MINISTRY OF HEALTH
OFFICE OF THE CABINET SECRETARY

PRESS RELEASE

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ALLEGED ORGAN TRAFFICKING AT MEDIHEAL HOSPITAL- ELDORET

I. Background

1. The Ministry of Health received a letter from Transplantation Society dated 20th July 2023 with concerns over increased Israeli nationals receiving kidney transplants in Kenya. The society highlighted concerns of an organized syndicate that was evading existing regulations in the Country with suspicion of organ trafficking. It further mentioned information from Israeli sources indicating that several kidney transplants involving trafficked foreign kidney donors had taken place specifically at Mediheal Hospital, Eldoret

2. The Ministry of Health constituted a multidisciplinary team comprising kidney transplant specialists, an ethicist, representatives from the Kenya Blood Transfusion and Transplant Services (KBTTS) Secretariat, the Kenya Medical Practitioners and Dentists Council (KMPDC), Ministry of Health administration, and academic experts. The team undertook a fact-finding mission from 5th to 8th December 2023. The team's terms of reference included: Verifying concerns raised by the Transplantation Society, Auditing transplant services at the hospital, and Providing actionable recommendations based on their findings.

3. The team developed terms of reference on the execution of the exercise as below:

    - Development of a Kidney Provider Transplantation Audit Form
    - Piloting of the audit form in MTRH
    - Visit to Mediheal Hospital
    - Compilation of the report
    - Recommendations to the ministry

II. Findings of the Multidisciplinary Investigative Team

1. Mediheal Hospital & Fertility Centre Eldoret is a Level 5 private hospital with requisite approvals to conduct Kidney Transplantation program and had since conducted transplant activities for the last 5 years and had **372** kidney transplants with ~~a~~ majority of transplant cases from the Kenya, East Africa Community (Uganda, Ethiopia, Burundi, DRC, Somalia) and a few international cases (Australia, Israel, Japan, USA, UK).

2. The facility had adapted new technologies as 99% of their transplants were conducted laparoscopically, with induction prior to the transplants and all donations were from living donors and consent to donate was available in all sampled files.

3. The facility lacked sufficient documentation to verify relationship between donors and recipient. The documents availed indicates some of the donors came from different nationalities.

4. All the Human Leukocyte Antigen (HLA) tests that enables distinction of "self" |and "non self" were done in India without the requisite approval of MOH for shipment of human samples outside the country.

5. There was no translation of documents for both donors and recipients who could not understand English.

6. There were high risk transplantations including for a patient with confirmed prostate cancer and extremes of age.

7. Transplants were conducted despite poor donor-recipient compatibility

8. The facility lacked clinical morbidity and mortality reports.

9. The hospital did not have multidisciplinary team (MDT) committee meetings

III. Recommendations of the Multidisciplinary Investigative Team

1. The Ministry of Health to develop, disseminate and implement National Standards and Guidelines for the Transplant Services to strengthen the clinical management for both donor and recipient.

2. The Ministry of Health to develop a legislative and regulatory framework to safeguard against organ trafficking and transplant tourism. National Standards and Regulatory Frameworks in transplant services will seal legal loopholes that can be exploited to allow for clandestine unregulated transplants

3. All donor and recipient evaluations to be presented to a multi-disciplinary committee. MDTs needs to be operationalized/ made functional and the hospital management to reconstitute the ethics committee to include interpreters who can clearly communicate with the recipients and donors, a patient advocate and experts not directly involved in the transplantation.

4. The audit realized that there was need to strengthen the donor recruitment process and consenting by involving and documenting family member conferences. This will involve documenting a list of family/people talked to and anyone who participates in the transplant process for accountability and transparency. The due diligence and duty of care must be upheld by all health care providers as they administer their services

5. Foreigners coming into the country for transplant services need a centralized registry for reference and indicate relationship status with necessary documentation from their country of origin. The due diligence conducted by transplant teams for all pairs should be structured and documented.

6. The allegation of organ trafficking must be investigated by relevant authorities since some of the recipients and donors are coming from more advanced health systems to a relative new transplant program and the reasons given cannot be ascertained.

7. There is a need to have a centralized registry for all the transplant services in the country.

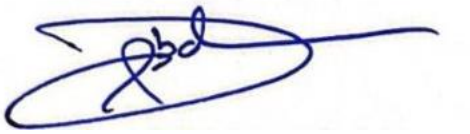
IV. Actions Undertaken by the Ministry of Health

1. The Ministry has developed **transplant service standards**, **guidelines** and frameworks awaiting validation

2. The Ministry has developed Kenya Policy on Blood, Cells, Tissues, Organs and others substances of Human origin.

3. The Ministry has developed a bill on Blood, Cells, Tissues, Organs and others substances of Human origin awaiting public participation.

The Ministry of Health will conduct a follow-up visit to the facility to assess progress on compliance and to conduct a comprehensive clinical audit. Additionally, similar audits will be extended to all seven(7) transplanting facilities across the country to ensure uniform standards and adherence to national transplant regulations.



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