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A Study on Primary Health Centre and Its Role on Public Service in Salem District

[1]Mrs. N. Malarvizhi, [2]Dr.D. Janagam
[1]*Guest Lecture Department of Economics Govt Arts college for Women Salem*
[2]*Assistant Professor Department of Economics Periyar University Salem-11*

***Abstract*—Primary Health Centre (PHC) is the most vital component of Public Health Care System as it is the first place of contact between the citizens and the Public Health System. The government is trying to improve the delivery of health care services through various pro-grammes, so as to improve the health status of people. The most important aspect of the success of health programmes is the extent of availing of public health services by the people. Thereby, it would be necessary to ascertain the factors which help in better accessibility of public health care service by people especially at PHC level, so that health for all is achieved. As the government is trying to address health issues of rural and urban areas through separate programmes, there is need to examine whether there is any difference in the accessibility of PHC services in these areas. Primary Health Centres (PHCs) particularly those belonging to rural and low-income segments have been playing an important role in health care in India. Services given by the PHCs are by and large free for a customer. A typical PHC provides such services as consultation, limited clinical tests, immunization, mother and child care (both ante-natal and post-natal), and family planning and sterilization in addition to dispensing medicines including pills, injections, vaccines, drips, etc. The PHCs also have bed facilities for admitting patients who require continuous care of medical staff. Health workforce includes clinically trained health professionals, health management and support workers. Imbalance in health workforce is a major challenge, as its size and quality positively determine country's ability to meet its goals of organizing and delivering health services, like immunization coverage, outreach of primary care etc.**

***Index Terms*—Challenges, evolution, India, primary healthcare**

I. INTRODUCTION

Primary healthcare is the foundation of total healthcare of any country because it is cost effective and has huge forward linkages with emphasis more on the prevention of the diseases than their curative aspects. Due to inadequate resources for curative health services, the preventive healthcare in developing countries attains more significance. The main components of the

preventive healthcare are immunization, nutrition and environmental awareness. Unfortunately, in the developing countries with huge population, prevalence of mass poverty and expanding income inequalities, the component of preventive healthcare is the neglected side of total healthcare. The health planners in India have visualized the PHC and its Sub-Centres (SCs) as the proper infrastructure to provide health services to the rural population. Health services in India rest traditionally upon a three-tier hierarchy of central, intermediate and peripheral Levels. With the aim of achieving an optimal level of health for its people, the Government of India launched the Rural Health Scheme in 1977 which is a three-tier system of health care delivery in rural areas based on the recommendations of the Srivastav Committee in 1975. Apart from other areas of action, the committee recommended the development of a 'Referral Services Complex' by establishing proper linkages between the Primary Health Centre and higher-level referral and service centres Primary Health Care is the first level of contact of the individuals, the family and the community with the public health system, which brings health care as close as possible to where the common people live and work. In the modern time, the basis for organisation of health services in India through primary health care was laid by the recommendations of the Bhore commit-tee in 1946. Later, based on the proposal of first integrated all round development programme (the community development programme) primary health centres were set up for each community development block. With the passage of time extensive changes have taken place in the Indian health system in the backdrop of Alma Ata declaration (1978), Health for all and off late the Millennium development goals. The Governments both at central and state level have started playing an effective role in providing health care services to the poorest of the poor. Government of India (GOI) has launched various health schemes under National Rural Health Mission (NRHM, sub mission under National Health Mission) in 2005, provided health insurance coverage to the poor and the unorganised workers (Rashtriya Swasthya Bima Yojna, Yashaswini and Vajpayee Arogyasri in Karnataka state), established numerous primary health centres both in rural and urban areas (2346 as per May 2012 in Karnataka), Com-munity health centres (146 as per May 2012) to include all in the web of health care system. Recently the GOI, has launched a new health programme named National Urban Health Mission (NUHM) under Ministry of Health and Family Welfare with an intention to upgrade the health status of the urban population in general and disadvantaged sections of the society in particular. The health planners in India have visualized the PHC and its Sub-Centres (SCs) as the proper infrastructure to provide health services to the rural population. The Central Council of Health at its first meeting held in January 1953 had recommended the establishment of PHCs in community development blocks to provide comprehensive health care to the rural population. These centres were functioning as peripheral health service institutions with little or no community involvement. Increasingly, these centres came under criticism, as they were not able to provide adequate health coverage, partly, because they were poorly staffed and equipped and lacked basic amenities. PHCs were established with proper infrastructure and aimed to provide comprehensive quality health care to the defined rural population. After the establishment of the PHCs, many studies were carried out on the existence of infrastructure, manpower and essential drugs, suggesting lack of some or many of them. the

