Center for Strategic and International Studies

TRANSCRIPT

Event

“Book Event: ‘Deployed’ by Kevin De Cock”

DATE

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FEATURING

Kevin M. De Cock

Former Director, CDC Kenya; Founding Director, CDC Center for Global Health; and Former Director, WHO Department of HIV/AIDS

CSIS EXPERTS

J. Stephen Morrison

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J. Stephen Morrison: Welcome to this one hour discussion of Kevin De Cock's new book "Deployed," just published by Johns Hopkins University Press. I'm J. Stephen Morrison, senior vice president here at the Center for Strategic and International Studies, CSIS, in Washington, D.C., where I direct our work in global health and health security. This event is part of the CSIS Bipartisan Alliance for Global Health Security, co-chaired by former Senator Richard Burr and former CDC Director Julie Gerberding.

I'll introduce Kevin and offer some framing remarks about the book momentarily, but first some special thanks to those who made this event possible. My colleague Sophia Hirshfield masterfully directs our series of book events here. In recent months we've hosted Seth Berkley, Tom Frieden, Mike Osterholm, and Mark Olshaker, among others. We seem to be at a moment here. These are all people who have led their generation in global health. They've all been in the fight about HIV, pandemic flu, Ebola, COVID. And all came to write their books to share their personal insights, and to varying degrees, tell their own inside story. And the same is true here with Kevin.

I want to offer special thanks to Caitlin Noe from our staff; and to our production team, Qi and Arturo, for pulling this all together. East City Books has kindly brought Sarah, their staff person, here to have books for the signing and the reception that follows. Johns Hopkins University Press, Marlee Brooks and Robin Coleman kindly helped us make that all possible. A bit about the flow. Kevin and I will have a conversation for about 40 minutes, and then we'll introduce some questions that we'll be gathering from the audience.

A few words about Kevin De Cock and "Deployed." First, I really enjoyed this book, Kevin. It was a very, very interesting read. Second, you have a lot of friends, I must say. Many of the glitterati of global health are here in this room today. And they're drawn from different domains – from diplomacy, from research, science, from public health. And they've come here to celebrate. And it's very clear in our communications with the many people that we have encouraged to come and enlisted to come the huge respect and admiration and trust that you command across these different fields.

And it's one very powerful indicator about the nature of your life, which is the value placed on building and sustaining relationships, and through those relationships achieving impact. And in this account there's repeated homage to mentors and teachers. It's a very important thing that comes across multiple times in which you pay – you pay the gratitude to those who were your mentors and teachers, and translated it into a very similar role that you played in teaching and mentoring.

You've led a very remarkable life. That remarkable life comes across very vividly. You're an amalgam of sorts. You're a Belgian, but then you're kind of British, you know? You're a Kenyan. You're an American. You're a Jesuit. It's an interesting identity that you bring to this book. And it comes across.

Kevin was born in Belgium, sent to private schools in the U.K. by an American mother, medical school at Bristol, a tropical medicine diploma at Liverpool, which was a little offbeat choice, I think, at that time, as you conveyed.

Three years at Kenyatta National Hospital at a really poignant moment in the history of that hospital and what was happening within Kenya. You returned to the U.K., complete your dissertation in about a year at Bristol, and then off to USC for training, and then from there a fateful move from L.A. to Atlanta to CDC, which began multiple stints at CDC with side stints to WHO and elsewhere.

You refer to yourself in the book as itinerant, at times rootless and restless. The flip side of all of that is very – what comes across as somebody who's very adaptive, infinitely curious, and open to chance and serendipity, and I'm sure you'll say more about that.

You crossed many frontiers – medical science and practice, public health, the research world, and the world of emergencies and crises. You had deep faith in these fields and in the – in the role of leadership and the role of personal responsibility. That theme comes across very – and you found yourself at the center of history.

You remind us that we had successive crises packed tightly against one another – HIV, pandemic flu, multiple Ebola, COVID. This was an era that you're documenting, over 25 years of, really, a golden era, and you were in it, part of it, shaping it, and now you've had the time at the closing of this book to sort of reflect rapidly on the rupture that happened in 2025.

You add a few segments at the end. So it's a very impressive – it's a very impressive piece of work. Let me turn to you now.

Tell us why you felt compelled to write this book. This is a major undertaking. I think any of us who read this book would be intimidated at the thought that we were going to sit down and come up with something as detailed and powerful as this.

So tell us, what motivated you? Who's your intended audience? And for those of us here, what are the top-line messages you want us to carry away?

Kevin M. De Cock: Well, thank you, Steve. Those are very generous comments and I would add, man, you actually – you actually read this book. (Laughter.) So thank you.

