Interview with…

Dr. Narcisse de Medeiros, member of the Project Advisory Group (PAG)

Dr. de Medeiros is UNICEF program coordinator in Togo

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Dr. de Medeiros, could you introduce yourself in a few words?
I'm a man of several passions, and a romantic, because my career and personal paths are characterized by both coincidence and obligation but always driven by a certain romanticism. I am the UNICEF program coordinator in Togo and served for eight years as the regional consultant in charge of communication for UNICEF programs for the 24 Western and Central African countries. My primary training is as a medical doctor, followed by a master's degree in community health and a Ph.D. in communication.

Why did you study medicine?
There are *seventeen* doctors in my family, so it is perhaps a question of exposure. My father was one of the first doctors trained at the William Ponty School in Dakar. It was during the colonial period, and most intellectuals from countries colonized by France were educated at Ponty. But perhaps I did not really choose to become a doctor because when I was in my final year at school, I wanted to become an airplane pilot, at a time when the best pupils in technical subjects were encouraged to take the exam to become a pilot. I was an intern at a senior high school in Porto-Novo and traveled with classmates by bus to take the exam in Cotonou, 30 kilometers away. We were given a packed lunch and when we arrived in Cotonou, the driver decided to take the coast road bordering the marina alongside the sea. I had always dreamed of watching the rain fall on the sea, without ever having seen it. At the time, it was raining, and I knew that rain was falling on the sea, about a hundred meters away below the road. I asked the driver to stop, which he did, thinking that I urgently needed to relieve myself. I asked the person in charge to give me my sandwich and told him, "I would like to get off the bus to go to the beach. I want to see the rain fall on the sea." I took the sandwich and let the bus leave without me. I crossed the street and went and sat on the beach, all by myself. I watched the rain fall on the sea … I was as happy as a clam. And that is how I missed my airplane pilot's exam. When I got home, everyone asked me how it went. I explained what I had done. They were in fact quite happy, since it was not unlikely that I would have passed the exam, and they were already planning for me to study medicine at university. So, after leaving school, I took the exam to do medicine. I passed and continued along that road. Perhaps if it had not rained that day, today I would be a pilot and not a doctor …

What led you to community health and communication?
Once again, chance. When I was in my fourth year of medicine I was sharing an apartment with two other students who told me that the Benin radio/television station was organizing

an exam to recruit outside contributors. They asked me whether I was interested and I said to myself "Why not?" The only advantage I could see was financial: an opportunity to supplement my student scholarship income. I took the exam, passed, and people recognized my talent in this field. It was not easy because we had to do everything—we woke very early in the morning to prepare and present the news bulletins, we went on location to do the outside broadcasts, etc., and I was trying to combine this with my medical studies including being on call. Furthermore, the university professors did not appreciate at all what I was doing. For them, it was very degrading for a future doctor to have to wait, microphone in hand, until one authority or another agreed to provide an interview.

Between my fourth and seventh year of medicine I had quite naturally become "Mr. Health" within the national media (radio and television broadcasting office) because I did all the reports on health-related events. When I finished my medical studies in 1980, I set up a weekly program called *For your Health.* I was working as a doctor 60 kilometers away from Cotonou, and returned two-and-a-half days per week to prepare and organize my program. To begin with, as I have mentioned, communication was a way of supplementing my student income, but gradually I came to like what I was doing. I realized that I was learning a lot from people I met in the rural community where I was working, and that I drew plenty from this context to use in my programs. I realized that the rural people related to me differently depending on whether I was working as a doctor or as a presenter of a health program. I wanted to understand this dichotomy. It so happened that the WHO Regional Director, while visiting Benin, saw one of my reports on television and offered me a three-year scholarship to do a master's in health information and education. I was lucky enough to be able to choose where I wanted to go, and since I had always dreamed of going to Canada, that is where I went. For me, this scholarship represented an opportunity to find answers to the questions raised by my dual activity as doctor and radio/television presenter.

