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SOCIAL CAPITAL PERFORMANCE OF PRIMARY HEALTH CENTRES IN KANYAKUMARI DISTRICT - A STUDY

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Abstract

The study explains about the "Social Capital Performance of Primary Health Centres". Social capital through a different disciplinary lens the common thread relates to the importance of positive social networks of different types, shapes and sizes in bringing about social, economic and health development among different groups, hierarchies and societies. The Districts are well developed in terms of literacy, percapita income and availability of basic facilities including health care centres and medical care institutions. Kanyakumari district has better socio-economic and health indicators in comparison with other Districts. In the district, there are 36 PHCs and 267 Health Sub Centres, the PHCs in the rural areas and 112 in the urban areas. There are 321 doctors and 512 nurses under the modern medicine and 56 doctors and 24 nurses under the Indian medicine in 2017-18. However, in health indicators such as IMR, MMR, LEB, CBR and CDR, Districts have a good record. The birth rate is 12.62, the death rate is 6.1 and infant mortality rate is 8.95 per cent in Kanyakumari District. The present study is carried out with the aim of finding solutions to the problems faced by the people of Kanyakumari Districts.

INTRODUCTION

Social capital through a different disciplinary lens the common thread relates to the importance of positive social networks of different types, shapes and sizes in bringing about social, economic and health development among different groups, hierarchies and societies. In the context of the health and wellbeing of children and adolescents it has been argued that traditional definitions of social capital have been conceptualised within an adult framework that

is incomplete in the context of young people's lives, which may differ in their social space and connectedness. For example, the community (or neighbourhood) may be less important than the home and school for children and adolescents, and in recent years' young people's social spaces have expanded to and through the Internet, which has the potential to influence both the positive and negative aspects of social capital.However, given the focus on children and adolescents the concepts of family and community social capital have been used to frame the presentation of the results. The family is considered to have an important role to play in the development and maintenance of bonding forms of capital that support positive developmental trajectories. The family is also thought to play a role in bridging and linking forms of capital that extend the child and their family into the wider social context. When undertaking this review, we have also sought to ensure that the role and impact of social environments particularly relevant to children and young people are explored (for example, the school environment).

Types of Social Capital

The type of social capital discussed the review included studies that had explicitly and implicitly drawn on the work of a broad range of theorists including Bourdieu, Coleman and Putnam. We sought to identify indicators of social capital at family and community levels. Studies were included if they sought to explore the role and impact of any of the following

Family Social Capital

Family social capital includes family structure quality of parent-child relations adult's interest in child parental monitoring and extended family exchange and support

Community Social Capital

Community social capital includes social support networks civic engagement trust and safety degree of religiosity quality of pre-school/school and quality of neighborhood.

If studies focused on any of the above but did not explicitly use the term 'social capital' they were included. For example, studies that focused on the role and impact of 'assets' such as strong parent-child relationships and friendship met this criterion.

Primary Health Centre

The Primary Health Centre (PHC) is the basic structural and functional unit of the public health services in developing countries. PHCs were established to provide accessible, affordable and available primary health care to people. In India,PHCs form a basic part of the health care system. In addition to the provision of diagnostic and curative services, the Medical Officer acts as the primary administrator for the PHC. The primary field staffs, which provide outreach services, are called ASHA (Accredited Social Health Activist) a village health nurse, depending upon the Indian state where the PHC is located. The village health nurse provides service at the point of care, often in the patient's home. If additional diagnostic testing or clinical intervention is required, the patient is transported to the PHC to be evaluated by the Medical Officer. Under the national rural health mission, PHCs are rapidly being upgraded. Presently there are 23,109 PHCs in India.

Primary Health Centres in Kanyakumari District

In Kanyakumari District majority of the people live in rural areas. Health care delivery system to the rural areas starts by 9 block in PHCs, 27 additional PHCs and267 HSCs. Each PHC consists of three medical officers (Assistant surgeons one for general other for family welfare and another one to attend public health activities in the villages) and other complementary staff, health inspectors, health visitors, multipurpose health workers (male and female) health assistants pharmacist and male nursing assistant's cum sweepers. Each HSC will be manned by one male and one female multi-purpose Health worker. The Government of Tamil Nadu has brought down the multipurpose target population to 30,000 from one lakh by each PHC. Each PHC comprises of 6 HSCs on an average. HSCs are established and maintained at the rate of one health centre for every 3000 population in hilly and tribal areas and one for every 5000 population in other areas. According to the population report 2008 the average population per PHC is 40127 and HSC is 5410in Kanyakumari District.

