NEO FOR NAMIBIA
HELPING BABIES SURVIVE

MISSION REPORT

Mission 2026–1

February 25 to March 22, 2026

AUTHORS
Prof. Thomas M. Berger

Lucerne, 21.04.2026

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1. INTRODUCTION

This was the 25th mission of a NEO FOR NAMIBIA – Helping Babies Survive Team, lasting from February 25 to March 22, 2026. It was conducted by Prof. Thomas M. Berger, MD, Flurina Bosshard, MD (arriving from Cape Town on March 2, 2026), and the driver and assistant, Isaak Boois.

Arriving from Johannesburg at Husea Kutako International Airport in Windhoek late in the evening (Fig. 1–3), Prof. Thomas M. Berger was allowed to enter the country on a provisional work VISA (valid for three months), and – supported by a representative from ENP Freight Logistics (Esther) – passed through customs in record time.

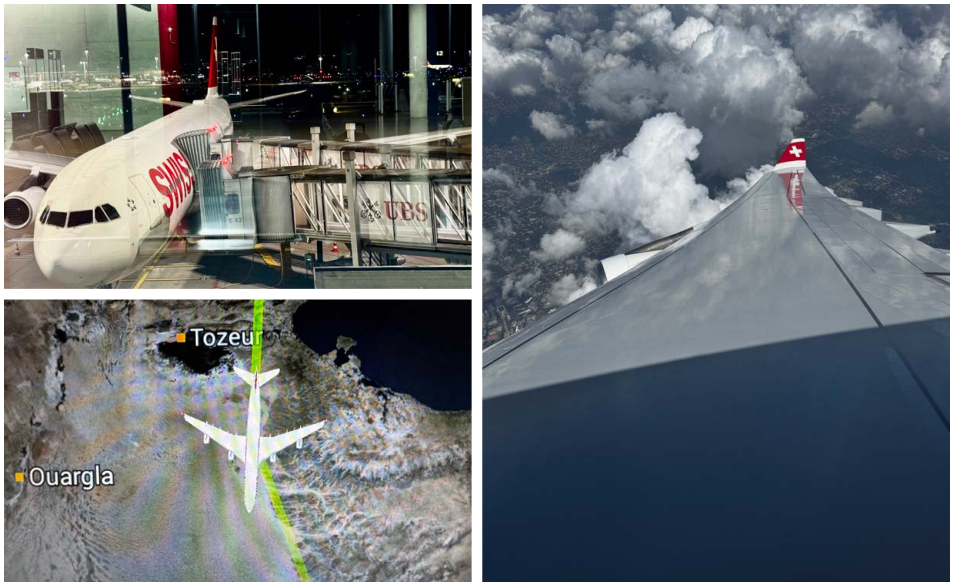

Fig. 1. Uneventful flights with SWISS and Airlink from Zurich to Windhoek with a 7-hour-stopover in Johannesburg.

Fig. 2. Dramatic cloud formations over South Africa, Botswana and Namibia.

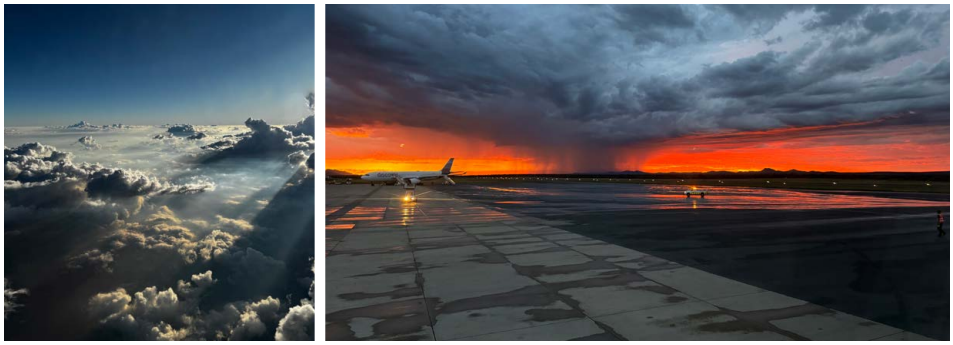

Fig. 3. Arrival at Hosea Kutako International Airport on February 26, 2026 at 19:45 o'clock after a scenic flight: the rainy season in Namibia lasts from September to April.

A day later, Prof. Thomas M. Berger had a meeting with the Executive Director (ED) of the Ministry of Health and Social Services (MoHSS), Mr. Penda Ithindi, and Mr. Lawrence Siyanga to discuss the future collaboration between the MoHSS and NEO FOR NAMIBIA – Helping Babies Survive. During the one-hour-meeting, it was decided that a Memorandum of Agreement (MoA) should now be finalized, and a follow-up meeting should be planned for March 19 or 20, 2026 (see below).

On Tuesday, March 3, 2026, the team drove up to Rundu with two cars to accommodate various consumables brought from Switzerland and hygiene products (soap, hand sanitizer and paper towels) and B Braun infusion pump supplies (IV lines) purchased from Taurus Maintenance Products in Windhoek and Sun Medical Supplies CC, respectively (Fig. 4).

Fig. 4. Loading donated equipment and consumables from Switzerland and lines for B Braun infusion pumps (bought from Sun Medical Supplies in Windhoek).

On a totally different and personal note: on Saturday, February 28, 2026, world politics took a dramatic turn when the conflict between Israel, the USA and Iran escalated. Over the following days, news on TV (particularly BBC and CNN) were dominated by these events. In contrast, Namibian print media reported much less on the new war (Fig. 5).

Fig. 5. Namibian newspaper headlines on March 2, 2026, three days after the war between Israel, the USA and Iran had started.

While following the international news over the coming weeks, the enormous gap regarding interests and resources between the countries at a war (apparently spending billions of US$ every day), other high-come countries (worried about their own wealth) and the poor people in Namibia's north became even more obvious and frankly absurd.

