EPISODE 73. LEADING TO ZERO

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Garry Aslanyan [00:00:07] Welcome to the Global Health Matters podcast. I'm your host, Garry Aslanyan. In global health, we talk a great deal about control. Reducing burden, managing outbreaks, keeping a disease in check. But control carries a quiet admission that some cases will remain part of the picture. Zero is a different proposition entirely. Zero means every village, every community, every child is equally important and valuable. It is a technical challenge as well as test of leadership. In this episode, we explore what it takes to lead a health effort all the way to zero and what happens the day after you get there. I'm joined by Dr. Jamal Ahmed, WHO Director for Polio Eradication, and Chair of the Global Polio Eradication Initiatives Strategy Committee. He has spent his career in polio eradication from surveillance and laboratory systems to programme implementation. Joining him is Dr. Stephen Vreden, Chair of the Committee for Prevention of Reestablishment of Malaria in Suriname. At the start of this century, Suriname carried the highest malaria burden in the Americas. In June of 2025, WHO certified the country malaria-free, the first in the Amazon region to reach that milestone. Two diseases, two continents, one shared question. What does it actually take to get to zero? Hi Jamal, hi Stephen, how are you today?

Jamal Ahmed [00:01:58] Quite good, good to hear from you, Garry.

Stephen Vreden [00:02:01] Hello, I'm fine. Thank you, and how are you?

Garry Aslanyan [00:02:04] Great, welcome to the show. So, let's get started, Jamal I want to start with you. In global health, we often talk about controlling diseases. So, to reduce the burden and to manage outbreaks, why do you think eradication or really getting to zero, is a very different goal and why do we need to pursue that goal?

Jamal Ahmed [00:02:30] First of all, thank you so much, when we talk about disease control, what does that mean? It effectively means accepting that the disease will remain within the population, and we are accepting that we will have outbreaks, we will have cases, we will have in the case of polio for example, disability, and we accept that we will have occasionally deaths. So, the goal, when we are talking about eradication is effectively zero. And zero means zero, and in reaching that has underlying positive meaning and the underlying meaning is equity. Because when you aim to deliver zero and that is the goal of eradication. What it means is every person, every community, every village is equally important, and you work very, very hard to reach every community and every child and deliver those services. So now in human history, we've eradicated smallpox, because we have done that it is zero for everybody, every child everywhere is now protected against smallpox. There's no differential risk. And that's very, very, very important. It is a leadership test, because it means if a disease, if we can eradicate the disease, why accept somewhere in between? Why accept having tens of thousands of cases or even sometimes millions of cases when we can deliver zero? And we do have the resources to do that, it's just that it's about prioritisation, so that is eradication, that's why eradication is extremely important. It's rare that we choose eradication because we have a whole number of factors that we need to identify, and before we say that this disease can be eradicated, and there are a few diseases that do meet those kinds of criteria and polio is one of them, and therefore delivering zero therefore is very important for humanity for all generations.

Garry Aslanyan [00:04:51] Okay, well that's a very good and comprehensive case for getting to zero. So, let's ask Stephen, earlier in this century, Stephen, Suriname had the highest malaria burden in the Americas. So, but last year in June of 2025, WHO certified Suriname as malaria free, really making one

of the malaria free countries in America's and especially in the Amazon region to achieve this goal. What was the turning point, Stephen, to get to that? And the moment when you knew that eliminating was really possible or it was within the reach.

Stephen Vreden [00:05:40] Thank you for that question, thank you for this interview. I think that indeed we came from a very high malaria burden that was still ongoing in the beginning of this century. And we managed to reduce the malaria burden in stable populations, and we're working on controlling malaria in the mobile and migrant populations. There's a lot to say about it, but I think that we'll be talking about some specific subjects later during this interview. But I think that around the year 2015, when we realised that there had been zero transmission of malaria in the stable populations, and there was less and less malaria in the mobile and migrant populations due to all actions that we're going to talk about afterwards. We thought that maybe we can get rid of this disease completely in this country. We knew that it would be challenging because in the Amazon region, people didn't even believe that the Amazon could be free of malaria because of the vectors, the climate, the temperature, everything. But we thought that if you have a specific programme and you pursue that continuously then maybe it is possible. In fact, to motivate all people and to also make clear that we were working on elimination, we proposed the Ministry of Health to change the name of the guiding board, which was the Malaria Board to change that name, Malaria Board into Malaria Elimination Task Force. That happened in the year 2018. Because then it was clear what the goal was of this committee. They had to eliminate malaria from Suriname. It took another three years before we had the first year of zero malaria transmission, that was in 2021. But you need to be malaria free for at least three years before you can apply for the WHO elimination certification. So, but the first year of zero transmission was 2021.

