NEO FOR NAMIBIA
HELPING BABIES SURVIVE



MISSION REPORT

Mission 2026–3

September 11 to October 1, 2026

AUTHORS
Prof. Thomas M. Berger, MD

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1. INTRODUCTION

The 27th mission of a NEO FOR NAMIBIA – Helping Babies Survive Team was conducted from September 11 to October 1, 2026, by Prof. Thomas M. Berger, and his driver and assistant, Isaak Boois.

Since June 2026, there have been direct flights from Zurich to Windhoek with Edelweiss (Fig. 1); thus, long trips via Frankfurt (Discover Airlines) or Johannesburg (Swiss, Airlink) can be avoided. After a 9 ½-hour daytime flight, Prof. Thomas M. Berger arrived at Hosea Kutako International Airport in the evening of September 11, 2026.



Fig. 1. Edelweiss now offers a direct flight from Zurich to Windhoek.

Upon his arrival, Mr. Lawrence Siyanga from the Ministry of Health and Social Services contacted him to explain that – despite multiple efforts – NamRA had not yet issued the VAT exemption letter for donations brought in his luggage, and, therefore, there would be no consignment agent assisting with customs clearance. Despite this last-minute disappointment, Prof. Thomas M. Berger proceeded to the customs station. He briefly explained the situation to the female officer on duty, and – to his surprise and relief – she waived him through!

After a one-night-stay, the team left Windhoek for Otjiwarongo on September 12, 2026. Their car was fully loaded with donations (ventilator breathing circuits for the EVE TR neo ventilators (6 sets), CRP tests (1'000 kits) from Switzerland, 25l containers with soap (n=5) and disinfectant (n=5), and paper towels (n=20 boxes) from Taurus Maintenance Products Namibia) (Fig. 2).



Fig. 2. Isaak Boois in front of the fully loaded car of NEO FOR NAMIBIA – Helping Babies Survive.

After a one-night-stay at the Out of Africa Lodge in Otjiwarongo, they arrived at the Kaisosi River Lodge outside of Rundu on September 13, 2026. The next five full days, they worked at Rundu Intermediate Hospital and accomplished most of their mission goals.

They also had a chance to visit old friends in their villages (Johannes, the night guard at Kaisosi River Lodge; Laurentia, head of housekeeping at Kaisosi River Lodge; Eleotelia Hamutenya, mother of a now eight-year-old former very low birthweight infant, and her sister, Ottilia "Unique" Hamutenya, a teacher) (Fig. 3–6).



Fig. 3. Isaak Boois filling the Toyota Hilux with food (flour, rice, pasta, sugar, tomato sauce, mayo, spices, cooking oil) bought at Agra.



Fig. 4. Cookies and fruit for the kids in the villages (left: at Johannes' place, right: at Laurentia's place).



Fig. 5. After many years, the children know the car of NEO FOR NAMIBIA – Helping Babies Survive and come running to line up for a treat.



Fig. 6. Always heartwarming to see the kids' joy.

On September 20, 2026, the team reached Katima after a one-night-stay at Riverdance Lodge near Divundu. After three days of work at the Katima State Hospital, they returned to Rundu via Divundu and completed their work at Rundu Intermediate Hospital (two more lectures, obtaining DR statistics, hand-over of the POCT US scanner).

On September 27, 2026, they left the Kaisosi River Lodge early and drove to Windhoek in one day (710 km). Finally, Prof. Thomas M. Berger returned to Switzerland on October 1, 2026, thus completing the 27th mission of NEO FOR NAMIBIA – Helping Babies Survive.

2. MAIN MISSION GOALS

The main goals of the 27th mission of NEO FOR NAMIBIA – Helping Babies Survive were:

- To reassess the quality of perinatal care at both Rundu Intermediate Hospital and Katima State Hospital and provide training for new staff
- To evaluate the use of new equipment that had arrived in May 2026 (monitors, GE Panda® resuscitation units)
- To provide additional training for a POCT handheld ultrasound scanner (Clarius® C7)
- To finalize and possibly sign a Memorandum of Agreement (MoA)
- To make final arrangements for the introduction of the Vayu® bubbleCPAP device and the Vayu® blender system in Namibia
- To obtain VAT exemption for Vayu® and VIA Global Health (MTTS, Vietnam) donations

3. HOSPITALS VISITED

3.1 Rundu Intermediate Hospital

3.1.1 Overall impression

The team was greeted by Isha Kamara, MD (Senior Specialist Pediatrics), Liina Sikwaya, MD (the new Senior Medical Officer (SMO) who had been trained in South Africa), Addisu Yohannes, MD (Specialist Pediatrician from Ethiopia), and Natalia Morengo, RN (Nurse-in-Charge of the Prem Unit). In addition, on the second day, there was a formal meeting with Theresia Shivera, MD, the hospital's Medical Superintendent.

The Prem Unit continues to function at a high level, but previously observed deficiencies have persisted. As pointed out in March and May 2026, strong leadership and thorough training of new staff must become a priority. Nevertheless, it was nice to see, that many suggestions from previous missions have been implemented (Fig. 7).