When I arrived in Canada, there was no master's program in health information and education, so they suggested I do a two-year master's in community health and a one-year diploma in communication. I took the master's in community health in the department of social and preventive medicine at the University of Montreal from 1986 to 1988, and then I was offered a [teaching] assistant position at the university. It was totally unexpected, but I said "Why not!" I accepted the position and obtained a doctorate in communication in 1994.

I imagine your background was different from the other students in communication: you were already a doctor and you had field experience as a doctor and communicator. Did the university make the most of this experience?
Once again, by chance, at this point in time the University of Montreal was opening up to the developing world, and an agreement was set up with the United Nations to implement a project on training in communication for all French-speaking developing countries, including most African countries. They were looking for someone with a very good knowledge of Africa to coordinate this program—someone who was also familiar with health challenges in Africa and who could dialogue with other disciplines, especially anthropology and communication. I coordinated the program until it was transferred to Africa. My challenge was to transfer a program that had been set up in the west in a favorable context and ensure a successful relocation to an African university, in this instance the Cheikh Anta Diop University in Dakar. I came back to Africa for good in 1995. In 1996, WHO asked me to strengthen the curriculum of the public health centers in Lomé

and Cotonou, and I became the regional consultant in communication for UNICEF programs.

You became a member of the Project Advisory Group ("PAG") in 2004. Were you surprised to be asked to join the PAG?
Surprised? No, because I knew the African scene in terms of communication and I believe that my skills in this area are well recognized. When I was told that my name had been suggested, I was interested because since 1997 I had put a lot of effort into setting up teams working in vaccination. The increased activity of EPI and polio vaccination dates back to this time, and we trained many people in communication, so my nomination to the PAG did not surprise me at all.

What can you contribute to the project as a member of the PAG?
The PAG is a panel of consultants to which MVP or its associates present results of their efforts. The members of the panel provide their opinions and ask questions. I think this is to MVP's credit, because it is unusual to ask for input from a panel of experts, which is often very critical—for we are quite serious. Our questioning is similar to parliamentary style so that we can understand, advise, and say "Pay attention to this or that." In the group, I am the only expert in communication and I believe that my role is to make sure that within the approaches and strategies adopted, provisions are made to facilitate reaching project objectives while respecting the cultural context. Respecting the cultural context helps ensure sustainability, which may, in the long term, reinforce acceptance of health services.

Have fellow doctors and dyed-in-the-wool scientists taken you for a crackpot or a braggart due to the importance which you place upon communication?
To begin with, yes, but by the time I was in my sixth year of medical studies, my programs had become very popular. I had become a sort of star in Benin and the professors who were skeptical to begin with were clamoring to appear in my programs. Eventually they came to see me when they had important messages to convey to the public. I had obtained a certain power and could decide "Yes, I'll pass on the message," or "No, I will not." I had gained respect in those circles. From then on, people in the health sector started to think in a more media-friendly way, which facilitated dialogue. It was one of the unplanned effects of my time spent working in the media.

How does this work out in the field, when you are caught between scientists and the general public—people who have not necessarily received an education?
People witness this every day. Shifting from medicine to communication is perhaps the most important experience of my life. First, because I am the *seventeenth* doctor in my family and in medical training it was almost as if we were told that we were *demigods* … We really believe that we are the centre of the universe. By turning toward communication, I learned genuine humility, empathy, to reconsider things and to really understand. While working in the field wearing my white coat and stethoscope or in the hospital, I was well respected. The public considered me a demigod and it was as if their lives depended on the choices that I was going to make. When I was not a doctor, I blended in and learned to make a greater effort to understand what people wanted, so as to be able to pass on these concerns to decision makers. I became a good listener. When we are sitting in our doctor's office and the sick come to see us, we behave a little as if the person we are examining is an object carrying an illness that interests us—merely an opportunity for information on an

interesting topic. In the lecture halls of medical school, we do not learn to communicate, nor how to listen.