Garry Aslanyan [00:08:03] Okay.

Stephen Vreden [00:08:03] So yes, when we said that we are going to eliminate malaria, we managed to actively reach that in three years.

Garry Aslanyan [00:08:14] Stephen, I really want to be a little bit more precise on who was we, and whose leadership, because it's so interesting for us and for listeners to maybe dig a little bit deeper into this. Like when you say we, maybe you are too modest, but is this like the group of people who worked, who was really pushing for it? Who was, who made that possible, Stephen?

Stephen Vreden [00:08:40] Well, I must say something very visionary of the Surinamese government was in the year 1996 to install a national malaria board. That was an oversight body in which there were all kinds of experts, but also relevant stakeholders making a plan to control malaria, to reduce the malaria burden, because at that time we had a serious malaria burden in so many villages in the interior, children dying, children staying out of school, people not able to fully function because they had continuous malaria attacks. So, I think the malaria board, that's where it started. That was in 1996.

Garry Aslanyan [00:09:30] Okay.

Stephen Vreden [00:09:31] And it was responsible for making a big plan for the reduction of malaria. So, when I say we, then it's the malaria part, which was late 2018 came the malaria elimination.

Garry Aslanyan [00:09:47] Elimination task force. That's really helpful, and maybe I can go back to Jamal because you see the strategies for elimination in different settings are developing differently. And I know civil society participation has been really also very key in achieving polio eradication. You have a lot of community engagement, mothers, grandmothers, you have Rotary International involved. How does

that community leadership translate to, really results in eradication? And Jamal, what would you say would be good to hear to inspire kind of the next generation to treat these kinds of eradication plans and not to see polio in the future?

Jamal Ahmed [00:10:36] No, absolutely. And I was actually very curious about the same topic and the same issue when Stephen was highlighting the Malaria Board. When we talk about communities, we talk about national communities, but we also talk about, you know, communities living across borders across multiple countries. And in the polio setting, let me be honest, polio, the whole fight against polio has been driven by communities, by people, from the very onset. If you go back long enough, you will see that even the vaccines and the tools that we use today is as a result of community mobilisation, primarily in the US, for example, we had the "March of Dimes" during the post-war period with Roosevelt, Franklin Delano Roosevelt, the former U.S. President. And that whole effort, that was community led. Mothers were sending dollars, you know, coins, dimes, and that was used to develop those vaccines. And the vaccine itself was a free vaccine. The genius about it is many of the vaccines today are patented, we don't know that some of these things were given for free to communities at the height of the fear of polio in many countries, including the West. And the vaccines that we do use today have done a good job in getting us to zero. So, polio has come down to near zero for a long, long time, including in areas where we are fighting the disease. But this is where now, those who are, you know where we come from, we say elephant has a long memory, and part of the reason we say that is because they live long and they remember and they keep a lot of, and they live in communities and they live in societies. In all our villages, in all of our communities, we have grandmothers, and we have grandparents and they know what polio was when it was extremely high. So, in our community mobilisation, we rely on the elderly quite a bit. We rely on community leaders. We rely on those with that long memory who remember when we talk about polio, what polio is all about. And at the same time, when you asked earlier about eradication and what it means, eradication means not leaving anybody behind, and in the work that we do, for example, we try to vaccinate all children in the country. A very good example in Pakistan, in one campaign, in one nationwide campaign, we reach more than 45 million. There's no way you can do that without bringing the community along at every step, and it is part and parcel, it is the fabric of the whole eradication effort and a special call out here to Rotary and Rotarians. They do a fantastic job. They are embedded within the community at every level. And within our partnership, within the global polio eradication initiative, they are the mobilizers at the community level in so many ways.

Garry Aslanyan [00:13:57] So this is very interesting because I have this feeling, we are going to need those grandmothers and grandfathers a bit more for many, many things. Because when it comes to some of the vaccine preventable diseases, that memory in some places is fading sometimes because the coverage is not stable everywhere. So, this an interesting point about, you know, remembering how things were before. Thanks for that particular insight. I'm going to go back to Stephen. Stephen, Jamal also mentioned this transmission around borders and migration and all of that, that you had to deal with in your efforts. So, around Amazon, this was a big challenge, you have few countries there, and also migrant gold miners. How did you have to think differently about working with this population who were remote, they were often mobile, I imagine they spoke different languages. Share that with us, I think it will be very interesting to learn more.