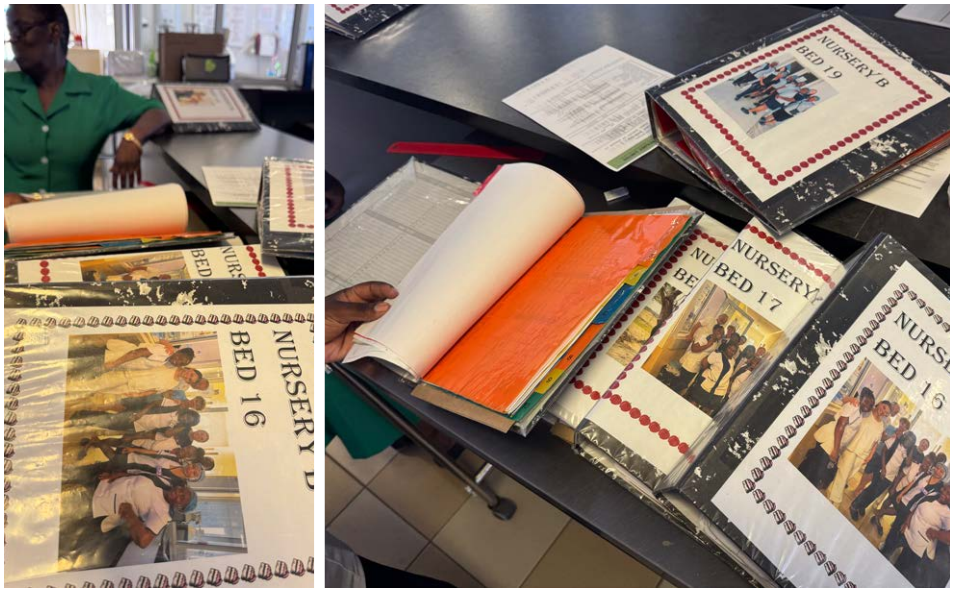


Fig. 7. Medical files: lists of diagnoses, progress notes, CPAP and ventilator nursing sheets developed by NEO FOR NAMIBIA – Helping Babies Survive are appropriately used.

As always, donations of consumables, including POCT CRP tests (n=600), EVE® TR neo ventilator patient circuits (n=6), pulse oximetry sensors (n=16, used), UVCs (40), Kiwi® vacuum extractors (n=4, used) were more than welcome.

3.1.2 Invasive mechanical ventilation – ongoing concerns

The two EVE® TR neo ventilators were always in use, mostly in asphyxiated neonates. Not surprisingly, the outcome of these patients was not good (see below). As noted during previous missions, further training of all health care professionals is still needed.

Prof. Thomas M. Berger, therefore, once again, gave a lecture on invasive mechanical ventilation, describing the parameters that must be set when using the machine in a pressure-controlled synchronized intermittent mandatory ventilation mode (PC-SIMV). He also emphasized inherent risks of invasive mechanical ventilation and focused on the importance of tight control of tidal volumes to avoid volutrauma (Fig. 8, 9).

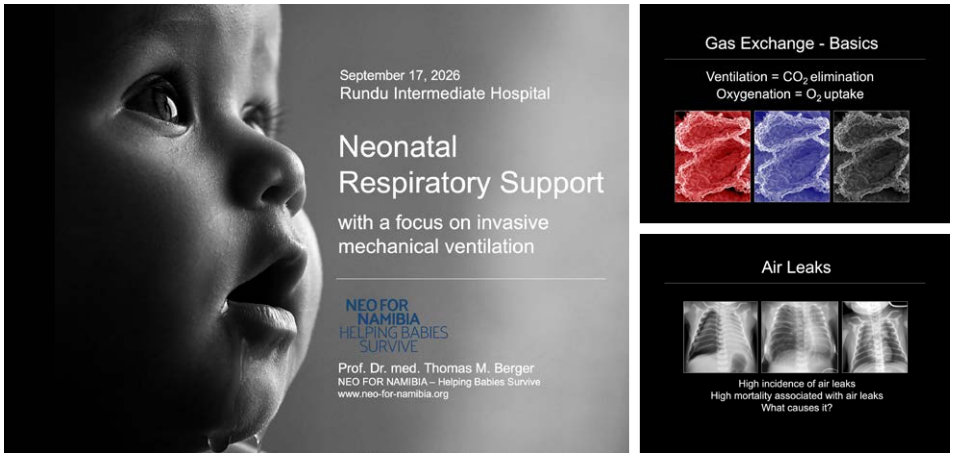


Fig. 8. Lecture on Neonatal Respiratory Support: physiological basis of gas exchange and different manifestations of air leak syndromes.