The Details of Infrastructure and Facilities of PHCs and HSCs are listed below.

Total Number (No) of PHCs = 36

No of PHCs functioning in Government Buildings - 31

Total No. of HSCs - 267

No of HSCs functioning in Government Buildings -140

No of HSCs functioning in Rent free Buildings -1

No of HSCs functioning in Rented Buildings - 126

No of PHCs with 30 bedded facility - 7

No of PHCs with Blood storage facility - 4

No of PHCs with functional Operation Theatre - 7

No of PHCs functioning as Birth and Death Units -36

Performance of PHC's in Kanyakumari District

The PHC in Kanyakumari District is entrusted with the responsibility of under taking the following health activities. They are, Safe Mother-hood and child Survival, Malaria and Filaria Control, Universal Immunization Programme, Oral Rehydration Therapy, Acute Respiratory infection control, Communicable Disease Control, Supervision of public health measures and sanitary arrangement for fairs and festivals Public health and preventive measures during natural calamities like drought, floods and unseasonal heavy rains, Monitoring of air and water quality by analysis of water and air samples Prevention of food adulteration by enforcing Food Adulteration Act, Health and Vital Statistics Community Nutrition and Research Education, Industrial health and control of dangerous and offensive trades, Health and Family Welfare Education and Training of Health Para Medicals.

Objective of the study

To study about the performance of PHCs in the study areas,

Methodology

The present study is based on secondary data collected from census of India and District Statistical office in Nagercoil. The sample tables are used analyse the data.

Table: 1 Kanyakumari District Table Data (2001-2011)

Description	2011	2001
Actual Population	1,870,374	1,676,034

Male	926,345	832,269
Female	944,029	843,765
Population Growth	11.60%	4.73%
Sex Ratio (per 1000)	1010	1014
Child Sex Ratio (0-6 Age)	964	968
Birth Rate (per 1000)	12.62	13.02
Death Rare (per 1000)	6.1	6.6
Infant Mortality Rate (per 1000)	8.95	10.59
Area sq.km	1,684	1,684
Density / km^2	1,111	995
Average Literacy	91.75	87.55

Source: Census of India 2011

The initial provisional data suggest a density of 1,111 in 2011 compared to 995 of 2001. Total area under Kanyakumari District is of about 1,684 sq.km average literacy rate of Kanyakumari in 2011 was 91.75 compared to 87.55 of 2001. If things are looked out at gender wise, male and female literacy was 93.86 and 90.45 respectively. Total literacy in Kanyakumari District is 1,567,580 which male and female are 792,385 and 775,195 respectively. In 2001, Kanyakumari District had 1,308,322 in its total region with regards to sex ratio in Kanyakumari it stood at 1010 females per 1000 males, compared to 2001census figure of 1014. The average national sex ratio in India is 940 as per latest reports of census 2011Directorate. The birth rate is 12.62, the death rate is 6.1 and infant mortality rate is 8.95 per cent in Kanyakumari District.

Suggestions

- ✓ The government should take adequate steps to improve the facilities of the existing primary health care services in both quantitatively and qualitatively by opening of more health care centers with sufficient health staff which will enable all people to get enough health services to the needy people.

- ✓ The government as well as the private hospital should provide free medical camp in the needed areas.
- ✓ Now a day the treatment given by the doctor's is based on profit oriented and commercialized. This unwanted trend should be changed by enacting laws and its serious enforcement.
- ✓ Community participation initiative and involvement are crucial element of the successful primary health care precipitation people should get awareness about these health care services facilities within the reach of common man.

CONCLUSION

The primary health care centres poor infrastructure and staff shortage are leading to loss of lives in government hospitals. Improve their PHCs infrastructure in from manpower and health centers are utilized. Almost all factors have been implemented either to control diseases and child health besides family welfare. PHC is also better able to address pervasive health inequalities, poor coverage of basic health care and lack of engagement by communities in health systems. Further some indices namely index of social development, healthcare facilities, utilization of services and others facilities quality of health care has been computed for District. The solution was to make the public health system accountable, affordable, and accessible by improved management of resources and community action. It is high time that the planners and government authority is to all efforts to reach the make health

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