

# THE DEVELOPMENT AND EVALUATION OF THE HAEMOVIGILANCE PROGRAMME IN NAMIBIA



15th International Haemovigilance Seminar  
(HIS)

in Brussels, Belgium  
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# Acknowledgement

The development of the haemovigilance programme in Namibia has been supported by a Cooperative Agreement with the U.S. Centers for Disease Control and Prevention and PEPFAR.

We gratefully acknowledge this assistance.







# Namibia

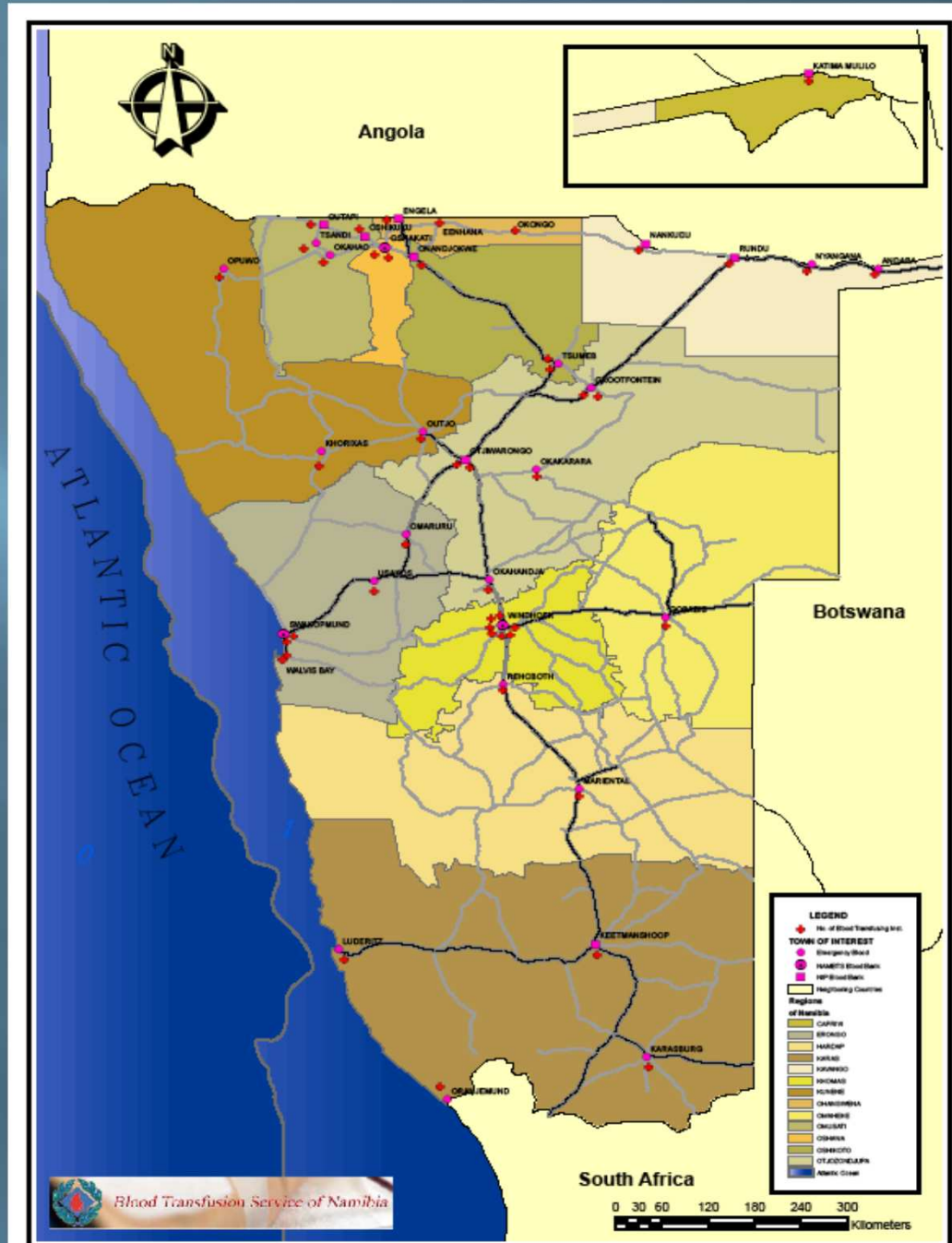
Area - 824 292 square km

Population - approximately **2.1 m**

# Blood Transfusion in Namibia:

- ❑ 46 blood transfusing hospitals
- ❑ Cross matching and/or issuing to hospital wards by:
  1. NAMBTS blood banks:
    - Windhoek (7 hospitals)
    - Oshakati (2 or more)
    - Swakopmund (4 or more)
  2. National Institute of Pathology (NIP ) laboratories
    - Remaining towns

# Memorandum of understanding (MoU) between MoHSS, NIP and NAMBTS



46 hospitals  
served by 31 blood banks



13 provide fully  
crossmatched blood  
to 23 hospitals



18 provide group O  
blood only  
(uncrossmatched)



In 2012:

23 500 units red cell concentrate  
1000 units paediatric red cell concentrate  
3000 units fresh frozen plasma  
800 adult apheresis platelets  
250 paediatric apheresis platelets  
30 units whole blood