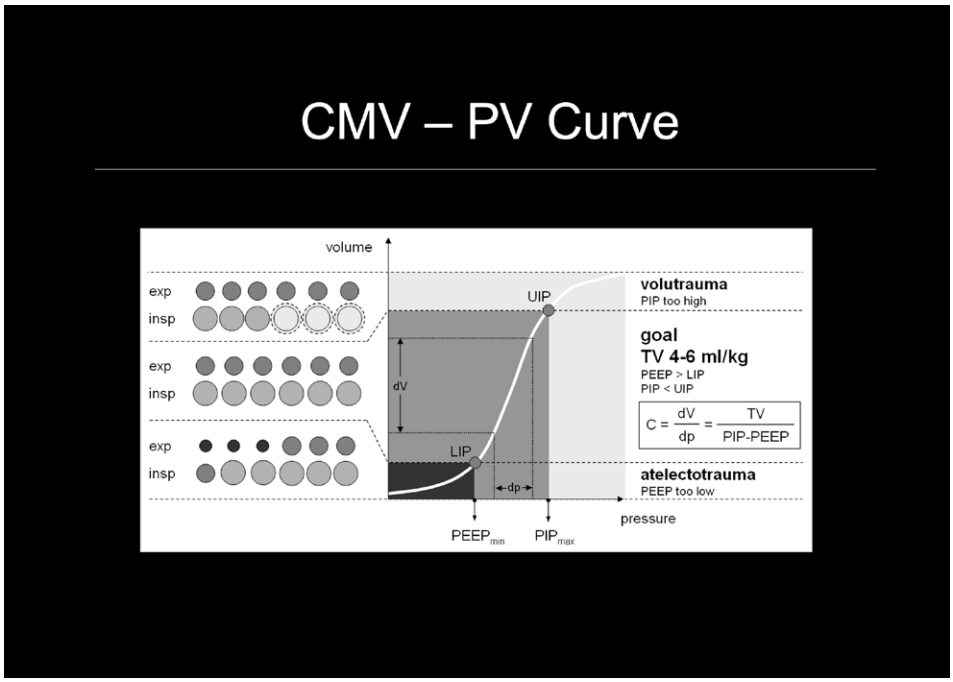


Fig. 9. Pressure-volume curve: importance of avoiding end-expiratory alveolar collapse and inspiratory overdistension to prevent atelectotrauma and volutrauma, respectively.

3.1.3 Equipment maintenance

The Cuban medical engineer, Leonardo Sandalio Sànchez de la Cruz, unfortunately had been forced to return to Cuba. He had been replaced by Yainier Hernàndez, a new Cuban medical engineer, who has a two-year-contract.

Yainier Hernàndez only speaks Spanish. Prof. Thomas M. Berger communicated with him using a Smartphone App and with the help of an intern who had gone to Medical School in Havanna, Cuba. In addition, he contacted Leonardo Sandalio Sànchez de la Cruz in Cuba and connected the two countrymen.

Yainier Hernàndez turned out to be skilled and eager to help. For example, he quickly fixed a leak on a GE Panda® warmer (detected during the first hands-on training session) and repaired three MTTS Dolphin® bubbleCPAP devices using spares ordered from MTTS Vietnam. With his help, eight out of nine MTTS Panda® bubbleCPAP devices were now working.

3.1.4 Donated monitors

Most of the donated small monitors (Philips IntelliVue® X2 and MP2) that had arrived in a large container from Walvis Bay in the final days of Mission XXVI (May 29, 2026) were deployed in the Prem Unit's Block A and B. Nurses and doctors confirmed that they were very helpful and easy to use.

On the other hand, none of the larger monitors (Philips IntelliVue MP30 and MP50) had yet been mounted on the walls. With the help of Edward Emuyeu (Head of Maintenance) a suitable wall mounting device was identified (unit price NAD 5'405.00 including VAT (15 %), i.e., CHF 273.60). Ten of them were ordered from Dellenich Medical Supplies CC in Ongwediva (Fig. 10).



Fig. 10. Philips IntelliVue® MP30 and MP50 monitors (left) have slightly different sizes but the same functionalities, wall mount for monitors (right) were ordered from Dellenich Medical Supplies Ltd.

Regrettably, the wall mounts were not delivered in time by the supplier for the mission team to help with defining appropriate positions for the monitors in Block A of the Prem Unit.

3.1.5 Lectures and teaching sessions

Prof. Thomas M. Berger gave a total of nine formal lectures to new interns and medical officers (08:00–09:00 o'clock, nursing training center) and nurses (14:00–15:00 o'clock, Prem Unit Block B) on the following topics (Fig. 6):

- Fetal physiology and pathophysiological aspects of neonatal resuscitation
- Neonatal respiratory support, including invasive mechanical ventilation (see above)
- Structured approach to the interpretation of chest X-rays
- Neonatal jaundice and practical aspects of phototherapy

- Neonatal sepsis (focus on biomarker-guided antibiotic therapy)
- Apnea of prematurity
- Neonatal cerebral ultrasound examination (physicians only)

Following additional training in the use of the recently purchased Clarius® C7 POCT scanner, the device was officially handed over to the doctors at Rundu State Hospital (for now, its use was limited to four physicians: Dr. Isha Kamara, Senior Specialist Pediatrics; Dr. Liina Sikwaya, Senior Medical Officer; Dr. Addisu Johannes, Specialist Pediatrician; Dr. Peter Chaziya, Pediatric Surgeon).

3.1.6 GE Panda® warmers

Rundu had received two GE Panda® resuscitation units. One of them is used in the admission bay of the Prem Unit (Fig. 11). Prof. Thomas M. Berger conducted several hands-on training sessions with nurses and doctors from the Prem Unit to explain the features of the warmer in detail.



Fig. 11. The GE Panda® warmer in the admission bay of the Prem Unit was repositioned to facilitate access from three sides (left: before, right: after).

The second unit is currently in a storage room and not used. Discussions with Dr. Isha Kamara revealed that the pediatricians were afraid to put the GE Panda® warmers into the obstetrical wards, because they fear that they would not be handled with care. Prof. Thomas M. Berger insisted that the device belonged in delivery rooms and the OR, but obviously health care professionals must be trained thoroughly in its use.

With the help of Isaak Boois, an instruction video was recorded to facilitate training of additional doctors and nurses (Fig. 12, 13).