PHCs have to be efficient, and to cater to the essential services for the people of rural areas and the vulnerable population. Facility surveys are being conducted in different states to find the required numbers, and in turn, fill the gaps. For continuous improvement in quality of care, standards are the main drive. Aim of this study was to assess the quality of facilities available at primary health care centres as per IPHS guidelines and to find out gap in delivering quality health care to community by PHCs.

II. SIGNIFICANCE OF PRIMARY HEALTH CARE:

The importance given to primary health care is because of underlying five ideas. First, it is the recognition of the importance of intersectoral action for development of health. This emerged because economic growth did not necessarily "trickle down" to the poor as economists had assumed. The nucleus of development was how to uplift the standard of life of the poor people. Second reason was the experience of earlier programmes that the key infectious diseases could not be successfully combated by specific and intensive isolated programmes, controlled and coordinated from the Centre. The third underlying idea was that preventive and promotive actions should not be separated from curative action, because for attaining the desired results proper integration of these is important. Fourth was the evidence that there was a range of health activities which were relatively cheap and very effective but did not reach millions of people throughout the world. Finally, it represented a strong action against authoritarian attempt of the health professionals to impose health on people guided by their vested interests. The Government will continue to give prominence to the health of women and children. Promotion of institutional deliveries by strengthening the Primary Health Centres and Health Sub-Centres with qualified and trained manpower, establishment of upgraded Primary Health Centres in each block with 30 beds, an operation theatre and various other facilities, provision of 24 hours delivery care services by provided. Most health systems around the world remain heavily focused on illness and do relatively little to optimize health and thereby minimize the burden of illness, especially for vulnerable groups. Failure to improve the underlying conditions for health is compounded by insufficient allocation of resources to address priority needs with equity (universality, accessibility and affordability). Instead, when engaged in public debate on health care, jurisdictions tend to focus on high-cost items that preoccupy administrators. This short-sighted focus overlooks 'upstream factors': health-promoting environments and workplaces, primary prevention, e.g., nutrition education, immunization, antenatal care, physical activity, smoking prevention, and social policies that influence literacy, employment, crime, housing quality, and community well-being. In particular, there is a global need to improve the response to the surging chronic disease burden. Research indicates that much of this burden is preventable by acting on modifiable behaviours, e.g., smoking, fitness, weight control; and about half of those who do develop these conditions can be prevented from progressing to complicated forms through attention to secondary prevention by identifying and engaging in early intervention for persons at risk, e.g., blood pressure screening and glucose monitoring. However, many decision makers remain preoccupied

with acute-care issues, crisis-prone yet glamorized, even overlooking important 'downstream considerations', e.g., long-term care, home care, whose availability determines the speed with which acute-care patients may move to more appropriate levels of care.

