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Global Kidney Exchange: Analysis and Background Papers from the Perspective of Medical Anthropology

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Global Kidney Exchange: Analysis and Background Papers from the Perspective of Medical Anthropology

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GLOBAL KIDNEY EXCHANGE:

Analysis and Background Papers from the Perspective of
Medical Anthropology

Edited by Alejandro Cerón

University of Denver, 2017

Introduction

Alejandro Cerón
University of Denver
December 20, 2017

Global Kidney Exchange (GKE) is a program aimed at facilitating trans-national kidney donation. Although its proponents aim at reducing the unmet demand of kidneys in the United States through the trans-nationalization of kidney exchange programs, the World Health Organization (WHO) and The Transplantation Society (TTS) have expressed concerns about its potential effect on black markets of organs and transnational organ trafficking, as well as on low- or middle-income countries health systems. For GKE to be implemented, it would need to be permitted to operate in at least some low- or middle-income countries. Should a low- or middle-income country allow GKE's implementation?

With the aim of answering this question, the eighteen University of Denver students in the Medical Anthropology course I taught in autumn 2017, identified and researched the different aspects that would affect this issue, and delved in a holistic analysis we present in this report.

Based on our analysis, health authorities in low- or middle-income countries faced with decisions about GKE need to consider the following aspects: the country's current and projected needs related to kidney transplant, as well as the capacity for addressing those needs; the country's current situation related to organ trafficking, transplant tourism and black markets of organs; the current and projected legislation related to both organ donation and human trafficking; the prevailing ethical considerations that inform the practice of all professionals related to organ transplant in the country; analyze end-stage renal failure as a preventable disease needing public health measures; and the sociocultural aspects that surround organ donation in the country. We consider that the concrete configuration of these aspects would influence the effects of implementing GKE. Additionally, we identified some issues of concern that are beyond the level of influence of local authorities: the unmet demand of kidneys in high-income countries is a reality that incentivizes organ trade and transplant tourism, and this is a problem in need of solutions; transnational organ trafficking as well as human trafficking with the purpose of organ donation are problems that need more visibility; for a global exchange of organs to be implemented, it would need to rely on supranational or transnational regulation and oversight; and the global epidemic of chronic kidney disease needs to be addressed through a public health perspective that emphasizes prevention.

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Analysis of Global Kidney Exchange

Alejandro Cerón
University of Denver
December 20, 2017

Global Kidney Exchange (GKE) is a program aimed at facilitating trans-national kidney donation. Its proponents, based in the United States, aim at reducing the unmet demand of kidneys in that country through the trans-nationalization of kidney exchange programs currently available nationally in different countries, including the US. Such kidney exchange programs facilitate donation when a donor is incompatible with a loved recipient, through a chain of donations that ultimately helps each recipient get a transplant. In the US, this organ exchange is ultimately funded by the individuals' health insurance, be it private, public or mixed. GKE would also be funded through US-based individuals' health insurance, which would cover the immediate costs for the foreign, uninsured donor and recipient, and the financial incentive for insurance companies is that over the years, the costs of such transplants are cheaper than replacement therapy through dialysis. Despite the enthusiasm of its promoters, GKE was met with skepticism by institutions like the World Health Organization (WHO) and The Transplantation Society (TTS), which together have decades overseeing the transnational situation of organ transplant, with a special concern about the existence of black markets of organs related to transnational organ trafficking. According to WHO and TTS, GKE would offer financial and symbolic incentives that have the potential of promoting organ trafficking, it wrongly assumes that low- or middle-income countries do not offer organ transplantation to those who need it, and it would add barriers to the efforts that low- or middle-income countries are already doing to improve their responses to end-stage renal failure and organ trafficking. For GKE to be implemented, it would need to be permitted to operate in at least some low- or middle-income countries. Should a low- or middle-income country allow GKE's implementation?

With the aim of answering this question, the eighteen University of Denver students taking the Medical Anthropology course during the autumn quarter, under my supervision as the course instructor, delved into an in-depth analysis of the problem. Informed by medical anthropology's goal of understanding the problem as holistically as possible, we carried on several tasks. First, we read articles, editorials, and comments directly addressing GKE that were published in 2017. Second, we read and discussed an ethnography about organ transplant in Mexico. Third, we invited Dr. Rudolf García-Gallont, specialist in transplants and member of TTS, to give a presentation via video conference about the global situation of organ transplant with an emphasis on low- and middle-income countries, as well as his analysis of GKE. With all this information, as a group we identified several topics we needed to further understand related to the larger context of kidney disease and organ transplants, and each student worked on a research paper addressing one of the topics. Topics included: illegal organ trade, organ trafficking, legislation, organ donation, ethical considerations, international efforts at addressing organ trafficking, sociocultural implications of organ donation, and others. Each student reported to the group on his or her assigned topic, and from there we embarked in a process of analysis that was aided by making mental maps to encourage divergent thinking, to

then build conceptual maps that helped convergent thinking. Throughout the process, we engaged in discussions aimed at trying to address all the angles of the problem.

Based on our analysis, health authorities in low- or middle-income countries faced with decisions about GKE need to consider at least some important aspects of organ donation in their countries. First, authorities need to analyze the country's current and projected needs related to kidney transplant, as well as the capacity for addressing those needs. An emphasis should be made on increasing the country's capacity to respond to the demand, in a timely and efficient fashion, paying attention to public or private health insurance mechanisms that would alleviate the financial burden that end-stage renal failure has on individuals, families, and the health system. This analysis should include an evaluation of the role that kidney replacement therapy through dialysis plays in the system. The country should know its needs and have a plan to meet them. The potential impact of GKE on the local health system should be contrasted to those needs and those plans. Second, authorities need to understand the country's current situation related to organ trafficking, transplant tourism and black markets for organs. It is important to know the extent of this problem and the country's capacity to enforce laws against human trafficking and organ trafficking. The potential for GKE to incentivize organ trafficking needs to be understood in the context of the local capacity to control or eradicate black markets and trafficking. Third, authorities need to assess the current and projected legislation related to organ donation and human trafficking. It is through such legislation that societies define who should be allowed to donate an organ, the legality of financial incentives for becoming a donor, and the incentives that would increase cadaveric donation. Consequences derived from GKE implementation would be restricted by such legislation. Fourth, authorities need to understand the prevailing ethical considerations that inform the practice of all professionals related to organ transplant in the country. There is a range of ethical considerations related to who should be allowed to be a donor and the incentives for becoming a donor. Implementation of GKE would depend on its synergy to local ethical standards surrounding organ donation. Fifth, authorities should adopt public health measures aimed at health promotion, as well as primary, secondary and tertiary prevention of end-stage renal failure, given that in many cases it is conceivably a preventable disease. Finally, authorities need to understand the sociocultural aspects that surround organ donation in the country, as they may have an impact on the country's ability to implement different strategies aimed at increasing the country's capacity to respond to the demand of organs.

We also identified some issues of concern that are beyond the level of influence of local authorities. First, it is important to acknowledge that the unmet demand of kidneys in high-income countries is a reality that incentivizes organ trade and transplant tourism. Although GKE hardly offers a solution to this problem, it is important to stress that the problem needs solutions. Second, transnational organ trafficking as well as human trafficking with the purpose of organ donation are problems that needs more visibility if solutions are ever going to be found. Third, for a global exchange of organs to be implemented, it would need to rely on supranational institutions harmonizing national legislation and also regulating the imbalances in counties' wealth and regulatory power. Finally, the so-called epidemic of chronic kidney disease needs to be addressed through a public health perspective that emphasizes prevention.

Characterization of the Illicit Organ Trade Globally

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November 2, 2017

Introducing the Organ Trade

The illicit organ trade, also known as organ trafficking, is defined as “the [illegal] sale and purchase of human organs for transplantation.” (Cholia, Ami) It is primarily associated with the acquisition and sale of human kidneys, more than any other organ in the human body (however it can include other organs as well). This global exchange affects those from around the world, with the major countries involved being “Israel, Egypt, Brazil, South Africa, Indonesia, India,” (Efrat, Asif) “Pakistan, the Philippines... China... Turkey, Kosovo, South Africa and other sites.” (Cholia, Ami) This is a world-wide issue that spans cultural, economic, and physical borders in the name of profit and what is supposed to be considered “health.”

The purpose of the trade is to facilitate healthy and viable organs, primarily kidneys, to more wealthier individuals who require a transplant option and are unable to get it through more legal means (i.e. family and close friends). Organs can either be sold or stolen from the “donor,” and from there are transferred to the purchaser for transplantation

Even though I won't be delving further in to the financial side of the illicit organ trade, this shall be covering its history, current components in terms of the people involved, the medical tourism that organ trafficking brings, and what can be concluded from it.

History

Theft of human body parts has been around since teeth were stolen from dead soldiers (or sometimes living people) to be sold and put in to dentures in the 19th century, (Kerley, Paul) and bodies were dug from graves to be sold for scientific study and analysis. The idea of selling and buying singular human organs, however, was considered useless due to a lack of actual use for an individual organ. Why purchase a single piece instead of the complete set (or in this case, the complete cadaver), after all. Singular organs had no definitive use yet, and they wouldn't until over a century later.

Individual organs finally found their purpose in the scientific community in 1954, when the first successful organ transplantation was accomplished. A man name Richard Herrick was dying at the age of 23; both of his kidneys were failing. In 1954, kidney problems were considered a death sentence, and the idea of organ transplantation was the equivalent of a science fiction story. Herrick's family was certain that he would die, it was only a matter of time.

However, there was a small group of doctors and scientists at Harvard Medical School, led by a surgeon named Joseph Murray, that believed successful organ transplantation could actually be achieved. (Debra Ruder et. al.) They wanted to test their theories, but couldn't find a set of twins willing to undergo such an operation. As it turns out, Richard Herrick had a twin brother – Ronald Herrick – who was just as willing as Richard was to give the experimental procedure a shot. And on December 23rd, at 11:15 in the morning, that was what occurred.

Richard lived on for another 8 years after that operation, much longer than he would've without it in the first place. His brother, Ronald, died on December 29th, 2010. Those brothers made history as the first organ donor and recipient in history, and became living, breathing proof to the scientific community that organ transplantation wasn't just pseudo-science.

From the point in which organ transplantation, and in turn the need for viable transplantable organs became viable, attempting to re-trace the history of organ theft is an extremely difficult task. Any form of legislature involving illegal organ acquisition wasn't enacted until the 1980's, at the earliest. Some of these laws include the National Organ Transplant Act of 1984 (US, 1984), the Transplant of Human Organs Act (India, 1994), and the Human Tissue Act of 2004 (UK, 2004).

The first official investigated case of illegal organ sale and trafficking was recorded in Bombay, 1993 (and actually lead to India's Transplant of Human Organs Act), but the doctor in charge wasn't captured or prosecuted until 2008. The same happened in the US in 2009, which was the result of a decade-long operation to find and eventually prosecute the man in charge of a US illegal organ transplant ring. There are other accounts of organ theft and illegal organ "donation," however legally prosecuted cases are spread thin across the world due to the setup of the operation and the multiple individually moving parts within the process of it. These components will be discussed in the next section to further explain the process of illegal organ trafficking.

Components

In the sale of organs within the illicit organ trade, there are three main parts to the process. There is acquisition, via a donor and/or a seller to a broker, the sale via the seller to the buyer (with the broker acting as the middleman), and finally the act of transplantation itself to the buyer. In this section, each individual component will be explained and analyzed for a better understanding of what occurs within the process of illicit organ trading.

Acquisition

Organs are acquired for the illegal trade in two ways: they are sold or they are taken. It's a question of economical supply and demand. Currently, "the demand for organs far outstrips the supply" (Francis, Leslie and John Francis) of willing and able donors currently available. "In 2007, only 21,489 deceased donors were reported to the Global Database on Donation and Transplantation... In the United States, as of the end of February 2010, 105,966 patients were on waiting lists for transplantation. In the United Kingdom, an estimated 9,000 patients need an organ transplant at any given time but only 3,500 transplantations were carried out in 2008." Mathematically speaking, the amount of kidneys needed in these more economically stable countries

is more than what can be legally provided. This is where the illegal acquisition of a kidney comes in to play.

In terms of the “donor” selling their own organs, more often than not it’s done for financial purposes. Between selling a kidney illegally versus donating it freely to the same person, those in financial distress or from economically poorer parts of the world stand to gain better monetary stability than they started off in. The only catch is the lack of post-op care offered, something that is extremely vital in terms of kidney surgery. And in terms of kidney sale and care, the buyer is basically “exploiting a donor if they are very poor and [are being given] a very small amount of money and no doctor is caring for them afterwards.” (Campbell, Denis and Nicola Davison) But with a lack of viable kidneys in circulation for those willing to purchase, this scarcity “has led to the identification of an abundant new source of organs in the bodies of the living, as well as of the dead, especially among the poor, the naïve, the medically illiterate, the displaced and the desperate – those whose social frailty and all too evident ‘bioavailability’ have proven too tempting to bypass or overlook.” (Scheper-Hughes, Nancy)

For example, in 2008 a woman named Vera Shevdko was in desperate need for money. She lived in Tel Aviv at the time, and actually saw an “ad in the paper that read ‘Looking for Kidney Donors.’” (Ginzler et. al) The ad “promised good pay and included a telephone number,” and when Shevdko called, “the man who answered the phone promised her \$10,000” in exchange for one of her kidneys. Shevdko agreed.

In another instance, an “organs broker” may “[promise] illegal immigrants freshly minted counterfeit passports in exchange for a freshly extracted ‘spare’ kidney,” (Scheper-Hughes) an option that holds high incentive for the “donor” if they are in need of a way to remain or enter a new country easier. This same incentive can also be used as blackmail to force a kidney donation, depending on the situation.

In both situations though, the basic process is the same. A person interested in selling their kidney meets up with a sort of middleman to broker the deal between the seller and the eventual purchaser. From there, the seller is given instructions by the middleman as to where to go for the transplant to take place. In the event of the seller needing to travel to for the operation, typically the purchaser receiving the kidney will pay for the travel expenses. Very rarely will the “donor” actually meet the person that is receiving the organ.

However, with that same lack of viable kidneys and a definitive need that is demanded to be met by the buyers, the seller is not always the person who originally owned the kidney. As stated earlier, there are two ways for a kidney to be sold. Willingly (and that using a loose definition of the word), albeit illegally, from a “donor” is one way. The other way is through theft, also known as “organ harvesting.” Organ theft/harvesting can be defined as “the [choice] itself of the person is coerced—through kidnapping, coerced payment, or the like—and organ removal occurs following the coerced transfer.” (Francis, Leslie P., and John G. Francis) In this scenario, an unwilling and unsuspecting victim can be drugged, kidnapped, and/or violently coerced in to giving up one of their kidneys. These people don’t receive money, and can be left with no memory of the event occurring at all (if they’re left alive in the first place).

In one story, a man was “travelling with his wife and they [gangsters] took both of them... They [gangsters] put them in separate rooms. He heard his wife screaming. After he went in and saw her on a table with her chest wide open and without her heart or kidney.” (Arsenault, Chris)

In another, “three victims were offered work for 150 rupees (about \$4) a day. Then all three men -- on varying dates over the past two weeks -- were taken to a house and kept there at gunpoint for several days... they were given shots that made them pass out and they woke up to excruciating

pain and scars that wrapped around their thin waists.” (Russo, Karen) Afterwards, they were told to never speak of what had transpired, or they would be killed. They knew what had happened to them, yes, but there was no way to get their kidneys back at that point. They were already gone, being shipped to a wealthy and sick buyer in another country.

Sale and Purchase

Where finding information on the process of this sale and trade is difficult overall, the hardest part to find direct information for is the sale and transportation of the organ. Once the organ needed for transplant has been acquired, one way or another, it is sent off to the buyer. At this point the kidney has already technically been bought by whomever needed it; typically, the initial purchase would have happened before the kidney was ever acquired (See Fig. 1 for order of events). The purchasing of organs illegally is typically done by a person from a wealthier country, with wealth of their own and deteriorating health. These patients may also be extremely low on the transplant list (if there is one) due to different determining factors such as “blood type, body size, severity of patient's medical condition, distance between the donor's hospital and the patient's hospital,” (U.S. Department of Health & Human Services) and organ survivability time outside of the human body. A person’s ranking on the transplant list, particularly a low one, can easily influence someone with enough money to circumvent traditional medicine and the law to acquire an organ much faster.