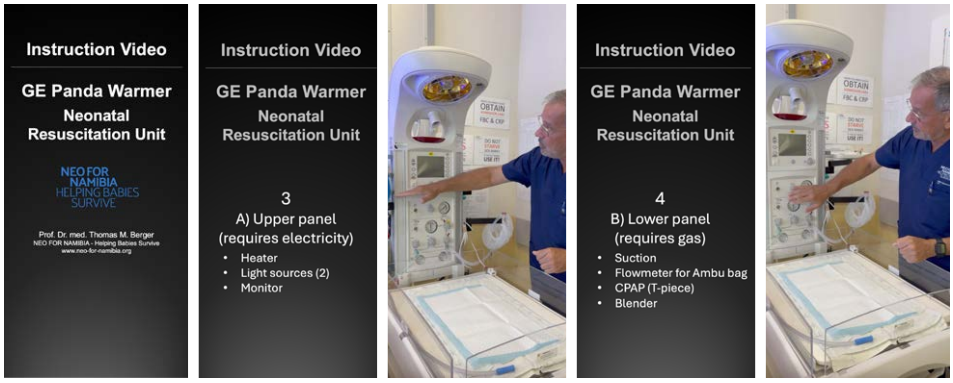


Fig. 12. Scenes from the GE Panda® warmer training video (Part I).

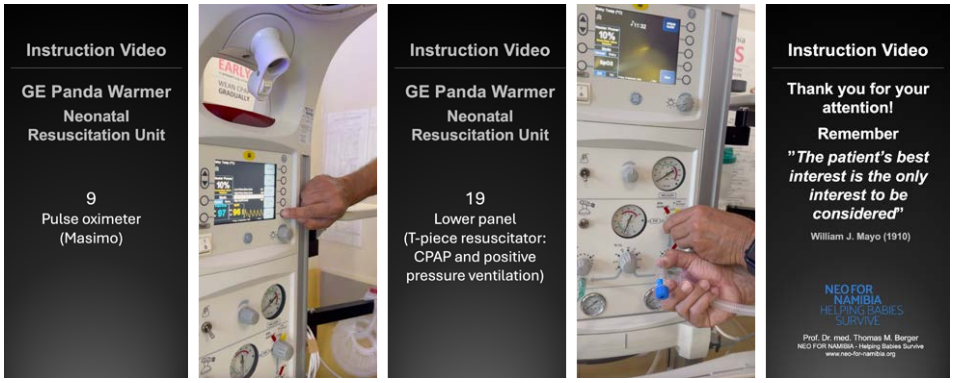


Fig. 13. Scenes from the GE Panda® warmer training video (Part II).

3.1.7 Meeting with Bettina and Victoria Kroning from Sun Medical Supplies

During his stay in Rundu, Prof. Thomas M. Berger also met Bettina Kroning (head of Sun Medical Supplies, Windhoek) and her daughter Victoria (medical engineer). They were in the north to service B. Brain infusion pumps and to provide additional training to the nurses.

Fortunately, Sun Medical is now the official representative of Masimo in Namibia. Therefore, it will be possible to purchase supplies for donated pulse oximetry equipment (patient cables, pulse oximetry sensors) from Sun Medical (hopefully at comparable costs). This should strengthen the supply chain significantly since the hospitals no longer have to rely on delivery by mission teams of NEO FOR NAMIBIA – Helping Babies Survive.

3.1.8 Prem Unit statistics

As always, relevant statistical data was abstracted from the Prem Unit's admission book and the DR data.

In the first eight months of 2026, here were a total of 3'239 deliveries, resulting in 3'267 live births and 34 stillbirths. The Cesarean section rate continued to be relatively high (especially compared to the one at Katima State Hospital, see below) at 25.3 % (820/3'239). Over the same period, 527 babies were admitted to the Prem Unit. Overall, there were 49 deaths (overall mortality rate 9.3 %). The mortality rate of outborn infants (20/105: 19.0 %) continued to be much higher than the one for inborn infants (29/422: 6.9 %). Birth-weight-specific mortality rates were as follows: < 1'000 g: 20/28 (71.4 %); 1'000 – 1'500 g: 6/72 (8.3 %); 1'501 – 2'500 g: 10/156 (6.4 %); > 2'500 g: 13/271 (4.8 %). These results were stable, but interestingly less favorable than those recorded in Katima (see below).

3.1.9 Case observations (Rundu Intermediate Hospital)

3.1.9.1 Birth asphyxia following uterine rupture

This baby was born by emergency Cesarean section at 35 weeks of gestation due to uterine rupture and fetal distress (September 17, 2026, at 22:55 o'clock). His mother was a 35-year-old HIV-positive G6/P6 with a history of three previous Cesarean sections. The baby's birth weight was 2'140 g.

After delivery, he was floppy and cyanotic with poor respiratory effort. Resuscitation included bag-mask ventilation, chest compressions, UVC placement and the administration of epinephrine (two courses). Apgar scores were 3, 4 and 5 after 1, 5 and 10 minutes, respectively. The baby was then rushed to the Prem Unit and intubated shortly after arrival and put on a ventilator. Shortly thereafter, seizures were noted.