III. EVOLUTION OF PRIMARY HEALTHCARE SYSTEM

Primary healthcare is a vital strategy that remains the backbone of health service delivery. India was one of the first countries to recognize the merits of primary healthcare approach. Long before the Declaration of Alma-Ata, India adopted a primary healthcare model based on the principle that inability to pay should not prevent people from accessing health services. Derived from the recommendations of the Health Survey and Development Committee Report 1946, under the chairmanship of Sir Joseph Bhore, the Indian Government resolved to concentrate services on rural people. This committee report laid emphasis on social orientation of medical practice and high level of public participation. With beginning of health planning in India and first five-year plan formulation (1951-1955) Community Development Programme was launched in 1952. It was envisaged as a multipurpose program covering health and sanitation through establishment of primary health centers (PHCs) and subcenters. By the close of second five year plan (1956-1961) Health Survey and Planning Committee (Mudaliar Committee) was appointed by Government of India to review the progress made in health sector after submission of Bhore Committee report. The major recommendations of this committee report was to limit the population served by the PHCs with the improvement in the quality of the services provided and provision of one basic health worker per 10,000 population. The Jungalwalla Committee in 1967 gave importance to integration of health services. The committee recommended the integration from the highest to lowest level in services, organization, and personnel. The Kartar Singh Committee on multipurpose workers in 1973 laid down the norms about health workers. Shrivastav Committee (1975) suggested creation of bands of para-professionals and semi-professional worker from within the community like school teachers and post masters. It also recommended the development of referral complex by establishing linkage between PHCs and high-level referral and service centers. Rural Health Scheme was launched in 1977, wherein training of community health, reorientation training of multipurpose workers, and linking medical colleges to rural health was initiated. Also to initiate community participation, the community health volunteer "Village Health Guide" scheme was launched. The Alma-Ata Declaration of 1978 launched the concept of health for all by year 2000. The declaration advocated the provision of first contact services and basic medical care within the framework of an integrated health service. Several critical efforts outlined Government of India's commitment to provide health for all of its citizens after Alma-Ata declaration. The report of study group on "Health for All: An Alternative Strategy" commissioned by Indian Council for Social Science Research (ICSSR) and Indian Council for Medical Research (ICMR) (1980) argued that most of health problems of a majority of India's population were amenable to being solved at the primary healthcare level through community participation and ownership. Alma-Ata declaration led to formulation of India's first National Health Policy in 1983.

The major goal of policy was to provide universal, comprehensive primary health services. Nearly 20 years after the first policy, the second National Health Policy was presented in 2002. The National Health Policy, 2002 set out a new framework to achieve public health goals in socioeconomic circumstances currently prevailing in the country. It sets out an increased sectoral share of allocation out of total health spending to primary healthcare. [3] Recognizing the importance of health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has launched the National Rural Health Mission in 2005 to carry out necessary architectural correction in the basic healthcare delivery system. The goal of the mission is to improve the availability of and access to quality healthcare by people, especially for those residing in rural areas, the poor, women, and children.

IV. CHALLENGES FOR PRIMARY HEALTHCARE SYSTEM IN INDIA

Delivering quality primary care to large populations is always challenging, and that is certainly the case in India. In India, communicable diseases, maternal, perinatal, and nutritional deficiencies continue to be important causes of deaths noncommunicable diseases like diabetes, cardiovascular diseases, respiratory disorders, cancers, and injuries are showing the rising trends. Mental health disorders are also on the rise also taking a substantial toll of human lives. The health issues related to elderly population are common due to increase in life expectancy. India has been witnessing rapid urbanization particularly in recent decades. Currently one-fourth of the urban population lives in slums with severely compromised health and sanitary conditions. While the primary healthcare system is struggling to provide services, there is an emerging need for addressing above mentioned issues. This presents huge challenge to the current primary healthcare system in India. Within the next few decades, we will see an extraordinary increase in the number of older people worldwide. The public health benefit of preventive medicine in old age comes from the compression of the time spent in dependency to a minimum. The rising morbidities clearly showed that a regular, complete health checkup of the elderly should be embedded in the essential elements of the primary healthcare Patient satisfaction represents a key marker for the quality of healthcare delivery and this internationally accepted factor needs to be studied repeatedly for smooth functioning of the healthcare systems. A better appreciation of the factors pertaining to client satisfaction would result in implementation of custom-made programs according to the requirements of the patients, as perceived by patients and service providers. It has been observed that there is poor level of client satisfaction in rural as well as urban areas of India regarding primary healthcare services. Client satisfaction is an important measure of the quality of healthcare and needs to be addressed in order to improve the utilization of primary healthcare services. Patients often complain of rude and abrupt health workers that discriminate against women and minorities from scheduled castes or tribes.

The current primary healthcare infrastructure and manpower is also deficient. According to Rural Health Survey (RHS) 2011, as on March 2011 there are 148,124 subcenters; 23,887 PHCs; and 4,809 community health centers (CHCs) functioning in India. The norms set for the population