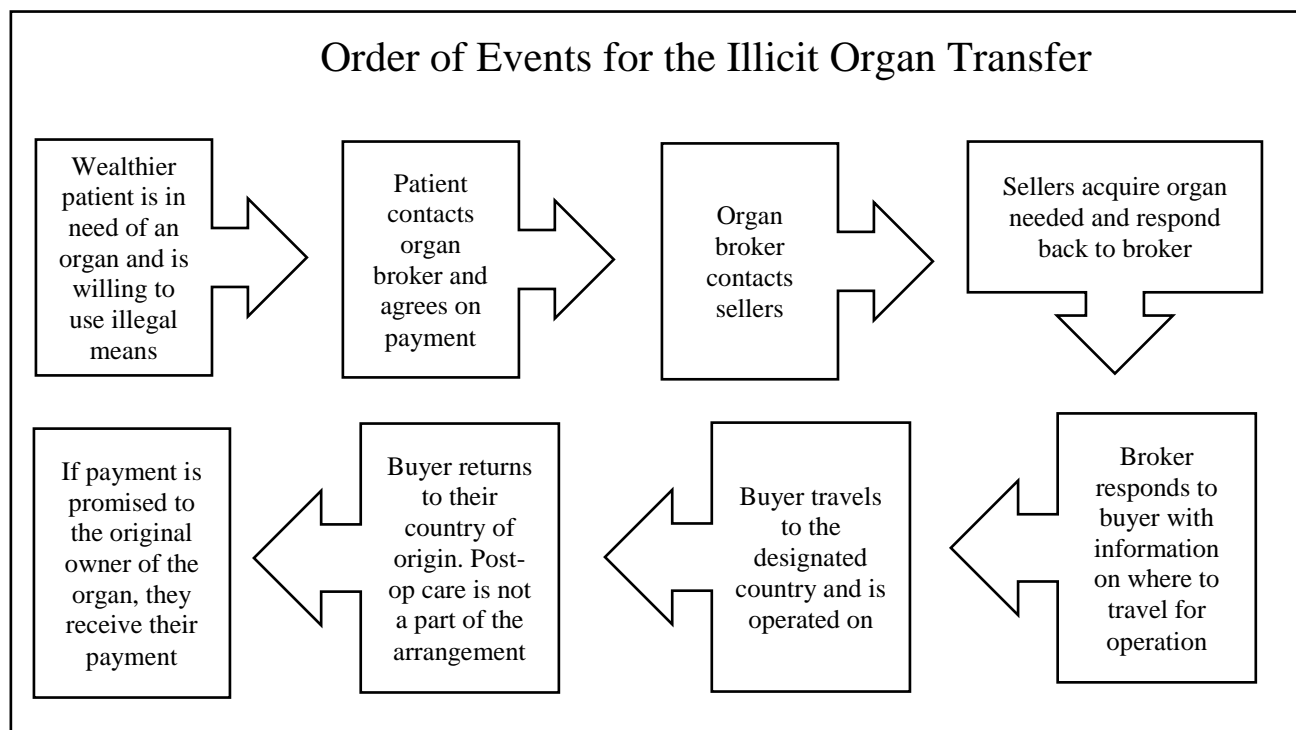


Figure 1. Order of Events for the Illicit Organ Transfer. This offers a short visual explanation of what happens along the chain of purchasing, acquiring, and transplanting an organ.

With the rise in technology, getting in contact with someone willing to act as the middle man in this type of transfer can be as easy as going online to “some sites [and posing] as a patient (or the relative of a patient) looking to purchase or otherwise broker a kidney.” (Scheper-Hughes) Other

times, less reputable doctors looking to profit on this deal may initiate the deal as well and put the patient in touch with the middleman.

In turn, the cost of the entire ordeal will typically be paid by the person in need of the organ, and typically covers “all hospital fees, the payment to the [organ] seller, accommodations for accompanying family members chartered, [and the] round-trip flight to the country where the surgery would take place.” (Finkel, Michael) The buyer will typically not know where the organ came from, besides a possible description of whether or not it will come from a live human or a cadaver.

In this type of deal, there is no legality whatsoever. No legal contract, no legal transplantation, and the operation may not even be performed in a legitimate hospital. In the case of post-op complications on the buyer’s side, typically “there is no way for [them] to prove where [they’ve] been and who performed the surgery.” (Finkel, Michael) In turn, attempting to take a sort of legal action in the case of malpractice isn’t entirely impossible, however a difficult thing to accomplish due to the lack of legality in the original transaction.

Transplantation

The transplant of the organ from the “donor” to the purchaser will not typically happen within the buyer’s home country. As stated earlier, a portion of what the patient pays for is the trip to a foreign country in which the surgery will occur. This is called “medical tourism,” (or in the case of organ transplantation, “transplant tourism”) a term that will be explored more in-depth shortly.

Under normal and legal transplant procedure, there are three parts to the process; the pre-transplant period, the operation itself, and the post-transplant period. During the legal version of the operation, “the transplant surgery is performed under general anesthesia. The operation usually takes 2-4 hours,” (Hyperarts, Rob Mayfield) excluding possible complications that include “bleeding, infection, wound healing problems, difficulty with blood circulation to the kidney, or problem with flow of urine from the kidney,” or even total rejection of the newly implanted organ later on in post-op. If any of these complications occur, another surgery later on may be required to correct them. In the case of organ rejection, “prompt treatment can reverse the rejection.”

However, this isn’t always the case in terms of illegal organ transplantation. The pre-transplant period is shortened in time considerably, if it can be considered to exist at all in terms of an illegal operation. These “transplant surgeries are performed at private for-profit hospitals in cities. However, most units are not accredited to adhere to practice standards for safety and quality of care. Thus, there is marked variation in qualifications and competencies of health professionals.” (Jafar, Tanzeen H.) During the operation the patient is still put under a general anesthesia, but from there it depends on the hospital the operation is being performed at and the quality of the organ being put in to the patient. Due to the fact that “government disease control agencies do not monitor underground organ trafficking, recipients risk contracting infectious diseases like West Nile Virus and HIV.” (Kelly, Emily) This means that the only assurance of a healthy and quality organ being transplanted into the patient is the assurance of the broker and the surgeons. There is no official, medical confirmation that it is a healthy organ being transplanted.

Once the transplant is complete, the recipient is sent back to their country of origin. There is no post-op care involved in this process, both for the donor and the patient. Post-op is completely at the discretion of those operated on, as well as whether or not they can actually afford the care. Patients simply return to their country of origin and await what happens next. If records of the operation are

needed for assistance in post-op complications, they can be incomplete, incorrect, or nonexistent. In terms of the actual transplantation part of the process, the buyer is the one taking the most risk.

In comparison to a likely death due to kidney failure, though, those risks are more than acceptable to a desperate patient.

Transplant Tourism and Its Effectiveness

As mentioned earlier, medical tourism is travelling to another country with the specific intentions of having a medical operation done due to better, cheaper, or quicker medical care. In turn, transplant tourism is similar to medical tourism, but with the intent of purchasing a new organ and having an organ transplant while in another country. Transplant tourism “involves not only the purchase and sales of organs, but also other elements relating to the commercialization of organ transplantation. The international movement of potential recipients is often arranged or facilitated by intermediaries and health-care providers who arrange the travel and recruit donors.” (Shimazono, Yosuke) In the case of illicit organ trade, this is organized by brokers and paid for by the patient in need of the organ.

Transplant tourism has actually become such a phenomenon within the medical community that “the World Health Assembly issued a resolution in 2004 for all WHO member states to prohibit transplant tourism,” (Francis, Leslie P., and John G. Francis) and “although countries have attempted to adhere to the resolution, efforts have met with substantial resistance.” This resistance is caused in part by legislative issues and an inability to actually follow through on these guidelines. The illicit organ trade and in turn, transplant tourism, are smaller operations with maybe ten people involved at the max (“donor,” seller, broker, buyer, surgeon, and nurses). In comparison to the large government operations trying to put a stop to the process, they are simply too slow to keep up with the smaller and faster operations of the illegal organ trade. Especially in larger and more densely populated countries like China or India, the idea of keeping track of such small groups of people amongst the throngs of thousands of innocents is the equivalent of looking for an illegal needle in a haystack – near impossible. The fact that these activities cross international borders only makes it harder to attempt to persecute those who are involved in the trade. There is an international law and international court that could attempt to handle these, but with current “jurisdiction of the International Criminal Court [being] limited at present to three crimes: genocide, crimes against humanity, and war crimes,” it can be difficult to fit organ theft within those boundaries.

Even though these activities are still considered illegal, that doesn’t stop those desperate and in need to take a trip to Egypt or the Philippines to get what they need. It comes back to the question of supply and demand, and even though the illicit organ trade and transplant tourism are considered illegal, they meet the requirements that stem from a low supply and high demand in more-developed countries and high supply but low demand in less-developed areas.

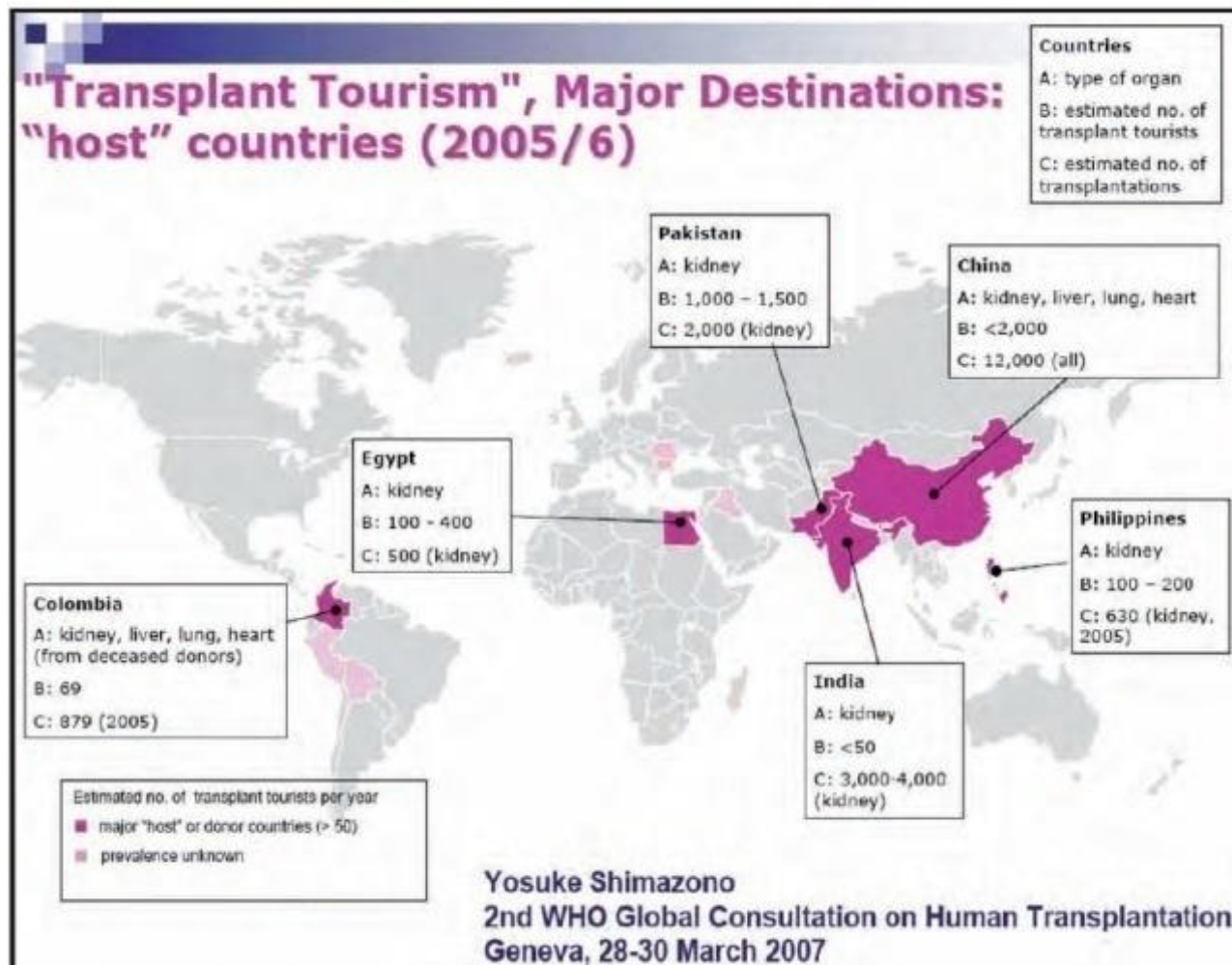


Figure 2. “Transplant Tourism,” Major Destinations: “Host” Countries (2005/6). Chart from 2007 Presentation on human transplantation and its popular countries of occurrence. [Source: Ehtuish, Ehtuish]

Transplant tourism is a sleek and effective operation, but its ramifications are severe. Transplant tourism through the illegal organ trade “exploits poor individuals who are desperate to make money for survival,” (Kelly, Emily) and puts those who receive the organs at risk due to the lack of testing on the organs past whether or not they’re a transplantable match. Those who aren’t even a part of the ordeal, but are separate and attempting to simply get their own medical care, can be sidelined by hospitals and doctors that are overrun with foreigners that are solely there for cheaper and faster transplants.

Transplant tourism, though a popular phenomenon in the medical world, exists to meet the supply and demand need that exists in the world. This process as a whole may seem easier and faster from an outside point of view – a way to fit a global need, so to speak – but once one takes the time to fully examine what all it entails the process becomes messier and more harmful than it originally appeared.

Conclusions

The illicit organ trade, its components, and the creation of medical and transplant tourism create more harm than they do good. Even though a societal need is being met, it is being met dangerously. There are no regulations among the trade, just word of mouth and the promise of an organ from someone who regularly deals in making these transactions possible, but not in the people involved that aren't paying.

Yet even with these inherent risks – no legality, no medical confirmation, no definitive care before and after the process – people still flock to it. The illicit organ trade is still considered to be a large problem, but why? Are we as a species truly that desperate or that reckless enough to put ourselves and complete strangers at risk of even worse health complications? Are we so desperate for money that we would do anything, sell a piece of our own bodies, for a few thousand dollars? What does this say about the state of humanity that a process like this still exists? And more importantly, if the illicit organ trade persists then what methods would be best for stopping it? What is currently being done is ineffective, with only a few cases of organ theft and trade actually making it to some sort of trial. These aren't questions that I have answers for, nor the rest of the world as of yet. But these are questions that are being asked, and in turn being used to hopefully change the current state of organ availability.

The process and existence of the illicit organ trade globally is a process that exists because we are not able to meet the needs of our fellow man on this Earth. The only question remaining now is what must be done to balance this inequality in the world, so that these occurrences no longer have a place of necessity among humankind.

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Reviewing the Global Kidney Exchange Program: The Influence of the World Health Organization

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Introduction

The World Health Organization, which was established in 1946 and held its first assembly in 1948, is a unit in the United Nations whose purpose is “to act as the directing and coordinating authority on international health work”; WHO has six regional offices around the globe (Roemer, 1594). The World Health Organization has helped promote health care initiatives such as eradicating smallpox in 1958, working towards increasing child immunization around the world since 1974, reducing maternal morbidity starting in 1987 (McCarthy 2002). The World Health Organization has helped to improve many health care systems all around the globe and because of such, it has the power to influence many programs that are coming about such as Rees et al.’s Global Kidney Exchange Program.

After the proposal of a global kidney exchange program by Rees et al. a letter was sent to the editor by Delmonico and Ascher in which they mentioned at the end that one of the problems with the program is that the World Health Organization was against the introduction of this program (Delmonico and Ascher 2017). In the following paragraphs, the opinions and regulations stated by WHO will be discussed and the GKE program will be analyzed by said standards to better understand WHO’s opposition.

WHO Regulations on Transplant

On the World Health Organization’s website, they have their “guiding principles” concerning transplantation available which contains eleven principles total (not including the preamble); by understanding these principles the GKE program’s cons may be highlighted (WHO 2010). In short, WHO’s guiding principles state that the process organ donation should be consensual, free of brokering, sale or other practices that would result in some kind of monetary gain for donors, doctors, next of kin, or any other third party, and allocation should be governed by clinical and ethical norms rather than any other factors. Guiding principle 9, which states, “The allocation of organs, cells and tissues should be guided by clinical criteria and ethical norms, not financial or other considerations. Allocation rules, defined by appropriately constituted committees, should be equitable, externally justified, and transparent.” The purpose of this principle is to ensure that no one be denied access to organ donation solely because of their economic status. It does not appear that the Global Kidney Exchange program that Rees et. al propose is in explicit violation of any of the 11 guiding principles for transplantation. In fact, their goals for the GKE coincide with the goals of WHO guiding principle 9, as they state, “we propose that KE could be extended to overcome poverty barriers in the

developing world, as well as immunologic barriers in the developed world, by enabling exchanges between them,” (Rees et al., 2016). However, there are logistical and other obstacles involved in such an exchange.