Diagnoses included HIE III with seizures due to birth asphyxia secondary to uterine rupture and fetal distress. On September 19, 2026, at 15:20 o'clock, the baby had a cardiac arrest; it had previously been determined that there would be no escalation of care, and, therefore, no attempts to resuscitate the patient were undertaken. However, the dead baby was kept on the ventilator until parents could be counselled (Fig. 14).

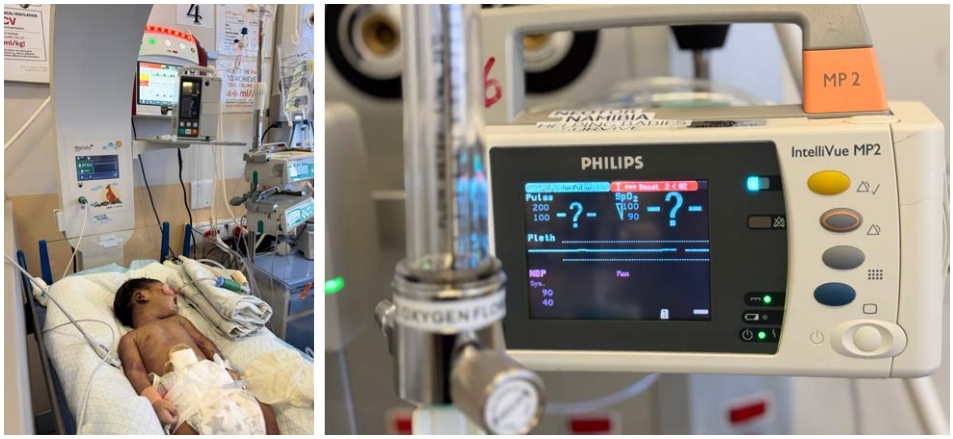


Fig. 14. Dead baby on invasive mechanical ventilation (left); the pulse oximeter shows no pulse wave signal, no SpO_2 saturation and no heart rate (right).

This case was illustrative for several reasons:

- First, the HIV prevalence in pregnant women in Namibia is high but varies greatly between regions. The Zambezi Region (Katima Mulilo) has the highest HIV prevalence in Namibia (30 – 37.7 %). Urban and central areas like Windhoek tend to report lower antenatal prevalences (around 9.6 %), whereas northern regions like Rundu and Onandjokwe historically range between 24 % and 26 %.
- Second, it demonstrates risks associated with high multiparity and previous Cesarean sections. In medical terms, multiparity refers to a woman who has given birth two or more times. When the term "high multiparity" or "grand multiparity" is used, it typically describes a woman who has given birth five or more times.
- Third, while resuscitation was "successful" despite the substandard equipment currently available in the operating theatre; additional training is urgently required to ensure that the GE Panda® warmers are used where they serve best.

- Fourth, therapeutic hypothermia (used routinely for babies with moderate to severe birth asphyxia in high-income countries), though effective in level III NICU environments, currently cannot be recommended because it has been shown to increase mortality in low- and middle-income countries.
- Fifth, the care of such patients at Rundu Intermediate Hospital is currently compromised by several factors, including lack of a functioning mobile X-ray machine and first-line anti-seizure medication (phenobarbital).
- Finally, it is not uncommon that redirection of care even in hopeless situations is delayed (sometimes for days). This is relevant for many reasons, including the fact that the availability of ventilators is limited, and continuing survival-focused care in a baby with an extremely poor prognosis may limit access to this therapy for patients with much better prognoses.

3.1.9.2 Extremely low birthweight (ELBW) infant

This baby was born via vaginal delivery at Nankudu District Hospital (110 km from Rundu) with a birthweight of 620 g and an estimated gestational age of 25 weeks. The mother, a 21-year-old G1/P1 without antenatal care visits ("unbooked"), presented with vaginal bleeding. This was initially interpreted as a miscarriage, and no antenatal corticosteroids to induce lung maturation were administered. Apgar scores were 1 and 4 at 5 and 10 minutes, respectively. When the baby did not die as expected, it was transferred on nasal cannula oxygen to Rundu Intermediate Hospital.

Further stabilization in Rundu included surfactant administration and support with bubbleCPAP. On day of life 2, the baby was stable on CPAP with an FiO_2 of 21–25 %, tolerating minimal enteral feedings administered via a B Braun infusion pump (Fig. 15). Several episodes of hypothermia had required adjustments of the incubator temperature.

On day of life 3, Prof. Thomas M. Berger noted that the humidity inside the incubator was insufficient (30 % instead of at least 80 %). The current weight of the baby had not been recorded (a minimal-handling policy had been introduced earlier that year), and electrolyte concentrations had not been measured.



Incubator care of an ELBW infant (Rundu)

1. UVC
2. Temperature sensor
3. Pulse oximeter sensor
4. NG tube
5. CPAP prongs
6. Eye protection

Fig. 15. ELBW infant with a birthweight of 620 g nursed in an incubator at Rundu Intermediate Hospital.

ELBW infants have highly permeable, unkeratinized skin and a high body surface-area-to-weight ratio, leading to massive transepidermal water loss and resulting hypernatremic dehydration if environmental humidity is inadequate. In ELBW infants, neonatal hypernatremia (serum sodium >145–150 mmol/l) and periventricular-intraventricular hemorrhage (PIVH/IVH) are closely linked, both severe clinical complications that typically occur within the first 72 hours of life.

Unfortunately, a POCT cerebral ultrasound examination performed by Dr. Liina Sikwaya, Senior Medical Officer in the Department of Pediatrics, revealed bilateral grade III-IV hemorrhages (Fig. 16).