Stephen Vreden [00:15:06] We have in Suriname a significant population of mobile migrant population. They are mainly working in gold mining, small-scale gold mining. The majority of them is originating from Brazil. But they are moving throughout the Guiana Shield. The Guiana Shield is, let's say, the northern countries from the South American continent. It includes French Guiana, Suriname, parts of Venezuela, Guyana itself and also some parts of Brazil. So, this is an area where these people move, and that is in fact very, it's almost the engine of malaria in this region. When we managed to get control of malaria in

our stable populations, we realised that in the mobile populations, you would need a different approach. And that was not only because of the language problem, because these people, they speak mainly Portuguese, but also because they were living in very remote areas where there was, in fact, no law enforcement because they were living in the middle of the jungle. And in such situation, you could not deploy your formal staff. You could not deploy them in an area where there's no police, where there is nothing. And then we realised that we needed to work with the communities themselves. So, we started, recruiting people from those gold mining communities, asking them whether they would like to be trained in malaria diagnosis and treatment. And for these people, it was very important because they were suffering a lot of malaria. So, we recruited people from these communities. We trained them to do malaria rapid tests, to give medication, also we train them to distribute impregnated bed nets to the community, and so this was the way that we built what we call a malaria surface delivery network. So, in all gold mining regions there are these people who have medication, who have diagnosis and who can provide this. So, this network is, I can easily say that without this network, Suriname would have never been able to eliminate malaria, because these people, they diagnose and treat malaria in places where you are not. And if you don't diagnose malaria, it will keep spreading. So now that we have eliminated malaria, we have been free of malaria for now for almost five years, but we still have a lot of imported cases from our neighbouring countries. And these people are involved in gold mining, so when they come into the country, they go to the gold mining areas that are vulnerable because the vector, Anopheles darlingi is present. So, if we did not have malaria surface deliverance in this region, we would already have reintroduction of malaria because these people come and they get malaria while they're in the forest. And it's only thanks to those, to this community participation, because that's what it is, that we managed to be free of malaria for five years.

Garry Aslanyan [00:18:39] Very interesting. Jamal, come back to this a little bit, because they're also in polio, you've had a lot of other kinds of coalitions, you have political kind of engagement, donors, heads of state, et cetera. Community is clearly an important thing here, what we heard from Stephen. What does it take to move that kind of diverse group of stakeholders, making sure they're aware, to really share this ownership around a goal. What can you share with us about that?

Jamal Ahmed [00:19:17] So, I was actually, again, highly curious about the mobile, before I come to Garry and answer and respond to your question.

Garry Aslanyan [00:19:26] Please.

Jamal Ahmed [00:19:27] The mobile populations that Stephen is talking about, it is also a very critical pillar to the eradication of polio. We have in the Lake Chad Basin, for example, in Nigeria, neighbouring Niger, Chad, you have many nomadic people moving around with cows and so on. We have mining villages and towns in D.R.C., in eastern D.R.C., in parts of Guinea, across Pakistan and Afghanistan you have this population movement. So infectious diseases move with human beings and those high-risk populations that Stephen is talking about is super super critical for polio eradication. The same way it is good for critical in Suriname and the Guiana Shield as you called it. So now, how do we mobilise, now coming to your question, and moving, how to move a coalition across the board? First, as we said, as I said earlier, the Eradication Initiative has been led by civil society and communities from the onset. So even today, when we are talking about stakeholders, we start at the lowest level, at the district level. In countries, for example, like Afghanistan and Pakistan, where we have the, these are the last two endemic countries for wild polio virus today. We begin conversations at the district level with the leadership of the district. We bring those stakeholders from the district administration, the political leaders who are elected or otherwise. We bring together the religious leaders and community elders and the whole society. And we create a stakeholder mechanism that goes to the lowest level. Stephen was talking about

a task force, a malaria task force at the highest level. When we, for example, in Pakistan at the lowest level, the smallest administrative unit is called a union council. At that level from the union council chair, we have a task force for eradication, at the higher level or the district level, we have a district polio eradication committee. When you come to the province level, we have a multi-sector, multi-departmental, multi-disciplinary group at the provincial level. And at the national level, even the prime minister himself chairs the task force. And all of that is being supported by a coalition of partners. This brings together WHO and UNICEF but also brings together other private entities and governmental entities like U.S. CDC., Rotary, the Gates Foundation, GAVI, and many other donors also come in across the whole world. And ultimately, the coalition is also anchored by the member states themselves, the countries themselves at a global level. And every year, we report back at the World Health Assembly. Every year, especially in the endemic regions, we do report back to member states and they provide their input. So, it is, coalition building, it is bringing all stakeholders together at every level for the sake of ending polio once and for all.