Issues with the Current State of Global Organ Trade

The current state of international organ trade is a serious issue in the realm of health policy for a number of reasons, as outlined by Yosuke Shimazono in his article, *The state of the international organ trade: a provisional picture based on integration of available information*, in the 2007 WHO bulletin. Although the goal of the GKE is to break down the economic barriers preventing those in underdeveloped nations from giving and receiving organs, Shimazono argues that international organ trade actually has a greater potential to put the less fortunate at a risk for exploitation. One seemingly inevitable consequence of globalizing organ trade is the increase in “transplant tourism,” which, “involves not only the purchase and sales of organs, but also other elements relating to the commercialization of organ transplantation,” (Shimazono, 2007). Transplant tourism also involves the recruitment of donors and travel arrangements facilitated by healthcare providers and other health care providers, posing quite the ethical dilemma as there are obvious economic incentives for all the parties involved.

There have even been instances when donors and recipients undergo the procedure in a third-party country, like South Africa. Illegal organ transplants are not uncommon in these countries, and police investigations in both Brazil and South Africa suggest that human trafficking is potentially being utilized for the purpose of illegal organ transplants. Also, there are countries in which organs are exported to other countries for pay. India is somewhat notorious for this, as the Voluntary Health Association of India disclosed that around 2,000 Indians sell a kidney every year (Shimazono, 2007). All of these practices are still in effect today despite national and international regulations, and thus it would be nearly impossible to ensure that donors in these countries are emotionally related, free of coercion, and fully informed of risk (Delmonico, 2017). Ultimately, the WHO and other potential oversight organizations are opposed to the implementation of the Global Kidney Exchange because at this point in time, the ethical dilemmas associated with globalizing organ donation are insurmountable.

Conclusion

Although the goals of the Global Kidney exchange program proposed by Rees et al. do align with values of altruism outlined in the World Health Organization’s guiding principles for organ transplantation, logistically speaking the program has the potential to do more harm than good. Incidents involving transplant tourism, organ trafficking, human trafficking, and organ exportation are already prevalent across the globe, and a chronic problem in many countries. Implementing such a program in a global society already combating numerous human rights violations is not advisable. The purpose of the World Health Organization is to improve the health of people around the world. It is expected that the WHO strives to improve the health and well-being of all in the policies and practices it supports. Subjecting people from underdeveloped nations to exploitation and other egregious practices already surrounding the realm of international organ transplantation is unethical,

and does not guarantee that the health and well-being of donors will be insured. For this reason, the WHO does not, and should not, support the Global Kidney Exchange program as proposed by Rees.

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The Declaration of Istanbul: The Global Impact

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What is the Declaration of Istanbul?

The demand for organs has increased since the invention of organ transplantation in the 1950s and an uncontrolled black market has arisen to meet those demands. In 2004, The World Health Organization (WHO) recognized this unregulated market's increasing illegal activities and the lack of effective legislation to deal with it. WHO called for international protection of the targeted, impoverished living donors (Nullis-Kapp, 2004). The Declaration of Istanbul (DOI) was the response.

150 global representatives of scientific and medical bodies convened in Istanbul, Turkey from April 30th to May 2nd of 2008 to acknowledge the appeal from WHO. Working with the global representatives were government officials, social scientists, ethicists, The International Transplantation Society, and the International Society of Nephrology. TTS and INS had already written a draft in 2007 so this 2008 summit meeting was a finalization of the draft that became the DOI.

The Declaration of Istanbul is a collaborative, global approach toward combating organ trafficking, transplant tourism, and organ failure. There are a number of socioeconomic and political factors that play a role in the creation and sustenance of these issues and the DOI looks to confront these while also identifying the prevention of organ failure as a strategy to reduce the demand for organs to begin with.

Organs are not commodities therefore this paper looks to outline the global initiative to end such practices. The first section provides historical context leading up to the DOI. The second section outlines the declarations in the document. The third section focuses on the progress and implementation of the DOI to present global implications of the document.

Historical Context Before the Declaration

In 2004, the WHO appeal outlined the resolution adopted at that year's World Health Assembly (WHA) that voiced, "concern at the growing insufficiency of available human material for transplantation to meet patient needs and urged Member States to extend the use of living kidney donations when possible, in addition to donations from deceased donors. It also urged governments to take measures to protect the poorest and most vulnerable groups from transplant tourism and the sale of tissues and organs, including attention to the wider problem of international trafficking in

human tissues and organs” (Nullis-Kapp, 2004: 1). One example of the lack of governmental protection for living donors is an international organ-tracking ring that was apprehended earlier in 2004 that arranged for Israelis to receive kidneys from impoverished Brazilians in Durban, South Africa (Nullis-Kapp, 2004). A second example is the Chinese government’s organ procurement operation beginning in 1999 that imprisoned Falun Gong practitioners and harvested their organs for commercial use (Lee, 2014). These international events spurred the WHA to publish Guiding Principles that concerned the complexity and implications of organ transplantation.

The WHA’s Guiding Principles of 2004 acknowledge the medical aspects of transplantation in addition to the legal, ethical, economic and psychological factors present in any type of organ transplantation. Many of these offenses were addressed in the declarations of the final document.

Content of the DOI

The grave human rights violations outlined above are addressed in three sections: the Preamble that outlines the consensus of all participants at the Summit, the principles that concern the legal and professional framework of organ transplantation and the proposals that aim to take on the multifactorial issues of organ transplantation.

The consensus in the Preamble summarizes the objective of the summit. It states: “All countries need a legal and professional framework to govern organ donation and transplantation activities, as well as a transplant regulatory oversight system that ensures donor and recipient safety and the enforcement of standards and prohibitions on unethical practices” (Participants in the International Summit on Transplant Tourism and Organ Trafficking, 2008). In order to meet this objective, a number of principles were established.

Principles

The Principles outline the legal and professional framework necessary to confront organ failure by encouraging engagement of national governments with international organizations and NGOs already dealing with the issue. The principles bring attention to the necessity of legislation surrounding transplantation and donor protection. There should not be any discrimination concerning who gets and gives organs. There should also be programs and policies that provide short-term and long-term care for both donors and recipients. Organ donations should come from within the recipient’s home country to establish self-sufficient, regulated organ donation programs. The principles also include the fact that human rights violations are results of organ trafficking and transplant tourism therefore they must be prohibited. With these standards established, this document provides structure for governments to tackle their own country’s organ transplantation system and the trafficking and tourism that result. The structure is further developed in the following proposals (Participants in the International Summit on Transplant Tourism and Organ Trafficking, 2008).

Proposals

These proposals are designed as strategies to increase donor pool, prevent organ trafficking, prevent transplant commercialism, and encourage legitimate and sustainable transplantation programs. They aim to increase legitimate deceased donation so countries can move away from relying on living donors for organs. The proposals focus on engaging governmental entities, health care institutions, medical professionals and NGOs so that transplantation infrastructure is stimulated and technology that improves organ donation efforts is shared.

These proposals are meant to protect and honor living donors while preventing organ trafficking, transplant tourism, and transplant commercialism. This includes the use of informed consent as well as including proper assessment and clear definitions of both the physiological and psychological impacts of organ transplantation on the donor. This also includes a psychosocial evaluation by a mental health professional as a part of the screening process. Care, standardization, transparency, follow-ups, and accountability in support of donation are all values laid out in these last principles (Participants in the International Summit on Transplant Tourism and Organ Trafficking, 2008).

Progress Update

After the Declaration was published, a significant amount has been accomplished. The Declaration of Istanbul Custodian Group (DICG), officially formed in 2010, is a group that monitors the progress, adherence and completion of aspects of the Declaration in the countries that signed it. They also encourage pharmaceutical companies, professional societies and other organizations funding transplantation research to comply with the Principles of the Declaration. Despite the lack of complete establishment starting in 2008 DICG began holding governmental authorities accountable for the alignment of their national policies with the Declaration they signed and with WHO Guiding Principles concerning organ transplantation. One of the Guiding Principles was transparency of transplantation activity, which has now been incorporated into the United Network of Organ Sharing (UNOS). UNOS has changed their policies and now collects data from candidates outside U.S. citizens or individuals coming to the U.S. for transplantation.

The DICG were successful in many countries such as the United States, India, Pakistan, Latin America, the Philippines, Eastern Europe and China. The DICG aided the Council of Europe in developing a convention that requires the prohibition of organ trafficking as well as taking down the Costa Rican transplantation tourist network. Due to pressure from the DICG, the Chinese government agreed to ban the practice that allowed the country to use executed prisoners for organ harvesting. Not every aspect of the Declaration has been implemented in each of the countries that signed it (Delmonico, 2017).

Conclusions

The Declaration of Istanbul aims to address the epidemic of illegal organ trafficking on a global scale by solidifying principles and proposals that address not only the medical aspects of organ

transplantation but also the legal, ethical, economic and psychological factors involved. This unanimous understanding of the complexity of organ transplantation and the negative effects of the unregulated, illegal organ market has led to a powerful document that has ignited change.

Although not every aspect of the DOI has been implemented in every country who signed the document, the DICG has played a key role in holding countries accountable to adequate policy change or creation in terms of organ transplantation.

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The U.S. Department of State on Organ Trafficking

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Introduction

In this section, we will tap into the weight of organ trafficking in the world by analyzing the U.S. Department of State's 2017 Trafficking in Persons Report. We will also be answering the following questions:

- a. How serious is the issue of human trafficking?
- b. How does organ trafficking relate to human trafficking?
- c. What actions are being taken in regards to this phenomenon? What does that tell us about the degree of severity of organ trafficking?

Understanding these major points will help us understand the level of crucially and severity of organ trafficking and its impact on the world. Through the data provided in the State Department's report, we will:

1. Analyze the U.S. Department of State's statements on human and organ trafficking
2. Examine their human trafficking classification system
3. Extract data relevant to organ trafficking and analyze it
4. Interpret the report's position on the severity of organ trafficking and how that relates to the issue in general

The U.S. Department of State's Stance on Human and Organ Trafficking

The report starts with a statement from Rex W. Tillerson, the Secretary of State, who describes human trafficking as "one of the most tragic human rights issues of our time." Rex also expresses how human trafficking "splinters families, distorts global market, undermines the rule of law, and spurs other transnational criminal activity. It threatens public safety and national security" (U.S. Department of State 2017). Following that is a statement by Susan Coppedge, the Ambassador-at-Large to Monitor and Combat Trafficking in Persons. Unlike Tillerson, Coppedge expresses her position on human trafficking using a story from a case that she personally prosecuted. This story is of Teresa, a victim of human trafficking from Central America, who was deceived to go to the U.S.

for promises of love and stability. A few weeks later she found herself forced into commercial sex and threatened to be deported and humiliated. That is only one of many cases of human trafficking that happen in a plethora of forms and degrees of damage across the world (U.S. Department of State 2017).

These two statements set the tone for the rest of the report and draw to our attention the depth and severity of human trafficking as understood and articulated by the U.S. Department of State. They also highlight some of the major disastrous effects that such a phenomenon has on individuals and societies across the world. But, how does this relate to organ trafficking specifically?

While the U.S. Department of State does not offer a direct definition of what it considers as human trafficking, it does so indirectly through its description of what an anti-trafficking law should include. In their *Scope and Efficacy of National Anti-Trafficking Laws* section, the report mentions the following: “A clear definition of human trafficking that describes the acts, means, and ends, as distinct from related crimes such as migrant smuggling, prostitution, kidnapping, organ trafficking, or illegal adoption” (U.S. Department of State 2017, 2). The State Department’s report recognizes organ trafficking as a related crime to human trafficking, but not as an issue serious enough to deserve separate or equal attention to other forms of human trafficking.

In the next section, we will continue looking at the State Department’s position on organ trafficking through analyzing the classification system used in the report.

Classification of Countries

The classification of countries according to the *2017 Trafficking in Persons Report* puts countries into 4 categories. This classification is determined by how compliant each country in the world is to the *Trafficking Victims Protection Act* (one of the most important anti-trafficking acts legislated by the U.S.) and how much work each country is doing to follow the act’s guidelines. The 3 major categories are as follows:

1. TIER1: Countries whose governments fully meet the *Trafficking Victims Protection Act*’s minimum standards
2. TIER 2: Countries whose governments do not fully meet the minimum standards of the act, but are making extensive efforts to improve their compliance with the *Trafficking Victims Protection Act*
3. TIER 3: Countries whose governments do not fully meet the minimum standards of the act and are not putting any effort into complying to its guidelines

The *Trafficking Victims Protection Act*, upon which this classification is done, is a U.S. legislative measure focusing on criminalization methods that solely deal with general issues of human trafficking. Organ trafficking is not included in this act. In fact, the act’s main focus is on sex trafficking and the necessity for governments to seek “Serious and Sustained Efforts” to continue their battles on human trafficking (U.S. Department of State 2017, 38).

The measures on which the U.S. Department of State has been basing its *Trafficking in Persons Report* do not take into consideration the issue of organ trafficking. In the section that follows, we

will examine the data concerned with organ trafficking in the report to continue our assessment of the State Department’s position on organ trafficking.

Data Extracted

The data in the report provides information on the following:

- a. The country’s classification
- b. Its human trafficking profile
- c. Its prosecution, protection, and prevention measures
- d. The U.S. Department of State’s recommendations

As can be inferred from the categories of information that the report provides on each country, the report deals mostly with human trafficking as a general issue. There is little focus and data on organ trafficking.

The table below showcases the countries’ reports in which data on organ trafficking was collected.

Table 1. Data on Organ Trafficking from the *2017 Trafficking in Persons Report*

Country	TIER	Data on Organ Trafficking
Angola	2	“3-12 years in case of organ trafficking done through force, fraud, or coercion” (U.S. Department of State 2017, 62)
Argentina	2	“Criminalizes sale of organs without regard to the use of force, fraud, or coercion” (U.S. Department of State 2017, 66)
Bolivia	2	“Law 263 diverges from the international definition of trafficking in persons by classifying non-trafficking crimes, such as illegal adoption and the removal or sale of organs without the purpose of exploitation, as human trafficking” (U.S. Department of State 2017, 92)
Brazil	2	“Article 149a of the new anti-trafficking law criminalizes brokering, enticing, recruiting, transporting, transferring, buying, harboring, or receiving a person by grave threat, violence, coercion, fraud, or abuse for the purpose of organ removal, forced labor (any kind of servitude or conditions analogous to slavery), illegal adoption, or sexual exploitation” (U.S. Department of State 2017, 98)
Egypt	2	“In 2016, the government investigated 23 cases of potential forced child labor, sex trafficking, and domestic servitude crimes, some of which were referred for prosecution; however, these cases also included perpetrators suspected of other crimes such as illegal adoption and organ trafficking, it was unclear how many

		of the 23 cases actually involved trafficking” (U.S. Department of State 2017, 158)
Finland	1	“The only data reported concerns the targeting of immigrants for organ trafficking” (U.S. Department of State 2017, 170)
Guinea	3	“Exploitation is defined as in order to commit pimping, sexual aggression, or sexual assault; holding a person in slavery; forced labor; forced begging; organ removal; and forced criminality” (U.S. Department of State 2017, 188)
Indonesia	2	“The anti-trafficking unit of the Indonesian national police reported 110 new trafficking investigations during 2016—a decrease from 221 reported the previous year, though figures from 2015 may have included forced marriage or organ trafficking cases” (U.S. Department of State 2017, 208)
Lesotho	2	“Describes trafficking as the acts of recruiting, transporting, transferring, harboring, providing or receiving a person “by any means” for the purpose of prostitution, pornography, sexual exploitation, forced labor, drug trafficking, slavery, involuntary servitude or debt bondage as well as for other ends, such as marriage with a foreign person, tourism packages for the purposes of sexual exploitation, adoptions or organ removal” (U.S. Department of State 2017, 250)
Mozambique	2	“The 2008 anti-trafficking law criminalizes trafficking for the purpose of organ removal” (U.S. Department of State 2017, 291)
Nepal	2	“The law criminalizes facilitating prostitution and removal of human organs. Prescribed penalties range from 10 to 20 years imprisonment, which are sufficiently stringent and commensurate with those prescribed for other serious crimes, such as rape” (U.S. Department of State 2017, 294)
New Zealand	1	“Under the Crime Act, the human trafficking provision includes the reception, recruitment, transport, transfer, concealment or harboring of a person for the purpose of exploitation, defined as the deception or coercion causing a person to be involved in prostitution or other sexual services, slavery and practices similar to slavery, servitude, forced labor or other forced services, or the removal of organs. It requires elements of deception or coercion in its provision criminalizing sex trafficking of a child, which is inconsistent with international law. The law prescribes sentences of up to 20 years imprisonment, a fine not exceeding \$500,000, or both; these penalties are sufficiently stringent” U.S. Department of State 2017, 299)

Norway	1	“The penal code was amended in October 2015; section 257 defines human trafficking consistent with the 2000 UN Protocol to include all forms of sex and labor trafficking; it criminalizes the use of force, fraud or coercion for the purpose of prostitution, labor, army recruitment or organ removal and specifies that with regard to the trafficking of children, the use of force, fraud or coercion is not a required element of the crime.” U.S. Department of State 2017, 308)
Portugal	1	“Article 160 of the penal code prohibits all forms of trafficking and prescribes penalties of three to 10 years imprisonment (up to 16 years if there are aggravating circumstances), which are sufficiently stringent and commensurate with those for other serious crimes, such as rape. Article 160 also encompasses illegal adoption and organ removal, crimes that fall outside the U.S. definition of trafficking in persons” (U.S. Department of State 2017, 329)
Spain	1	“Article 177 bis of the criminal code criminalizes forced labor or begging, sexual exploitation and organ removal by means of force, fraud or coercion. In keeping with international law, reliance on means of force, fraud or coercion is not necessary to prove a crime of trafficking when the victim is a child. The law prescribes penalties from five to eight years of imprisonment” (U.S. Department of State 2017, 368)

Interpretation and Analysis of the Data

In this report, there is only 15 countries out of 187 where data on organ trafficking is provided. For all of these 15 countries, the data provided is related merely to the documentation of existent legislation and measures on organ trafficking in the studied countries. The report also provides no recommendations to any of the countries on additional measures that need to be taken when it comes to combatting organ trafficking. Once again, we can see how the *U.S. Department of State Trafficking in Persons Report* gives minimal attention to the issue of organ trafficking.