2. MAIN MISSION GOALS

The main goals of the 25th mission of NEO FOR NAMIBIA – Helping Babies Survive were:

- To assess the current quality of perinatal care at both Rundu Intermediate Hospital and Katima State Hospital (direct observations at the bedside, review of statistical data)
- To update inventories, both for medical equipment and consumables and to identify the most critical deficits and most urgent needs at both hospitals
- To streamline data collection for improved quality control
- To meet Mr. Penda Ithindi, Executive Director (ED), Mr. Lawrence Siyanga, Control Chief and Health Program Officer responsible for International Collaborations, and Mr. Johannes Geoseb, Director of Tertiary Health Clinical Services at the MoHSS, to draft a Memorandum of Agreement (MoA) and to discuss the next necessary steps for the implementation of the Vayu® bubbleCPAP project (see below)
- To renew VISA and work permits of Prof. Thomas M. Berger and Sabine Berger for another two years (Mr. Lazerus Doeseb, Senior Manager, Human Resources at the MoHSS)

3. HOSPITALS VISITED

3.1 Rundu Intermediate Hospital

As always, the team of NEO FOR NAMIBIA – Helping Babies Survive was warmly welcomed. The various consumables brought by the mission team were desperately needed and therefore much appreciated (Table 1).

Description	Rundu no. of items	Katima no. of items	Total no. of items	Total Value CHF	Total Value NAD
Equipment					
Axonlab (Switzerland)					
QuikRead go (Aidian); backup device	1	1	**2**	**2'162.00**	**44'926.36**
Consumables					
Axonlab (Switzerland)					
QuikRead go easyCRP tests	750	250	**1'000**	**3'891.60**	**80'867.45**
Zuger Kantonsspital (Switzerland)					
Umbilical venous catheters 5FR	130	70	**200**	**2'695.95**	**56'021.84**
Endotracheal tubes ID 2.5	140	60	**200**	**302.96**	**6'295.51**
Endotracheal tubes ID 3.0	100	50	**150**	**210.00**	**4'363.80**
Endotracheal tubes ID 3.5	60	40	**100**	**140.00**	**2'909.20**
IV300 paediatric catheter dressing	600	200	**800**	**169.20**	**3'515.98**
Perfusor line with 3-way stopcock, 10 cm	350	150	**500**	**257.25**	**5'345.66**
Tegaderm (transparent, 10 cm x 10 m)	20	12	**32**	**450.36**	**9'358.48**
Mefix stretch	80	40	**120**	**136.33**	**2'832.94**
Ambu King mask size 1	130	70	**80**	**649.20**	**13'490.38**
Ambu King mask size 2	130	70	**80**	**651.36**	**13'535.26**
Sun Medical Supplies CC (Windhoek)					
Consumables B Braun IV pumps	variable	NA	**variable**	**3'367.63**	**69'979.35**
Taurus Maintenance Products					
Liquid soap, folded paper towels	variable	NA	**variable**	**135.93**	**2'824.65**
Final Grand Total				**15'219.77**	**316'266.85**

Table 1. Equipment and consumables brought by Prof. Thomas M. Berger and his team to the government hospitals in Rundu and Katima.

3.1.1 Overall impression

During the team's two stays at Rundu Intermediate Hospital, the patient census was relatively low (18–24), but some babies were extremely ill and required invasive mechanical ventilation.

While the overall quality of care has had remained stable, and the use of many devices (e.g., warmers, incubators, phototherapy units, CPAP devices) have become routine, knowledge and skills required for the care of intubated patients were still inadequate and will have to be improved (Fig. 6).

3.1.2 Invasive mechanical ventilation

The EVE TR neo ventilator donated by NEO FOR NAMIBIA – Helping Babies Survive remains the preferred device for invasive mechanical ventilation (Fig. 6). It is mostly used in a volume-control mode (VC-SIMV), while the pressure-control mode with pressure support ventilation (PC-SIMV & PSV) is used when the VC-SIMV fails. A Fisher & Paykel F850 heater and humidifier is used for proper humidification of inhaled gas.

When both units are in use, and another patient requires intubation and mechanical ventilation, a Mindray SV300 is borrowed from the High Care Unit (Fig. 6); unfortunately, appropriate training for this machine has never been offered to the health care professionals, and it is used without humidification. Therefore, additional training and supervision of inexperienced nurses and doctors is urgently needed. Ideally, a third EVE TR neo should be purchased. This would allow to streamline devices and consumables, facilitating both use and stock management.

Fig. 6. Intubated term infant supported with an EVE TR neo ventilator (left); the Mindray SV300 (right) is used when both EVE TR neo machines are already in use.

In addition, some recommendations made following Mission XXIV still hold true: "Training and supervision of newly appointed nurses must be improved. Some of them do not yet understand even very basic aspects of neonatal care. They are not familiar with standard alarm settings and do not know how to use incubators and warmers properly (e.g., warming modes (manual versus baby mode), humidification). In part, this is because various types of incubators and warmers are used, making it more difficult to operate all of them correctly. Proper training is often not provided by the Namibian companies that sell medical equipment, and user manuals are either missing or rarely consulted."

3.1.3 Equipment maintenance

The Cuban medical engineer, Leonardo Sandalio Sànchez de la Cruz, continues to do his best to maintain and repair medical equipment donated by NEO FOR NAMIBIA – Helping Babies Survive. Unfortunately, working conditions and resources remain difficult. In addition, some pieces of equipment are beyond repair and will have to be replaced (Fig. 7).

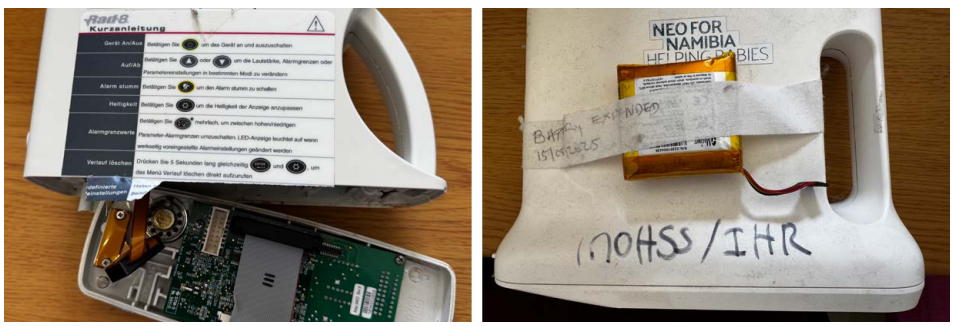

Fig. 7. Some of the equipment donated by NEO FOR NAMIBIA – Helping Babies Survive has been in almost uninterrupted use for years and is now beyond repair; therefore, some of the equipment will have to be replaced.