Garry Aslanyan [00:22:48] So some things actually are emerging as they are similar, maybe not completely, but this whole task force and all of that obviously are key and critically important. Stephen, you said the thing has been around for 30 years, right, the task force. You may have had some government funding cycles, political changes. Was it hard, was it not very hard, to keep their attention on this task force and hold this task force together and kind of keep it going. And also, maybe tell me what happened now with the task force? Is it still around and what do they do now after they've achieved the goal?

Stephen Vreden [00:23:34] They are still around because I can tell you one thing, reaching elimination, being certified for malaria, it certainly doesn't mean that you can sit back and relax, because you need to prevent reintroduction. And as a matter of fact, we have asked the ministry this year to again rename this committee. So, we are no longer a task force, but now we are the committee for the prevention of reestablishment of malaria, because that is something that you need do. If you sit back, you will get malaria again. That's happened in so many places in the world. If you reduce funding, you will get malaria again and one thing is important, we need to realise that the Global Fund has invested over 20 million dollars in Suriname and this was, I think, maybe one of their best returns of investment because malaria is gone now. But if you stop, and if you don't pay any attention, then it will come back. So, this committee, it's still there and it's still working. Yes. I think that's, that's what you wanted to know.

Garry Aslanyan [00:24:50] Yes, I wanted to know how you kept it up for 30 years with a lot of maybe external changes, political changes. What was the magic sauce?

Stephen Vreden [00:25:00] Well, I think the magic sauce was that this committee, the first issue of the malaria board, was chaired by the Director of Health, who is comparable to the chief medical officer in other countries. And one specific thing that this committee had, it had executive power, because if you are just a committee that gives advice to the ministry, if this advice arrives at someone who is not really aware of what's going on, it can just end up in a drawer. But if you have, as a committee, you have executive power, you can implement things. And I think that is one of the most important things. We were not a passive committee; we were an active committee. So, we were taking care of the Global Fund grant requests, and so on and so on. So that was very important. And I think that we were left alone by all governments, probably because they saw that we were performing. And, I think also, they saw that we are adjusting the committee according to its needs. I can tell you that, initially, we had the most important stakeholders were always a member of the committee. In the first edition of the malaria board, we had a representative of the army. Why? Because soldiers in the interior were suffering from malaria and you may know that the most important drug for malaria prevention at that time was

mefloquine. But mefloquine, because of its possible psychological, psychiatric side effects was contraindicated in people wearing arms and also in pilots. So, we needed to make a specific approach for malaria prevention for the army. But you can only do this when you have them involved. And the same goes for the Ministry of Education. We wanted to introduce malaria knowledge in the curriculum of the schools. You can only, you can not just impose that on someone, you need to involve people from the Ministry of Education to explain it, so this is the mobility that the committee has had, and that made it stay strong and be very effective. So, all these things helped, and I think that, of course, we need to applaud the governments that they really did not intervene in the committee because that's very good. But I think the committee itself also tried to perform.

Garry Aslanyan [00:28:12] Interesting, very interesting. Jamal, you have a set of other issues sometimes when it comes to resurgence of polio in places really linked to, you know, geopolitical conflict, sometimes constraints around access, vaccine hesitancy, obviously in this case, more done in case of malaria. What kind of strategies and approaches you have to use and leadership kind of you have to use in those kinds of situations that are quite complex, not just health, but at the scale of where we are globally.

