

## Conversations With Ministers of Health

### Belarussian, Georgian, and Russian Ministers Reflect on Healthcare in Their Countries

During AIHA's annual conference in November 1999, *CommonHealth* staff had the opportunity to talk with Russian Minister of Health, Dr. Yuri Shevchenko, and Dr. Igor Zelenkevich, Minister of Health for Belarus. Then, in February 2000, Dr. Avtandil Jorbenadze, minister of health and social welfare for the Republic of Georgia, spent time with *CommonHealth* while on a trip to the United States.

Their insights into the state of healthcare within their countries and the role of AIHA and its partners in helping them implement important healthcare reforms provide a unique perspective from government leaders whose support of AIHA's programs are often critical to their continued success.

#### Minister Yuri Shevchenko

Appointed Minister of Health of the Russian Federation last July, Yuri Shevchenko brings with him a long and varied experience in healthcare. Shevchenko, who received his medical degree in 1978 from the Kirov Military Medical Academy in St. Petersburg—then known as Leningrad—has a background in cardiovascular surgery and military healthcare. He was previously head of the Russian Military Medical Academy in St. Peters-

burg as well as chief cardiothoracic surgeon and head of the Cardiothoracic Center of Leningrad Oblast.

Minister Shevchenko says he envisions healthcare as essential to the sustainability and security of the nation and sees proactive programs geared toward preventive medicine and maintaining a healthy lifestyle as a viable approach.

*Q: Can you please comment on current healthcare initiatives under way in the Russian Federation.*

*Shevchenko:* With the personal support of the government, we are committed to changing the public's attitude toward healthcare in general. As I see it, healthcare involves the general population, medical workers, and the government. Healthcare should be the priority among all the country's activities because it is the sphere that supports survival. Actually, it's part of the nation's security—and that's exactly what should determine our attitude about it. It's very important for our citizens to realize that. They should take care of their own health. There are a lot of opportunities for that now. We should undoubtedly invest money in keeping people healthy.

If we invest money only in keeping people who are very ill alive and don't think about the actual process of preventing illness, then our energies are mispent. Certainly, when a person is helpless and cannot take care of himself, we should put money together to support him. But in that case, we are not supporting health; we are helping one individual survive. We could grow in that aspect, but no economy, even in the most influential or largest country, could support that. Even the economy of such developed countries as the United States couldn't bear such expense.

Like defense, healthcare should be an internal organ, with the same list of priorities. Both are essential to the security of the nation. That's why financing for health maintenance should be provided. Of course, we are going through a very difficult time; we are living through a grave economic crisis. At the same time, we need to change the mentality of our population so people take more responsibility for their own health. Unfortunately, our people were raised on socialist ideas. For example, a man who was drinking and smoking so much that it was taking a toll on his health would in former times come to the government and say, "Take care of me. Under the constitution, I have the right to be treated. I want it free of charge, as is guaranteed by the constitution. If you cannot take care of me here, perhaps some other country can." It shouldn't be that way.

*Q: You've spoken about the importance of preventive health, and how people should take care of themselves before they become seriously ill and require expensive services. Can you give me a few specific examples of how you plan to address public health issues?*

*Shevchenko:* First of all, by educating the population. This also takes money, but is much less than what would be needed to treat a person already ill. Then I think we should introduce certain legal or economic sanctions. For example, perhaps people who regularly drink or smoke should be required to pay more within a structured system of health insurance. My advisors are working on that, but these are general ideas.

*Q: What have you gained from your attendance at AIHA's annual conference?*

*Shevchenko:* I really appreciate the idea of healthcare partnerships and the reforms



Photo: Daniel Peck Studios

Yuri Shevchenko

AIHA has initiated. They are very much in line with what I have been talking about.

With these reforms, a lot of diseases and illnesses that we now treat in hospitals could be moved to outpatient care, especially with the use of advanced technologies which are now available. It is also important to change the way we train nurses in our country. We are very often much more dependent on the quality of nurses than of physicians. That's why I'm working on this now; we're using other countries' experiences to help raise the authority of our nurses, develop their skills, and make this profession prestigious from the point of view of the general population. This has been neglected in our concept of healthcare.

### Minister Igor Zelenkevich

Igor Zelenkevich has served as the Minister of Health of the Republic of Belarus since his February 1997 appointment by President Aleksandr Lukashenko.