Critique of the U.S. Department of State’s Report

In her analysis of human trafficking literature from 2000 to 2004, Ashley Russell examines the types of human trafficking issues that are underrepresented in the reports and articles that deal with this matter. According to her findings, organ trafficking is not widely talked about or examined by a lot of the literature on human trafficking. Analyzing the *Trafficking in Persons Report* from

2016, she confirms the State Department’s lack of focus on organ trafficking. She even goes further to explain that “since the removal of organs is not defined in the Trafficking Victims Protection Act, and subsequently not a priority when examining countries for their placement within the Trafficking in Persons Report, other countries are not as likely to focus efforts and resources on the issue” (Russell 2017).

Conclusion

Organ trafficking falls under the umbrella of human trafficking according to the *U.S. Department of State Trafficking in Persons Report* (U.S. Department of State 2017, 2). Unfortunately, this issue seems to get little attention from most of the literature that deals with human trafficking. The State Department’s report offers meager details about organ trafficking and does not convey its actual importance. Amnesty International and Human Rights Watch’s reports, for example, on the organ trafficking of executed prisoners in Taiwan and China shed light on how prevalent and serious this issue is (Auto 2009; Griffiths 2017). Within the lack of literature on organ trafficking and the lack of awareness of its severity, there is still so much work to be done to combat the threat of this issue on the stability and safety of individuals and nations.

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Overview of Project EU HOTT: Combating Trafficking in Persons for the Purpose of Organ Removal

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November 1, 2017

Introduction: What is Project EU HOTT?

Project EU HOTT (Project European Union Human Organ Transplantation Trafficking) is a group of researchers who “aimed to increase knowledge and information, raise awareness about the crime (Trafficking of Human Beings for the purpose of Organ Removal, aka the Black Market of organ transplants) and to improve its non-legislative response.” (HOTT Symposium on Human Trafficking for Organ Removal. Home) This group operated from November 1st, 2012 to October 31st, 2015. (HOTT Symposium on Human Trafficking for Organ Removal. Timeline)

Project EU HOTT conducted scientific, empirical research of THBOR throughout several countries, created products and synthesis, and shared these information with non-legislative parties including but not limited to judicial and police forces, transplant professionals, international organizations, and human rights organizations.

There are many components to the group EU HOTT itself, international locations, research products, modes of raising awareness and improving responses.

Components and Location of the Group Project EU HOTT

Project EU HOTT includes a coordinator, co-beneficiaries , associated partners, specialized advisors, and financial supporters.

The coordinators, Erasmus MC University Hospital Rotterdam, are stationed in Rotterdam, Netherlands. The researchers include Willem Weimar, Frederike Ambagtsheer, Linde van Balen, Marian van Noord, and collaborations with the kidney transplant unit from the Erasmus MC University Hospital Rotterdam. (HOTT Symposium on Human Trafficking for Organ Removal. About Us. Coordinator.)

There are three co-beneficiaries: Lund University, the Bulgarian Center for Bioethics, and the Academic Society for the Research of Religions and Ideologies. (HOTT Symposium on Human Trafficking for Organ Removal. About Us. Co-beneficiaries.)

The associated partners were responsible for report work, gathering data, reading reports, co-writing reports, editing reports, and informational research. The associated partners include the

Central Division of the National Police of the Netherlands, the European Police Office (EUROPOL), the United Nations Office on Drugs and Crime (UNODC), the University St. Cyril and Methodius, the Renal Foundation, Eurotransplant International Foundation, the European Society for Organ Transplantation (ESOT), the Ethical Legal and Psychosocial Aspects of Organ Transplantation (ELPAT), the South African Police Service, The Hebrew University of Jerusalem, and the Special Prosecution Office of the Republic of Kosovo. These associated partners were located in the Netherlands, Europe, the United Nations, South Africa, Jerusalem, and Kosovo. The associated partners are associated with universities, police services, foundations, societies, and offices. (HOTT Symposium on Human Trafficking for Organ Removal. About Us. Associated Partners.)

The advisors from multiple universities in multiple countries were responsible for providing precise and specific knowledge from their personal fields, in order to gain more well-rounded knowledge and understandings of THBOR. Their areas of expertise include The advisors include R. van Swaaningen from the Erasmus School of Law, W. Duijst from Maastricht University, D. Siegel from the Willem Pompe Insitute, D. Zaitch from the Willem Pompe Insitute, A. Tibell from the Karolinska Institute, T. Bezlov from the Center for the Study of Democracy, C. Krolokke from the University of Southern Denmark, K. Hoeyer from the University of Copenhagen, the Dutch National Rapporteur on Trafficking in Human Beings and Sexual Violence against Children, N. Scheper-Hughes from the University of California, R. Sondejker from the Immigration and Naturalisation Service, and A. Lennerling from the University of Gothenburg. The financial supporter for Project EU HOTT is the European Commission Prevention of the Fight Against Crime Programme of the European Commission. (HOTT Symposium on Human Trafficking for Organ Removal. About Us. Advisors.)

The one sponsor for Project EU HOTT is the European Commission: Directorate General Home Affairs Prevention of and Fight Against Crime (ISEC). ISEC is located in Brussels, Belgium. ISEC 600.000 Euros.

Project EU HOTT is located throughout the world, including the United Nations, the Netherlands, Europe, South Africa, Kosovo, Jerusalem, and the United States.

Planning, Actions, and Responses of Project EU HOTT

In order to accomplish their goals of increasing “knowledge and information, raise awareness about the crime and the improve its non-legislative response,” Project EU HOTT’s objective must be broken down. (HOTT Symposium on Human Trafficking for Organ Removal. Objectives.)

In order to increase knowledge and information, Project EU HOTT conducted scientific, empirical research of THBOR with their associated partners. Their research included a literature review, a study on transplant tourism, and researching prosecuted cases. The literature review was led and edited by Assya Pascalev. More than ten authors contributed to the literature review, which includes chapters on causes of the crime, the trafficking network, recipients, suppliers, brokers, transplant professionals, other facilitators, financial aspects, moral aspects, and gaps in the literature. (HOTT Symposium on Human Trafficking for Organ Removal. Our Work. Research. Literature Review.) The transplant tourism study included 22 interviews of patients “who traveled abroad for paid kidney transplantations. Interviews were conducted in Macedonia, Sweden and The Netherlands. Questions focused not only on facts and experiences, but also on patients' motivations. The results were presented on 21 November 2014 at the symposium.” (HOTT Symposium on

Human Trafficking for Organ Removal. Our Work. Research. Transplant Tourism.) The prosecuted case studies were conducted in order to gain specific information about large scale cases in order understand what hurdles prosecutors and investigators encountered, what other countries can learn from their experiences, and to gather information about the non-legislative responses to this crime. (HOTT Symposium on Human Trafficking for Organ Removal. Our Work. Research. Cases.)

In order to raise awareness and improve the responses from non-legislative entities, Project EU HOTT coordinated throughout multiple countries symposiums, presentations, public lectures, and presented indicators and recommendations to their non-legislative audience in order to help fight the crime. Target groups include: transplant professionals, legal experts, representatives of ministries, international organizations, national rapporteurs, individuals of expert groups, organ trafficking researchers, persons working for human rights organizations, and other stakeholders. (HOTT Symposium on Human Trafficking for Organ Removal. Our Work. Raising Awareness.)

Every six months project meetings were held in order to discuss and evaluate Project EU HOTT's ongoing work. (HOTT Symposium on Human Trafficking for Organ Removal. Our Work. Project Meetings.)

Outside of the presentations, lectures, symposium, and other social gatherings, Project EU HOTT created nine reports and multiple publications that include their findings of their research. These nine reports include their literature overview (December 2013), the organ recipients who paid for kidney transplants abroad (November 2014), their case study report (November 2014), their recommendations (August 2015), their recommendations for ethical/legal obligations of healthcare providers, their recommendations for protection of targeted or trafficked persons, their recommendations for improving cross-border cooperation, their recommendations for partnerships between transplant professionals, their indicators (August 2015), and Project EU HOTT's Associate Partner's, Jessica de Jong of the Dutch National Police Services, report on the trade in human organs and trafficking in human being sin the Netherlands and Europe. (HOTT Symposium on Human Trafficking for Organ Removal. Reports.) The publications to arise from Project EU HOTT includes their book "The HOTT Project: Results and Recommendations," two PHD theses, and multiple scientific publications. These reports and publications are available on their website, as well as for purchase. (HOTT Symposium on Human Trafficking for Organ Removal. Publications.)

Conclusions

Project EU HOTT's concrete reverberations from their work are not easily identified. What IS concrete about Project EU HOTT is that their goals to educate those directly affected in the process of black market organ transplantations were accomplished with their incredibly thorough presentations and incredibly thorough reports. Project EU HOTT's work is an example of a specific group supporting the eradication of the black market of organ transplants, and how to go about eradicating and discouraging black market organ transplant on the micro level. This project can serve as an example as to how to go about implementing research in order to start of the process of deterring the black market that affects the GKE. Project EU HOTT could also be beneficial to the GKE by further educating those who are considering accepting the GKE process on the actual world of organ transplants, and how to kill two birds with one stone by implementing the goals of the GKE as well as discouraging black market organ transplants.

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Ethical Implications of India's Legal Organ Trade and the Works of Lawrence Cohen

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November 12, 2017

Introduction

As medical skills and technologies improve, it is equally important to ensure that ethical boundaries ensure medical care for everyone- up to and including a cadaver- is not only of the best quality possible, but also never done in the name of harm. Researching such ethical affairs often falls into the bailiwick of medical anthropologists- including, for our purposes, one Dr. Lawrence Cohen, of the University of California, Berkeley's anthropology department. Cohen's work has often dealt with the legal organ trade in India, the underlying cultural phenomena that enabled it to gain such disquieting prevalence, and, the ethical implications that this has for that country's medical establishment. This is largely analogous to the studies of Nancy Scheper-Hughes in countries such as Romania or the Philippines. Cohen's analyses of India have included interviews he conducted (from an shelter owned by an acquaintance) amongst the populace of a relatively impoverished urban area in India. It is from these interviews that Cohen gives us an impression of what kind of culture produces this phenomenon and how it reflects on the ethical standing of the associated physicians.

Organ Sellers in India

The facility in which Cohen meets his interviewees is located in Chennai, in the neighborhood of Villavakkam, which Cohen describes as a slum area. Indeed, the phenomenon he's chosen to study has enough of a presence here that he recounts a local nickname for the area- "Kidneyvakkam". Although responses show some variation, a consistent narrative begins to emerge: some local, usually running low on both assets and credit, elects to undergo a nephrectomy, hoping to use the donor benefits for enough money to get by. Perhaps surprisingly, many of those who had underwent this- indeed, all four of Cohen's shelter interviewees- were in fact women, and married women at that, who took it upon themselves to help the household situation, choosing to spare the patriarch of the family the frailty accompanying the recovery time, so that he could better continue his work as the principal breadwinner (Cohen, *Where It Hurts*, pg. 140) (although Cohen indicates the ratio may be different in more rural areas with a higher population of male migrant workers). This would imply that these women had at least some awareness of the possible negative effects they could suffer as a result of donation, but closer inspection shows the matter may be a bit more complicated than that.

Informed Consent

One of the chief concerns in medical ethics is the informed consent of those who commit themselves to procedures like nephrectomies. Cohen's research into the organ trade is in part an

investigation into where this standard may have lapsed. His work describes a worrying “illiteracy” amongst the country’s population with regards to kidney ailments. On one occasion Cohen wrote that he “found [him]self repeatedly asked, by men: would having the kidney operation make one a eunuch? I mentioned this concern to one of the resident doctors... As I recall he laughed, and said, these illiterates confuse their operations.” (Cohen, *Accusations of Illiteracy*, pg. 128). Cohen also recounts having to correct a man who was under the impression that kidneys were testicles. As it happens Cohen does take care to incorporate bits of the interview related to how the patients were informed; Cohen writes that statements along the lines of “I did not know what a kidney was; the doctors showed me a video. It passes water; it cleans the blood... You can live with one, but you may get sick or die... without a kidney childbirth is very dangerous” were common from his interviewees (Cohen, *Where it Hurts*, pg. 136). All of this is broadly true, and all of it is crucial information for a patient to have before going through with the procedure. Cohen also makes a point of stressing that investigations by anthropologist colleagues failed to uncover any “evidence of the often-reported practices of cheating, stealing from, or misinforming sellers” (pg. 136) from a prominent clinic.

Conflicts of Interest

Now, consider this widespread ignorance along with the behavior of local professionals. One of the first things Cohen mentions in the article is the clinic of Dr. K. C. Reddy, which was also the venue through which three of the four organ sellers he spoke to received their operations. As it happens, this Dr. Reddy is also, according to Cohen’s account, as “India’s most outspoken advocate of a person’s right to sell a kidney” (Cohen, *Where it Hurts*, pg. 136). When a party neither donor nor recipient stands to gain financially from organ transplantation programs, the potential for a conflict of interest should be a source of concern. Pinpointing which parties benefit most from this policy helps us understand whether or not it ultimately betters society.

Conditions for the Donors

Organ sellers come largely from poverty. Indeed, according to Cohen, implying one’s mother is a kidney seller is something of a local analogue for implying she is a sex worker, highlighting the desperation to keep financially afloat (Cohen, *Where it Hurts*, pg. 140-141). As hinted at earlier, the interviewees commonly (although specifics are not presented) report the need to pay off debts as one of the major causes of their decision to sell a kidney. The state of poverty is relevant because it is intertwined with other conditions in the lives of organ-sellers which bear examination for an encompassing understanding of how their decision affects them. The poor of India, as with the poor everywhere, have difficulty receiving hospital care, are unlikely to get quality nourishment, and often engage in strenuous labor (the interviewees reported being in the workforce as well as their husbands, apparently commonly). Additionally they are likely to live in neighborhoods where alcoholism and disease are statistically more prevalent, as well as physical cases of domestic violence (one interviewee reported that her husband tends to strike her on her postoperative scar). All of this should be taken into account to inform a patient of the possible side effects, and any of them makes for a compelling reason to advise against undergoing a nephrectomy. Whatever the motivation, an organ donor’s contribution is of great help to the medical community, and wherever possible we should strive to mitigate the suffering that may come from their donation.

Conclusions

Non-maleficence is one of the foremost guiding principles in bioethics and medical ethics. Although a general desire for freedom and the realities of poverty make the legal organ trade in India a desirable practice, Cohen's work shows the need to examine this policy with a critical eye. The questionable approach to informed consent, the clear risk of conflicted interest, and the general life conditions of donors post-op all demonstrate that the policy may be doing much more harm than good to the communities of impoverished India. All of these symptoms should be borne in mind by policymakers and international ethical advisory boards in the future.

