

Chapter 4

Healthcare Services for Nomadics through a Mobile Framework

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ABSTRACT

Many patients are often associated with various types of health related records, needing care and attentions. Healthcare system is intended for all that live in the country. Normally, there is spread of people across the geographical locations, of both the rural and urban communities. Even though the healthcare service is intended to spread across the country, the services are not always available as individuals require it. Hence, there is need for Mobility of healthcare services at both primary and secondary healthcare levels, particularly in the developing countries such as Namibia. In Namibia, the population is scantily spread far apart in the average of about 175 kilometres between major towns, necessitating movements of individuals and groups, particularly the old, poor, and nomadic people. The challenge is, healthcare records in the country are not centralised or virtualised, making accessibility into patients' records difficult or impossible. As a result, healthcare service delivering is challenged. This chapter explored the possibility healthcare services through virtualisation or centralisation as empowered by different translation of activities. The objectives of the study were to identify and discuss actors in the mobility of healthcare services. Mobility in this paper refers to the availability of services to the nomadic patients. The study employed the qualitative approach, within which data was gathered from primary healthcare services providers using open-ended questionnaires. The moments of Translation from the perspective of ANT was used a lens to analyse the data to examine and understand the power and factors which could influences mobility of healthcare service in Namibia.

DOI: 10.4018/978-1-4666-9446-0.ch004

1. INTRODUCTION

The Ministry of Health and Social Services (MoHSS) in Namibia is the leading organisation in Namibia when it comes to healthcare provision. It is mandated to provide an integrated, affordable, accessible, quality health and social welfare services, which is responsive to the needs of the Namibian population (MoHSS, 2012) at healthcare facilities located at different levels of operandi (Hamunyela & Iyamu, 2013) of the health sector. Processes and activities at the MoHSS, are performed either on paper-based technology or HIS. This can be a huge setback for the services which the MoHSS provides to the communities in the country such as distribution of the HIV treatment and immunisation against contagious disease's outbreaks. Worse, the manual approach significantly delays centralisation of processes and activities (Hamunyela & Iyamu, 2013). This indeed is dangerous to patient needs, particularly those who are of intensive and chronic nature and nomadic patients.

In addition, there is mobility of individuals and groups within a country. Hence, there is need for the inclination of centralizing healthcare services at both primary and secondary healthcare levels in developing and developed countries. In Namibia, the geographical spread of the population, the widely held image of the healthiness of people in rural area, different groups with needs for healthcare (the old, the poor, nomadic people est.) necessitates the mobility of healthcare services.

The movement and spread of the population in developing countries can impact healthcare service provision (Hjortdahl, 2007). To ensure effective healthcare services provision, states and healthcare organisations are engaged in transforming the industry. According to Sander Granlien and Hertzum (2012), to improve the quality and efficiency of healthcare many hospitals are involved in extensive efforts to substitute electronic patient records for paper records. Another effort that has been made by some organisations is the integration of health information systems to improve quality of healthcare service.

Also, the shift from curative to planning and preventing of disease outbreaks and control has significantly necessitated the need for Healthcare data management, efficient service delivery, healthcare information flows between health practitioners and patients, as well as information sharing between healthcare levels of operandi (Chaulagai, 2005). The mission of curative, preventing and disease control can only be made possible if the information of the whole population based is made available to policy makers, healthcare profession, administrators, donors and all healthcare organisations.

However, different categories of patients exist in the healthcare sector and the needs for healthcare services are diverse. There is the nomadic patient. This inflates the need to investigate different dimensions of healthcare service provisions processes in a country (HIS module 11). In Chang's (2011) argument, there is a scenario where the patient may visit a different healthcare organisation, either because the patient is dissatisfied with the treatment of his or her previous visit or the patient moves to a different location. Distinctively in this case is the mobility of healthcare services in Namibia.

Mobility in this paper refers to the state of easy accessibility of health services from any geographical location. The essentiality of mobility of healthcare is centred on factors such as portability, transferability and availability of healthcare information including real-time interaction between healthcare providers and the needing (Fardoun and Oadah, 2012). In healthcare, mobility is typically associated with mobile healthcare systems and applications, the use of health public kiosk, cellular phone devices, and other portable computing devices (Cisco, 2007), this paper argues that mobility can also be classified by the availability of healthcare services at different levels of healthcare operandi.

Mobility of healthcare services could be translated by various human actors (patients and healthcare workers), based on the different moments. Translation is a key tenet of actor network theory (Latour,

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