Prof. Thomas M. Berger, supported by the medical engineer, nurses and Flurina Bosshard, MD, was able to put together a complete inventory of medical equipment donated by NEO FOR NAMIBIA – Helping Babies Survive and its consumables. This list will serve as a basis for planning future acquisitions of equipment (mostly to replace machines that can no longer be repaired) and defining the future organization of supply chains for consumables required for the use of these machines.

3.1.4 Lectures and teaching sessions

Prof. Thomas M. Berger was able to give four formal lectures to new interns on the following topics (Fig. 8):

- Fetal physiology and pathophysiological aspects of neonatal resuscitation, with a focus on timely initiation of bag-mask ventilation to aerate the baby's lungs ("respiratory transition is an absolute prerequisite for cardiovascular transition")
- Peripartal asphyxia and hypoxic-ischemic encephalopathy (HIE), emphasizing the importance of close collaboration between pediatricians, midwives and obstetricians ("prevention is best")
- Neonatal respiratory support, highlighting the importance of adequate oxygen saturation targets to minimize oxygen toxicity by dosing oxygen and setting adequate oxygen saturation alarm limits both for babies receiving supplemental oxygen (88–97 %) and babies breathing room air (88–100 %)
- Mechanical ventilation using the EVE TR neo (basic principles of gas exchange, differences between PC-SIMV with PSV and VC-SIMV: urgently needed!). The same lecture and a practical session was attended by Prem Unit nurses.

Fig. 8. Topics of lectures given to interns at Rundu Intermediate Hospital.

3.1.5 Statistics DR and Prem Unit

As always, relevant statistical data was abstracted from the Prem Unit's admission book and put into context with statistical data from labor & delivery.

In 2025, there were a total of 5'741 deliveries, resulting in 5'753 live births and 75 still-births. In addition, 4 babies died in the delivery room. The Cesarean section rate was 21.3 %. Over the same period, 889 babies were admitted to the Prem Unit (742 inborn (admission rate 12.9 %), 147 outborn). There were 74 deaths (overall mortality rate 8.3 %). Of these, 51 were inborn infants (mortality rate 6.9 %) and 15 were outborn infants (mortality rate 15.6 %).

Birthweight-specific mortality rates were as follows: < 1'000 g: 16/26 (60.0 %); 1'000 – 1'500 g: 9/79 (12.5 %); 1'501 – 2'500 g: 13/208 (6.1 %); > 2'500 g: 12/318 (4.7 %) (Fig. 9). One baby born in November 2025 (birth weight 750 g) was still hospitalized in Block B (stepdown unit) with a current weight of only 1840 g and still requiring low-flow oxygen (Fig. 10).

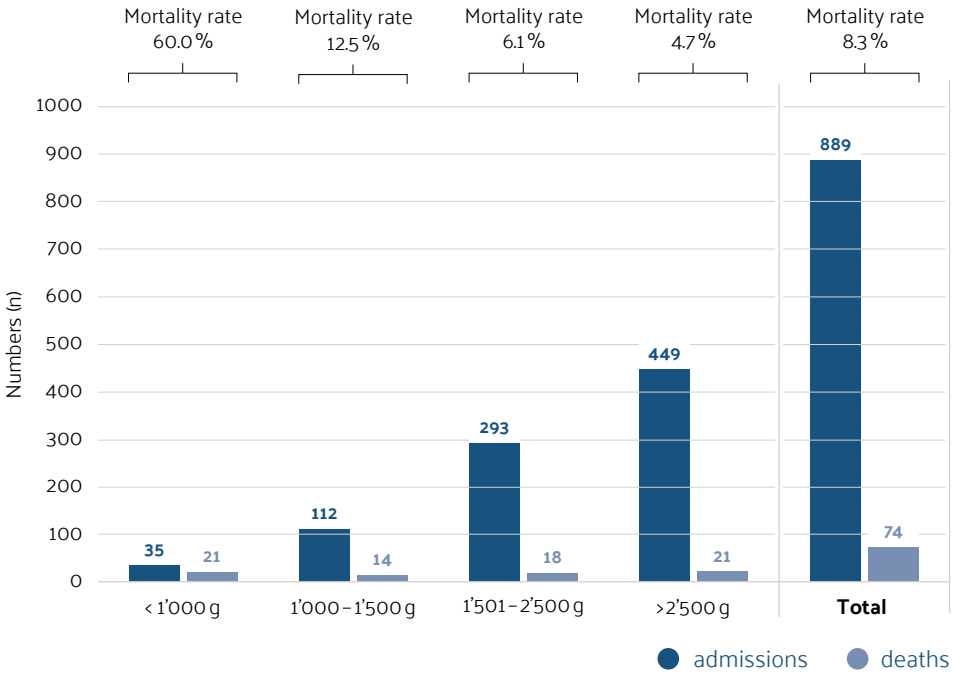

Fig. 9. Overall and birthweight-specific number of admissions and mortality rates (Rundu Intermediate Hospital).

Fig. 10. Surviving extremely low birthweight infant (birth weight 750 g) at the age of three months, weighing 1'840 g and still requiring low-flow oxygen.

3.1.6 Case observations (Rundu Intermediate Hospital)

3.1.6.1 Congenital diaphragmatic hernia

This term infant was admitted from home at the age of two weeks because of mild respiratory distress and feeding difficulties. When her condition failed to improve, a chest X-ray was obtained, and a diagnosis of left-sided diaphragmatic hernia was made. The baby was operated in Rundu and recovered rapidly (Fig. 11). At the time of this writing, the baby was still hospitalized in Block B of the Prem Unit but in a stable condition.