Born in 1952, Zelenkevich received his medical degree from the Minsk State Medical Institute in 1976 and later studied medical management under the Belarusian Council of Ministers. Specializing in urology, Zelenkevich worked at Minsk Clinical Hospital No. 4 and later became deputy director of the facility. He also served as the head of the Minsk City Health Department and deputy head of the Minsk City Administration.

Minister Zelenkevich says healthcare reform in Belarus should be aimed at improving the quality of people's lives; the ministry's emphasis on primary care and public awareness reflects this goal.

**Q:** *Can you broadly state your current health initiatives in Belarus?*

**Zelenkevich:** This conference is important

to us because it allows us to see how things are progressing in other former Soviet countries. In our country, healthcare is still financed by the government through the state budget. I would say that to introduce medical insurance in a country such as ours whose economy is in crisis would be too early. Our attitude toward healthcare reform is that reforms should be aimed at improving people's quality of life while being understandable to both doctors and the population. That's why our current emphasis is on primary care. We already have 119 general practitioners; two years ago, we had only two. We are changing our system of educating and preparing doctors, mostly through post-graduate education.

We think that local governments and authorities as well as all Ministries should be involved in helping change peoples' attitudes about healthcare and the way they take care of themselves. Our government recently passed a new program called "People's Health." One aspect of this program is the improvement of environmental conditions—including improvements in water supply, workplace safety, quality of food-stuffs, and so on. I would say that we have found our own approach to improving the treatment of TB. We have passed a special government program on how to deal with TB issues in our country. Another program is for cardiology and diabetes. There is also a presidential program called "Children of Belarus." These are our approaches to these serious and complicated issues; if there is a government program for it, there is financing available. As to hospitals and outpatient clinics, we are now in the process of introducing standard protocols of treatment, preparing the foundation for the introduction of medical insurance.

Another experiment now under way concerns an economic aspect of health-

care. We have introduced a program to evaluate the quality of health services provided by doctors. We evaluate and assess physicians based on how they treat their patients. On the basis of this evaluation, we pay them differently.

We are working very intensely to make our AIHA partnerships work; it's important that we see them produce results. Yesterday we signed one MOU, and today we are to sign two more. These partnerships will address the creation of an EMS Training Center, initiate a new community-based primary healthcare partnership, and establish a Women's Wellness Center.

**Q:** *You say you now have 119 general practitioners (GPs), and are focusing on primary healthcare. How have ordinary citizens responded to the new role of GPs? Do they understand it? Are they benefiting from this new form of healthcare delivery?*

**Zelenkevich:** We introduced GPs mostly into rural areas. At first, the population couldn't understand this delivery system. They asked, "What's the difference?" But when people started coming to these doctors, they discovered that a lot of problems could be settled where they were without traveling to another oblast or city. These doctors can provide emergency medicine to people in their areas, or go to visit them personally. I have looked very closely at how family care practitioners work in rural areas, and have found that they become a part of the families they serve. They know everything about these families—who goes to church, who is drinking too much, everything. I think that's very good. In most cases, people have had very positive responses to this



Igor Zelenkevich

Photo: Daniel Peck Studios.

system of care, and what's more important, local authorities are supportive.

*Q: You also mentioned an EMS initiative. What is the current state of emergency medical services in your country and what do you hope to accomplish with AIHA in that area?*

**Zelenkevich:** According to statistics, injury and poisoning are the third leading causes of death in Belarus. Now only medical providers treat these problems, but as we know, in emergency situations, minutes and even seconds matter. First of all, we should train and re-train doctors on how to provide emergency medical services. We would also like to train traffic police, fire departments, and the population in general. The new AIHA partnership will train ambulance drivers.

*Q: What is the current state of women's health in your country and what are your plans to remedy any concerns or problems?*

**Zelenkevich:** We have one Women's Wellness Center [WWC] under way in the city of Minsk. This project is very successful. I would say that maybe we are in a better situation than other former Soviet states, because the infant mortality rate in Belarus is only 11.1 per 1,000 births. We also have a low rate of childbirth mortality for women. But we have many problems. First, the deterioration of women's health. Second, a very high abortion rate. I would say that as to "family planning," the family is not involved—just men are. There are also concerns about teenage pregnancy—a very serious problem. Also sexually transmitted diseases, although the transmission is currently decreasing. But notwithstanding the lower rate, the number of teenagers with STDs is growing.