# Haemovigilance in Namibia

Prior to 2005 –

- No formal record of donor reactions
- Recipient reactions reported by hospitals and a brief report returned by NAMBTS following investigation.

2005 onwards –

- Start of PEPFAR Blood Safety initiative
- Haemovigilance identified as key to monitoring blood safety.

# Aims and Expectations

Haemovigilance = Availability of information!


- ❑ The frequency, severity and type of donor reactions
- ❑ The frequency, severity and type of recipient reactions
- ❑ Extremely useful in raising awareness amongst clinicians i.e. information sharing amongst the medical fraternity.
- ❑ Enables comparisons of blood usage patterns between hospitals
- ❑ The appropriateness of transfusions i.e. the diagnoses for which blood is used
- ❑ Improves bedside transfusion practices



# THE DEVELOPMENT OF A HAEMOVIGILANCE SYSTEM IN NAMIBIA



# Haemovigilance – timeline

- 
1. *Namibian Haemovigilance Report*
  2. Programme to *formally record and classify adverse reactions*
  3. Programmes for *training hospital staff* (since 2006)
  4. *Hospital audits and training* (2010)
  5. Hospital Transfusion Committee ( *HTC* )  
*Implementation programme* (2011)
  6. *Study and survey* on Haemovigilance  
(CDC/NAMBTBS) (2012)
  7. *Hospital audits and TR training* (2012)