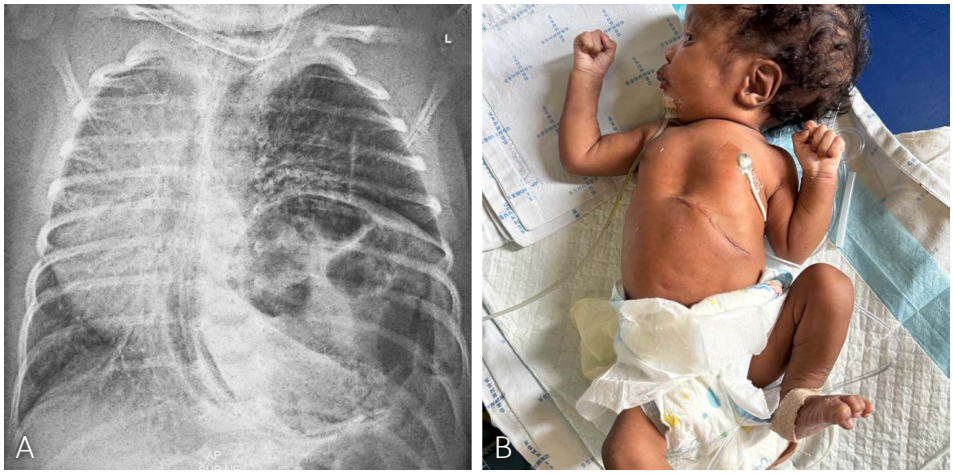

Fig. 11. Successful surgery for congenital diaphragmatic hernia (CDH) at Rundu Intermediate Hospital: X-ray evidence of left-sided herniated bowel (A), baby after successful surgery (B).

Pediatric surgery and pediatric anesthesia had only recently (in 2025) become available at Rundu Intermediate Hospital. Long and risky transfers to Windhoek can thus be avoided.

3.1.6.2 Larva migrans as an incidental finding

This near-term baby (birth weight 2'310 g) was intubated shortly after arrival in the Prem Unit following home delivery because of perinatal asphyxia and hypoxic-ischemic encephalopathy Sarnat stage II. The patient could not be weaned from the ventilator and was diagnosed with late-onset neonatal sepsis and ventilator-associated pneumonia. .

Mobile chest X-ray examinations were not available because the machine had been broken for almost five months. In desperate attempts to make a diagnosis, patients – often the sickest ones – must be transported by ambulance to the X-ray department, obviously a high-risk undertaking, particularly in intubated babies (Fig. 12).

Fig. 12. Ambulance transport to the X-ray department: because the mobile X-ray machine has been out of order for almost five months, patients must be brought to the X-ray department by ambulance.

Over a period of one week, three chest tubes were inserted to drain clinically diagnosed pneumothoraces; these were never confirmed radiologically when chest X-rays were finally obtained in the X-ray department after risky ambulance transports (no transport incubator, ventilation by hand, no monitoring) (Fig. 13).

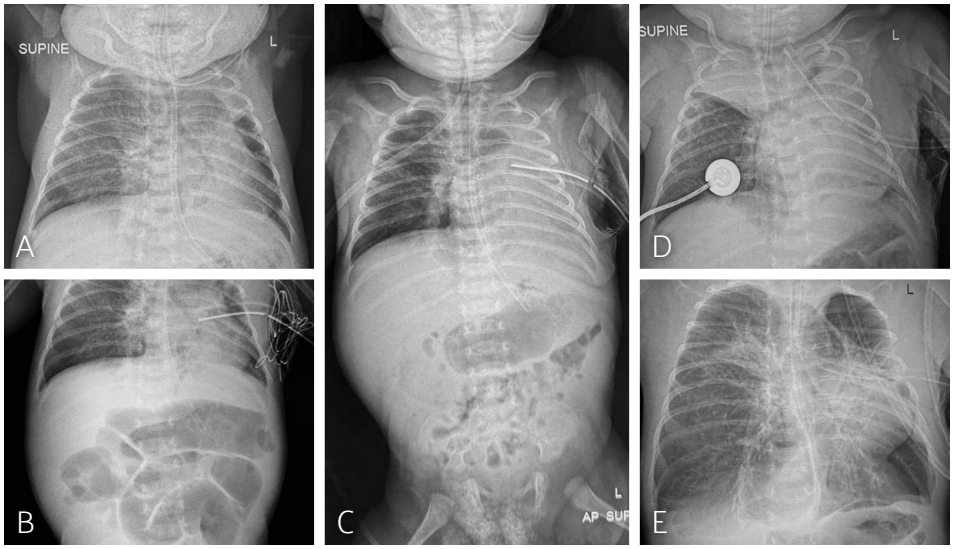

Fig. 13. Term baby with severe respiratory distress: over the course of one week, three chest tubes were inserted to drain clinically diagnosed pneumothoraces (mobile X-ray in the Prem Unit was not functioning).

At two weeks of life (the baby was still intubated), a superficial, linear eruption was noted (Fig. 14). It was diagnosed as larva migrans or creeping eruption. Initially, it was treated with a hydrocortisone cream because no anti-parasitic cream was available.

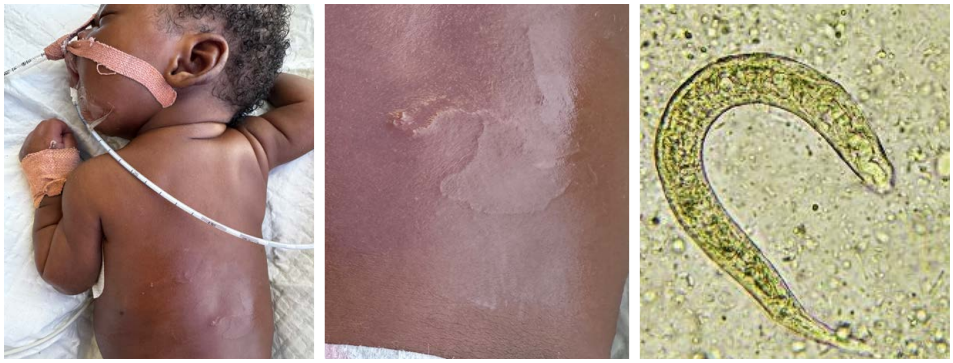

Fig. 14. Evidence of larva migrans: larvae of hookworms (usual host cats, dogs) penetrate the skin of the patients and cause a creeping eruption.

Creeping eruption, or cutaneous larva migrans (CLM), is a skin infection caused by hookworm larvae from cat or dog feces. Although self-limited, it is commonly treated with antiparasitic drugs, specifically oral ivermectin or albendazole, which quickly stop the infection; topical thiabendazole is an alternative.