One more problem I will be open

about is that women's healthcare workers often lack adequate skills. We need to change the attitude of physicians who provide care to women, in obstetrics in particular. Unfortunately, I must say that sometimes there is negligence. Why would I say that? Within the 11.1 per 1,000 infant mortality rate, 30 percent could be avoided. That 30 percent is due to medical negligence. This shows we have room for improvement.

*Q: What are women's reactions to the new WWC in Minsk? How much is it being used by them?*

**Zelenkevich:** One thing you need to know is that the WWC provides services free of charge. If a catchment doctor thinks there is a need, he can direct a woman there. Women also go there on their own initiative. At first, women couldn't understand the reasons for a new center or for going to the WWC, since we already have special women's care outpatient clinics. But, when they saw that the approach of the WWC was different, attitudes changed.

Women's wellness is important to us; it is important to the government and the whole state. That's why the President of Belarus visited the Center. While he was there, we explained the WWC concept to him—why we are doing this, and what the results have been. As a result, he has asked us to replicate this program as soon as possible. Even at the head of state, these issues are understood and a lot of attention is paid to them.

After his visit to the WWC, the President initiated a year-long program for the improvement of Belarus' healthcare system. The program focuses on financial support for healthcare as well as three major issues: one, the reconstruction and refurbishment of existing medical institu-

tions; two, the introduction of new technologies within those reconstructed medical structures; and three, the introduction of efforts to change peoples' attitudes about their health, including the provision of opportunities for rehabilitation or self-care after a patient is discharged from the hospital.

*Q: How do you propose to change your population's attitudes about healthcare in the ways you are describing?*

**Zelenkevich:** We have a lot of projects sponsored by WHO to promote the nation's health. The major emphasis is on prevention, in which we stress the involvement of the population. For example, we have very successful diabetes and asthma education centers. Now we are establishing such centers for people with high blood pressure. These centers are full-fledged educational systems for patients with chronic illnesses; they also provide a means to educate people about preventing such diseases.

It's important for each citizen to realize that it is much more economically beneficial for him or her to be healthy than to be ill. Economic incentives, I think, are very effective. We are now taking a few steps in this direction, but what we really need to do is change the mentality of the population—a very difficult task. For generations, people were taught that their health was the responsibility of the government. Often, people just can't understand what we are talking about. We have a lot of commercials now on TV promoting healthy ways of life, and sometimes people don't understand them. "Why is this toothbrush talking to me?" they ask. But people are gradually beginning to understand. As far as dentistry is concerned, this is the first field of medical care where we are introducing more paid services,

and I think that is right. Children and pensioners still receive dental services—including orthodontics—free of charge.

*Q: What have you gained from your attendance at AIHA's annual conference?*

**Zelenkevich:** I would like to express my gratitude to the organizers of this conference. I think that this conference is very important for both recipient and donor countries. We see that reforms in medical care are under way in all Independent States. I wish success to all these countries and to the American health organizations involved, and to us I wish success in continuing to introduce and conduct our own healthcare reforms.

### Minister Avtandil Jorbenadze

Avtandil Jorbenadze has served in the government of Eduard Shevardnadze since the Republic of Georgia's independence from the Soviet Union in 1991. Born in 1951, in the village of Chibati in the Lanchkhuti district of Georgia, Jorbenadze studied at the Tbilisi State Medical Institute, receiving his medical degree in 1974, after which he worked as an army medical doctor, focusing his medical career on internal medicine. He later became an attending physician, and then head doctor at the Tbilisi City Hospital #1. In the early 1990s, he served as the deputy chief and then the chief of the Healthcare Department of the Tbilisi municipal area.

Minister Jorbenadze's portfolio has been recently expanded to include both social welfare and health. The responsibilities of the newly created Ministry include healthcare, employment, labor code policy and development, and the protection of socially at-risk groups such as pensioners, the poor, veterans, and the disabled.

*Q: You have been in the ministry in the Georgian government since it won its independence from the Soviet Union and you have also been health minister for the last seven years, longer than most other NIS ministers. How have the ministry's goals changed in that time, and what are some of the successes and challenges you've met?*

**Jorbenadze:** The early years were a very difficult period for Georgia. It was the beginning of the development process for the new state, the beginning of the development of a market economy, and I kept thinking about what the healthcare system should look like in this new state system. I thought about what role the government should have and its responsibility to its people—what are the rights and responsibilities of the citizens and what role should the employers and contributors play in deciding these issues.