Development



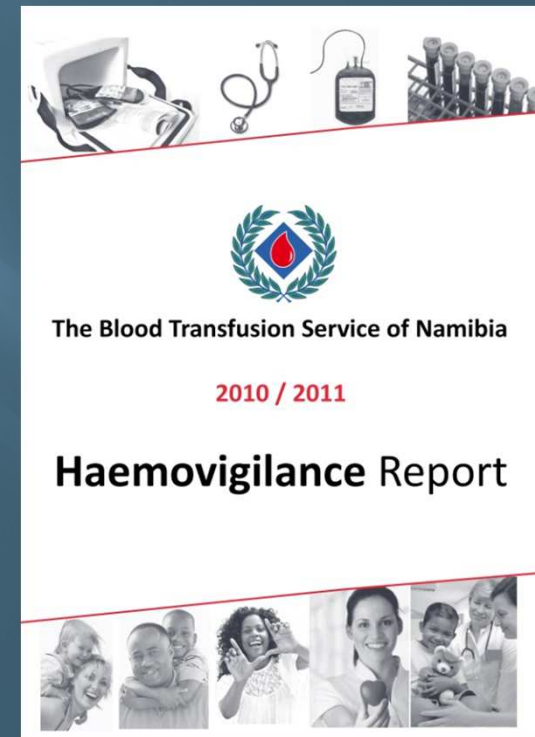
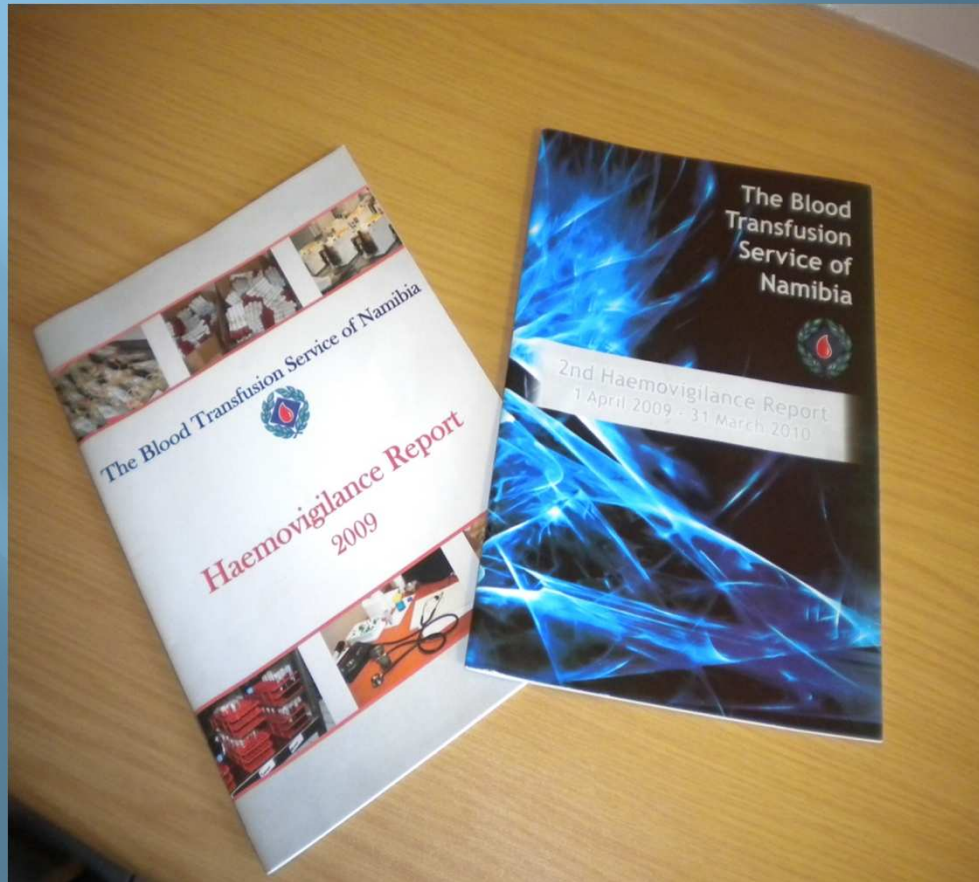
Evaluation

# 1. Haemovigilance Reports

1<sup>st</sup> - time period financial year 2008/2009

2<sup>nd</sup> - 2009/2010

3<sup>rd</sup> - April 2010 to Dec 2011 (in print)