Jamal Ahmed [00:28:57] You've hit the nail on the head. The biggest challenge, and why it has been a challenge to end polio for good has been because the last strongholds of polio, the last, for example, let me say the last two endemic countries for wild polio virus have been at the epicentre of global geopolitical competition, and that itself has increased insecurity. In some of the, and we're talking about the borderlands between Afghanistan and Pakistan now, it has increased challenges when it comes to accessibility. We've faced accessibility challenges for many decades across populations. And therefore, the kind of leadership therefore that we have been deploying and continue to deploy is that calm leadership, but persistent leadership that says, yes, there are challenges. But those challenges are not insurmountable. Then we have to work every day to see what we can do better. So, in the two countries, for example, at the moment, if I can reflect on that specifically, we have conflict, we have areas that are inaccessible to vaccinators because of that, and we do work with local influencers, local community members, and through them, even in the midst of conflict, we work to have access to the villages and the children in those villages that may be inaccessible otherwise. We deliver vaccines and we try to do that. We also consistently and continuously map out where we are unable to reach. One other way we do is, you know, the polio, as we said earlier, the scale of polio has reduced across the board. So, it is not seen clearly as a threat by many communities. Even in those inaccessible areas, the numbers are quite low. The vaccines, you know, the success of vaccines is paradoxically, it's also its weakness, right. That success is also, you know, vaccines are victims of their own success, if I can say that. And that's true, and that's why you see this hesitancy go up. So, from our perspective again, in addition to polio, we work very hard to use polio as an entry point, because these communities that are not reached by our vaccinators, are also, other health systems, you know, other vaccines are not reaching there, other health services are not reach there. So, we try to use polio as the vanguard, bring in other elements through what we call an integrated service delivery for nutrition, for example. For, you know, water and sanitation, other vaccines across the whole routine immunisation spectrum. And we work as hard as possible to deliver these other services together, so that the community then sees that we're not only coming with the two drops that we need to end the transmission.

Garry Aslanyan [00:32:11] Okay, so just again, our listeners, I mean, thousands of people listen to these episodes and the podcasts and many work in different public health settings and many work on different public-health issues. So, I want to ask both of you to help with what they can learn from these experiences and some transferable lessons. And I also have a feeling that both of you are very modest because both of really play or played or are playing, all tenses, a really critical role of who you are in this

process with your own leadership principles. So maybe I can hear from both of you in case of polio, what are the principles for this work and that really translate into these efforts and can be used for any other disease. And same with you, Stephen, similarly, as a leader working on malaria in this case, what kind of transferable principles of leadership or practises you can share from your experience in Suriname and what's need to be in place by those listening to us that they can deal with their own public health issues. So maybe Stephen, you go first and then Jamal.

Stephen Vreden [00:33:41] What I think is that you need a national oversight body to address specific problems. Secondly, I think that decentralisation and community involvement are very important, and one of the things I just heard Jamal saying is that it's integration of health services, because we started providing malaria diagnosis and treatment in the mobile and migrant populations. But in fact, now that there's no malaria anymore, the people are partly interested because you need to keep continue screening, but the people are hardly interested in screening. And what they say is we'd rather have you check our diabetes or our hypertension because we are living here in an area where there are no health facilities. So, we have trained our malaria services deliverers now into people who can provide more services. They can measure blood pressure, they can check diabetes, and even they can assist in getting medication in today's very far location. I think that when Jamal just said it, I said yes, that's something that's very important. We need to look at, even if you're focusing on one disease, that doesn't mean that you need to ignore other health problems. So that is very important. And the third point that I would like to add, of course, is funding. Because we haven't mentioned that yet, but I think that funding is very important if you want to achieve certain milestones. And it can be international funding, if it's national funding, it means that the government, even with its limited funds, should have a certain commitment to really make funds available for a specific project. So, I would say these things are fundamental in achieving goals.

Garry Aslanyan [00:36:03] Good, thank you for that. Jamal, what about you?

Jamal Ahmed [00:36:06] What I will add here is, first of all, the clarity of goal. When we talk about eradication, we mean zero. So, all of us understand that zero is the goal. And zero doesn't mean zero locally, it means zero globally, everywhere, across the whole world. So that is extremely important. The second thing is conviction, then the idea that we believe that this is doable, both technically and the feasibility from the actual implementation perspective. So, those two are extremely critical at the higher level because once you have that level of belief, the technical aspects are robust and solid and it's doable and we have that clarity of goal. And that's true, by the way, for elimination also because you're really pushing the envelope when you're not working on control, you're pushing to stop transmission as a whole. So, that's also true for malaria elimination. So, then the other component I'll say is the community, the community trust. Because without the community you can't go far away. Political level, political accountability, for us absolutely critical because at every level the decision makers have to be on board, they have to own the problem and then help us push. Then now when you get out of all of that is the technical issues, surveillance, surveillance, surveillance, you have to detect every virus and from a polio perspective we collect stool samples, we test tens of thousands of samples every year, even if we detect few, those negative results are as important as the positives. We collect wastewater from sewages from runoff canals from shanty towns and we test, and that's where wastewater testing is important. And then every detection matters. We have to act quickly. The minute you detect something, you don't wait. You respond quickly and expeditiously. Early response, quick response is critical because it's not easy to contain the virus that is dependent on human movement in a small geography. Once in a while, it will spread. It will be imported somewhere else and you have to deal with those exportations and so on and keep that population fully protected. And finally, a dose of humility goes a long way, because without, you will fail again and again in different points, because you are dealing with a

relentless transmission chain in areas that are very, very difficult to work, and therefore you don't give up, you come back again and see what more can we do. So that is, I think the lessons from our end.