The state is responsible for providing programs to protect its citizens, such as medical care for vulnerable groups and controlling those dangerous to society. The entrepreneurs and employers were considered significant players in supporting our development of a healthcare system. They were asked to introduce health insurance. Currently we are putting much effort into developing the insurance market in Georgia; insurance system regulations have been developed.

An important issue is promoting health education and healthy lifestyles, as well as making sure that citizens actively participate in the transition and development of new healthcare systems. We delegated certain responsibilities to regional and local authorities, who are now responsible for the provision of primary and emergency care. This is basically the main work of our healthcare facilities.

In developing new systems, it is vital

to create the legal regulatory base for healthcare: health insurance laws, political laws for healthcare, and laws governing human and patient rights. Another important thing we have done is to develop a national health policy for Georgia. This 10-year strategic implementation plan for health policy has gotten much support from WHO.

As far as Georgia facing financial problems in local healthcare delivery, many financial donor organizations have participated in funding initiatives, such as USAID, the American and Japanese governments, and many other countries who have intermittently supported the government. I think that our own resources combined with this international support will allow us to reach our goals.

*Q: In regards to health promotion, how do you reach out to the citizens of Georgia and work with them to stop smoking, to get them to drink less and eat better?*

**Jorbenadze:** A special committee has been created to implement a healthy lifestyle promotion program; the committee is, in fact, headed by the President of Georgia. We have problems with respect to our limited budget, but government money is allocated for health promotion programs in the country. These health promotion programs are multi-institutional. We are using a coalition approach that includes the Ministry of Education, the Ministry of Science, and many other agencies.

We are introducing health education programs in high schools, especially through promoting exercise and sports. We are working to provide information about the negative effects of smoking and



Photo: Encarna Villalon.

alcohol, and to provide educational materials that talk about an active way of life. This is the major focus of this initiative.

*Q: Given the new responsibilities of your position, are there things that you can draw on from your experiences in the healthcare sector that will help you with other social sectors?*

**Jorbenadze:** I consider healthcare a part of the social sector. There are a lot of things that are inter-related. If we don't address issues of employment, we will not be able to address poverty. If we do not address poverty, we will not be able to address quality-of-life issues. When quality of life is low, the health and access to healthcare of a person is reduced as well. Healthcare issues come back to social welfare and social security. These are some of the many things we are thinking about.

There are a lot of problems we need to address: the elderly, the disabled, veterans, children, women. These issues are all related. When quality of life goes down, the educational level of the population also goes down, and that brings problems with it. We are trying to prevent the causes of the problems.

One of our major goals during our visit to Washington is to get support from the IMF and the World Bank to develop an innovative anti-poverty campaign. This campaign will kick off our poverty alleviation program. We will be able to address poverty significantly, improve quality of life, improve the health of the population, and improve access to healthcare. That will allow us to improve social security benefits for certain social groups.

We are currently working on the development of a social policy for the country. We have developed a conceptual paper for that, and are now working on a social pol-

icy and strategic plan that I hope the United States and many other developed countries will assist us in developing and implementing. The IMF and World Bank are also playing a significant role in this process. I think that poverty alleviation should be the major goal of international organizations who are involved in helping Georgia.

Each citizen, in each country, in each small place of the world must have the right to live. The right to live means that there should be a certain level of quality of life provided. I know that human development is very important. I believe it is important that the support given by developed countries and international organizations helps countries in transitional periods to overcome these problems. The 21st century should be the century of poverty alleviation in the whole world.

Finally, I would like to emphasize my thanks to AIHA. The partnership program has been very important, and I am very happy that we are working on new partnership programs and giving some social orientation to those programs as well. So we are happy that the programs are involved and I believe we will have true and interesting roads to fruitful cooperation in the future.

## AIHA Board Members Share Thoughts

In November 1999, the AIHA Board of Directors announced the election of two additional Board members and a new slate of officers. AIHA's new Board members are Sheila A. Ryan, former dean and current professor of the School of Nursing at the University of Rochester

in New York, and Louis W. Sullivan, former secretary of the US Department of Health and Human Services and current president of the Morehouse School of Medicine in Atlanta, Georgia.