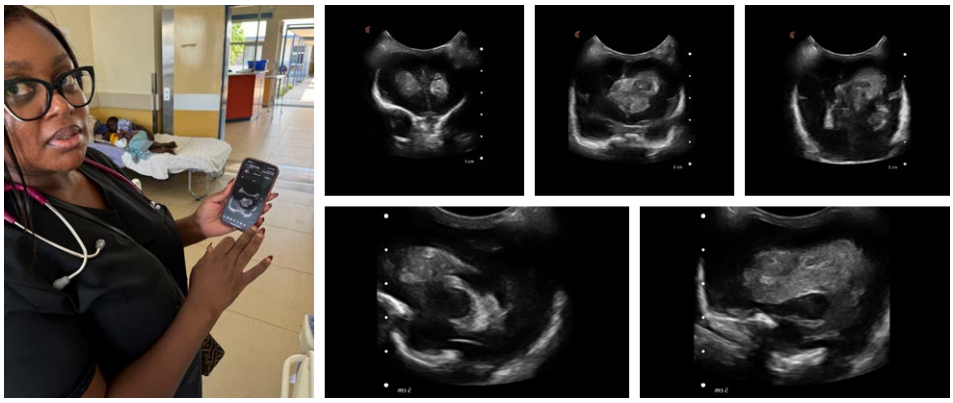


Fig. 16. POCT cerebral US examination (ELBW infant, birthweight of 620 g) revealing extensive intraventricular-periventricular hemorrhages (PIVH III-IV).

Despite an extremely unfavorable prognosis, survival-focused care was continued and during a blood transfusion the baby had a cardiac arrest. Resuscitation (details not available) was unsuccessful, and the baby died the same day.

The case illustrates recurring problems: 1) poor antenatal care, 2) inadequate transport systems for sick neonates, and 3) reluctance to redirect care from survival-focused to palliative comfort-oriented care. The latter may have an important cultural background, but, given very limited resources, it should be re-examined.

3.1.10 Next steps

NEO FOR NAMIBIA – Helping Babies Survive plans to continue its support of Rundu Intermediate Hospital, provided adequate funding can be secured. Ownership of the program will have to be transferred to the hospital in the not-too-distant future (time frame: 3 years). The NGO's support will focus on the supply of relevant consumables and occasional replacement of equipment that has reached end-of-life and can no longer be repaired.

3.2 Katima State Hospital

3.2.1 Overall impression

Once again, the mission team was impressed: the Neonatal Unit at Katima State Hospital is well organized and has reached and maintained a high standard of neonatal care (Fig. 17–19). To a large part, this is due to the commitment of two Cuban doctors: Dr. Yurisleydi Valdes, neonatologist, and her husband, Manolo Berbe, obstetrician and gynecologist. Their work is truly outstanding.

During their short stay in Katima (four days), the mission team was able to abstract statistical data, to provide GE Panda® training to groups of doctors and nurses from the Neonatal Unit and the Labor Ward, and to briefly demonstrate the Clarius® POCT US scanner.



Fig. 17. Despite being busy, the Neonatal Unit at Katima State Hospital is well organized and clean.



Fig. 18. Skillful stabilization of a preterm baby (left); the next day, the baby is still on CPAP but stable in room air (right).



Fig. 19. Baby on a MTTS Wallaby warmer, monitored with a Philips IntelliVue® MP3 pulse oximeter and Masimo sensor.

3.2.2 GE Panda® warmers

The two GE Panda® warmers donated to Katima Hospital had been installed in the OR (Fig. 20) and a delivery room (Fig. 21). Since there was still no wall outlet for compressed air, gas cylinders had been placed next to the resuscitation units. Unfortunately, only one cylinder was available and had the be shared with anesthesia for their anesthesia machine.

Prof. Thomas M. Berger emphasized that essential equipment for neonatal resuscitation (e.g., self-inflating bags and adequately sized masks, suction catheters) must always be readily available; currently, this was not the case (Fig. 21). Once again, it became obvious that the required leadership qualities (leading by example, supervision, responsibility, accountability) were not always present.



Incubator care of an ELBW infant (Rundu)

1 Power source

2 Oxygen

3 Compressed medical air

Note: the warmer was set up in the middle of the OR for the training sessions

Fig. 20. GE Panda® warmer (OR): power, oxygen and compressed medical air were not available from wall outlets.



Fig. 21. GE Panda® warmer (delivery room, left): essential equipment (e.g., appropriately sized masks and self-inflating bags with PEEP valves, right) were not available.

During three training sessions for the GE Panda® warmer, it became clear that most doctors and nurses had not yet discovered the many valuable features of the device. Therefore, Prof. Thomas M. Berger therefore all to study the training video (see Fig. 12, 13). He also encouraged the head of Obstetrics and Gynecology to supervise these efforts.



Fig. 22. Poor maintenance (left and top right); poor organization: gas wall outlets had been installed in the ICU, but the high-pressure adapters (HPAs) had not been delivered, and the gas sources cannot be used.

3.2.3 Equipment maintenance

Maintenance and repair of equipment and appliances had remained inadequate (Fig. 22); this may may in part be due to lack of funds, but disinterest, poor work ethic, coupled with lack of accountability certainly play an important role as well.