coverage for subcenter, PHC, and CHC for plane areas are 5,000; 30,000; and 120,000; respectively. As per RHS, 2011 the average population covered by a subcenter, PHC, and CHC was 5,624; 34,876; and 173,235; respectively. As on March, 2011 the overall shortfall in the posts of health worker (female (F))/auxiliary nurse midwife was 3.8% of the total requirement. For allopathic doctors at PHCs, there was a shortfall of 12.0% of the total requirement for existing infrastructure as compared to manpower in position. Similarly, in case of health worker (male (M)), there was a shortfall of 64.7% of the requirement. In case of health assistant (female)/lady health visitor, the shortfall was 38% and that of health assistant (male) was 43.3%. For allopathic doctors at PHC, there was a shortfall of 12.0% of the total requirement. As compared to requirement for existing CHC infrastructure, there was a shortfall of 75% of surgeons, 65.9% of obstetricians and gynecologists, 80.1% of physicians, and 74.4% of pediatricians. Overall, there was a shortfall of 63.9% specialists at the CHCs as compared to the requirement for existing CHCs. As per 2011 census, India's population is more than 121 crores. 83.3 crores (68.84%) of Indians live in rural areas. Considering the population norms for PHC of 30,000 in plane areas (here the population norms for PHC of 20,000 for tribal and hilly areas is not considered), India requires more than 27,700 PHCs. So when compared with RHS, 2011; India requires 3,800 more PHCs. There is urgent need to address inadequate infrastructure as well as manpower for better service and delivery of primary healthcare. Only after addressing these issues we can think of applying Indian Public Health Standards to all healthcare infrastructures.

The current primary healthcare structure is extremely rigid, making it unable to respond effectively to local realities and needs. The lack of resources, which is acute in some states, is certainly a contributing factor to the poor performance of the primary healthcare system. There is a need to explore and understand the reasons that prompt people to visit health facilities and the reasons driving them away from free government care. Ubiquitous absenteeism, low client-provider interaction, poor referral systems, and a low perceived quality of care could emerge as possible reasons for this situation. Large diversity in India calls for local adaptation of the basic healthcare package and its delivery mechanism. The question confronting health systems in India is how best to reform, revitalize, and resource primary health systems to deliver different levels of service aligned to local realities, ensuring universal coverage, equitable access, efficiency and effectiveness, through an empowered cadre of health personnel. To encourage accountability, access should be monitored at district level by an independent agency. There is growing need of research in improving the service delivery of primary healthcare. Qualitative research into this area could yield lessons for the delivery of future services. Research into factors influencing service utilization could lead us to developing a public health marketing strategy for care access. A conjoint effort by the state and the institutes can thus be used to reinvent primary healthcare and bring it to the forefront. Several opportunities can be explored within the facilitating atmosphere of National Rural Health Mission (NRHM). Thus, it is evident that the success of health systems exists in tapping the existing potential and making appropriate structural changes. The role of primary care should not be defined in isolation but in relation to the constituents of the health system.

The Millennium Development Goals (MDGs) which include eight goals were framed to address the world's major development challenges with health and its related areas as the prime focus. In India, considerable progress has been made in the field of basic universal education, gender equality in education, and global economic growth. However, there is slow progress in the improvement of health indicators related to mortality, morbidity, and various environmental factors contributing to poor health conditions. As rightly mentioned by Nath, even though the government has implemented a wide array of programs, policies, and various schemes to combat these health challenges, further intensification of efforts and redesigning of outreach strategies is needed to give momentum to the progress toward achievement of the MDGs.

V. FOCUS OF PRIMARY HEALTH CENTRES

Apart from the regular medical treatments, PHCs its have some special focuses.

- Infant immunization programs: Immunization for newborns under the national immunization program is dispensed through the PHCs. This program is fully subsidised
- Anti-epidemic programs: The PHCs act as the primary epidemic diagnostic and control centres for the rural India. Whenever a local epidemic breaks out, the system's doctors are trained for diagnosis. They identify suspected cases and refer for further treatment.
- Birth control programs: Services under the national birth control programs are dispensed through the PHCs. Sterilization surgeries such as vasectomy and tubectomy are done here. These services, too, are fully subsidised.
- Pregnancy and related care: A major focus of the PHC system is medical care for pregnancy and child birth in rural India. This is because people from rural India resist approaching doctors for pregnancy care which increases neonatal death. Hence, pregnancy care is a major focus area for the PHCs.
- Emergencies: All the PHCs store drugs for medical emergencies which could be expected in rural areas. For example antivenoms for snake bites, rabies vaccinations, etc

VI. STUDIES ON PRIMARY HEALTH CARE

Ranganayakulu Bodavala (2002) writes on “ICT applications in Public Health Care System in India: in India’s public healthcare network is five decades old. It is plagued by many problems like absenteeism of doctors, lack of proper facilities and most significantly lack of proper referral services to urban hospitals and specialist centers. Due to these reasons the utilization and confidence in the public healthcare system is very low. Successive governments have tried to improve the various measures in the system with marginal success. Application of ICT tools will improve access and delivery of healthcare services to Ivast majority of poor people living in rural areas in india.