I read it – I wrote it because I thought there were stories to tell with lessons from them relevant to global health. To explain global health, it's a diffuse subject. It's kind of difficult to define and it always evolves.

And, you know, global health as we know it today kind of emerged from tropical medicine for the old colonial era – you know, for the empires, international health around the time of independence of many of these countries, and then today's global health, which, of course, has evolved so much and continues to do so.

I wrote it for – to try and convey those thoughts and some of those lessons, I suppose, the most – I mean, to anybody who's interested or, you know, who thinks about these things, and there is a broader audience.

So it's – so it's written in a way, I hope, that is understandable by a broader non-medical audience. But I hope particularly younger people would read it, younger professional colleagues, in – you know, in the breadth of health work.

And you write it for yourself, actually.

Dr. Morrison: Yes.

Dr. De Cock: You know, I wrote it, you know, late in my career, closing my career, really, to sort of look back and say, well, you know, what did it all mean? Did it make sense? Was it worth it?

I think it was worth it. You know, it meant a lot to me. But to try and put it together and say, well, that's what I did and –

Dr. Morrison: What did you learn about yourself in writing this book?

Dr. De Cock: You know, I think – and one of the quotes I have in the book, and I think – I think it was Dickens but it might have been Voltaire, and they both may have said it, that vices are but virtues carried to excess, and I've often thought about the need in our profession for humility, but to get – to get the right balance, you know, excess humility is lack of self-confidence and paralysis, and too much pride is arrogance.

So I do think I've sort of struggled or worked to get balance in all of this. You obviously, you know – and if you're a thinking person, you, obviously, question yourself about the appropriateness of the leadership you've given. Have you done it – what could you do better? So I came to – I think to a balance in all of those sorts of analyses. As you get older – and we all face this – there comes a time when you're not on the frontline anymore and you're going to have to close it down and thinking about not so much what will I do, but who will I be, you know, based on past analysis.

I did spend – what I have often thought is, you know, I had some very senior positions and could have stayed in them. So I do think, sort of, about the counterfactual, what would have happened if you didn't do this or didn't do that. Of course, you know, we make personal decisions based not only on professional considerations but life responsibilities and so on. So it's – you know, it's – I have sort of oscillated somewhat between high-visibility leadership type of positions back to field work again. And I must say I always felt perhaps more comfortable in the field simply because, ultimately, I'm just a doctor. (Laughs.)

Dr. Morrison: Well, you know, in your case I think humility is very present in the right way, not in – not in a – not in the negative way but in a very right way. And you make case that field experience is sort of a sine qua non. I mean, you see yourself as embodying what was learned and gained by having such a depth of field experience. Say a bit more about that, because that message comes through loud and clear.

Dr. De Cock: Well, the book, for those who haven't seen it, it's divided into three parts. It's clinician, epidemiologist, and bureaucrat. (Laughter.) And I use the term "bureaucrat" not in a pejorative sense, because I think we need good and better health bureaucrats.

But you know, in clinical medicine, what is – which was very important to me. I could have stayed in academic clinical medicine, which is what I thought was going – I was going to do, because I was rather surprised in a way to find myself at CDC. Once I was there, I sort of thought, gee, I've left clinical medicine behind. (Laughs.) Maybe I should have realized that. (Laughs.)

But it was so evident to me in clinical medicine how important experience is. I mean, there is something unfortunate about, you know, the big professor who actually is not a competent clinician. You don't want to be like that. There's a saying I've used in the book that – and it's relevant to medicine and I think it's relevant to public health, and maybe to life – that you see only what you look for and you recognize only what you know. And in the same way in public health, the field experience –

field experience, I think it's the currency of global health. And it's what gives, I think, credibility and legitimacy to sit at a table and argue for what you want to argue for. And I think that's a – you know, I think that's very important for younger colleagues who aspire to make a career in this. And the health bureaucrats, it's – and I had positions that would be considered bureaucratic, but that field experience really gave insight to me about, you know, what was important, so.

Dr. Morrison: You made a point that – I think you were quoting Bill Foege, the renowned former head of CDC who passed just recently, actually. You quote Bill Foege saying, "Don't make a plan; make a philosophy." What does that mean?

Dr. M. De Cock: Yes. Bill Foege, obviously, he was a giant, literally because he was six-foot-seven tall, but figuratively just a major, major figure in public and global health. Yes, I learnt this from him, and he used to – he used to say this particularly in schools of public health, that life is too – life's unpredictable, as, I think, events in the last few years have shown. Medicine changes. Science advances. It lurches. It's not linear. But what you learn today in 10 years, in five years may be, you know, still relevant but maybe very different. I mean, look how – as we went through COVID, for example.