3.1.7 Next steps

NEO FOR NAMIBIA – Helping Babies Survive will continue to support Rundu Intermediate Hospital, provided adequate funding can be secured. As mentioned in previous reports, ownership of the program will have to be transferred to the hospital in the not-too-distant future (time frame: 3 – 5 years). A Memorandum of Agreement (MoA, see below) has been drafted and will hopefully be helpful for the transition process.

3.2 Katima State Hospital

As had been the case in Rundu, the team of NEO FOR NAMIBIA – Helping Babies Survive was warmly welcomed by both doctors and nurses. Supply chains continue to be brittle, and the consumables brought by the mission team were therefore much appreciated (Table 1).

3.2.1 Overall impression

The Neonatal Unit at Katima State Hospital continues to provide solid neonatal care at an Intermediate Care Unit (IMC) level (Fig. 15). The Cuban neonatologist, Dr. Yurisleydi Valdes, continues to provide excellent care. She is almost always present in the unit. The fact that her contract will end in June 2026 and its extension has not yet been granted by the Cuban government is highly concerning.

Fig. 15. Neonatal Unit at Katima State Hospital: solid quality of neonatal care at an intermediate Care Unit level.

3.2.2 Equipment maintenance

Equipment maintenance at Katima State Hospital remains unreliable (Fig. 16) and renders work for doctors and nurses difficult. Similar to the situation in Rundu, the mobile X-ray device in Katima is not functional. The reasons given for this remain obscure and contradictory.

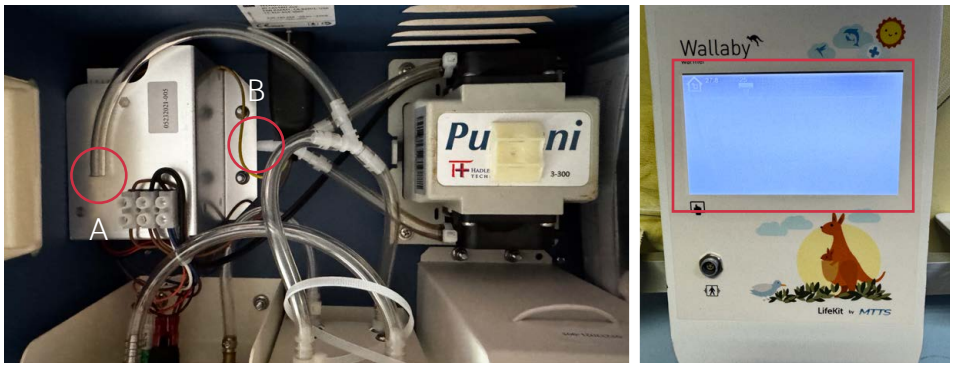

Fig. 16. Equipment maintenance: even simple defects are not corrected (left: disconnected tubing in a Pumani® bubbleCPAP device); more complex problems (right: malfunctioning touchscreen of a Wallaby® open warmer) are even less likely to be repaired.

3.2.3 Statistics DR and Prem Unit

In 2025, there were a total of 3'693 deliveries, resulting in 3'706 live births and 62 stillbirths. The Cesarean section rate was 9.6 %. Over the same period, 544 babies were admitted to the Prem Unit. Overall, there were 29 deaths (overall mortality rate 5.3 %).

Birthweight-specific mortality rates were as follows: < 1'000 g: 13/16 (81.3 %) 1'000 – 1'500 g: 6/48 (12.5 %); 1'501 – 2'500 g: 4/182 (2.2 %); > 2'500 g: 6/298 (2.0 %) (Fig. 17)

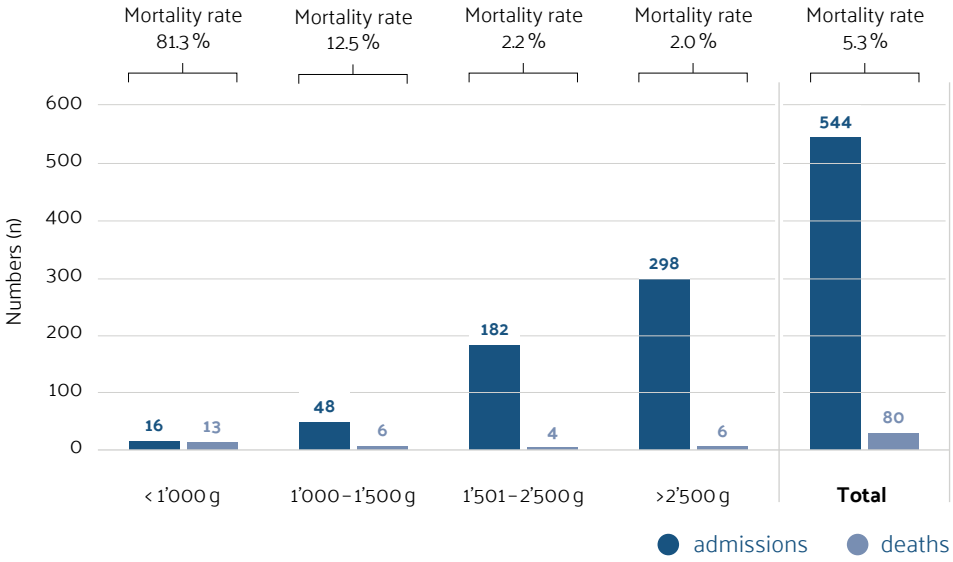

Fig. 17. Overall and birthweight-specific number of admissions and mortality rates (Katima State Hospital).

3.2.4 Case observations (Katima State Hospital)

3.2.4.1 A girl named Hope

The mother of this two-month-old infant fled from an attack during the rebel conflict in Democratic Republic of Congo (DRC). This is the historical background of her story: in early 2025, fighting between Congolese security forces and militant groups led by the s-called March 23 Movement (M23) escalated rapidly, culminating in M23's capture of Goma, the regional hub of the DRC on the Rwandan border. Rwanda, the primary backer of the M23 armed group, supported its offensive in eastern DRC with three to four thousand ground troops. As Goma fell, thousands of locals – many of whom were already internally displaced – fled the region.

When the mother arrived in Katima, she was well advanced in her fifth pregnancy (likely the result of rape). She was noted to be HIV positive with a very high viral load. In addition, the mother suffered from a psychiatric disorder with uncontrollable and regressive behavior (e.g., scatolia: stool smearing) likely to be the consequence of what she had experienced in the DRC and while fleeing. The whereabouts of her other four children and her husband were unknown (dead or alive?).