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Ethical Aspects of Organ Donation and Trade: How Ethics Shape Organ Donation Globally

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November 2, 2017 (or the actual date)

Introduction

The global organ trade is arguably one of the most ethically complex medical issues today. Complex questions arise in any case where life and death decisions are commonplace. There are a wide variety of reasons why a person might require an organ transplant, however there are fewer reasons why one might donate. The donation of one's organs is reliant on numerous medical intricacies, however the point of this paper is to examine the ethical aspects. It is the responsibility of the medical officials involved in organ donation to carefully examine the involved ethics of practice, as well as how to ethically treat both the donor and recipient of transferred organs. The world has a significant organ shortage compared to supply. According to an article published by The Economist claims a stark contrast between supply and demand in the United States. The article claims, "In America, nearly 30,000 organ transplants are now carried out per year: an average of 82 a day. The number of available organs is not keeping up. A record 100,000 Americans are on waiting lists, with 4,400 names being added each month" (Economist, 2008). In this case, the United States acts as an example of a universal problem. This contrast causes multiple severe ethical issues in a truly global system.

Ethical Organ Legislation

Government plays a significant role in determining how ethics are applied in a legislature to account for the varying factors of organ transplantation. Different governments implement ethics into legislation very differently, generally depending on the medical development of their system.

The Indian Example

Due to its high population and relatively low level of development across varying regions within its border, India is a major actor in the global organ trade. India plays both a major roll in the licit and illicit organ trade as it acts a significant supplier for organ transplant in the developed world including other Asian nations. Ethical issues in developing countries like India are prevalent, as government has limited control over a deeply economically divided society. Wealth inequality plays a major role in organ trade in economies such as India's.

The Indian government has organized legislation to try and control and monitor organ transfer within their system, specifically within the Transplantation of Human Organ Act (THO). This document spells out how ethical organ transfer can be achieved in India. An important part of this legislation regarding the authority of one party for the removal of human organs is the inclusion of the clause, “The donor had, in the presence of two or more witnesses (at least one of whom is a close relative of the recipient), unequivocally authorized as specified in Form 5 before his death, the removal of the human organ of his body after his death for therapeutic purposes and there is no reason to believe that the donor had subsequently revoked the authority” (Schroff, 2009). This legislation speaks to the specific ethical question of how one can gain approval to harvest organs from a cadaver.

Cadavers as a Source for Organs

Cadavers represent the most common and important source for organ donation as they supply the greatest potential for organ harvest. It is impossible to harvest certain organs such as the heart and eyes from a living healthy participant, however if the procedure is carried out quickly post-mortem cadavers have the potential to supply these crucial organs. Yet it seems organ harvest from deceased persons is a far more complex ethical issue than one would arbitrarily assume.

Culture plays a significant role in determining the justification of harvesting from a recently deceased person. Burial traditions can vary greatly and in some the harvesting of any organs from the deceased can be problematic to tradition.

The Brain-Death Dilemma

One particular aspect of death that can prove to be quite controversial is differences in the definitions of what is and isn't considered “brain dead”. Brain death has been hotly debated in the medical community for the past 25 years, as total brain death can be tedious to declare and complicated to completely measure. Amir Halevy discusses this topic in this article, *Brain Death: Reconciling Definitions, Criteria, and Tests*. Halevy discusses the numerous methods for determining brain death, which are currently employed, as well as the debate between legal criterion and standard clinical tests. In the article Halevy presents an approach which “does not acknowledge any sharp dichotomy between life and death and incorporates the proposition that the questions of when care can be unilaterally discontinued, when organs can be harvested, and when a patient is ready for the services of an undertaker should be answered independent of any single account of death” (Halevy, 1993). Therefore I argue in some circumstances it is the responsibility of the medical professional to determine the mortality of a patient's brain based on the legality of the dead-donor rule.

Recently Deceased Donors

The dead-donor rule (DDR) is an informal way of legislating the ethical stage in mortality at which the deceased' organs may be harvested for donation. Within the medical community, many see cadavers as the true answer to demand concerns for organ supplies. There is no ethical way to force donation from living donors yet there remain too few willing to offer their own body parts for donation. So the question is posed, how can the organ trade offer ethical incentive for potential donors to offer their organs without completely jeopardizing their own health?

Most living donations are supplied to either family or a specific person with whom the donor has a history of emotional or social connection. An interview with Doctor Robert Truog and Jeremiah Lowney on the ethic of living organ donation shines some light on the difficulty of finding potential donors without any close connection to the recipient. This instance is where the illicit organ market plays its biggest role.

Race and political identity sometime play a role in the allocation of donated organs. Truog discusses this by noting, "The most ethically problematic cases are those in which the recipient is chosen on the basis of race, religion, or ethnic group. In one case, for example, the family of a brain-dead Florida man agreed to donate his organs — but insisted that because of the man's racist beliefs, the recipients must be white" (Truog, 2005). This provides another ethical challenge, which pertains specifically to the donor themselves and how medical staff must account for their beliefs and health.

Conclusions

It is the responsibility of organ transfer professionals to account for both the ethical and medical wellbeing of donors. Monetary transfer plays a major roll in this situation, as compensation for the donation of vital organs should theoretically be provided. However many within the medical community also believe the most ethical option to be non-compensated donation: meaning the negation of for-profit organ donation. Donation for the sake of monetary profit complicates topics of race and economic class in an issue that should be humanitarian in nature. Nonetheless, incentive should be supplied in the cases of living donors to ensure the quality of life is not harmed for potential donors.

Organ donation inherently involves many ethical questions. I have addressed the most pressing of which in the above text, however I will note that as technology in medicine and medical legislation advance, ethics will continue to play a significant role in the harvest and allocation of organs. One cannot ignore the pressing concerns of ethics when discussing the procurement of life-giving entities such as organs. The global organ trade continues to challenge medical professionals with questions of ethics and development.

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An Exploration of Stigma and Organ Transplantation

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Introduction

When approaching the subject of stigma in relation to organ transplantation, there are several dimensions in which stigma enters into the transplantation process from the initial donation of the organ to post transplant recovery. This includes stigma generated around potential organ donors during the initial donation process, stigma which is institutionalized by medical practice in the form of policies which police who is able to participate in organ transplant at all, as well as stigma faced by recipients of organ transplants and its transformative effect on identity. Goffman defines stigma as “... an attribute that is deeply discrediting...”, and also calls attention to how stigma is given meaning within the specific social and cultural context in which such attributes are situated and judged as deviant or normative. (Goffman 1963) This paper will briefly discuss some of the dimensions of stigma as related to organ transplant and to the greater topic of GKE.

Normative vs Deviant Social Expectations

In many countries around the world, including the US, there is unofficial expectation that family members should be willing to donate organs for their kin, often at the medical and financial expense of the donor. Nancy Scheper-Hughes uses the example of David Biro, a physician who wrote an essay and memoir about his experience of receiving a blood marrow transplant from his estranged sister. (Scheper-Hughes 2007) Biro explains in his memoir that in spite of the fact that he and his sister were never close and had little contact, he expected her to donate her blood marrow because she had a familial obligation. Though this kind of social expectation is common enough to manifest in medical redirect, it cannot be generalized as a universal attitude towards organ donation, and it is in communities where those social expectations diverge that we start to see stigma arise.

Stigma Related to the Donation of Organs

When considering different populations of potential organ donors in the US, ethnic minorities have a clearly lower rate of organ donation in comparison to the overall population. Little research

has been done to qualify the reason for this disparity in participation within organ donation, most of which has focused on African American and Latino populations. However, in a study focused on Chinese Americans, philosophical and religious perspectives were identified as a possible cause for the difference. (Lam Et al 2000) Particularly related to Confucianism, Daoism and Buddhism, the concept of filial piety frames the body as a sacred gift which must be returned to one's ancestors in the same state that it was given by a person's parents. Consequently, removing an organ, even in an effort to donate to and help a family member, would be in direct conflict with filial piety as the body would then become incomplete. This concept can be applied to organ donation from live donors or even cadavers. Similarly, some buddhist believe that removing an organ from someone's body, even immediately after death, can cause the spirit suffering as it passes into the afterlife and may even prevent it from being able to reincarnate. These only represent some of the religious or philosophical beliefs that may create a stigmatized outlook on organ donation based on how an attribute, in this case having an "incomplete" body, can be perceived as disadvantageous or problematic in a specific social context.

Stigma in Relation to Medical Practice and Policy

Stigma may also manifest as a form of structural violence within medical practice in relation to organ transplantation, specifically within policies which decide who is able to donate organs for transplant. Bansal Et al discuss how in relation to lung transplant, the CDC (center for disease control) designate certain donors as "high risk" for participating within certain social behaviors, specifically those which may cause the donor to come into contact with the HIV virus. These include men having sex with men, those with a history of intravenous drug use or sex work, or even having sex with someone who is suspected to participate in "risky behaviors" or come into direct contact with HIV. (Bansal et al 2015) Those who fall into the high risk donor or "HRD" category are less likely to be considered for organ donation unless the perceived benefit outweighs the risk for the recipient. However, Bansal et al concluded after their study that transplant recipients had at least an equivalent survival rate when "HRDs" were used as compared to "NHRD". In this situation, even being associated with HIV is considered a negative attribute, let alone having or coming into contact with HIV. It shows how stigma generated around another health condition can be strong enough to affect another seemingly unrelated one.

Stigma in Relation to Life Post Transplant

Probably one of the most visible areas where stigma enters into the organ transplant process is in how the recipient's social identity is transformed by the transplant process itself. Leslie Sharp talks about how recipients are perceived differently post transplant as they often become trapped in a liminal state between patient and able bodied. Many recipients may become labeled as "medically retired" post transplant in spite of the personal feelings of the recipient themselves, and often find themselves having difficulty finding employment due to stigma generated around their bodies being

considered “disabled”. (Sharp 1995) This leads to a variety of other social and emotional issues which may complicate a recipient's life post-transplant, including stress around the issue of the financial stability of dependents paired with living with the constant fear of organ rejection. The harsh reality of life post-transplant often contradicts with the language and rhetoric of medical professionals during the transplant process which frames the post-transplant experience much more positively, often not considering the social and psychological issues which may distract from the recipients overall quality of life. (Sharp 1995)

Conclusions

The above examples only scratch the surface of the complex nature of stigma and how it enters into the process of organ transplantation. While considering that the social and cultural environment in which the transplantation process is situated has a substantial effect on how stigma may manifest, it does seem to manifest in multiple stages and dimensions of the process including the initial donation of organs and in the lives of recipients post-transplant. There are also ways in which stigma is institutionalized within medical practice and perpetuated by practice within the backdrop of cultural ideals and political systems. Overall, stigma is a complex concept and a beats of a research subject in relation to organ transplantation, one that has only be briefly approached by this paper but that deserves a more extensive analysis.

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Financial Aspects of the Global Illicit Organ Trade

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October 31, 2017

The Global Impact of Illicit Trade

All illicit trade is estimated to be roughly 1.5% of global GDP or \$850 billion a year (Basu, 2014). Specifically, the illicit organ trade market is a multimillion dollar black market industry (Amahazion, 2016). In 2011, the illicit organ trade was estimated between \$600 million and \$1.2 billion a year (UNODC, 2015). Illicit organ trade is hard to quantify in terms of money and people, since those involved are dodging laws and ways to trace them. However, in March of 2007, the World Health Organization claimed that 5-10% of all kidney transplants around the world was made possible by organ trafficking (Budiani-Saberi, 2009). Even though it is hard to quantify, experts believe that the trade is growing due to the spread of transplantation technology as well as the increasing demand and decreasing supply (Kelly, 2005). This trade system is internationally organized, but tends to center around countries with poorer populations and a lack of powerful organizations to oppose the industry (Kelly, 2005).

The Role of Legal and Medical Organizations

In many underdeveloped countries, the legal and medical organizations do not actually investigate any claims of illegal organ trade, but instead simply respond to complaints (Kelly, 2005). Of course, the only way for there to be anything for the legal and medical organizations to respond to is for people (mainly doctors or nurses) to file complaints in the first place, but in some countries, medical professionals are involved in the trade. For example, in Thailand, the hospitals have not come together to compile a list of all of the people on the waitlist for organs. In addition, the private hospitals are ineffectively supervised, making it easier for doctors to participate in the organ trade, whether it is for their own financial needs or if they are trying to find more donors to balance out the supply and demand (Kelly, 2005). Another example of where doctors are involved in the organ trade is in the Philippines. Poor people are willing to donate to improve their finances, so a medical team will go to the poorer neighborhoods and will set up their own list of donors. They test people's tissue and blood, keep the results in a file, and will get in touch with a broker to match the donor and recipient (Kelly, 2005).

The Individuals Involved in Illicit Trade

As mentioned before, poorer people are more than willing to donate their kidneys or other organs, especially if their finances are in terrible shape. Some believe that there could be an increase in the organ transplants in the illicit organ trade because of an increase in poverty, making people

more desperate (Tate, 2007). The living donors use the money that they receive from the donation to pay off existing debts (Budiani-Saberi, 2009). When the poor are desperate, there are people, such as doctors, but primarily brokers and criminal middlemen, cannot resist the money to be gained through setting up a deal between a donor and recipient.

These middlemen have a lot to profit from coordinating deals for organ transplantation. When they are determining their price for the kidney, the middlemen have to consider, as well as participate in, the illicit supply chain. The illicit supply chain is made up of numerous organizations that are participating in any number of illegal activities that have to do with sourcing, obtaining, creating, planning, or disbursing illegal goods (Basu, 2014). In order for the middlemen to take part in the illicit supply chain and transport the organs wherever they need to be, they have to pay. In addition to there being costs to coordinate with other organizations, the middlemen have to consider the cost in case the organs are confiscated by law officials. They have to pay to disguise their illegal activities, as well as avoid any laws or officials and, if necessary, bribe them to let the organs by (Basu, 2014). For these reasons, the price that the middlemen charge the recipients are sky high. In Israel, the price of transplants abroad started at about \$40,000, then increased to \$70,000, and increasing again to a range of \$100,000 to \$120,000 (Efrat, 2013). Middlemen in India charged \$60,000 for the donation (Should we regulate the organ trade?). Brokers in general can charge their wealthy patients about \$100,000-\$200,00 to set up the donation (Tate, 2007).

The recipients of these kidneys or other organs are generally wealthy “transplant tourists”. Transplant tourists are people who are on the waitlist for an organ, but get impatient and travel to a country where the laws are a less strict (Budiani-Saberi, 2009). These people are usually upper class travelling to poorer countries because there is an increased likelihood for them to find a donor (Efrat, 2013). While waiting for their organ transplant, they spend money on food, lodging, and other costs that accompany travelling to a different country. This actually contributes to the country’s economy (Amahazion, 2016). The contribution positively affects the tourism and hospitality sector of the countries.

Who Benefits?

It is easy for the middlemen and brokers to take advantage of both the donor and the recipient. Both are desperate: the donors are typically poor people desperate for money, and the recipients are desperate for a potentially life-saving organ donation. Donors, despite believing that donating an organ will improve their life financially, find out the hard way that they tend not to get any richer. After the surgery, most of them suffer complications due to the lack of necessary care (Kelly, 2005). As well as suffering medical complications, donations actually decreased the family’s income by about 1/3, because the donor could no longer work, whether it was because of stigma around donation or never fully recovering from the surgery (Goyal et al, 2002). On top of all of this, most of the time, the broker did not even give the donor the amount promised for their organ. For example, in India, donors were promised anywhere from \$450 to \$6,280, but received only \$450 to \$2,660 for their organs (Goyal et al, 2002). In Jordan, a donor could be offered about \$3,000 for their kidney (Tate, 2007). Middlemen charge upwards of \$40,000, but donors receive usually far less than \$5,000, meaning that the middlemen pocket the difference. For both the donor and the recipient, there is a lack of basic care after the surgeries, leading to health problems for both parties (Should we regulate the organ trade?, 2011).

Conclusion

The only party to benefit from the organ trade is the brokers and criminals who set up the transplants. Countries where there is a higher concentration of transplant tourists do benefit economically from the transplant tourists coming and spending money, but it is unclear as to how much a country can benefit from this. A solution would be to increase the laws surrounding organ trade in the countries with more transplant tourists, however, that could very easily result in just the patterns of transplant tourism relocating (Budiani-Saberi, 2009ef). Also, an increase in transplant laws will lead to an abrupt increase in the number of people on the transplant list, putting more pressure on domestic transplant programs (Efrat, 2013). One other solution left is to turn to commercial transplantation, meaning that all organ donors would be financially compensated for their donation, however, that creates questions of morals and ethics in the medical field (Amahazion, 2016).