So he said, really, what younger people – even older ones – what we need to be thinking about is not so much a plan, because it's unpredictable, but a life philosophy; you know, what man or woman do you want to be? What's that kind of north star that will guide you? And you know, if – in difficult times, if you have the right training and you've worked that out for yourself, then, you know, no matter how bad things get, you know, what's in your head nobody can take away from you. And it really – I think it's been very useful. But it leads to having to respect serendipity and taking risks. But knowing when to jump. And you can't jump in two leaps. You have to commit. You know, Yogi Berra famously said, "When you come to a fork in the road, take it." But you have to recognize the fork. And, you know, I advise people, don't do crazy, but you have to realize that you have to take risks. You have to commit, and go –

Dr. Morrison: So it's a matter of judgment.

Dr. De Cock: It's judgment.

Dr. Morrison: And that's something difficult to teach.

Dr. De Cock: I that's another point I make. Yes, you know, you can teach – you can teach biostatistics and study design and all of that, but what the results

actually mean and how you use them really does require judgment. And judgment, you can't really teach. And that's true in clinical medicine and it's true in public health.

Dr. Morrison: You say at one point towards the end of the book – you say, people are people and organizations are organizations. Explain what that means.

Dr. De Cock: I've been struck. You know, I've worked in many different places. I've worked in places with big names and places with no names. And it just struck me that people are the same. And to say that, you know, biology is stronger than culture. People in different countries are essentially the same. The motivations, the good and the bad. You know, some people work hard. Some don't. Some are smart. Some are not. Some advance. Some don't. And it's not just based on competence all the time.

And, actually, I often thought of – I often thought of something that Eleanor Roosevelt said. And she was actually referring to human rights. You know, she was so instrumental in that field. And she asked, where do human rights begin? And I thought, well, this applies to health as well, or public health. They begin in small places. And she said, places so small that you can't find them on any map of the world. And public health, like politics, the famous saying, it's – a lot of it is local. And it just struck me that you see some really good work in remote places that nobody will ever hear about, and bad. But the same is true in big organizations.

And the way organizations work, big and small, the need for – you know, for vision, definition of where they want to go, and all the rest of it, the organizational structure, I found it the same everywhere I went. With the same strengths and mistakes across different organizations. And finally, the recognition that, you know, talent is pretty equally distributed around the world, but opportunity is not.

Dr. Morrison: Yes. Thank you. Let's talk about CDC. It played a central role in your life, across a whole span of different moments, and different challenges, and different roles that you were playing, in Kenya, in Atlanta, elsewhere. You voice a lot of admiration of the institution, a lot of excitement about different moments when it was in an expansionary and very exciting period of growth. And you saw it in action across all of these areas. You saw how harrowing and difficult it was in the Kivus with Ebola. You saw how demanding, as HIV – as the PEPFAR program was massively expanded, how difficult it was to stay ahead of the demands, the bureaucratic and administrative demands.

You worried a lot about corruption and insecurity and what that would mean. You had also premonitions, I noticed, in this book. I mean, you

talked about your concerns about the vulnerabilities and weaknesses within CDC, and that those might, if not resolved, come back to haunt the institution. And I think you were very prescient in making that. Talk a bit about CDC and your reflections over time, because you've played – it played such a huge role in your life, and, inversely, you in its development.

Dr. De Cock: Well, I joined CDC in 1986 as an officer in the Epidemic Intelligence Service, which is this two-year training program, the so-called disease detectives training program. And it was a very supportive program. And you were with likeminded people. It was really – you know, it was exciting. It was very – the group ethos was very supportive. And we benefited from – most of us, anyway – from good supervision. And you just got – you made contacts with people across disciplines. Entering the EIS program was entering an extraordinary network. I mean, you could meet ex-EIS officers the other side of the world, and you could just immediately have something in common. It was very privileged that way. And you were – you know, you were thrown into all kinds of opportunities.

You know, my first foray was into the Democratic Republic of Congo. And I say in the book, it was an investigation which was more like something out of a Graham Greene novel, but anyway. But then a very – after that, a very large epidemic of yellow fever with – working with the Tom Monath, you know, one of my mentors. He was the world expert. I mean, how often – how often does that kind of opportunity come up? And then I, you know, had the opportunity to – working in the HIV field – the opportunity to go to West Africa to set up a research site for CDC. There were just opportunities which, you know, going back to the earlier discussion, you have to seize them. You have to jump. You have to make judgments.

And as you get more senior – I really did feel it was a sort of spiritual home. It was a technical home, even if I missed clinical medicine. But as you get more senior you realize that – you know, as I say in the book – you realize the limitations. That there's more – there's a lot that happens behind the scenes that early on you're protected against, but as you get older and more senior you have to deal with. You know, there's a lot that never gets into the materials and methods of a scientific paper. Sometimes it's even more important than the results.