Hope was born by Cesarean section. She adapted well and was admitted to the Prem Unit because the mother was unable to take care of her. Given her mother's untreated HIV status (high-risk for mother-to-child transmission), she was put on antiretroviral drugs for PMTCT (prevention of mother-to-child transmission). At the time of this writing, it remained unclear whether Hope had been infected (1st test positive, 2nd test equivocal, 3rd test negative).

Doctors and nurses in the Neonatology Unit at Katima State Hospital take loving care of her (Fig. 18), until the mother and Hope can be transferred to a refugee camp in Otjiwarongo (460 km south of Rundu).

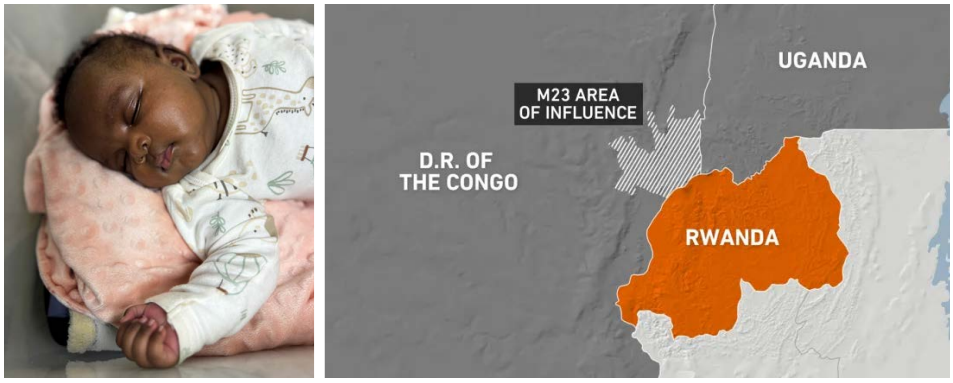

Fig. 18. Hope (left): how armed conflicts (rebel conflict in the Democratic Republic of Congo, right) harm the most innocent.

3.2.4.2 Two cases of obstetrical fetal decapitation

Both cases were reported by Manolo Berbe, MD, head of obstetrics and gynecology at Katima State Hospital. They highlight the importance of good antenatal care, ideally including a detailed sonographic anatomy or anomaly scan at 18–22 weeks of gestation.

Case 1

This 15-year-old pregnant girl (first pregnancy) arrived at the hospital in the expulsive stage of labor. Based on the information gathered at that time, it appeared to be a hidden pregnancy without any prenatal care. Upon delivery of the head, a mass in the occipital region was noted, suggestive of an occipital encephalocele. Delivery maneuvers failed to deliver the rest of the body. Due to the impossibility of extracting the body and suspected additional malformations, an ultrasound examination demonstrated that the fetal abdomen was abnormally large, making vaginal delivery impossible.

When neither vaginal delivery of the rest of the body nor reintegration of the head into the uterus were feasible, decapitation of the fetus (who had already died) was performed. The mother was then taken to the operating room for a hysterotomy and extraction of the remaining fetal body. The baby's abdomen was grossly distended and hard; since no autopsy was performed, the underlying condition remained undetermined (Fig. 19).

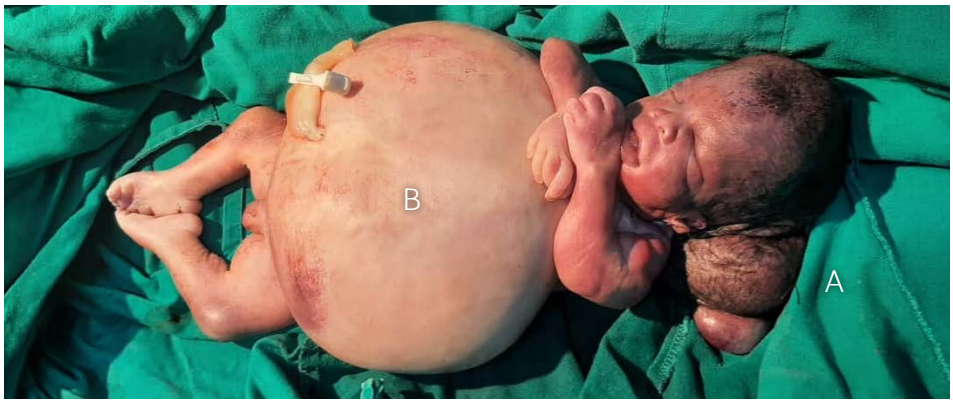

Fig. 19. Baby with occipital encephalocele (A) and grossly distended abdomen (B): due to obstructed labor, the head had to be separated from the body, which was then delivered by Cesarean section; the head was reattached to the body following delivery.

Unfortunately, uterine contraction was insufficient, and uterine bleeding could not be stopped despite the use of various medications and conservative surgical techniques. Obstetric hysterectomy was deemed necessary as a last resort to save the mother's life. Following the operation, the patient recovered well and was discharged from the hospital.

Case 2

This 25-year-old G3/P2 had not attended antenatal care during this pregnancy and attempted home delivery with family support. The fetus was in breech presentation. The family noticed a malformation on the back of the fetus, and when delivery of the head proved impossible, they decided to go to a clinic (50 km from the hospital). Upon arrival at the clinic, fetal death was confirmed, and since delivery of the head was still impossible, the patient was transferred to Katima State Hospital.

At the hospital, ultrasound examination revealed massive hydrocephalus with associated bone malformations, which could make delivery of the head difficult even after drainage of the fluid (e.g., encephalocentesis). The deceased fetus was decapitated, and the patient was taken to the operating room for hysterotomy and extraction of the fetal head (Fig. 20). Due to the size of the head, a longitudinal incision of the uterus was chosen; the classic incision of the lower segment would not have been sufficient, and the risk of damage to the uterine arteries (which run along both sides of the uterus) was too high. Surgery was uneventful. The patient had a favorable postoperative course and was discharged home.