After more than seven years of leadership and service to AIHA, Daniel Bourque has stepped down as chairman of the Board and assumed the newly created position of Past Chairman. Larry S. Gage, who previously served as secretary of the Board, has assumed the chairmanship. Donald W. Fisher, chair of the AIHA Finance and Audit Committee, has been elected secretary. All new appointments and officer changes went into effect on January 1, 2000. We asked AIHA's new chairman and board members about their vision for the organization's newly launched initiatives and future directions.

### Larry S. Gage, JD

Larry S. Gage is president of the National Association of Public Hospitals and Health Systems (NAPH). NAPH members include more than 100 of the nation's largest urban teaching hospitals and health systems, serving a large percentage of publicly sponsored patients. The association supports the development of innovative approaches to public sector health delivery including the integration of managed care, primary care, and public health. Gage is also a senior partner with Powell, Goldstein, Frazer & Murphy, LLP. He has previously served as deputy assistant secretary for health legislation, US Department of Health and Human Services, and staff counsel, US Senate Labor and Human Resources Committee.

*Q: As someone who has served on AIHA's Board of Directors since the organization's inception in 1992, you have a good understanding of how the organization has grown*



Larry S. Gage

*from supporting a handful of hospital partnerships seven years ago to the nearly 80 partnerships it has sponsored to date. In terms of new and*

*continued initiatives and the number of regions served, what future directions do you foresee for an organization with a record of such rapid growth?*

**Gage:** While AIHA's growth may appear rapid, it is important to understand that it has been carefully planned and cautiously implemented. The partnership concept itself was a powerful one, enabling AIHA and USAID to tap into the vast knowledge base and selfless commitment of individuals and institutions on both sides. Our early emphasis was therefore on building an outstanding core staff and putting in place other necessary tools to support the partnership concept generally. These tools range from the most basic financial and logistic support to analytical, cultural, editorial, and program evaluation—to name just a few areas of expertise.

Once AIHA's core competence was established, it could be extended with little difficulty to a significantly increased number of partnerships, as well as to new kinds of partnerships or new regions. AIHA's overworked staff may not always agree, but from the Board's perspective, they can manage 30 partner exchanges in any given week as easily as three (or a conference for 400 as effortlessly as one for 50).

This base of expertise and flexibility is a tremendous and unique asset. It enabled AIHA to expand almost effortlessly at USAID's request into Central and Eastern Europe, and to broaden the focus beyond hospital partnerships to include health management, primary care, women's well-

ness, and other areas. Because most of the core support needs will be the same, I am convinced that we have the ability to further expand our activities into new regions and additional substantive areas—perhaps even outside of the NIS and CEE and beyond the health sector.

**Q:** *The emphasis on AIHA's new partnerships is on community-based primary healthcare. In what areas do you see the most potential for these partnerships to reach their goals of improved community health for their regions?*

**Gage:** There is a growing appreciation in the United States (and worldwide) that improving the health of communities and individuals involves a wide range of factors and influences. Sanitation, the environment, adequate housing, improved nutrition, lifestyle—all of these factors and more can have a profound impact on health. AIHA's partnership model is clearly flexible and adaptable enough to address concerns and meet needs in all of these areas. In fact, we are already doing so in some of our current partnerships. I believe this will give us the opportunity to look at expanded funding sources and new regions as well—something the Board will be seriously exploring in our strategic planning efforts this year.

### **Sheila A. Ryan, PhD, RN**

A leader in nursing at the national level, Dr. Ryan has been elected a fellow of the American Academy of Nursing, a member of the Institute of Medicine, and treasurer of the National League for Nursing. She served as associate professor and dean of Creighton University in Omaha, Nebraska from 1980-86 before coming to the University of Rochester. At Rochester, she has served as dean and professor, School of

Nursing, and director, Medical Center Nursing. She has been responsible for reorganizing faculty government; expanding faculty tracks for promotion; developing a strategic plan for the School of Nursing; initiating the Community Nursing Center; and managing and advancing the Commonwealth Fund Executive Nursing Fellowship Program. She has previously worked with AIHA on its Nursing Initiative and served as a member of the Primary Care Advisory Committee convened last December with the goal of establishing a framework for the implementation of new partnerships focusing on primary care.

**Q:** *Elevating the role of nurses and training them in clinical skills has been a priority of AIHA since its inception. How can your background in nursing leadership contribute to the nursing initiatives that AIHA continues to implement in countries unaccustomed to nursing as a clinical profession?*

**Ryan:** Elevating the role of nursing as a profession is achieved through advancing clinical skills. My own background is rooted in the bedside, home, or clinic nurse. Regardless of location, professional nursing aims to improve care outcomes (something Florence Nightingale first taught us) and to improve healthcare systems. My background in both education and practice will draw upon my many relationships with colleagues to engage them in the partnerships throughout nursing. The best partnerships require infusion and exchange about clinical skills and educational needs. They go hand in hand.