And then, you know, PEPFAR changed – in some ways, CDC became more like USAID, because we had to start dealing with purchasing stuff, and commodities. And it was much more program – big program implementation, rather than just very focused investigations. And CDC

was – it's actually a domestic agency. It didn't have the permissions and the legal –

Dr. Morrison: Authorities.

Dr. De Cock: Yeah, the authorities, that's the word – for some of the international work we had to do. So there was sort of misalignment in some ways that caused trouble across the board.

And then, of course, heroic work by the agency. And credit to Tom Frieden for throwing the agency into the crisis of Ebola, 2014 to 2016. I mean, there's, there's two chapters in the book on Ebola. Those were extraordinary experiences. But, again, you start seeing the difficulties of being in the field but reporting to Atlanta, which sort of tended to work with a 3,000-mile screwdriver. And they, of course, had to report up the chain to – even directly to the White House. And you're in the field trying to say, look, I don't think anybody's paying attention to what I'm saying and my comments are actually important.

And then there's the history of COVID, of course, which is maybe you want to discuss that a bit more separately. COVID, of course, was difficult for CDC. Now, I was in Kenya. I wrote a chapter on COVID, really, as a CDC insider, but outside the United States sort of looking back into what was happening at CDC, or what did happen. And comparing it with what happened in Kenya. And it was a difficult experience for CDC. And things – you know, after COVID already there was difficult stuff to deal with and changes that had happened, and then 2025. So it's been a difficult evolution, I think.

Dr. Morrison: Well, you do describe the stumbles, right, the testing debacle, and the communications problems, and the erosion of trust, and things galloped forward, and their weakness and vulnerability. Now, of course, it's subject to something not unlike the DOGE assault upon AID. I mean, people aren't calling for the eradication of CDC, but there are measures being taken which are having deep demolition impacts on that institution. And plenty of reason for concern about how long and how do you go about reconstructing. What's the path forward, in your view, from this current moment?

Dr. De Cock: No, I think there's major concern. And you know, my feeling is one of dismay and, I mean, more than dismay, because I think what has happened is so very negative because it is simply not helping the health of the United States. And I think so much has been given away, frankly, for very – to me, very unclear purpose.

Withdrawing from WHO I think is a mistake. If one of the reasons is that adversaries have too much influence, well, if we withdraw and leave a vacuum, what do you expect to happen, you know? And somebody will fill that vacuum and be not necessarily someone we want.

The agency itself I think everyone knows, you know, it lost a quarter to a third of the staff, a lot of funding. Senior people have gone. And it is not the agency it was. If we had Ebola today like in West Africa, I don't think CDC could respond that way. Maybe the political decision would not be taken anyway.

But so it's – I think we're in a very – frankly, a dire situation, and what to do? Well, I think we are in a difficult situation, and I think to get out of it I think we have to get through it. You know, I respect the people who are there and I – the professional and technical people who are there, and you know, I give them all my encouragement.

Dr. Morrison: But I do think we need to begin planning now –

Dr. De Cock: I agree entirely. I agree entirely.

Dr. Morrison: – for a reconstitution.

Dr. De Cock: I agree entirely.

Dr. Morrison: It may be a quite different-looking institution.

Dr. De Cock: Well, I was – I was going to say, I've sort of – I don't discuss this in the book because, you know, the book was written by then, but I've been thinking over the past year two themes from literature have come to mind, actually. One is, as far as global health is concerned, you know, the myth of Sisyphus, the Greek mythology. Sisyphus, who is pushing his boulder up a hill, gets to the top and it rolls back down to the bottom, and that's his lot. And I sort of think, gee, in global health are we Sisyphus, who have sort of the boulder's rolling down? Well, I think we're in a better place than that, but we really have to think about and countries have to think about how do they stop that rock falling back.

The comment about CDC, there's an Italian novel called "The Leopard" written by Di Lampedusa. It's about – it was published in the early 1950s. There's a very – it's about Italy in the 19th century, the second half of the 19th century, about Sicily. And there's a – it's about a noble family, and there's a line in there saying, if we want things – if we want things to stay the same, things will have to change. And I think that applies to CDC. We have to start planning now or those who are involved

need to start planning now for what comes afterwards, but it will not be the same and it shouldn't be the same.

Dr. Morrison: And we'll face a huge political challenge, which is the erosion of trust and the political polarization that exists today. I mean, there was a bipartisan consensus around CDC. That's broken right now.

Dr. De Cock: Yes.

Dr. Morrison: And so it's going to take a special skill politically to move toward some reconstitution in some new form.