# Scope of the Namibian Haemovigilance Report

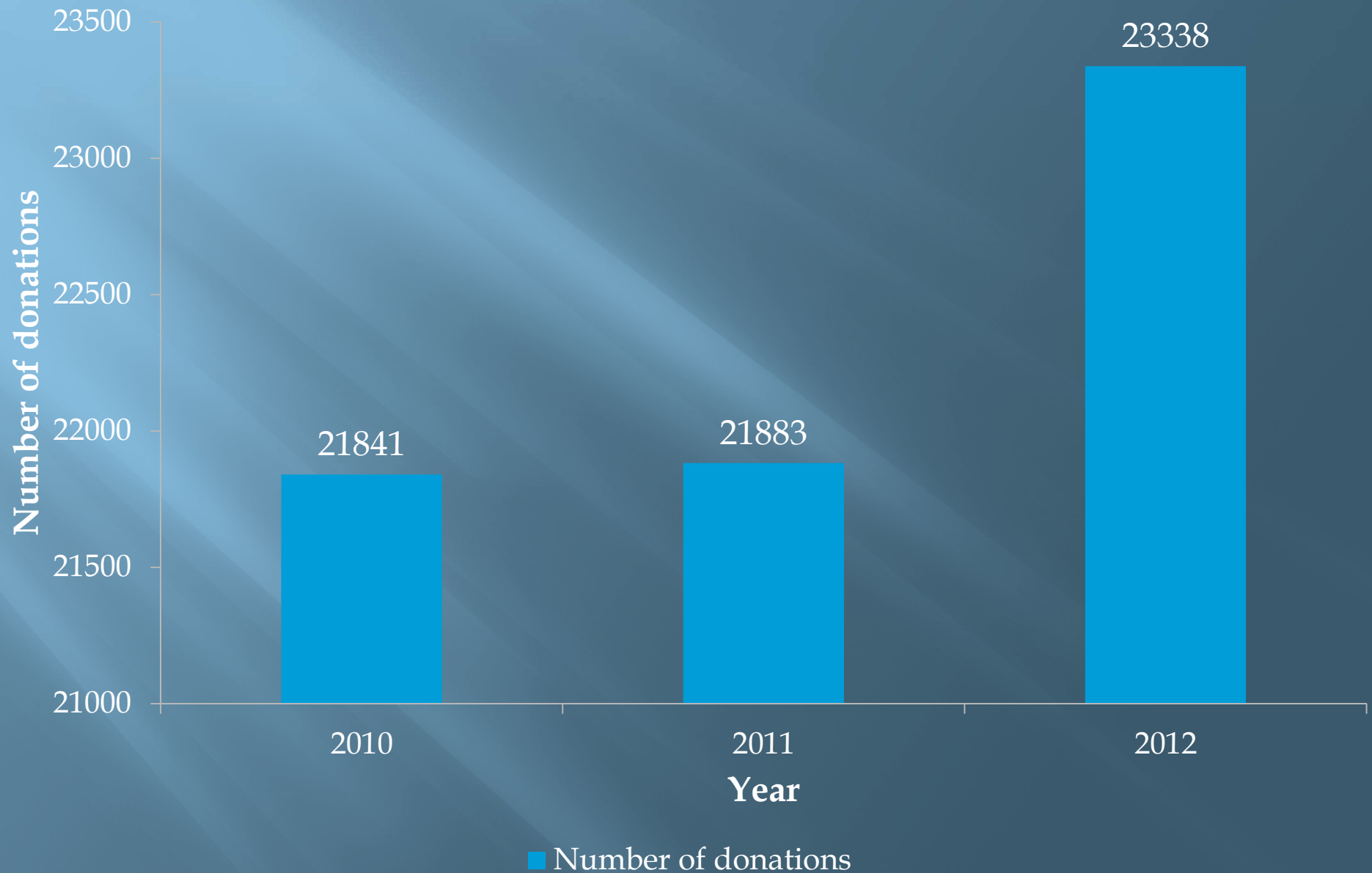
- Special Programmes during report period
- Blood collections
- Blood safety (TTI statistics)
- Donor reactions
- Recipient reactions
- Blood usage
- Blood wastage
- Recommendations