It is through fieldwork that I discovered that the spiritual and religious dimensions are major determining factors in people's behavior, including health-related behaviors. This is particularly important in the African context. Nobody came to medical school to talk to us about religion and customs. We were informed about harmful practices, female circumcision, force-feeding … but there are so many other customs that people practice either through ignorance or based on religious or cultural beliefs, which we can take advantage of because the prime motivation is survival.

Can you provide a concrete example?
I went to a place where a child was suffering from measles with complications. If we did not treat this child, he was going to die. His mother was giving food to the traditional fetish in their house—in any case she was pouring oil over the fetish because she thought that the child was ill because of the fetish. The medical staff were trying to convince the mother to let them treat the child and give a vaccine to another, but she was not willing to listen and considered it a waste of her money. I had to work with the health care staff and the mother. This involved first helping the mother buy what she was putting on the traditional fetish. We put the food on the fetish and asked her to explain where this custom came from. She explained that she wanted to save the child. We tried to find a local proverb meaning "Two solutions are better than one." We took her to the health center where we showed her children with the same type of illness and explained that for people from other cultures, vaccines are a bit like what she was pouring over the traditional fetish. She was able to see that the children at the health center were not ill because they had taken this medicine. We asked the mother if she knew the proverb "Two shoes or two crutches are better than one," and if she would agree to use the other solution at the same time as she continued to feed the fetish. She allowed us to treat her child, who was cured. For the first few months, she continued to believe that it was because she had fed the fetish, but relations between the health care personnel and that family, which had been very poor due to the prejudices of the medical personnel, swiftly improved. The family not only became much better at listening and participating in the activities of the health service, but they also became partners and spokespersons for the health services.

Today, I cannot categorically state that local customs have disappeared, but thankfully we have succeeded in convincing people that a "foreign" solution can help save their children … because they *want* to save their children. The attitudes of the medical staff often mirror what is learned at medical schools: traditional practices are harmful; there is only one answer, which is to provide vaccines and treatment. All the rest does not count. However, a mother feeding a traditional fetish refers to a reality which she will use to interpret other aspects of her life. Even if we tell her "Stop," and she does, she will still use the same reference to give meaning to other events in her life. So, when we tell her, "Stop, that is useless, you should forget about it," we do not just tell her, "Your child will die if you continue doing that"; we are also saying that the other dimensions of her life are without meaning. At medical school, we did not learn to analyze in this way. We did not learn to ask people to explain why they do one thing or another, which may seem absurd but which we can use to help them. It is through this sort of experience that I have learned to be very, very humble, and to listen much more than I did before when my medical training did not

permit it. I can sincerely say that although it is by chance that I have got to where I am, if I were asked to abandon it and go back to pure medicine, I would refuse.

What are the biggest communication challenges that MVP will have to overcome in Phase II and then with the introduction of the vaccine?
The difficulty is not inherent in the phase itself, nor in the vaccine, but is intrinsic to behaviors and practices learned by those responsible for carrying out the research. If the medical staff do not listen sufficiently to the public, to the parents who are going to *bring* their children … if they do not listen to what people have to say and their concerns because they are busy taking notes and filling in forms, people will feel that they are part of an experiment. This means that we should listen, especially since our primary goal is to care for people, to be responsive and to be available to help and guide people and work with them to solve problems. I think it is especially important to encourage health practitioners and other people who will be in contact with the parents to listen and to really pay attention. We should anticipate the problem of rumors and be ready to contain them, because there are also enemies and jealous people, etc. The two major communication challenges are rumors and the fact that it is a new vaccine.

Even in the case of routine vaccination activity, vaccination managers say that they have a community approach and are used to speaking with community leaders when we carry out technical briefings to prepare for vaccination campaigns and address the issue of communication. For them, they always assume that everything is understood. As long as there are no problems, in all countries, with communication related to vaccination, everyone always makes this assumption. We think we have communicated because we have distributed information and carried out awareness campaigns with community leaders. We assume that we do not need special briefings. This is untrue. It is only when a crisis occurs that we panic and realize that we have not paid attention to factors that have caused the current situation.