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Legislation Regarding Organ Procurement in Switzerland: Then and Now

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Introduction

When thinking about organ donation within Europe, Switzerland is not the first place that comes to mind. There are a number of European countries with significantly higher donation rates, especially post mortem rates. The causes of these extremely low post mortem rates in Switzerland have to do with the laws and regulations surrounding the idea of consent. The purpose of legislation put into effect in Switzerland in past years is to address and change the ways of going about consent in regard to organ donation after brain death diagnosis.

Legislation of the Past

Europe is known for the implementation of presumed consent, defined as assuming a patient to be a donor unless the deceased had expressed otherwise while living. European countries that are opt-out instead of opt-in have significantly higher rates of donation (Roels and Rahmel 2011). Switzerland, however, is known for having significantly lower donation rates compared to that of the rest of Europe. In 2013, the Swiss government voted against becoming a presumed consent country (Luterbacher 2017); however, in recent years other initiatives have been taken to increase donation rates and close the gap between rates of Switzerland and those of the rest of Europe.

Transplant Guidelines Added to Swiss Constitution

In 1999, new guidelines regarding organ transplantation were approved to be added to the Swiss constitution. The changes to the constitution contained general laws to regulate transplant medicine as well as specific clauses that prohibited money in return for donation and assured equal opportunity to receive organs regardless of gender, social status, or race. However, these additions to the constitution did not specify 'death' or give a stance on brain death. There was also a lot of criticism on these additions because none of the new regulations addressed, or outlawed, xenotransplantation, the practice of transplanting animal organs into humans (Bahnsen 1999).

Transplantation Act of 2007

In 2007, the Transplantation Act was put into effect. This act regulates all organ donation and transplantation. Designed to change Switzerland to “patient-oriented national allocation of organs,” (Uehlinger et al. 2010) and created with the purpose of preventing misuse of organs, this act also made Switzerland into an explicit consent country, unlike most of Europe. The act has three different parts to it. The Transplantation Ordinance regulates the handling and removal of the organs. The Organ Allocation Ordinance regulates the waiting list and allocation, the Organ Allocation Ordinance FDHA gives details on allocation criteria (“Legal Basis” 2017).

Organ Donation Awareness Campaign of 2013

The Federal Council launched a “More Organs for Transplantations” campaign with the intent of increasing the rate of cadaveric donation by increasing awareness of consenting to organ donation (Legal Basis 2017). Studies have been done to assess the rates of consent pre and post the 2013 campaign in Switzerland. Between 2008 and 2012, the refusals by next of kin increased to 52.6 percent (Wurz 2013), as compared to a rate of 51.5 percent in 2014 (Weiss et al. 2014). It improved a small amount but is still extremely high compared to the average refusal rate of Europe.

International Organ Exchange in Switzerland

The concept of exporting and especially importing organs has been introduced to Switzerland and other European countries in recent years. European Organ Exchange Organizations work to expand donor and recipient lists. By sending unmatched organs to other countries where there is a match, they are eliminating the problem of unused organs (Schneider et al. 2011). This has been proven to have a very positive affect on Swiss transplant rates (Weiss et al. 2015). and is especially beneficial for pediatric patients, who have the highest mortality rates on the waiting list (Schneider et al. 2011).

Impact of Changes

The number of transplants in 2016 is up 55 from the number of transplants preformed in 2012 (Luterbacher 2017). That may seem like a small amount, but it is still 55 more lives saved. Legislation passed by the Swiss government and initiatives started by the Swisstransplant Organization have helped to prove that presumed consent is not the only way to improve organ donation within a country, but the amount by which rates increase is very clearly visible when comparing countries with presumed consent and those without it. Opt-out policies are not only solution, but they are one of the most effective ones that’s been seen.

Transplantation and Donation Today

While rates have increased small amounts with each of these new ideas, Switzerland still has a long way to go before they catch up to the rest of Europe in terms of organ donation and transplantation. If the deceased possible donor is carrying a donor card, the next of kin can still overrule that decision and choose to not donate their loved one's organs. The fear of ramifications from families after disregarding their choices outweighs the gain that would come from the organs donated. The biggest issue in Switzerland is, and has always been, consent. Whether or not the problem can be solved without implementing laws of presumed consent is unknown.

Conclusions

The world of donation and transplantation is ever-changing. New technology, methods, and laws are always being implemented. And yet, over time, there has constantly been a gap between the number of organs up for donation and the number of people who need organs. The laws, campaigns and regulations implemented in Switzerland over the past years offer some insight into what works and what doesn't in terms of boosting organ donation rates. By pulling together ideas from other countries, similar laws can be put into effect in other places, thereby boosting donation and transplant rates all across the board.

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Models of Kidney Donation: A summary of the various forms of kidney donation and transplantation strategies

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Introduction

Kidney transplantation from a living or deceased donor is considered the best treatment option for an individual with end-stage renal disease. The alternative treatment option, known as dialysis, has significant drawbacks. In many cases, patients are on dialysis for extended periods of time; during which their health does not typically improve and healthcare costs accrue rapidly. To get patients off long-term dialysis a healthy, compatible kidney must be available for donation and transplantation.

The following will discuss various forms of kidney donation as well as several key components that play a role in organ donation. There are three main forms of donation models which include a one-to-one approach, paired donation, and domino paired donation. Various forms of both paired and domino donation exist and each rely on components such as Non-Directed Donors and the United Network of Organ Sharing. Ultimately, the goal of these models is to provide strategies to get patients off long-term dialysis and save lives.

One-to-One Model of Donation

In a basic scenario, kidney donation involves one donor and one recipient. Typically, this involves candidates who have family members or close friends who are willing and able to donate a kidney. This model, as seen in Figure 1, can be referred to as a one-to-one model (Gentry et al., 2006). Simply, an organ from donor 1 would go directly to recipient 1 [Figure 1]. Unfortunately, blood type incompatibilities exist as a major hindrance to this form of donation. Approximately, one third of donor-recipient pairs are biologically incompatible due to mismatched blood types and are therefore unviable for donation (Chkhotua, 2012). One method used to circumvent this obstacle is done by removing or neutralizing blood group or human leukocyte antigen (HLA) specific antibodies, thus desensitizing the patient's blood and allowing for an incompatible donor kidney to be transplanted without rejection (Chkhotua, 2012). However, this method is not preferred because it is expensive and unreliable. Alternative strategies have been developed to ultimately get patients off long-term dialysis when a one-to-one kidney donation model is not possible.

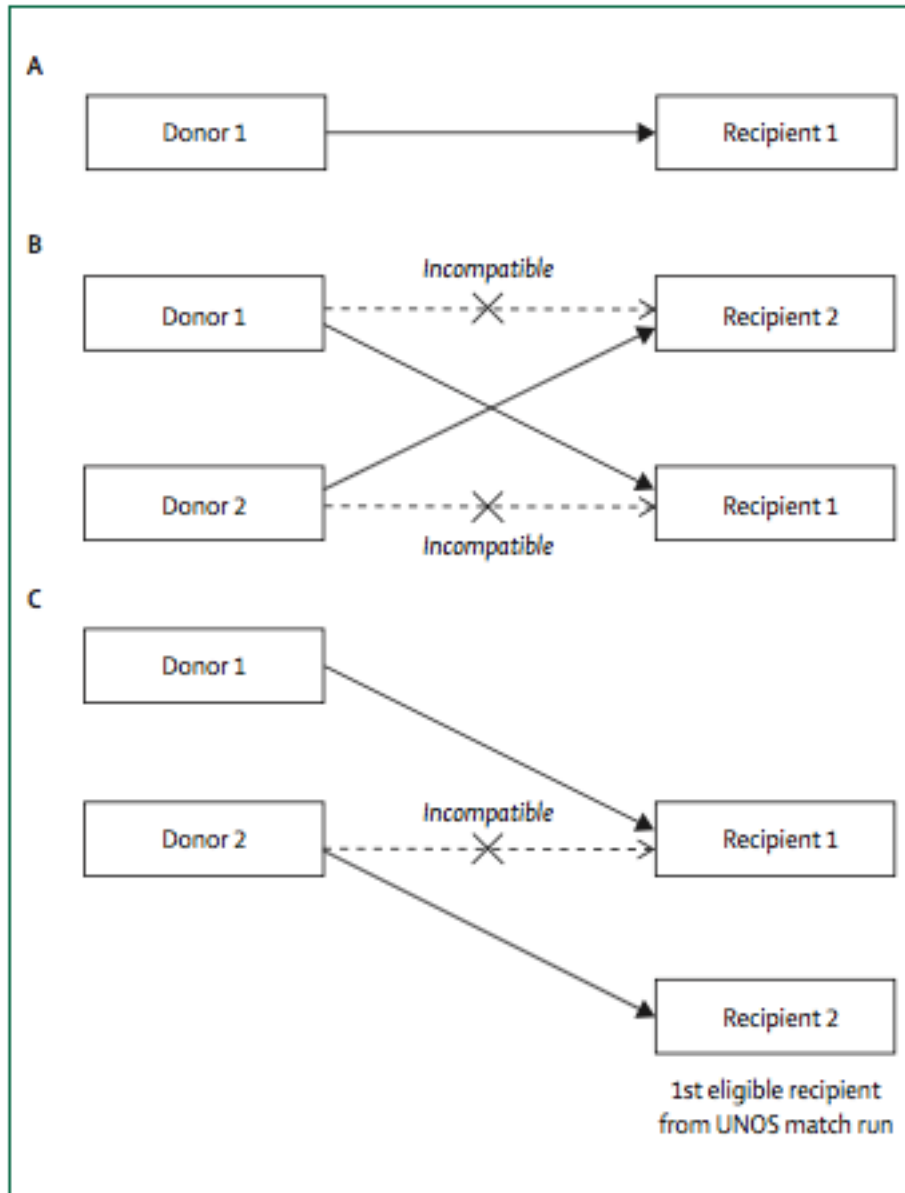


Figure 1. Three basic models of living donor kidney donation [Gentry et al., 2006]. (A) One-to-one model. (B) Model of paired donation between two incompatible donor-recipient pairs. (C) Model of domino paired donation.

United Network of Organ Sharing

One alternative strategy involves deceased donors. In this model, candidates are placed on a transplant waiting list until an organ becomes available from a deceased donor. In the United States, the agency that oversees the allocation of deceased donor organs is known as the United Network of Organ Sharing or UNOS (Gentry et al., 2006). The main drawbacks to this model are that candidates on the deceased donor list could be waiting for an undisclosed amount of time, during which they are

subjected to the burden of lofty expenses and risk of numerous complications that result from long periods on dialysis (Gentry et al. 2006).

Living Non-Directed Donors

The waiting list can be circumvented by an organ donation from a Living Non-Directed (LND) donor. These donors are referred to as altruistic, good Samaritan, anonymous, or benevolent community donors because of their willingness to donate an organ to a recipient who they are not related to and do not know. LND donation makes other models of donation possible; one LND donation can benefit many people through donation models like Domino Donation (Gentry et al., 2006).

Kidney Paired Donation (KPD)

An alternate strategy for kidney transplantation, when one-to-one models are not viable, is Kidney Paired Donation or KPD. The main goal of KPD programs is to increase living donation by eliminating the obstacle of incompatibility (Gentry et al., 2011). Under this model, incompatible donor-recipient pairs exchange kidneys so that each recipient receives an organ from a compatible donor [Figure 1]. There are many variations to this model; the most basic form of KPD is referred to as a two-way KPD or “direct swap”. Other forms of KPD include three-way and four-way KPD, compatible KPD, list-paired KPD or LPD, and domino KPD (Chkhotua, 2012). KPD was first described in 1986 and was eventually implemented in many countries throughout the world, including the Netherlands, Canada, Korea, the United Kingdom, and Romania (Gentry et al. 2011).

Two-Way Kidney Paired Donation

Two-way KPD, otherwise referred to as a paired exchange, kidney exchange, kidney swap, direct swap, or 2-way cycle, is the most basic form of KPD (Gentry et al., 2011). Donor 1 gives an organ to recipient 2, while recipient 1 receives an organ from donor 2 [Figure 1]. The goal of this model is to circumvent incompatibility and does not involve the deceased donor wait list. It is estimated that this model has the potential to allow for 47% more donor-recipient pairs to exchange kidneys (Chkhotua, 2012).

Three-way Kidney Paired Donation

Three-way KPD can also be referred to as a three-way cycle. This model allows three donor-recipient pairs to be matched and therefore increases the proportion of incompatible pairs that are able to find a compatible donor (Gentry et al., 2011). It is estimated that three-way KPD could increase the number of pairs able to exchange organs by 54% (Chkhotua, 2012). A visual

representation of three-way KPD can be seen in Figure 2 below. Similar the two-way KPD, this model does not involve the deceased donor wait list.

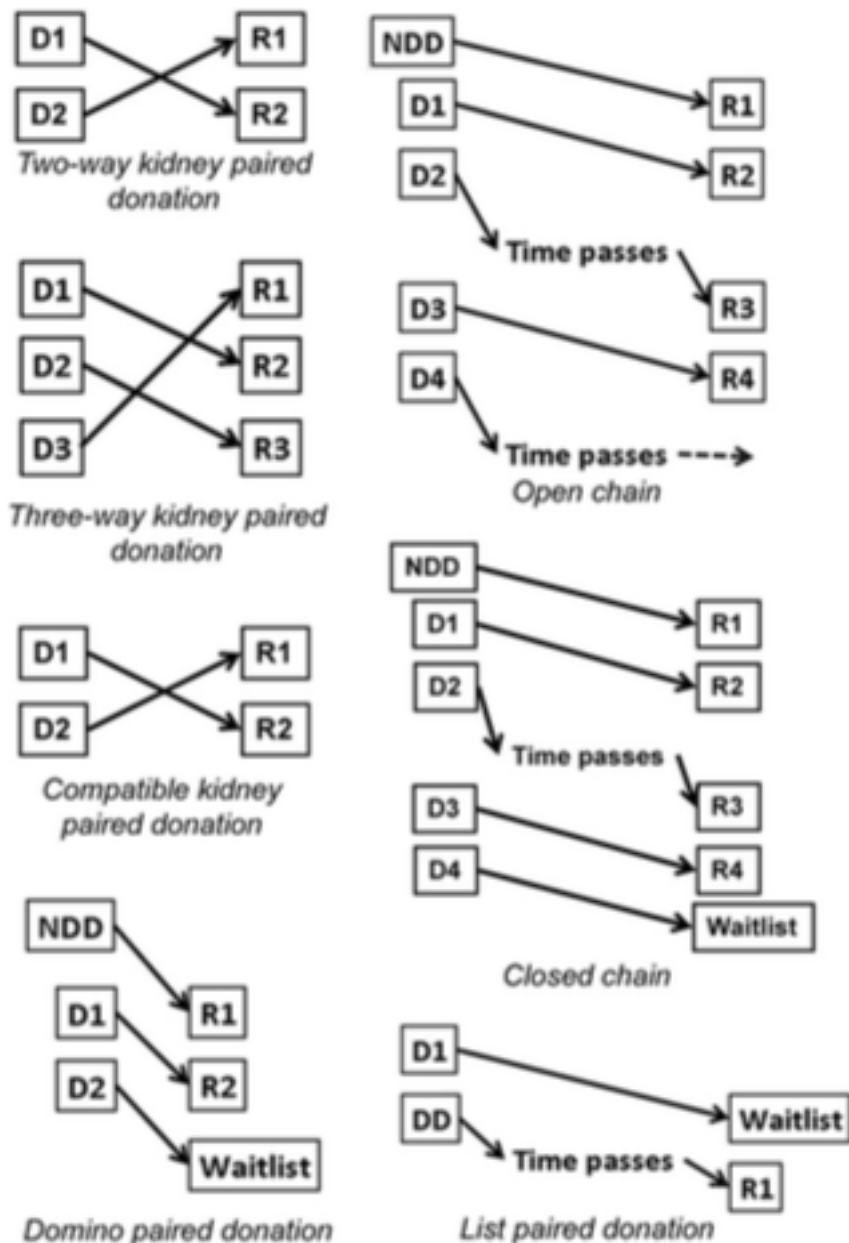


Figure 2. Variations of Kidney Paired Donation [Gentry et al., 2011]. Abbreviations: D, donor; R, recipient; DD, deceased donor; NDD, non-directed donor.

Compatible Kidney Paired Donation

Compatible KPD can also be referred to as altruistically unbalanced exchange or voluntary compatible paired donation. While the goal of traditional models of KPD is aimed at circumventing

the obstacle of incompatibility, compatible KPD is unique because compatible donor-recipient pairs may choose to participate in KPD rather than using a one-to-one model for medical, or even altruistic, reasons. Medical benefits may include finding a younger donor, better kidney size match, or better immunological match (Gentry et al., 2011). Additionally, compatible donor-recipient pairs may be motivated by altruism, similar to LND donors, with the goal of helping other candidates get off the wait list and long-term dialysis.