Garry Aslanyan [00:38:53] Both of you have a huge dose of humility, I've sensed that you have very much a realistic view of these things. This was extremely useful. I want to finish on asking you a final question. If you can reflect in terms of what gives you each hope that eradication in your case Jamal, an elimination that you had in Suriname Stephen, will be achieved or will be maintained and sustained, and what do you want listeners to this episode to carry with them when they are finished listening? Stephen, you go first.

Stephen Vreden [00:39:37] You're talking about hope, and I would rather not speak of hope, but of conditions. I think elimination of diseases is one of the most important goals of humanity now. And I'm afraid that just hoping will not get us there.

Garry Aslanyan [00:39:55] Hope is not a strategy. I heard one of the prime ministers said that recently. That's a good point, yes.

Stephen Vreden [00:40:01] Especially if you know what it takes to reach a certain goal, because then you must shape the conditions to reach that goal. And the most important condition is, in my opinion, is global commitment, and that means that funds are safeguarded that are needed. After that, I think national governments should be urged to make it possible because I think that finally the people, they are ready to do what needs to be done if we explain to them why and how. So, I would say not so much hoping but making what the conditions are and living up to those conditions.

Garry Aslanyan [00:40:57] Okay! Jamal.

Jamal Ahmed [00:41:00] What gives me, I would say hope maybe, is that the commitment, the level of commitment we continue to see. In May we had the World Health Assembly in Geneva bringing all member states, 64 member states took the floor, all of them fully supportive, all of them endorsing the idea of ending polio for good. Many of those countries have not seen polio for many, many decades, and that gives me hope, everybody's still on board. The second thing that gives me hope is the distance we have already covered. When we look at Stephen now, he's in Suriname, he's is in South America, we haven't seen for many, many years any polio outbreaks in transmission, sustained transmission across South America including big countries like Brazil, despite all the challenges and many other issues, polio remains zero. When you look at Asia, which has been polio-free now, the Western Pacific region and the Southeast Asian region, a big country like India, despite all its challenges, despite the many naysayers has delivered zero. And that gives me hope because they have remained zero for decades now, for more than a decade, and what gives me hope, is also that every day when we go to the field and we meet mothers and we need community leaders, that belief is still there even at the local level. So that also gives me hope and I think doing this remains critical, and Stephen said global commitment and the importance of global commitment, I could not agree more, that is extremely critical because without the resources and the solidarity that global programme provides, weaker countries and lower-income countries will not be able to end diseases like malaria and polio. So, we need that to be sustained, we are lucky that that commitment still exists for polio through the Global Polio Eradication Initiative, and we hope that we get to zero as quickly as possible so that we deliver a world that's polio-free.

Garry Aslanyan [00:43:14] This was a very, very interesting conversation. I really appreciate this. I'm sure our listeners will really enjoy. So, I'll just say thank you for your time and sharing your experiences. This was an excellent discussion and best of luck with everything you do.

Jamal Ahmed [00:43:35] Thank you so much.

Stephen Vreden [00:43:36] Thank you.

Jamal Ahmed [00:43:37] This is wonderful.

Garry Aslanyan [00:43:40] I found today's conversation with Jamal and Stephen very interesting. There are three reflections I would like to share. First, zero is a statement about equity. As Jamal put it, eradication means no one is left behind. Second, the people closest to the problem carry the programme. Suriname could not reach gold miners deep in the forest with formal staff. So, it trained people from the gold mining communities to test, treat, and distribute bed nets. Polio relies on grandmothers who remember what the disease used to do and on task forces that reach from the Union Council to the Prime Minister. In both examples, the structures that worked were the ones built with communities, not simply delivered to them. And finally, reaching zero is not the end of the work. Suriname renamed its task force from elimination to preventing re-establishment because the vector is still there and imported cases still alive. I hope this episode strengthened your resolve to hold the line on the goals we have already so nearly reached. To learn more about the topic discussed in this episode, Visit the episode's webpage where you will find additional readings, show notes, and translations. Don't forget to get in touch with us via social media, email, or by sharing a voice message, and be sure to subscribe or follow us wherever you get your podcasts. Global Health Matters is produced by TDR, a United Nations co-sponsored research programme based at the World Health Organization. Thank you for listening.