Are jealousy and rumors really that common?
What I have understood through working in this field in Africa is that everything is a potential reason for power struggles, whether it concerns health care personnel, different departments that must work together, or community or religious leaders. Everything represents an opportunity to obtain more power, either to use later on or to settle scores. Any opportunity is ripe for it. I have a pretty good knowledge of the history of social, intercommunity, and political relations which characterize the countries of our region and I can safely say that there are many players involved, at different levels and from different categories, who use it as a power play. It is even more apparent in regions where there are minorities, injustices and where people are only interested in power, whether monetary, social, or political.

What are the major differences between being a communication specialist in Africa and in Canada or Europe?
The approach is different because in Europe, unless you focus on local minorities or immigrant populations, you do not need to cover certain aspects which you cannot avoid here. If MVP conducted a trial in Europe, for example, I assume that people would easily understand the reasons for this type of research because they realize that their society has made progress due to research of this type, whether at industrial or other levels. Both from their culture and daily information, they are well prepared to accept this without worrying

about a supernatural or religious problem because your societies have progressed through their history to quite a different level compared to what is happening here.

How will blood sampling be perceived by the population?
Research on the anthropology of blood in Africa demonstrates that as soon as blood is involved in Africa, it is sacred. People are not always aware of this, and it is not something that you read about in medical school. Therefore, everything depends on the quality of relations and interactions between the clinical staff and the people. The way that people interpret the blood sampling will be greatly determined by the degree of trust developed between the nurse and the mother or population. We should also not forget that the nurse, before being a nurse, is African. *He* comes from somewhere. He may derive his basic beliefs from his own cultural background, and this should be taken into consideration. It is not because he is part of the MVP project that he will completely black out the fact that for him, in his culture and community, blood is sacred. We do not just have to win the trust of the population, but also that of the nurse.

During the investigators' meeting, you used the image of a triangle and you talked about the vital role that vaccinators play. Could you elaborate on this?
The triangle represents the idea that the clinical staff must be careful about the way they behave and the way they talk about the study, so that they do not adversely affect three things: the clinical site; through the clinical site, the entire vaccination service; and the MVP project. I realize that they have not received training to this effect, but it is important to develop good-quality, positive relationships with the mothers who bring their children to be vaccinated, especially since this involves a candidate vaccine and research. The work that we communicators must perform with the vaccinators is to encourage awareness that the person who is really doing a good turn in this context is the mother who brings along her child, not the vaccinator. We *need* the parents, we *need* the mothers to bring their children to us. This should make us more humble and encourage us to listen and be more available. This implies developing an attitude that they [the vaccinators] are not used to having in their other relations with the population. Complicity between the medical staff and the population has to be developed; they must recognize that they both depend on each other. If the site manages to set up a climate of trust conducive to full implementation of the project, it will reap future benefits.

MVP has been criticized because the vaccine is produced by an Indian company and the project is funded by Americans. Does this really cause problems in certain circles in Africa?
One must be objective and look at this in a global context. I think that Bill Gates is one of the international financial backers who has provided the most subsidies to combat AIDS, tuberculosis, and malaria over the last few years. Until recently, the West, and in particular the Americans, were criticized because of their lack of involvement [with these diseases] since they do not decimate their population. Now that we finally have found someone who is providing money to help combat these diseases, it is unfair to say that he has ulterior motives. We cannot let it lead to Bill Gates withdrawing his donations. We cannot have it both ways. Yet, there are people who may want to know why Americans are backing the project, and we simply need to explain that it is money that has been given to help fight diseases that we cannot fund. So much the better if we are given resources to fight against diseases that are prevalent in our countries. Everyone is working together: there are Africans, African intellectuals from all religious denominations who are participating in this

project; if the vaccine receives market authorization and all African countries in the meningitis belt can take advantage of this, it will not be forgotten that it was first tested in Mali and Gambia and these countries can benefit from this recognition.

