been totally transformed, and so too then has our mission as epidemiologists and laboratory scientists dedicated to public health practice. We face a critical question. If we're no longer the primary destination, how do we make sure that the evidence-based methods and the population health perspectives that we know, work and save lives can reach all the places where trust now exists?

Well, since Alexander Langmuir in the early days of the Epidemic Intelligence Service, our fundamental principle has been to go where the diseases are traveling. Long distances and adapting to tough conditions to reach populations in need. Today, I challenge us to apply that same grit and determination to go where the trust lies. Just as we have never hesitated to deploy to remote villages or overcrowded hospitals, we now need to embed our expertise in other remote locations like corporate settings.

Substack, the manosphere, and TikToks. How do we do that? Well, I've got some ideas. I know you do too, and I want to hear them. But for now, I'll end by saying that when we go where the trust lies, we aren't abandoning or replacing our storied public health institutions. We are extending their reach. As the geography of trust continues to evolve.

So, let's meet people where they are on those less traveled side roads so that everyone makes it to their destination. Safer. Healthier. 24/7. Thank you.