List Paired Kidney Paired Donation

Another unique form of KPD is list-paired donation or LPD. This model is also referred to as living/deceased donor paired exchange and involves an incompatible donor who donates to a person on the deceased donor wait list (Gentry et al., 2011). In return for this donation, his or her intended recipient is moved to a higher priority placement on the wait list and is therefore more likely to receive the next available compatible deceased donor kidney (Chkhotua, 2012). A visual representation of this model can be seen in Figure 2. The goal of this model, like other forms of KPD, is to circumvent the impediment of incompatibility and results in one less candidate on the wait list.

Domino Paired Donation

Domino paired donation, which is a form of KPD, otherwise known as a donation chain, daisy chain, or w-chain, greatly increases the opportunity for a paired donation. It is estimated that the number of pairs able to exchange organs is increased by 56% in unlimited domino paired donation chains (Gentry et al. 2012). In this model, a chain of kidney donation and transplants is initiated by a LND donor. First, the non-directed or altruistic donor's (NDD) organ is matched to a compatible recipient (R1) who has a willing yet incompatible donor (D1) [Figure 2]. The first donor (D1) can then donate a kidney to a candidate on the wait list and so on [Figure 2]. There are two variations of domino KPD known as open or closed chains.

Open versus Closed Chain

Open chain domino KPD is also called the never-ending chain or NEAD. As mentioned before, a chain is initiated by a LND donor. However, this model does not involve the deceased donor wait list. The final donor in each exchange becomes a "bridge donor" and initiates all following exchanges (Chkhotua, 2012). This model could theoretically extend for years and could provide transplantations for numerous candidates, all through the initial gift from an LND donor. Closed chain domino transplantation can also be referred to as a NEAD chain that ends in the wait list. They are nearly identical to open chain domino KPD except the last donor donates his or her kidney to a candidate on the deceased donor waiting list, or to a recipient without an intended, incompatible donor, thus closing the chain [Figure 2].

Conclusions

The variation in donor models is widespread and complex. The goal of each model is ultimately to provide a donor-recipient match that will facilitate transplantation thus saving lives and money. Although currently there is no one agency responsible for organizing incompatible pairs and kidney paired donation (Gentry et al.,2011), it is likely that achieving this could significantly decrease the organ donation shortage in the United States and globally. Additionally, it should be mentioned that all the donation models described here could theoretically be utilized in a Global Kidney Exchange project. No matter the model variation, paired donations greatly increase the likelihood of compatible matches and subsequent lifesaving kidney transplantation procedures.

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Ethical and Legal Implications of Compensated Organ Donation

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October 26, 2017

Introduction

Of all kidney donations that are currently in circulation, approximately half of those transplants are received from the procurement of a living donor (Shaw & Bell, 2014). A recent problem with organ transplantation is the fact that while demand is increasing, the supply of available organs is remaining the same. Ethics and legal issues come into play when trying to compensate for this shortage of available organs. Issues such as human organ trafficking have occurred to try to remedy this issue. Within this, it becomes incredibly crucial to understand the role that ethics and legality play within this ever-growing procedure. Compensated organ donation comes into consideration as the people, donors, doctors, and communities grapple to decipher between a life and death situation in regards to paying for a kidney.

Guiding Principles of Organ Donation: Legalities

The main law surrounding organ transplantation that is currently in effect is the National Organ Transplantation Act of 1984, whose purpose is to address organ shortages and improve and elaborate the distribution of organs nationwide. In regards to compensated organ donation, there is no law in place specifically against compensation for organs, but there are many systems of principles in place in which transplant centers can follow, if they so wish to implement them.

One of the principles in circulation is the Guiding Principles enacted by the World Health Organization. The purpose of these is to outline the ethics and legal facts behind organ donation in an effort to combat the illegal black market side of organ transplantation throughout the world. These guiding principles further break down the definition of organ transplantation to include and encompass “therapeutic purposes” as well.

While these guiding principles include the notion of the incongruence of compensation and maintain that no such payment should be received for such transplantations, the principles therefore remain as a set of guidelines, not a rule of law. The World Health Organization states that the Guiding Principles, “prohibit giving and receiving money, as well as any other commercial dealing in this field, but do not affect payment of expenditures incurred in organ recovery, preservation and supply” (WHO, 2017). They further cite that organs and tissue may be removed from a deceased body or from a living body, only if they are in accordance with the Guiding Principles.

In addition to this, The World Medical Association's "Statement on Human Organ and Tissue Donation and Transplantation" includes a section that mentions, "In the case of living donors, special efforts should be made to ensure that the choice about donation is free of coercion" and persons incapable of making informed decisions should be donors in only "very limited circumstances"

(Encyclopedia of Bioethics, 2004), meaning that there should be no risk of incentive or ulterior motive behind such donations, those in which might stem from perceived compensation or payment for their procurement. Once again, these are a set of guidelines, not an explicit dogma of law.

The Guiding Principles are a set of nine guidelines for organ transplantation that set up the framework for dealing with the ethics and legal problems that can arise with this procedure.

However, the Guiding Principles remain just that—a guide for each nation/state to determine the definition of "deceased person" and criteria of death and what it encompasses, as well as the means of implementing the Guiding Principles. The principles, taken directly from the World Health Organization website are as follows:

Principle 1: Organs may be removed from the bodies of deceased persons for the purpose of transplantation if:(a)any consents required by law are obtained; and (b)there is no reason to believe that the deceased person objected to such removal, in the absence of any formal consent given during the person's lifetime.

Principle 2: Physicians determining that the death of a potential donor has occurred should not be directly involved in organ removal from the donor and subsequent transplantation procedures, or be responsible for the care of potential recipients of such organs.

Principle 3: Organs for transplantation should be removed preferably from the bodies of deceased persons. However, adult living persons may donate organs, but in general such donors should be genetically related to the recipients. Exceptions may be made in the case of transplantation of bone marrow and other acceptable regenerative tissues. An organ may be removed from the body of an adult living donor for the purpose of transplantation if the donor gives free consent. The donor should be free of any undue influence and pressure and sufficiently informed to be able to understand and weigh the risks, benefits and consequences of consent.

Principle 4: No organ should be removed from the body of a living minor for the purpose of transplantation. Exceptions may be made under national law in the case of regenerative tissues.

Principle 5: The human body and its parts cannot be the subject of commercial transactions. Accordingly, giving or receiving payment (including any other compensation or reward) for organs should be prohibited.

Principle 6: Advertising the need for or availability of organs, with a view to offering or seeking payment, should be prohibited.

Principle 7: It should be prohibited for physicians and other health professionals to engage in organ transplantation procedures if they have reason to believe that the organs concerned have been the subjects of commercial transactions.

Principle 8: It should be prohibited for any person or facility involved in organ transplantation procedures to receive any payment that exceeds a justifiable fee for the services rendered.

Principle 9: In the light of the principles of distributive justice and equity, donated organs should be made available to patients on the basis of medical need and not on the basis of financial or other considerations.

Currently, it is up to each organ transplant facility to determine which determining factor or type of guiding policy that they will implement and adhere to, thus leaving the issue of legal factors surrounding compensation highly polarized.

Compensated Organ Donation: Ethics

Arguments in place surrounding compensated organ donation include two parts: those who are against compensation, stemming from the grounds of what is called ‘commodification,’ and those in favor, whose argument surrounds the creation and use of the compensation markets’ attempt to eradicate the continual stagnation of supply in human organs. To this group, compensation proves as a form of incentive and strategy of trying to create an alternative means for human organ transplantation.

Within this dichotomy, those who are against commodification state that there are “limits to what can be bought and sold as commodity” (Castro, 2017). Thus, the selling of human organs breaches the notion of common decency and right of a person, and revolves around human organs as life-sustaining elements of human beings. This argument further presents itself along the notion that, “human beings ... are of incomparable ethical worth and admit of no equivalent. Each has value that is beyond the contingencies of supply and demand or of any other relative estimation. They are priceless” (Castro, 2017). Consequently, to sell an integral human body part is to “corrupt the very meaning of human dignity” (Center for Bioethics, 2004).

The primary ethics surrounding compensated organ donation are the fact that many people need organs, but there aren’t enough available for everyone to receive one. According to the United Network for Organ Sharing, there are around 83,000 people awaiting transplants in the United States (Center for Bioethics, 2004). Here a term called, ‘Distributive justice’ comes into the works. Distributive justice notion states, “there is not one “right” way to distribute organs, but rather many ways a person could justify giving an organ to one particular individual over someone else” and goes on to break down how receiving organs should be based, one of which includes the criteria of ‘equal access.’ This includes the length of time waiting (meaning that those on the list first should receive it first) and age (youngest to oldest).

One problem that arises with adopting this theory of equal access is that thus in the strictest sense; everyone should be able to access and benefit from it. Excluded from this then, would be the idea of including medical biases into determining candidate eligibility, or only allowing organs to go to ‘worthy’ candidates who adhere to a healthy lifestyle.

Also within the equal access criteria is the concept of ‘maximum benefit.’ This constituent states that medical need and probable success of transplant procedure must factor into the decision. Ethicists who argue along these lines remark that since organ transplantation is a medically worthy and crucial procedure, organs shouldn’t be wasted without considering who it would benefit best. However, a problem here arises because predicting the probability or likelihood of success isn’t always accurate or easy to predict, and thus is difficult to use as a determining factor.

Ethics regarding organ transplantation and compensation are a very difficult and grey area for ethicists and organ transplant centers, because it has to do with determining and identifying the social, biological, and cultural aspects of personhood, and ultimately defining where value should be placed in regards to this. Several sides persist throughout each of the organ transplant criteria, and involve many layers of deep-rooted ethics and principles that are up to each to determine.

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Kidney Procurement Procedures and Origins in Various Countries: Argentina, China, Mexico, Spain, and the United States

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Procurement in its Entirety

Procurement, in its loosest meaning is defined as the recovery or obtainment of organs from a donor source. However, due to the dualistic nature of organ transplant procedures, the term procurement takes on two vastly differing meanings for both parties involved. For the purpose of this analysis, procurement in reference to the recipient will discuss the procedures and steps one must go through in order to obtain a kidney while procurement in reference to the donor will discuss the origins of the kidneys used in transplant surgeries.

In the process of kidney transplantation, procurement is the threshold step in which an organ is transferred from one individual to another. Therefore, the origin and means in which a kidney is obtained are of utmost important to ensure that transplants are carried out in an ethical and efficient manner. That being said, there are currently a multitude of methods for procurement in effect around the globe. This analysis of kidney procurement uses five countries (Argentina, China, Mexico, Spain and the United States) as models to demonstrate the vastly differing methods of kidney procurement in effect. The entirety of this analysis will provide an abbreviated summary of how transplant recipients obtain a kidney, the origin of kidney donors, and a brief conclusion on the importance of balancing efficiency with ethics during the process of kidney procurement.

Procurement from the Perspective of a Recipient

As previously discussed for this analysis, the working definition of procurement in reference to a kidney recipient is stated as: the procedural steps one must adhere by in order to obtain a viable kidney for transplant. Viability, therefore indicates that the kidney is a biological as well as financial match for the recipient. Typically, procurement in this sense of the term consist of the interaction or involvement of governmental or nonprofit organizations in order to organize patients in need of a kidney. An alternative method to the use of such organized systems is the illegal black-market trade and private hospital-doctor teams willing to participate in these illicit dealings. Following is a brief summary of the factors involved in procurement for the five previously mentioned countries.

Brain Death

Brain death is typically characterized by the cessation of circulatory, respiratory, and all brain function. Of the five studied countries, Argentina, Spain, and the U.S. have adopted comprehensive definitions of brain death and the concept is well understood which makes deceased donation significantly more common in these countries. China and Mexico have yet to adopt such definitions of brain death and in both countries, cultural and religious beliefs make cadaveric donations unpopular. (Jha, 2015; White, et.al, 2014)

Defining “Related”

The definition of “related” donor varies in all five studied countries. The definition of related ranges anywhere from only nuclear family all the way to individuals who are only emotionally connected to the recipient. (Jha, 2015) For example, Argentina allows for donations up to individuals related on a fourth degree, meaning a spouse or blood related first cousin, where as China allows for donation of an emotionally connected individual such as a lifelong friend.

Commoditization and Incentivizing of Organs

All five of the countries studied illegalized the commoditization of organs. Additionally none of the countries studied possess incentivizing programs for organ donation. That being said, most of the countries still experience pressure from the black-market for organ trading and Spain in particular faces large amounts of transplant tourism due to their ample supply of cadaveric organ donations. (White, et.al, 2014)

Procurement from the Perspective of a Donor

Conversely, for this analysis, the working definition of procurement in reference to a kidney donor is stated as: the origin of the kidney donation and manner in which an individual donor came about obtaining the status of donator. Donors are classified by several criteria: living vs nonliving and related vs non-related. Similarly, donation programs are defined using the criteria: opt-in vs opt-out. Opt-out donor programs operate under the assumption that any legal adult, defined by the criteria of that specific country, is automatically a registered organ donor unless they specifically indicate that they do not wish to be. Opt-in programs operate under the same legal criteria except that individuals are assumed to not be organ donors unless they specifically state otherwise. In both situations, organ donation (living or deceased) from a non-legal adult is only made possible with consent from a parent or legal guardian. Following is a table that summarizes the most common method of kidney procurement in the five previously mentioned countries.

Table 1. Primary methods of organ procurement. (Crowley-Matoka, 2016; Jha, 2015; SOTNO, 2011; USRDS, 2017)

Country	Living	Cadaveric	Related	Non-related	Opt-in	Opt-out
Argentina		X				X
China		X			X	
Mexico	X		X		X	
Spain		X				X
U.S.		X			X	

Note: All cadaveric donations are assumed to be from non-related donors thus the Related and Non-related categories are used only to specify for living donations.

As seen above in the table, the majority of kidneys are obtained from cadaveric donors with Mexico being the exception. An additional exception to note is that the majority of cadaveric donations come from brain dead donors based on the criteria for the specified country. The exception in this instance is China, where the majority of the donated kidneys are obtained from executed prisoners. (Jha, 2015) Furthermore, the majority of the countries studied in this analysis operate using an Opt-in program rather than the assumed consent Opt-out program. However, recent policy changes indicate a shift in focus to Opt-out programs as a solution to organ shortages around the world. (White, et.al, 2014)

Ethics and Efficiency

The recent shift towards Opt-out programs brings to consideration the balance of ethics and efficiency in transplant procures. Policies surrounding organ transplant procedures on procurement need to take into consideration the efficiency in which they obtain organs for recipients and the ethics in which they obtain organs from donors. Statistical data indicates that the average wait time a patient spends on an organ transplant list is anywhere from 3-5 years. At such a point in time, the majority of patients have already become too sick to be considered for a transplant, indicating that the efficiency at which organs are being procured is too slow to keep up with the high demand. (DHHS, 2012) Furthermore, ethnographic research suggests that living donor post-op care is being severely neglected. In Mexico, where living donations make up the majority of organ donations, often times donors are incapable of managing the financial burden of post-operation care, leaving them in a compromised health and financial state. (Crowley-Matoka, 2016) Thus, based on this evidence, future policy reform such as the Opt-out program needs to focus on increased organ procurement efficiency for recipients and improved ethical treatment for organ donors.

Conclusions

Based on the analysis of kidney procurement for these five countries, it is increasingly clear that no one country operates under the same model. Furthermore, it emphasizes the fact that there is no universal standard for the definition of brain death or a universal legal age at which organs can be donated. Additionally, the variety and inconsistency among countries' procedures for organ procurement opens opportunities for illegal practices such as transplant tourism and black-market trade. In regards to differing cultural and religious beliefs, creating one universal set of procedures for procurement would prove significantly difficult if not entirely impossible. However, future policy and procedural reform cross culturally should emphasize increased efficiency in organ procurement for recipients and increased ethical practices when obtaining organs from donors.

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Legislation on Organ Procurement in the United States

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Introduction

Over the past decade, the necessity for kidney transplantation in the United States has augmented significantly and rapidly. As of now, the growing numbers of patients in need of a transplant have overtaken the number of available donors, creating a seemingly insurmountable shortage. While programs such as the Organ Donation Collaboration Initiative have exhibited modest success in procurement of organs from deceased donors, about half of all organ donations are still sourced from living donors (Nat'l Kidney Foundation).