**Q:** *What role will nursing play in the new emphasis on primary care being seen in the NIS?*

**Ryan:** Nursing plays many important roles in delivering primary care in the community. Such needs include health promotion, dis-

# AIHA Voices

ease prevention programs, closer monitoring for maintenance of those with chronic conditions, and earlier referral to the physician. Earlier referral requires less intensive resources. Nurses play a central role in moving the treatment of patients “upstream” (as this is often referred to in our country).



Photo courtesy of Sheila A. Ryan.

Sheila A. Ryan

**Q:** *What form would you like to see nurse training take as many NIS nurses struggle to make the transition from a supportive role in relation to physicians to a complementary one?*

**Ryan:** The best training for nurses to develop their complementary role with physicians is *more education, more education, and more education.* By this I mean that all education should result in advancing one's degrees and practice opportunities. This happens over time (as it has resulted slowly in America over the last 50 years). It is difficult to point to one course, one training session, or to one degree; however, no one would disagree that nurses are functioning in advanced and complementary roles to physicians in the States. Said in another way, to function as peers on a team, one needs similar levels of education for starters.

## Louis W. Sullivan, MD

Sullivan began his distinguished career in academia by teaching and conducting research at Harvard Medical School, the New Jersey College of Medicine, Boston University Medical Center, and Boston University School of Medicine. However, chief among his many achievements is the founding of the Morehouse School of Medicine (MSM) in Atlanta, Georgia in 1978. He remained dean and president of the school

until appointed by President George Bush in 1989 to the Cabinet position of Secretary of Health and Human Services. After serving in this post during the length of the Bush administration, he returned as president of MSM in 1993. At MSM, he has developed collaborative programs in Haiti, Senegal, Zimbabwe, Uganda, Nigeria, and Liberia in which students and faculty from MSM address issues associated with primary care. During his tenure at MSM, the school has been a participant in the AIHA-sponsored Atlanta/Tbilisi partnership and in the recently established Atlanta/Kutaisi, Georgia partnership.

**Q:** *How do you perceive your expertise in the field of academia will translate into leadership for AIHA's numerous initiatives in health management education and various programs in health professions training and re-training?*

**Sullivan:** I have been fortunate in having a large, multifaceted career in academic medicine as: a) a research clinician in hematology; b) a teacher of medical students and residents in the classroom, the laboratory, and at the bedside; c) an administrator of a blood services program at a major teaching hospital; d) a founding dean of a new medical school focused on training young people for careers as primary care physicians and orienting them for work in medically underserved areas; and e) a consultant to various international healthcare and health professions educational initiatives, primarily in African countries. These experiences should be helpful in my role of providing oversight and advice to AIHA with its various programs.

**Q:** *Can you comment on your experience with MSM's healthcare partnerships in Africa and how it will contribute to*

*AIHA's leadership in health reform in the NIS?*

**Sullivan:** In Africa, my colleagues from MSM and I have been involved in a number of projects over the past 15 years, including support of curriculum development and evaluation in primary care at MSM for participants from various countries in Africa; an AIDS/HIV education program in Zambia; a traditional medicine-western medicine program at Fatik (Senegal); the development of a school of public health at the University of Dakar (Senegal) in partnership with Tulane University School of Tropical Medicine and Hygiene; the development of a school of public health at Medical University of South Africa (MEDUNSA); and a scholarship program for health professions students in South Africa, through an organization, Medical Education for South African Blacks (MESAB), based in New Brunswick, New Jersey.

**Q:** *What experience do you bring as a former Cabinet member to the continued success of AIHA's current international initiatives in primary care and community health in regions where these concepts are unfamiliar?*

**Sullivan:** As US Secretary of Health and Human Services, I made visits to some 24 countries in Africa to learn about their health systems and their health problems. The most notable was a two-week trip I led to some 8 countries in sub-Saharan Africa with a 35-member delegation from the US Public Health Service and USAID. I will draw on lessons learned from these experiences, and bring them to my role as a Board member.



Louis W. Sullivan

Photo courtesy of Louis W. Sullivan.