Dr. De Cock: And that bipartisan trust which has been lost is matched by international trust which has been lost. I mean, one of the – I was truly saddened, I think it was back in 2020, when I was – I was in Kenya. I was CDC lead for the – for the COVID response. I was listening to National Public Radio and heard a(n) interview with a public health official in the Middle East. I think it was in Lebanon. And she was saying she used to look to CDC as, you know, the guidance, the reference to go to, and she said, well, I'm not sure I can do that now. And I thought, gosh, that's a real loss. So getting that trust back is absolutely critical, not easy, and it's going to require – it's certainly going to require good communications, but above all, you know, clear thinking and the right –

Dr. Morrison: And a turn back towards just simple pragmatism. I mean, Americans need CDC for the protection of themselves. Governors need CDC.

Dr. De Cock: Yes.

Dr. Morrison: Mayors need CDC.

Dr. De Cock: Yes.

Dr. Morrison: We've lost that. We just need to bring it back to around, do we really want to see those protections of our citizens eroded to this level? And on the international side, yes, we've done away with AID; we have not done away with all the country offices of CDC, nor some of the regional offices. They're poorly staffed and poorly funded and poorly supported at the moment, but we're going to need them, pragmatically, just like we need The Global Fund to move forward our new global health strategy.

I want to talk a little bit about politics. In some portions of the book, you talk about how, like, in – while in Kenya, working with then Ambassador Johnnie Carson, how that partnership worked so effectively at having diplomatic leadership and political skill teamed up with you.

And in that sense, things went very, very well, and there are other instances that you cite. But you seem a little ambivalent and uneasy about politics. At the end of the book, you say this is not a political book. And I sort of chuckled at the time – this book is nothing but politics. (Laughter.)

So, you know, say a bit about this. Public health oftentimes is uncomfortable about politics, when in reality they need political skill. They need to have gravitas and sway, and they need to build relationships outside of themselves, like you did with Ambassador Carson.

Dr. De Cock: Yes, and in the third part of the book, there's a chapter called "Health Diplomacy" and there's a chapter called "Health Bureaucracy," and I think it discusses some of this.

Public health is political and global. You know, it's political because it deals with people's daily lives – you know, the food we eat, the water we drink, the air we breathe, the jobs we do, the roads we drive, the drugs we take, illicit and illicit medicines, the housing we live in.

And it's political because it concerns allocation of resources. And in the same way that public health, what we do to assure that people can be healthy, global health is what we do for the world to be healthy, so it is political and I accept that.

What I – what I meant was that I was giving my personal views on more technical stuff, but – I used to say, and actually I want to mention AIDS a little bit – I used to say that my experience at WHO taught me that WHO and CDC were mirror images of each other.

Now, what I meant by that was, you know, back-to-front images, because CDC is a technical organization that when I worked there had political implications, whereas WHO is a political organization whose work has technical implications.

In recent time, because of the events we've seen, I think that's become a bit blurred. But, you know, clearly, it all is very political in that sense. But as a technical person, I always tried to sort of navigate my way through that.

I do want to – there was a very good YouTube video made by Bill Roper – Dr. Bill Roper, who's a former CDC director, late '90s – late '80s, early '90s. And he, you know, clearly articulates that public health and public health science need to work with the political process, and the political process needs to work with public health.

You know, the politicians, I saw this in the United Kingdom, for example, who hide behind saying, well, we're just following the science during COVID, for example. You know, that's –

Dr. Morrison: It didn't do so well.

Dr. De Cock: Yeah, it didn't do so well, and it's not completely what happened, because it's not the public health official who signs the declaration that, you know, there's this mandate or folks have to do this or that. But they really have to work together, and during COVID we lost that and we saw, you know, the fragmentation that we saw.

What I wanted to mention about AIDS, because some of these things we've talked about and some of the history of CDC's AIDS response and the politics of that, is covered in another book written with Jim Curran and Harold Jaffe, "Dispatches from the AIDS Pandemic."

They always tell you when you're promoting a book don't talk about any other book. But I thought I should just get that – get that in there.

Dr. Morrison: Thank you. We're going to turn to some great questions that have come in from your many friends who are here. They still write tough questions, Kevin.

Dr. De Cock: I was going to say, I'll let you know whether they're friends or not. (Laughter.)

Dr. Morrison: You wrote the epilogue in April of 2025. So that was the thick – you know, the early phase of the demolition that happened in Trump II. What are your reflections 11 months later? What has been lost? What will recovery look like?

This is – this question is pointing to the larger question around how do we think about the post-golden era era?

Dr. De Cock: Well, I think – so, yeah. I mean, concerning global health, for example, in September we saw the America First Global Health Strategy published. And there has been an attempt, and, Steve, you've written – you know, you've written about this yourself in that article in the BMJ – about some of the adaptations that have happened, sort of course correction to a very limited degree.

