THE DEVELOPMENT AND EVALUATION OF THE HAEMOVIGILANCE PROGRAMME IN NAMIBIA

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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)
5. Hospital Transfusion Committee (*HTC*) 
   *Implementation programme* (2011)
6. *Study and survey* on Haemovigilance 
   (CDC/NAMBTS) (2012)
7. *Hospital audits and TR training* (2012)
1. Haemovigilance Reports

1st - time period financial year 2008/2009

2nd - 2009/2010

3rd - 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
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

- Donor reactions
- Transfusion reactions

Years: 2000 to 2012
Classification of 41 adverse transfusion reactions reported (April 2010 – Dec 2011)

- Allergic Reactions: 14
- Anaphylactic Transfusion Reaction: 1
- Acute haemolytic transfusion reactions (AHTR): 5
- Transfusion associated dyspnoea (TAD): 1
- Febrile non-haemolytic transfusion reaction (FNHTR): 2
- Transfusion associated circulatory overload (TACO): 10
- Hypotensive TR: 6
- Not transfusion related: 1
- Bacterial contamination of blood product: 1