An example of regular maintenance is the three-monthly measurement of the light intensity of the phototherapy lights to treat neonatal jaundice. No such system is in place. NEO FOR NAMIBIA – Helping Babies Survive has now purchased an MTTS lightmeter, a specialized medical diagnostic device used to measure the blue light (400 to 520 nm) irradiance of neonatal phototherapy units treating infant jaundice (Fig. 23).



The **American Academy of Pediatrics** defines intensive phototherapy of **late preterm or term neonates** as exposing them to light with an **irradiance of at least 30 µW/cm²/nm**. If TSB is very high or rapidly increasing, the irradiance is increased to around 60–70 µW/cm²/nm. **Extremely low birthweight infants** are usually exposed to light with a level of **irradiance at 15–30 µW/cm²/nm** increasing to around 40 µW/cm²/nm.

Fig. 23. MTTS lightmeter (left) and irradiance required for effective phototherapy (right).

The mission team and Dr. Manolo Berbe checked all phototherapy devices. Irradiance was adequate in all but three MTTS Colibri® phototherapy units; those returned to adequate levels following cleaning as advised by MTTS. In contrast, the phototherapy lights of the Davis Medical Device Co. (China) warmers were all insufficient (Fig. 24). Dr. Manolo Berbe will now take care of the maintenance of the phototherapy units.



Fig. 24. Poor procurement and poor maintenance: the MTTS Colibri phototherapy units perform well (A, B: 58 µW/cm²/nm in boost mode), whereas the warmer from David Medical Device Co. (China) does not reach adequate light intensity (C, D: 15 µW/cm²/nm).

3.2.4 Case observations (Katima State Hospital)

3.2.4.1 Skin rash in an HIV positive baby

This term baby was born at home. Since birth, she was noted to have an extensive polymorphic rash. She was seen at a local clinic and sent home with an emulsifying cream. By history, the mother had a similar rash related to untreated HIV infection (retroviral disease (RVD) positive). The baby was also HIV positive (dried blood spot (DPS) positive) and was put on presumptive therapy.

At 22 days of life, the baby girl was referred to Katima State Hospital with a fever, moderate jaundice and abdominal distension. She also had widespread erythematous and scaly skin lesions (Fig. 25). On physical examination, there was moderate respiratory distress (respiratory rate 67/min, SpO_2 83 % in room air), jaundice and hepatosplenomegaly.

Her laboratory results were remarkable for a C-reactive protein concentration of 330 mg/l, a hemoglobin of 85 g/l, a platelet count of 21 G/l and abnormal liver function tests. Given her DBS positivity, she was started on broad-spectrum antibiotics. She also received packed red blood cell, fresh frozen plasma (FFP) and platelet transfusions.



Fig. 25. Extensive skin lesions in a term infant with HIV.

At the time of Prof. Thomas M. Berger's visit, she was doing well but still had an elevated CRP level (39 mg/L) and persisting hepatosplenomegaly. The skin rash had much improved (Fig. 26). Her mother was on HAART (highly active antiretroviral therapy), and the baby was exclusively breastfed.



Fig. 26. At one month of age, the condition of the baby with vertically transmitted HIV had greatly improved, but hepatosplenomegaly had persisted.

As pointed out above, the HIV prevalence among pregnant women is very high in the Zambezi region (> 30 %). Without medical care or antiretroviral therapy, the risk of vertical transmission ranges from 15 % to 45 %. With antiretroviral therapy (ART) and other medical interventions the risk of transmission can be lowered to less than 2 %. Thus, antenatal screening is of paramount importance, and access to prevention of mother-to-child transmission of HIV (PMTCT) services has a high priority.

3.2.4.2 Hope – an update

The little girl, who had found a shelter in the Neonatology Unit at Katima State Hospital earlier that year after her mother (fugitive from the Democratic Republic of Congo (DRC) and rape victim) had to be admitted to the psychiatric ward, has finally been adopted by a Congolese couple. Hope is doing very well (Fig. 27), but the doctors (especially Dr. Yurisleydi Valdes and her husband Dr. Manolo Berbe) and the nurses miss her.



Fig. 27. A resilient little girl: Hope (left: May 2026, right: September 2026).

3.2.5 Statistics DR and Neonatology Unit

In the first eight months of 2026, there were a total of 2'531 deliveries, resulting in 2'500 live births and 40 stillbirths. The Cesarean section rate continued to be low at 11.5 % (291/2'531). Over the same period, 352 babies were admitted to the Neonatology Unit. Overall, there were 17 deaths (mortality rate 4.8 %). In contrast to what has been observed at Rundu Intermediate Hospital, the mortality rate of outborn infants (2/27: 7.4 %) is only slightly higher than the one for inborn infants (15/325: 4.6 %). Birthweight-specific mortality rates were as follows: < 1'000 g: 7/12 (58.3 %); 1'000 – 1'500 g: 4/35 (11.4 %); 1'501 – 2'500 g: 2/112 (1.8 %); > 2'500 g: 4/193 (2.1 %). These results continue to be amazing with very low overall and birthweight-specific mortality rates; only seven years ago, the overall mortality rate was 33.0 %.

3.2.6 Next steps

Given the success, NEO FOR NAMIBIA – Helping Babies Survive is highly motivated to continue to support Katima State Hospital, provided adequate funding can be secured. As for Rundu Intermediate Hospital, ownership of the program will have to be transferred to the hospital in the not-too-distant future (time frame: 3 years).