But I think there's genuine problems with what's happening. The strategy of – you know, of leaving multilateralism and going to bilateral country relationships, I don't think that is an effective global health

strategy. I think it doesn't provide the United States with what we need in terms – or guarantees it, in terms of information from across all the countries of the world that, you know, only can – WHO can sort of coordinate. It doesn't guarantee access to specimens if we need them. And it's unclear how these will play out. And I commend you for that BMJ article.

The Make America Health – Make America Healthy Again, we can't argue with some of the aspirations of dealing with noncommunicable diseases. I mean, America is a pretty unhealthy country, especially in relation to the amount of money we spend on health. But is there – again, going back to the risk factors we've alluded to, to some extent, you know, sugar, salt, tobacco, alcohol, bad air, is there really the political will to deal with these – you know, these risk factors? That really are about social determinants of health – bad housing, for example. It's not the climate – the political climate that takes these risk factors head-on.

So I am curious to see how we're going to get out of this, or how it will evolve. And democracy is a difficult system, because, you know, when President Biden came in and said, we're back, some – you know, I heard some people in Europe say, well, yes, but for how long? So, you know, but I think – I think we have to – change will have to come. Things will have to change. And we'll see what democracy delivers in terms of elections and so on.

Dr. Morrison: Now, one of our audience members wrote: It's a very tough time to be a mentor in global health right now. And the question is, how can we continue to harness the energy of young people, who still hope for a better world starting with better global health? We have a number of students here today who are visiting Washington, who have agreed to come over and join. You'll have a chance to talk to them afterwards.

Dr. De Cock: Yeah. Yeah, well, I think we – it is a difficult time. And, you know, you can't pretend it's not. On the other hand, you know, global health will still be there. I mean, it's not going away. The health challenges we face are not going away. My comments earlier about getting the right training, finding that North Star, that's absolutely critical. Get the right training. And always make sure you can get a job in your own country. That is really important. But there are still opportunities. They're very different from the ones I had. You know, there's faith-based work, there's the nongovernmental organizations, they're all out there – MSF, Catholic Relief, et cetera, et cetera. They're still there. And some things are more difficult. You know, if you want to go into an academic career right now looking for grants is challenging. But there are still opportunities, and one has to try and find them. But get the basics right.

Dr. Morrison: Are you called upon for advice on how to stay hopeful, stay optimistic, stay –

Dr. De Cock: Occasionally, yeah. I mean, I've been, you know, giving a number of talks about the book in recent time, and in different places. And, yes, those are the sorts of questions that come up. Yeah.

Dr. Morrison: Thank you.

Dr. De Cock: Yeah.

Dr. Morrison: Given the demise of the U.S.-WHO relationship, what direction or reform is needed in Geneva, do you think? What's it going to take to turn opinion here? What kind of reform agenda should we be thinking about for WHO?

Dr. De Cock: I think what's really needed is, you know, radical stuff, because what's – what I've been struck by, ever since including when I worked at WHO, is there's always call for reform, without clear definition of what that means. It's a very – it's an essential organization and a flawed organization. And part of its problem is its constitution, because it's actually not really an organization. It's more like a confederation, or a –

Dr. Morrison: Yes.

Dr. De Cock: You know, because you've got Geneva, you've got headquarters, regional – six regional offices, country offices. And the director-general doesn't have line authority over all of these. So it's a difficult organization to run. So I think there's some – I think there's some radical thinking needed. It needs to be much more lean, much more focused. It needs to define clearly what it can and cannot do. Some of its – you know, it has six core functions: knowledge and knowledge gaps, leadership in global health, health policy, health guidelines, technical assistance, monitoring, trends. It can't do all of those. And other people have stepped into the breach, like monitoring trends. There's probably better people. You've got – you know, you've got Seattle Institute for Health Metrics and Evaluation churning out stuff, and other academic groups.

So a real focus and definition of what it can do. In any organization, the first thing I think they need to ask themselves is, you know, who's my closest competitor? The closest competitor is the one who's most like you. And your advantage derives from the distance between you and your closest competitor. So what it is only WHO can do? Their unique strength is their convening authority. And they need to capitalize on

that. But they need to focus and not try and do everything, which I think has been the case somewhat.

Dr. Morrison: We do have one opportunity emerging. We were talking earlier today with some visiting students. You know, WHO's leadership changes on July 1st of 2027. The campaign season will open at the World Health Assembly as it passes resolutions setting out the schedule. And people are already putting feelers out, some very, very promising candidates out there. Many of them will bring to the table support from their government and other governments, governments that matter to Washington. So there is a – there is a moment approaching where there could be some reconsideration. The COVID-19 origin quagmire, you know, has stuck, but it can't stick interminably, right?