What assets for accomplishing its mission does the project possess?
We can capitalize on the many lessons learned on how to contain rumors and on the challenge of vaccinating. This project can also benefit from the lessons learned on how to work with communities, the way in which people react, approaches to communication, and problems that may be encountered in terms of vaccination. However, learning a lesson is one thing, and putting it into practice is another. It is a pity that, in spite of all we now know, we still start studies with the following frame of mind: "No, to start with, we do not need communication because, here, we know how to communicate." This approach will lead to later problems resulting from poor communication.

In the beginning, were you skeptical about the chances of the project being a success?
To start with, I saw it as WHO research. I did not see the MVP project. I must admit that my initial involvement was primarily to gain information. WHO has already supported attempts to test vaccines against malaria. I know that it is something that must be done. If we want to make progress, there has to be a starting point somewhere, and I personally believe that WHO, the organization in charge, is credible and has the necessary authority, so I did not hesitate. I then received further information, which seemed transparent to me, since MVP was clear about what worked and what did not. The thing that got the scientist in me asking questions was that the vaccine had been tested with adults and now was to be tested on children. But, when it was compared to the Men C vaccine tested and now used in Great Britain, they said that it could work. The issue is whether it can also work here. However, it is merely in relation to the target population that I have this concern. It is strange, but the more PAG meetings and meetings like this [July 2006 Investigators' Meeting] that I attend, the more sure I am that it is going to work.

There are diseases which are more dangerous than meningitis. What would you say to people who say that meningitis should not be a priority compared to AIDS, malaria, etc?
The impact of the disease must be looked at over time. By comparing the effect of diseases simply through the number of people they affect, you can be accused of an exercise in sophistry since when WHO speaks of health for *all*, when UNICEF speaks of the right to *health*, it is the right of *everyone* to health. Go and ask someone who is suffering from meningitis or sickle cell disease whether they think it is worth being treated. It is easy for someone who lives in a place where there is not a meningitis epidemic to say that. If that person was born here, if his or her child had meningitis and if we asked them whether vaccines should be developed to treat this disease, I think that this person would say, "Yes, of course!" Sometimes people are not objective because we do the same thing here in Africa when we watch television and see the astronomical sums that are spent in Europe on understanding congenital defects which only affect a very tiny portion of the population. It is true that it is their money, but when we see that, in comparison to what we see here, we start to wonder. The most reasonable and humane attitude is not to say, "Why meningitis?" As long as it affects tens of thousands, or even millions of people, and as long as it is a disease that is debilitating because it can leave sequelae and stunt development, then we cannot say that eliminating it is too much of a sacrifice. It could have been other diseases, but it so happens that it is this one. I do not have prejudices with regard to that because when you live here, when you see the social impact, the psychological impact on those who

suffer, the environmental impact, the way it affects the development of the country, we cannot do without the vaccine.

Your concluding remarks?
I have come to understand what communication can help to achieve, something which I could have done sooner if I had been initiated in or exposed to communication earlier on, because it is these questions which have led me to where I am today. I have had the opportunity to shift back and forth between the roles of a doctor working in rural areas and a journalist who returned to these rural areas to tackle "foreign" questions that confronted me with a reality that I did not fully understand. This questioning led me to rediscover myself as a simple citizen and not a demigod. It provided me with what I value most today, which is my ability to listen and to try and understand, because I did not learn to do that at medical school. It is a wonderful resource. When I look back at all the ground I have covered, I understand that people who have taken different paths in life do not always grasp the importance of what we (communicators) are doing and saying. Then again, is this not also our challenge, to help them share in our experience? It is important to avoid becoming discouraged. I have seen how far we have come since 1997–1998, when we helped recover the status of the fight against communicable diseases, prevention via vaccination, etc. Today when I look back, I have the impression that things are on the move in the right direction, and that it can only continue in this direction since there is growing recognition that communication is a major element, a determining factor on the behaviors that people are urgently trying to influence. I personally think that the MVP project will be a success and I hope that above and beyond the project's results, the relations that it will have helped foster and the lessons that it will provide, that it will be perceived as a major contributor to the growing field, in which many people are working today, of "communication in development." I am sure that the impact of the project will be seen in these terms, if we are permitted to work effectively in our field.

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