4. VAYU® BCPAP PROJECT DELAYED

With the support of Mr. Lawrence Siyanga from the Ministry of Health and Social Services, NEO FOR NAMIBIA – Helping Babies Survive had received permission to introduce the Vayu® bubbleCPAP and air-oxygen blender systems to Namibia. Operation of the device requires no electricity and only compressed oxygen because of a blender system that is based on the so-called Venturi effect.

Although attempts to organize a meeting for nurses and doctors from potential target hospitals had failed, NEO FOR NAMIBIA – Helping Babies Survive had ordered:

- 25 Vayu® bCPAP systems with consumables
- 25 Vayu® bCPAP accessory packs
- 25 Vayu® OBS (oxygen blender systems)
- 50 Vayu® OBS (oxygen blender systems) accessory packs

A letter of donation and request for VAT (15 %) exemption had been submitted on August 12, 2026. Unfortunately (once again…), the one-page-letter from NamRA was not available when the shipment arrived from the manufacturer Revital Healthcare (EPZ) Ltd., Kenya (Fig. 28). The team from Vayu® Global Health Innovations in Boston therefore decided to pay the VAT (approximately NAD 60'000.00, i.e., CHF 3'000.00). All the goods were shipped by DHL Namibia to Rundu Intermediate Hospital on September 28 and 29, 2026. The VAT exemption letter arrived when Prof. Thomas M. Berger had returned to Switzerland.



Fig. 28. The Vayu® bCPAP and oxygen blender systems were developed by Vayu® Global Health Innovations (Boston, USA) and is manufactured by Revital Healthcare Ltd. In Kenya.

Doctors and nurses in Rundu and Katima are familiar with the device, but for other interested parties, training must now be organized. This was discussed when the team met with Mr. Lawrence Siyanga at the Ministry of Health and Social Services on the day of Prof. Thomas M: Berger's departure.

5. IMPRESSIONS FROM THE 27TH MISSION

As always, to conclude this report, some images will illustrate various scenes the team encountered during their three-week-trip through Namibia (Fig. 29 – 38). Enjoy!



Fig. 29. Donkey cart (left) and donkeys grazing along the roadside (right).



Fig. 30. Travelling along the Caprivi strip.



Fig. 31. A boy playing with his wonderfully detailed wire toy car.

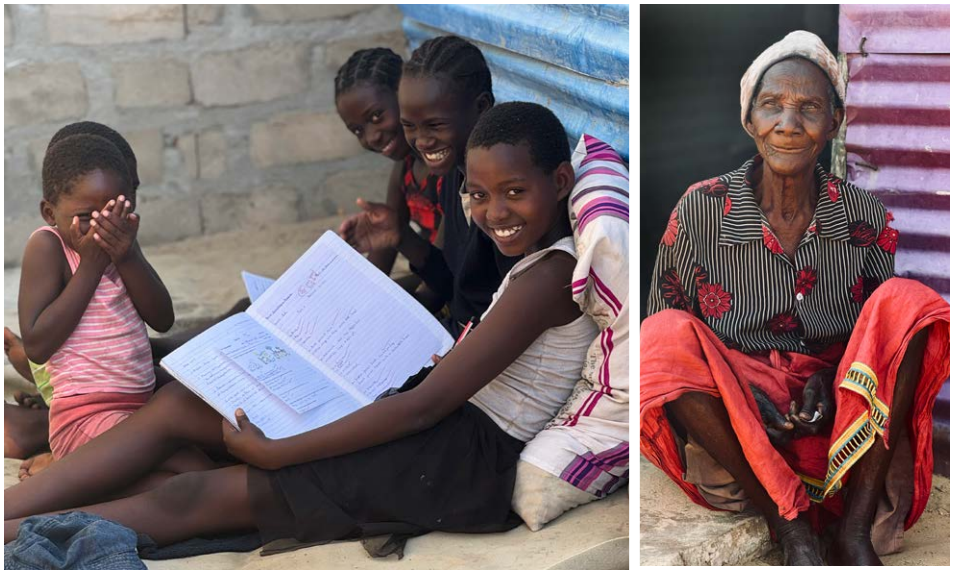


Fig. 32. Children at the Hamutenya sisters' place doing their homework (left); nearby, an old woman (reportedly 80 years old) sitting in front of her hut.



Fig. 33. Hippos grazing on the premises of the Kaisosi River Lodge (left); Kudus at the roadside (middle and right: male and female, respectively).



Fig. 34. Blooming flowers: Frangipani (left); Jacaranda tree (top right); various flowers at the Kaisosi River Lodge (bottom right).



Fig. 35. Departing from Rundu for Windhoek early in the morning at sunrise.



Fig. 36. Isaak's Farm (part I): simple life with limited electricity from a solar panel, no water yet, but still, something to build on.



Fig. 37. Isaak's Farm (part II): dogs and cats are kept to guard goats and sheep and to keep snakes away.



Fig. 38. Isaak's Farm (part III): simple life in a quiet environment with a sky full of stars at night.



Fig. 39. Neonatology Unit at Katima State Hospital: this is what NEO FOR NAMIBIA – Helping Babies Survive is all about!



Fig. 40. Neonatology Unit at Katima State Hospital: "The best interest of the patient is the only interest to beconsidered" (William J. Mayo, MD, 1910).

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