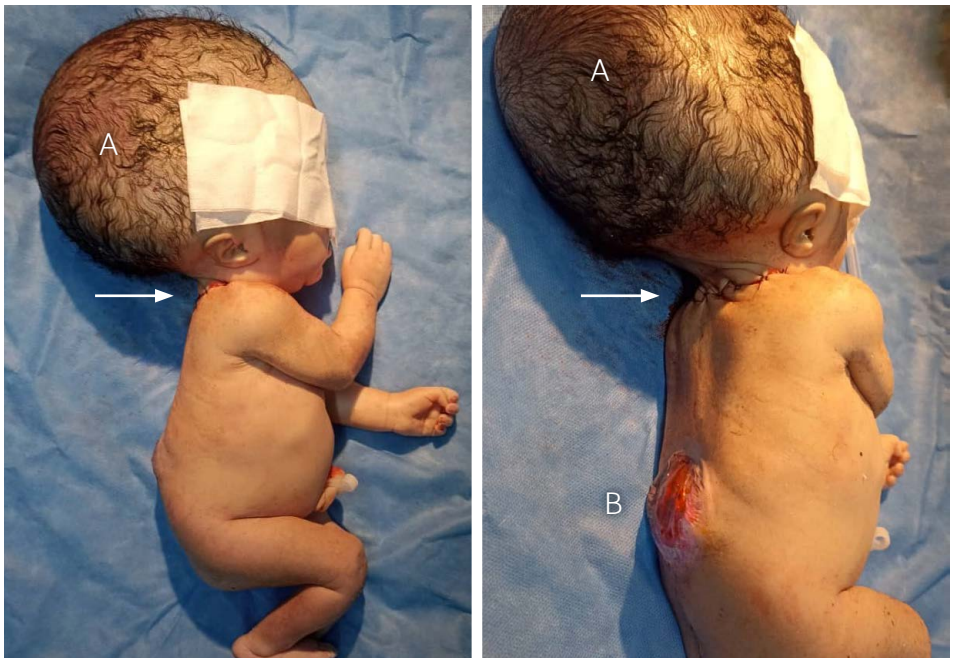

Fig. 20. Baby with hydrocephalus (A) and a thoracolumbar myelomeningocele (MMC) (B): following delivery of the body from a breech presentation, the head had to be separated from the body and then delivered by Cesarean section to save the mother's life; the head was reattached to the body following delivery (arrows).

Discussion

The two cases illustrate the potentially dramatic consequences of a lack of adequate antenatal care. While the fetal malformations were so severe that prognosis would have been poor even if the conditions had been diagnosed antenatally, the mortality risks for the mothers could certainly have been minimized.

So-called destructive operations have virtually disappeared in high-income countries. On the other hand, a literature search revealed that such operations are still performed in low-resource settings: the procedures are performed when the fetus has died, and the mother's lives are endangered. The operations include craniotomies, decapitations, evisCerations and cleidotomies.

In an emotional testimony, the Cuban doctor who had to perform these operations stated: "I have ten years of experience as a specialist in gynecology; I had only heard stories of decapitation from my professors who had worked in Africa. My first case was in 2022, when we had just arrived in Katima (case 1), and the most recent was last week (case 2). It's very traumatic, even knowing that it is a lifeless body and that it is the only way to save the mother. The images..., because you can't stop looking at what you're doing, for fear of hurting yourself or the mother. The sensation in your hand while performing the procedure... After everything is finished, you join and suture the head to the body of the fetus. It's not easy to forget; there's no way you can prepare for that in medical school. It's all very different from what we see and do, even in our own country (Cuba), which is in constant crisis."

3.2.4.3 Congenital syphilis

This term baby had been admitted from home with an extensive skin rash with bullous and desquamating lesions (Fig. 21) . Diagnosis was made based on infant antibody titers (RPR: rapid plasma reagin, and TPHA: Treponema pallidum hemagglutination assay) that were more than four-fold higher than the mother's titers. The baby was treated with a ten-day course of X-Pen (penicillin G).

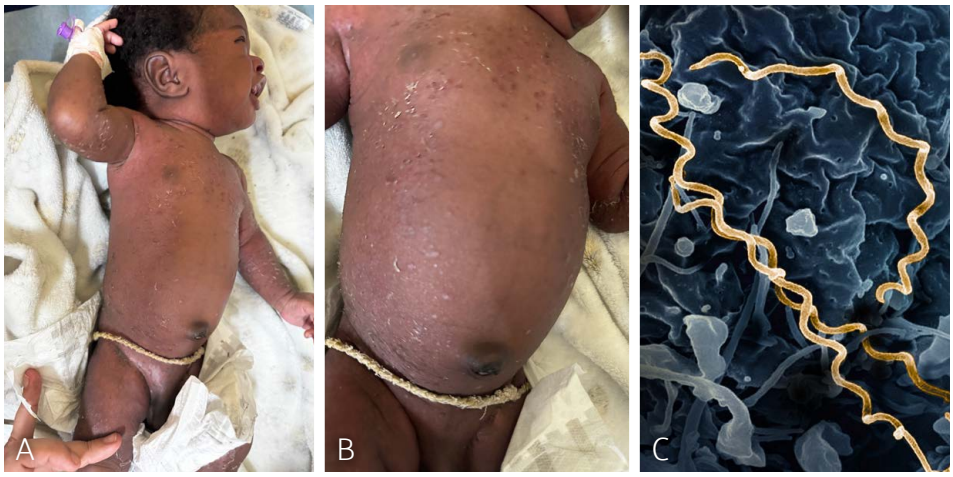

Fig. 21. Baby with skin rash typical of congenital syphilis (the ribbon around his waist indicates that he had been seen by a traditional healer) (A, B); the disease is caused by Treponema pallidum (C).

Congenital syphilis occurs when a mother with untreated syphilis passes the infection to her baby during pregnancy or at birth. Untreated syphilis during pregnancy may result in a wide range of outcomes, including stillbirth, birth of an infant with clinical signs or symptoms of congenital syphilis, and birth of an infant with no documented signs or symptoms of congenital syphilis.

Characteristic features of congenital syphilis include a rash, fever, large liver and spleen, a runny and congested nose, and inflammation around bone or cartilage. There may be jaundice, pneumonia (pneumonia alba), meningitis, warty bumps on genitals, deafness or blindness. Untreated babies that survive the early phase may develop skeletal deformities including deformity of the nose, lower legs, forehead, collar bone, jaw, and cheek bone. There may be a perforated or high arched palate, and recurrent joint disease. Other late signs include intellectual disability, hydrocephalus, and juvenile general paresis (source: www.wikipedia.org).