Dr. De Cock: If I could just comment on that. I don't think we're ever going to know the right answer, but both theories are plausible. You know, it could have been a natural transfer. It could have been a laboratory incident. Both are plausible. So actually, what we need to do is be prepared for both, rather than get too fixated on trying to pin blame, you know, on China. And I think in retrospect, perhaps we were a little bit naive. You know, if China was not open about SARS, or about Tiananmen Square, or about – you know, there's no freedom of the press in Hong Kong, why would we expect anything different when COVID came along?

And in fact, what – I mentioned this in the book – you know, in retrospect, but be careful about the retrospective scope. I don't want to be, you know, the professor of advanced hindsight. In January of 2020, China, in the middle of the month, built a 1,000-bed hospital in less than two weeks – an extraordinary feat of logistics. That's not preparedness. That's to respond to an ongoing crisis. And we should have paid attention to that, and some other – some other observations at the time. But, anyway, it is behind us now and we need to move on.

Dr. Morrison: And we'll see what happens. I mean, President Trump is going to be in China soon for a summit visit with President Xi. Health is on the table, we hope. President Xi will be back here for the G-20. And in between there's a(n) APEC meeting, and the health working group, and the U.S. has just joined in that health working group.

Dr. De Cock: It's going to be interesting to see how we manage, the U.S. manages, you know, not being in WHO, yet sort of wanting to be at the table and influencing things. And it can be slightly awkward. (Laughs.) But we'll see what happens.

Dr. Morrison: Well, I think we have to see that contradiction and that tension is an opportunity to get people to rethink about this, and try to think why –

on what national security grounds do we reengage? I mean, the administration was making very, very strong demands for internal reforms. Many of the reforms that have been instituted at WHO were due to the pressures that came from the U.S. withdrawal. And in some – and this administration can take a certain amount of credit for what's happened. The reforms don't go far enough, obviously, but I think that there is a scenario in which you could imagine some rethinking going on.

All right, this is one of our questions: Global health is one of the few foreign aid issues to a certain extent that can garner bipartisan support in the United States. And bipartisanship has always been foundational here in the United States for support of PEPFAR, of The Global Fund, of global health security, of Gavi, of the Global Polio Eradication Initiative, the sort of big superstructure and long-term U.S. leadership forums. How do you see the role of global health practitioners becoming advocates or storytellers to maintain political support for their work? I mean, that's what you are doing here today.

Dr. De Cock: I think – I think communications, obviously, is absolutely critical. I mentioned that other book, the AIDS book, "Dispatches from the AIDS Pandemic." My colleague Harold Jaffe often made the point that in the early days of AIDS in some ways perhaps it was easier than now because we didn't have social media. I remember the early AIDS says in the early '80s, when CDC would send out – I was working in Los Angeles, and CDC would send out surveillance reports that were sort of typewritten and sent by mail; and slide sets, you know, the old things you had to into a carousel or whatever. And it worked. In a way, there wasn't this pressure for a knee-jerk reaction as soon as you got an electronic message. So I think the advent of social media has given great opportunity, but also made things difficult in some ways. And of course, we know all negative stuff and the disinformation.

But we really need to think about communications and the specialist – get specialist advice about how to use this – the multiple channels of communication for these very purposes. We need to remember – people like me and colleagues in public health or medicine, we need to also remember, you know, we may respond to data, but people don't. People respond to stories. They respond to individual anecdotes. We need that skillful balance to tell anecdotes that represent the data but are true and meaningful to people who, you know, don't particularly thinking about – highly of epidemiologists. (Laughs.)

Dr. Morrison: Before we close, I'd like you to tell us if you have a shortlist of what the administration might do to reform CDC right now, like one or two or three topline steps. What would you do if you were called by Jay

Bhattacharya and asked what are the – what are the two or three things to do right now to rescue and recharge and reset the institution?

Dr. De Cock: Well, firstly, it needs a good leader, and there have been some very good leaders at CDC over the years. But they all come with a technical background. I mean, they're not political appointees. And you know, this is the world's premier public health agency. It needs to be led by somebody with all of the political skills and advocacy and so on, but somebody who's technical. And we don't have that.

There needs to be trust in the workforce, which – I mean, there's some things that have been said about the workforce which I just find appalling. I mean, you know, talk about corruption. Well, I worked for CDC for the better part of 30 years; I did not see corruption in my time. So respect for the workforce and support for the workforce, who are really committed people.

And, thirdly, since you asked for three, getting the messaging – the messaging that CDC puts out has to be credible and –

Dr. Morrison: Faster.

Dr. De Cock: Faster, credible, but valid. So, you know if you look at the CDC website, there's stuff on there right now that are political/ideological statements about vaccines and autism and stuff. You know, we understand – we have to understand that, yes, public health is political, but the messaging has to be correct and medical and technical.