Rychetnik, et al (2002) published "Criteria for Evaluating Evidence on Public Health Interventions" Public health interventions tend to be complex, programmatic, and context dependent. The evidence for their effectiveness must be sufficiently comprehensive to encompass that complexity. This paper asks whether and to what extent evaluative research on public heal interventions can be adequately appraised by applying well established criteria
for judging the quality of evidence in clinical practice. It is adduced that these criteria are useful in evaluating some aspects of evidence. However, there are other important aspects of evidence on public health interventions that are not covered by the established criteria. The evaluation of evidence must distinguish between the fidelity of the evaluation process in detecting the success or failure of an intervention,

Narayana (2003) published an article entitled "Changing Health Care System" in 'Economic & Political Weekly'. To improve the financial viability and quality of health care in public hospitals, the Andhra Pradesh Government initiated a series of reforms. However, because of lack of resources, there has been stagnation in the size and decline in the quality of
public health care. The state's patronage of the private sector in health care has been justified on the ground that it would ease the pressure on government hospitals. But in reality private hospitals are replacing rather than complementing public hospitals by weaning away resources from government hospitals.

Shivakumar (2005) published a paper entitled "Budgeting for Health: Some Considerations" in 'Economic & Political Weekly'. The announcement of the National Rural Health Mission and the commitment in the recent budget to increase allocations for health are necessary steps in the right direction to correct India's shockingly poor health record. As national and state level strategies unfold over the coming months, a vigorous and informed public discussion is needed to create a national consensus for dramatically increasing investments in health with concurrent improvements in accountability and management of the healthcare system. Equally important is induction of a cadre of village-based health activists, all women, who will link communities to an upgraded public health system.

Sathyamala (2006) to study about Foundation of India marks the coming together of interests that are inimical to public health. The Public Health Foundation of India and its institutes – albeit located in India and with the blessings of the Indian government – will in effect function as an extension of American interests. It is to be governed by technocrats/bureaucrats and nominated Non-Governmental Organisations and will be subjected to little or no accountability/scrutiny by the Indian polity.

Objectives:

- A Study on primary health centre in rural and urban area.
- The impact of primary health centre in Salem District.
- A study on Primary health centre programme and development.

VII. DISCUSSION ON PRIMARY HEALTH CARE SYSTEM IN SALEM DISTRICT

TABLE 1.1 HEALTH INDICATORS OF TAMILNADU DURING THE PERIOD 1985-86 TO 2006-2007

Year	Life Expectancy at Birth (y1)	Crude Birthrate (y2)	Crude Death rate (y3)	Infant mortality rate (y4)
1985-86	58.40	24.7	9.5	81
1986-87	58.50	23.8	9.5	80
1987-88	58.60	24.0	9.9	76
1988-89	58.70	22.7	9.3	74
1989-90	59.80	23.1	8.7	68
1990-91	61.20	21.6	8.7	59
1991-92	61.30	20.8	8.8	57
1992-93	61.70	20.7	8.4	58
1993-94	62.6	19.5	8.2	57
1994-95	63.85	19.2	8.0	59
1995-96	63.95	20.2	8.0	54
1996-97	64.12	19.5	8.0	53
1997-98	64.72	19.0	8.0	53
1998-99	65.30	19.2	8.5	53
1999-2000	65.4	19.3	8.0	52
2000-01	65.6	19.3	7.9	51
2001-02	66.12	19.1	7.7	49
2002-03	66.72	18.5	7.7	44
2003-04	66.85	18.3	7.6	43
2004-05	66.95	17.1	7.5	41
2005-06	67.1	16.5	7.4	37
2006-07	67.40	16.2	7.5	37

Source: Director of Public Health and Preventive Medicine, Chennai-6. Census of India 1991, 2001. www.mohfw.nic.in, www.tngov.in