4. METTINGS WITH REPRESENTATIVES OF THE MOHSS

During his stays in Windhoek, Prof. Thomas M. Berger met with several representatives of the Ministry of Health and Social Services. At a first meeting, Prof. Thomas M. Berger, accompanied by Mr. Lawrence Siyanga, met the Executive Director (ED) of the MoHSS, Mr. Penda Ithindi (Fig. 22).

Fig. 22. Meeting with Mr. Penda Ithindi (right), Executive Director (ED) and Mr. Lawrence Siyanga (left) of the Ministry of Health and Social Services (MoHSS).

4.1 Memorandum of Agreement (MoA)

Such a document would facilitate future collaborations between the Ministry of Health and Social Services (MoHSS) and NEO FOR NAMIBIA – Helping Babies Survive; a draft was written by Mr. Lawrence Siyanga (Control Chief and Health Program Officer responsible for International Collaborations) and Prof. Thomas M. Berger (Fig. 23). At the time of this writing, the draft has been forwarded to the Attorney General for approval. Hopefully, it can be signed in May 2026.

DRAFT MEMORANDUM OF AGREEMENT

Entered into between

THE REPUBLIC OF NAMIBIA, through MINSTRY OF HEALTH AND SOCIAL SERVICES, herein represented by **Mr. Penda Ithindi,** in his capacity as the **Executive Director** and duly authorised hereto

NEO FOR NAMIBIA HELPING BABIES SURVIVE

NEO FOR NAMIBIA – Helping Babies Survive, herein represented by **Prof. Thomas M. Berger,** in his capacity as **Co-Founder, Secretary and Chief Medical Officer** and duly authorised hereto

Fig. 23. During Mission XXV, a draft of a Memorandum of Agreement (MoA) was written by Mr. Lawrence Siyanga and Prof. Thomas M. Berger.

4.2 Vayu® bubbleCPAP project

With the support of Mr. Lawrence Siyanga, Prof. Thomas M. Berger met with Mr. Johannes Geoseb, Director of Tertiary Health Clinical Services at the MoHSS, to discuss the next steps that would be required to donate Vayu® bubbleCPAP devices. It was concluded that a letter signed by the ED stating acceptance of such a donation would suffice to exempt the device from registration in Namibia. A letter addressed to Vayu® Global Health Innovations (Prof. Thomas F. Burke, CEO and Co-Founder) would have to be written to confirm exemption from device registration and allow the units to be delivered.

4.3 VISA and work permits

Accompanied by Mr. Lazerus Doeseb, Senior Manager, Human Resources at the MoHSS, Prof. Thomas M. Berger was able to submit his temporary permit for a two-year-visa to be stamped into his passport. Unfortunately, despite personal discussions at the Ministry of Home Affairs, the same was not possible for his wife, Sabine Berger, because she was not in the country. This will have to be done on the next mission.

5. CONCLUSIONS AND OUTLOOK

While challenges persist, the collaboration between the Ministry of Health and Social Services (MoHSS), local Namibian health care professionals and NEO FOR NAMIBIA – Helping Babies Survive continues to be successful.

Hopefully, the Memorandum of Agreement (MoA) will be ready to be signed in May 2026 (Mission XXVI will take place between May 4, 2026, and June 2, 2026). As it describes the roles and responsibilities of NEO FOR NAMIBIA – Helping Babies Survive and the MoHSS, it ought to facilitate administrative aspects of the collaboration, thus insuring a successful future.

After a delay of several months, the NGO's largest donation yet (more than 100 monitors, GE Panda resuscitation units, GE Giraffe incubators and warming beds) is finally on its way on the container ship ALULA EXPRESS. At the time of this writing, it has reached the port of Tangier in Morocco (Fig. 24). It will likely take another month until the ship reaches Walvis Bay in Namibia. From there, the equipment will have to be transported to Rundu by road.

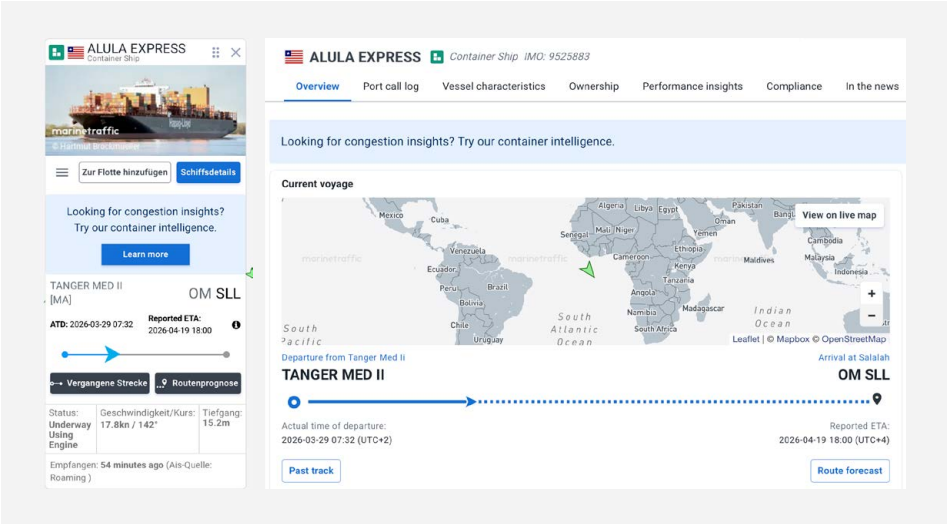

Fig. 24. The container ship ALULA EXPRESS has finally left Hamburg on March 16, 2026. and is on its way to Walvis Bay.

6. IMPRESSIONS FROM THE 25TH MISSION

To conclude this report, some images will once again illustrate the beautiful landscapes, animal life and people the team encountered on their mission (Fig. 25 – 30). Enjoy!

Fig. 25. Scenes from the Kaisosi River Lodge near Rundu.

Fig. 26. African flowers.

Fig. 27. On the way to Katims (Caprivi strip).

Fig. 28. At David's place: over the years, the woodcarver's business is progressing: may the tourists come!

Fig. 29. At Unique's pre-school.

Fig. 30. Kids at Unique's pre-school.

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