# Blood Donors

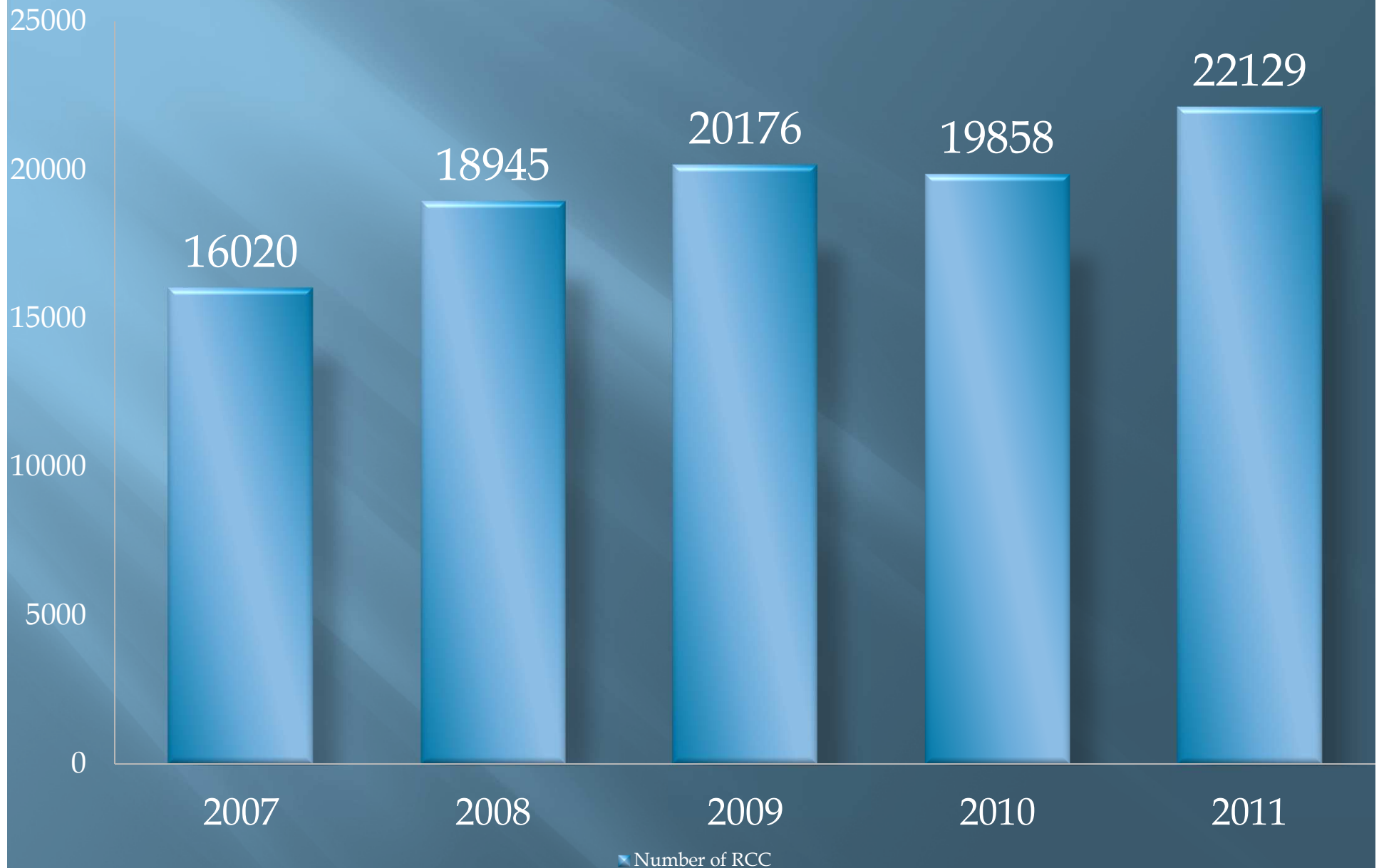




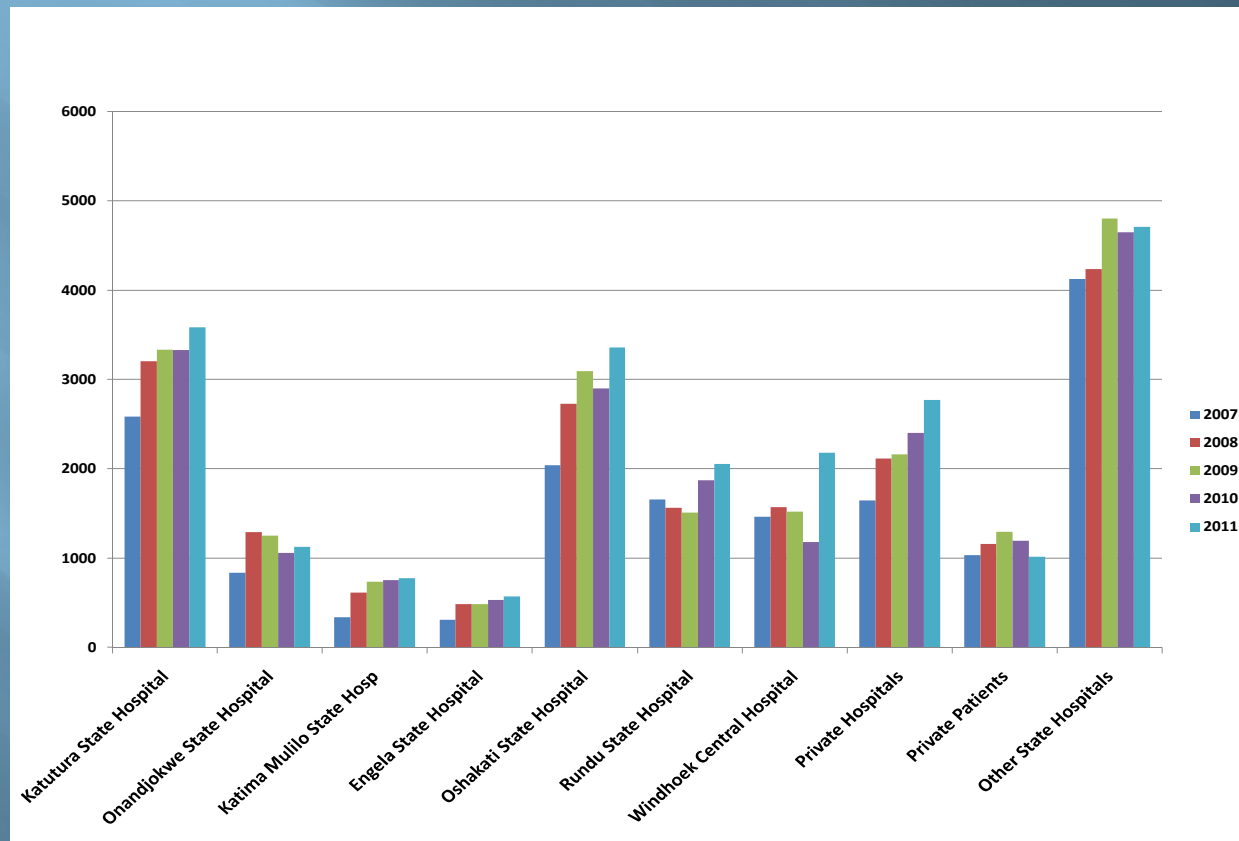
# Blood Collections 2010-2012



# RCC issue per year 2007 - 2011



# RCC issues to individual hospitals for the years 2007-2011



## 2. Formal recording and classification of adverse reactions

### ▣ Donor reactions

- Training of clinic staff
- New donor reaction recording forms
- Weekly discussion of donor reactions
  - change of donor feeding/snacks/rehydration

### ▣ Recipient reactions

- Training on management of TR
- Re-design NAMBTS Blood Requisition form and Transfusion Reaction Report form for better data collection
  - Exact instructions to enable investigations



# Trends in Reporting



Reported Donor and Recipient Adverse Reactions

# Classification of 41 adverse transfusion reactions reported ( April 2010 – Dec 2011)