The Table 1.1 shows that a reduction in the indicators such as birth rate, death rate and Infant mortality and increase in life expectancy at birth over the period, particularly after Alma Ata declaration and the National Health Policy 1983 published by Indian government. The experience of Tamil Nadu during the 1985-86 to 2006-2007 indicated steady progress in the health indicators. In 1985-86 the birth rate was 24.7 which was steadily decreased and reached 16.2 on 2006-07. The death rate was 9.5 in 1985-86 which was continuously reduced in a constant way and reached 7.5 in the year 2006-07. Likewise, the infant mortality rate was 81 in the period immediate after Alma

1985-86, which was declined to 37 in 2006-07. Meanwhile the life expectation at birth has been increased from 58.4 in 1985-86 to 67.40 in the year 2006-07. Such a decline in the indicators of crude birth rate, crude death rate and IMR and increase in Life expectation at Birth could be attributed to better health status of Tamil Nadu, technology and its adoption of health care delivery and its utilization and health awareness and attitudes of the people. The increase in life expectation at birth shows the efficiency of health delivery system in the state.

Rural Health Care System in India
Rural Health Care System – the structure and current scenario

The health care infrastructure in rural areas has been developed as a three tier system and is based on the following population norms:

Table 1.2

Centre	Plain Area	Hilly/Tribal/Difficult
Sub Centre	5000	3000
Primary Health Centre	30,000	20,000
Community Health Centre	1,20,000	80,000

As on 31st March, 2015, there are 153655 Sub Centres, 25308 Primary Health Centres (PHCs) and 5396 Community Health Centres (CHCs) functioning in the country.

POLICY CONTEXT
The government has developed a number of enabling policies and environment as an effort to strengthen the health services in the country. Enabling policies are both national and international commitments like National Vision 2025, National Strategy for Growth and Reduction of Poverty (NSGRP), Millennium Development Goals and National Health Policy, Health Sector Strategic Plan, and Policy Paper on Local Government Reform.

Health Sector Reforms
Health sector reform aims at improving the health sector in provision of quality health services for communities. Health sector reforms is a sustainable process of fundamental change in national health policy and institutional arrangement that are evidenced based. The reform has nine strategies as follows: -

- District health services;
- Secondary and tertiary level referral hospital services;
- Role of the central MOHSW;
- Human resource development;
- Central support systems;
- Health care financing;
- Public and private mix;

- Donor coordination;
- HIV/AIDS.

The National AIDS Control Programme:

The National AIDS Control Programme (NACP) of the Ministry of Health and Social Welfare (MOHSW) plans to expand and strengthen the care, treatment and support services to rural communities and make the services accessible to all in need by 2017. Based on the targets that were set in the previous Health Sector Strategy for HIV/AIDS (2003 – 2006), the NACP is currently providing care and treatment services in 200 facilities across the country. The facilities include; referral, regional, district hospitals and also non-Governmental organization and faith based owned hospitals. From year 2007, the services will expand to rural communities by including 500 primary health care facilities of health centres and dispensaries. The number of patients to be initiated with anti-retroviral drugs (ARVs) is expected to increase from the targeted 440,000 in the year 2008 to 800,000 in 2017.

VIII. CONCLUSION:

CO Primary health-care interventions provide a means of dealing with the main health problems faced by communities. Technically, they are the fruit of numerous experiences in the field and of the intensive research that has been carried out in recent years and has given them true credibility. The procedures involved are very complex, however, and require a careful analysis of each situation. To ensure the implementation of a consistent and effective health strategy, health staff must be included at all levels of the decision-making process. Through their activities in the field, they can also take advantage of the direct contacts they establish within communities to further the ICRC's protection efforts. This is not a minor aspect of their work, but an integral part of their responsibilities. Moreover, PHC has several challenges to overcome, such as the traditional health care, poor quality and effectiveness, little impact on improving the health conditions of the population, fledgling social participation, difficulties in organizing the PHC, professional devaluation, the need to be overcome especially by improving the planning, organization and qualification of the PHC. The literature also pointed out a similar reality in various aspects involving the PHC in South America, in countries such as Argentina, Bolivia, Chile, Colombia and Peru, showing that Brazil is inserted into a regional reality that requires larger investments, with respect to the first level of health care. Evaluative studies in this field are of paramount importance in order to identify the strengths and weaknesses and to direct attention to health in the region.