Dr. Morrison: Let me ask you a question around technology and innovation. You know, there's a lot of excitement around lenacapavir, the twice-yearly prophylaxis PrEP injectable on HIV. The administration's committed to working with The Global Fund and with Gilead Sciences in bringing – catalyzing 2 million folks coming online in 10 different African countries in a fairly short timeline. And lots of steps have been taken by industry to get through the clinical trial period, get the prequalification, get through all these different gates and regulatory approvals and the like, and get production, and convince the generic producers that there's truly a market there, and to try and – and there's a lot of excitement for this. And it brings together private-sector-driven innovation along with political will and creativity and the aptitudes that The Global Fund represents.

There's also all this talk now about how AI is going to bring into some level of interaction frontier labs in places like India. China frontier labs are looking at health services in low- and middle-income countries, the Indian labs. But now you have interest coming forward from the U.S.

frontier labs and these new partnerships that Gates Foundation and others are engineering, and OpenAI coming into a number of countries. This oftentimes somehow is seen as another wave of activity that has lots of promise and interest, but it's not tied as explicitly to rebuilding excitement and rebuilding bipartisanship and rebuilding new forms of partnerships. Say a few words about this. Where's your thinking on this?

Dr. De Cock: Well, firstly, lenacapavir is, of course, an extraordinary scientific advance. I mean, the concept of long-acting PrEP for HIV is remarkable. But at the same time, we have to give it to the right people – you know, the right people in the right place. And the – you know, what's been said about the sort of suppression of certain names or words that, you know, we can't talk about certain populations or pretend they don't exist, I mean, that has to be dealt with. So there has to be acceptance that the drug needs to get out there, but it's to key populations – you know, men who have sex with men, sex workers, transgender people, et cetera. And in public health and medicine you sort of have to tell the truth, and pretending something doesn't exist just lets it fester. So that's one comment. But it's a great advance and, yes, if it can go out to the right populations – which includes, of course, young women – young women in southern Africa, particularly, and parts of East Africa. Tremendous advance and strongly support it.

The whole – one of the things that struck me when I – especially during the Ebola time – struck me, was how we had underinvested in data management, in informatics and data management. And in other programs, I've always thought that as well. And that we're always vulnerable to sort of electronic chaos because, you know, different companies trying to sell their particular product for electronic medical records, and so on. And it's a whole area that really needs to be better managed in a more homogeneous way or it does get very disorganized and chaotic. And I sort of think, you know, AI, which obviously has huge potential – and it's not my area of deep knowledge – we have to start thinking that we don't just increase the digital divide between Global North and South. But I'm also struck by something Jim Curran said. And I think I quote it in the book. That, you know, we always think that science and technology will save us, but at the end of the day it's really about people and their relationships. Which I think is a wise statement.

Dr. Morrison: Kevin, this has been a wonderful conversation. Thank you so much for taking the time to be here with us.

Dr. De Cock: Thank you.

Dr. Morrison: I just want to offer you a chance to say, to our audience online and here in person, any closing thoughts.

Dr. De Cock: Perhaps one, just about how we – since there's so much emphasis on health security, a couple of comments on that. One thing I've been struck by, working on different epidemics that are so different biologically – you know, HIV, COVID, Ebola. So different in transmission and everything else. Yet, common themes emerge, and I think common approaches are necessary. I was struck, for example, HIV, we know we've always recognized stigma and discrimination. I didn't expect that during Ebola days. But it's there. And even some of the impact, like orphanhood, disrupted families, again, Ebola, because it clustered in families, same sort of thing.

But the approach we use as a country, as a community, there's a few, you know, common elements that are necessary across the board. Firstly, the science has to be right. You know, we have to understand the agents, the organism. Its biology, its transmission, natural history, diagnosis, et cetera. Secondly, communities have to be involved with just instructing communities, whether they're very focal groups or the broader community, it doesn't work. They have to be involved. You know, the slogan, nothing for us without us. Political leadership is absolutely essential.

And we can look at – and it's in this book – it's in both of these books – discussions of, you know, what went well, what went badly. I've already talked about the need for political leadership to work with the public health science. The commodities, the program – the commodities have to be able to be delivered. I mean the lessons of inadequate PPE, and so on. And then, fifthly, the communications, which admittedly are more difficult today than perhaps they were in earlier days. But there are these common themes. And I think they need more thought and need to be more systematically addressed. So those are some thoughts.

Dr. Morrison: Thank you, Kevin. Thank you, and congratulations on this book.

Dr. De Cock: Well, thank you.

Dr. Morrison: And best of luck in engaging and touching the audiences we want to touch. Please join me in thanking – (applause) –

Dr. De Cock: Thank you. (Applause.) Thanks a lot. (Applause.)

(END.)