In response to the urgent demand for donated organs, various extensive efforts have been implemented in order to supplement donation rates, which includes, but is not limited to, regulated compensation for living donors. By employing new legislative action, it is hoped that the gap created by the current organ shortage will become easier to narrow. Paired with the National Organ Donor Leave Act of 1999 (US Public Law), which grants supplementary, paid furlough for federally employed persons who are living organ donors, several states have initiated the use of statutes which further assist living donors. The state of Colorado championed primary legislature in 1998 (as seen in Figure 1), which mandated up to two days of paid furlough for government employees who were living organ donors (CO revised Statutes). Following suit, other states produced legislation which provided diverse types of assistance such as tax benefits and both paid and unpaid extended leave.

Overview of Legislation

Prior to the 1960's, governmental involvement in organ transplantation was basically nonexistent. During this era, the process of transplantation was most often accomplished through more localized enterprise, with a group of medical professionals and some simplistic variation of an organ procurement organization. The exchange of organs between hospitals was relatively informal, and based on volunteer action (Prottas et. al 1994) In later years, with the augmentation of transplantable organ demand, the involvement of a more developed infrastructure was necessary to decelerate the widening of the gap between organ supply and transplant demand. In 1984, the National Organ Transplant Act (NOTA) was enacted, which called for a greater exploration and regulation of issues surrounding organ procurement, including ethics, living donor compensation and transplant pairing (Prottas et. al 1994). From this, the grants for Organ Procurement Organizations were put into action, successfully establishing both the Organ Procurement & Transplant Network (OPTN) and the United Network for Organ Sharing (UNOS). Following 1984,

there have been several amendments to NOTA to make it more effective in terms of global interconnectedness.

Contemporary Legislation Goals

Due to the fact that NOTA, OPTN and UNOS outlined various legal regulations surrounding transplantation, contemporary legislation is heavily focused on enacting statutes that seek to increase both living and deceased donation rates. The statutes aid in decelerating the organ shortage but also uphold and bolster the guidelines set forth by government infrastructure. As of now, there are various strategies brought forth by legislation which are pursuing the increase of donation rates, however, tax breaks and “regulated compensation” for living donors are of greatest significance to contemporary organ procurement legislation.

Tax Break Policy for Living Donors

Main concerns for living donors are centered in both medical and financial spheres. For many potential donors, the possibility of complications following donation or extended, uncompensated absence from employment can be considered a disincentive to donation. Also, aware of potential implications, both medical and financial, transplant recipients are exceedingly hesitant to make contact with possible donors - only widening the gap between organ supply and patient demand (Pradel et. al 2003). The main objective of contemporary, federally-enacted initiatives and statutes is to surmount the aforementioned disincentives to living donation through a combination of assistance via employer and government. This additional support may bolster donors' biomedical recuperation with offered leave and aid in abating potential financial costs following living donation. While the aforementioned public policies are benevolent in nature, their efficacy on the augmentation of donation rates is still in question.

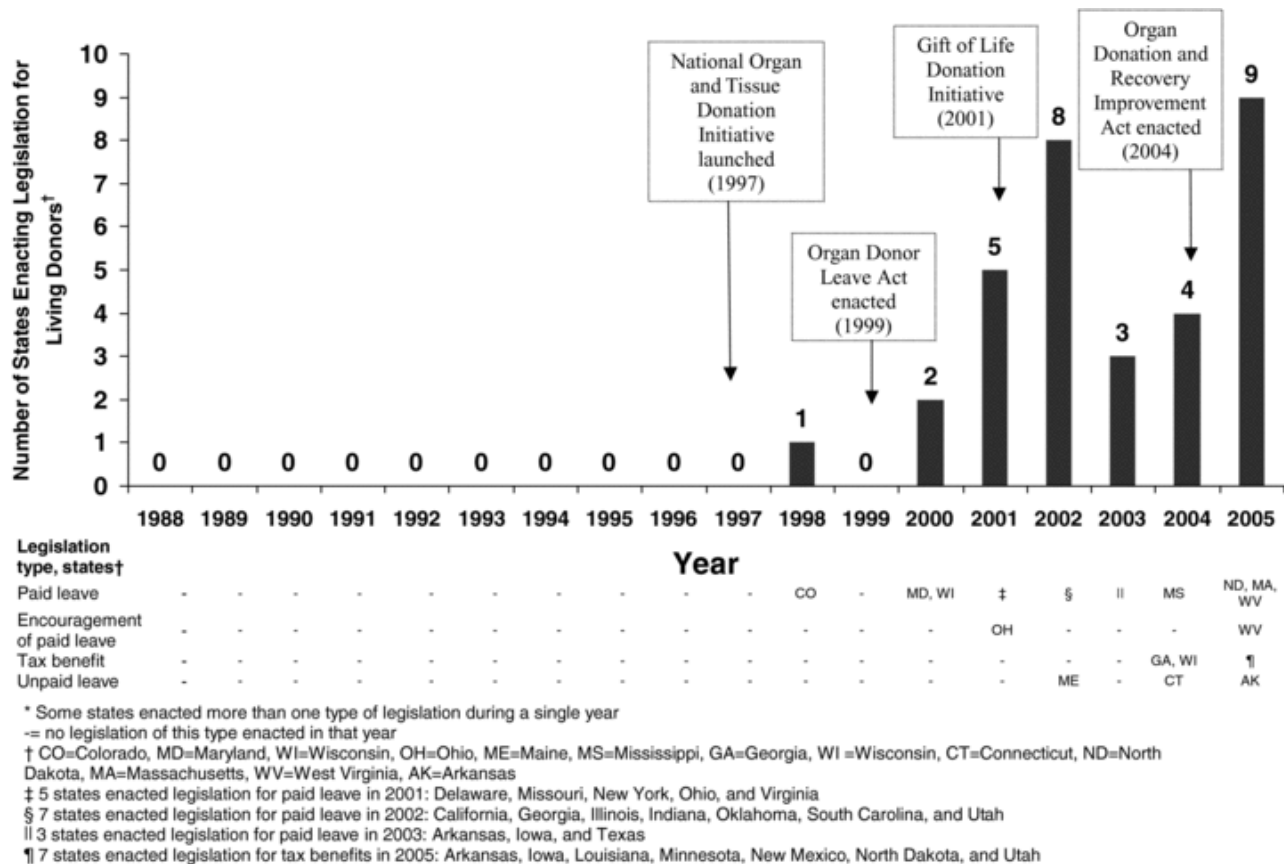


Figure 1. Number of States Enacting Legislation for Living Donors from 1988-2005 [Boulware 2008.] As shown in the figure, following the launching National Organ and Tissue Donation Initiative in 1998, there was a large increase in states passing legislation on living donations.

Tax Break Policies on Living Donation

In years 2004-2008, fifteen states enacted legislation which offered tax deductions in an effort increase living organ donation by way of financing of potential medical fees, lodging and loss of wage through work absence (Venkataramani et. al 2012).

A sound case which outlines the aforementioned objectives of tax deduction can be seen in the 2004 tax deduction legislation implemented in Wisconsin. This statute allows living donors to “deduct up to \$10,000 in travel, lodging and lost wage costs accruing from the donation act” (Venkataramani et. al 2012). While this legislature was well-meaning in nature, some members of the public claimed that the policy had an unethical basis and the propensity induce coercion of individuals into organ donation. However, regardless of the dispute, living donation expense tax breaks have gained greater traction since then (Fusco et. al 2004). With increased publicity, this policy perfused to more than 10 other states by 2009. However, even with increased state-enacted legislation, the true efficacy of these tax breaks is still relatively debatable when broken down numerically.

Efficacy of Tax Break Policy and Monetary Return

As of now, there are a few explanations as to why the legislative action set forth by many states has not been especially efficacious in augmenting living donor numbers, and in turn decreasing the overall organ shortage. Primarily, the tangible monetary return for such tax deductions is relatively insignificant in comparison to the overall potential costs of living organ donation, both medical and financial. Based on the median household income of a family of four in Wisconsin, a \$10,000 tax deduction would return only a little more than \$550 in actual cash (Wellington et. al 2011). Additionally, according to a study performed by Clarke and Klarenbach for the Journal of Nephrology, Dialysis and Transplantation, the total financial cost for a living kidney donor in the US is between \$900 and \$3100. This cost includes travel cost (airfare, etc.), lodging, paycheck cuts for lost work time, and medical fees associated with the transplant surgery. It must be taken into account that fees will fluctuate based on the severity of donation surgery performed and recovery time of the donor. With this, it is calculated that the tax break only supplements a small percentage of the overall financial burden that the living donor must take on. In order to make a sufficient difference in financial burden, an increase in the monetary value of tax deductions may help to reduce the perceived disincentives by living donors. Additionally, “transition from tax deductions to tax *credits* which for the same dollar amount would be more valuable and, if refundable, can potentially reduce a payer's tax liability below zero—may have a larger impact” (Venkataramani et. al 2012).

Ethical Considerations of Tax Break Policy

An additional reason the tax policy may have had diminished effectiveness on donation rates could have had connection to the potentially negative views of the general public and possible donors. The “incentivizing” of organ donation via tax breaks may have been perceived as unethical and that turned donors away from donation, even if the end decision on donation by the donor would have been totally voluntary.

Conclusion

In conclusion, even with current state-by-state and federal policies implemented in order to augment living donation rates, the overall efficacy of these policies is relatively unsuccessful in terms of significantly closing the organ-supply and patient-demand gap. Various policies, like tax breaks for living donors, added slight supplemental aid for the donors, but did not completely cover then entire financial burden that was acquired following donation. However, even without the entirety of the donation being covered, many living-related donors felt that their medical and financial well-being wasn't severely decreased with donation. In the future, it is hoped that more beneficial legislation can be passed to further diminish the perceived disincentives brought forth from living organ donation, and with that not only increase living-related organ donation, but living

unrelated donation as well. Additionally, many states hope to continue to build contemporary legislation surrounding well-established infrastructure set forth by governmental agencies.

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A Summit on Organ Trafficking and Transplant Tourism: The Vatican Declaration on Organ Transplant

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Introduction

In early February of 2017, the Pontifical Academy of Science in the Vatican City convened a Summit on Organ Trafficking and Transplant Tourism. This summit, which ran for two days, included over 75 doctors, ethicists, and religious leaders (Riella, 2017). The summit also included the members of the Pontifical Academy of Science, as well as The Transplantation Society Executive and Council, and the Declaration of Istanbul Custodian Group Executive. In other words, one of the world's largest nonprofit on organ transplantation and the council that had published the Declaration of Istanbul in the spring of 2008 (Riella, 2017).

As stated in the document itself, the purpose of this convening was to produce another declaration to supplement the Declaration of Istanbul and update the goal it contained. That is, to condemn human trafficking, and specifically human trafficking for the purpose of organ harvesting, this time with the weight of the papacy and the Vatican behind it, in hopes such actions will be formally declared a crime against humanity. This was written and declared in the name of Pope Francis.

The declaration proposes specific measures that could be implemented to combat and prevent human trafficking and organ trafficking crimes from happening. It also proposes measures to protect those who are vulnerable to fall prey to such crimes, and measures to protect and help those whom have already been victimized (Beliaevski, 2017).

The declaration makes eleven requests of the global community at large. We shall explore them here.

Francis' Eleven Points

The Vatican Declaration on Organ Transplant is two pages long and is organized roughly in two parts. The first page is an introduction that outlines the factors that can leave an individual vulnerable to human trafficking and organ trafficking. The factors identified are the following: poverty, unemployment, and a lack of socioeconomic opportunities. Those who fall prey to trafficking typically are those desperate enough to sell their organs. The declaration agrees with “a

number of international legal instruments” that condemn and criminalize the practices of human and organ trafficking, including those who actually complete the operations.

The second portion of the document, most of its second page, lists the eleven recommendations, which are broadly proposed to the “national, regional and municipal governments, ministries of health, to the judiciary, to the leaders of the major religions, to professional medical organizations, and to the general public for implementation around the world.” These eleven recommendations fall into roughly four categories: legal, administrative, education, and social. Legal is the largest category, with five of the eleven recommendations under its umbrella. There are four administrative recommendations, one social recommendation, and one educational recommendation.

The legal recommendations call for the internal regulation of transplantation surgeries in each country, international and domestic codification of human trafficking and organ trafficking as criminal offenses and crimes against humanity, and for possible judicial reform in countries. These are perhaps some of the more grand aims of the declaration, as they are larger projects to be implemented on massive scales around the world.

The administrative reforms in question are pointed toward actors not directly involved in transplantations; actors such as insurance companies, nurses who tend to donor and recipient before and after the surgery, and those who keep records of donors and recipients. The declaration asks that there be more extensive records kept on donors, recipients, and the activities of criminal networks that work in the black market of organ sales, and that this information be shared across jurisdictions if the need arises. The declaration also recommends both donor and recipient undergo an ethical and medical review before undergoing surgery, and recommends that an efficient structure of communication be implemented for those not directly involved to raise concerns should any warning signs be spotted.

The social recommendation encourages religious leaders in particular to condemn human trafficking and organ trafficking, which is logical for a declaration from the Pope to include. No specific instructions are levied for this recommendation, which allows for the implementation as a leader sees fit. This makes sense; no two congregations, temples, masses, or followings are the same, and a leader usually knows best how to address the people of their community on issues like this.

The final recommendation provided by this papal declaration is an educational recommendation, that asks for awareness to be raised regarding human trafficking and organ trafficking, and for the international guidelines to be seen by a wider audience. The last half of this particular recommendation is likely so that suspect behavior might be more easily recognized and reported.

The Effect on China

Although this document is still comparatively young, not even a full year old yet, there is much to suggest that its very creation and existence have wrought change in a country notorious for harvesting the organs of prisoners executed for that purpose.

China was, and possible still is, known to have executed prisoners to harvest their organs, keeping them alive until a need arose, treating the prisoners much like a human incubator. Many human rights organizations claim this still occurs in China, while according to Beijing officials this

particular brand of forced organ harvesting was discontinued in 2015, according to a Beijing official (BBC, 2017).

According to BBC, *Global Times*, and other news sources, not only was there pressure from the international community for China's invitation to the summit to be rescinded, and the Vatican went so far as to defend its choice to invite China to the February summit. While the head of the Pontifical Academy of Sciences admitted prior to the summit that he was unsure if the organ harvesting practices in China had truly ceased, he hoped China's participation in the summit would "discourage" such practices.

By June, according to *Global Times*, at least four of the most prominent international health organizations in organ transplantation had praised and expressed gratitude for China's on-going reform of organ transplant policies. The organizations in question were those who had led the initial summit in February: The Transplantation Society, the World Health Organization, the Declaration of Istanbul Custodian Group, and Pontifical Academy of Sciences.

Conclusions

The Vatican Declaration on Organ Transplant is still a young document. At the time this report was written, the declaration had only been in existence for 268 days. There is still time for the recommendations it contains to be implemented. While there does not seem to have been an immediate and widespread movement to adopt the eleven points declared in Pope Francis's name, the fact remains the document's creation and its existence has likely already had significant impact upon a country with a large population and a history of executing prisoners to harvest the organs left behind. The recommendations are well thought out, and now countries need to sit down and think through them and how they might best be implemented. Now we move forward for another ten years, hoping that when the world's doctors, ethicists, and religious leaders meet again, they will have overseen great change and will be ready to set another round of goals even loftier than the ones that came before them.

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Nancy Scheper-Hughes: Research on Organ Exchange

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Nancy Scheper-Hughes

Nancy Scheper-Hughes is an anthropologist who has spent most of her career focusing on international activism. However, in her many fields of research she has focused on the organ exchange system. She was a member of the Bellagio Task Force on Transplantation, Bodily Integrity and the International Traffic in Organs which gave her a unique insight to black market trafficking of organs. As an anthropologist, she worked to frame herself in a postmodern approach. By doing this, she was able to incorporate the narratives of those individuals who are being affected by the organ exchange system. In order to collect these narratives, she needed to instill hermeneutic methodologies. Often interpreting stories and collecting data in some discreet ways since the nature of the topics she was addressing tended to be sensitive. Her research falls in to two parts. The first is analyzing and tracking the systems that allows the exchange of organs outside of the direct donation process. This could involve the black market or any donation chain that passes the organ through multiple hands and loop holes before it reaches the intended patients. The other is looking at the culture that influences the donor in the direct donor programs. She focuses on different countries and their beliefs on organ donations. In both accounts, she tends to write romantically about the situations at hand, yet still remains accurate and true in her research.

Black Market Analysis

Scheper-Hughes did a great deal of digging and tracking of organs to find the pipelines that make up the underground market. She reflects back to the movie “Dirty Pretty Things” when analyzing the global underground market. While Hollywood made the setting more appealing to viewers, she claims that the content was quite accurate to the underground market. (Scheper-Hughes, 2004: 30). While referencing the movie, Scheper-Hughes talks about the difficulty to gain support for her research. She believes that Hollywood creates a complex situation for those wishing to study the black-market organ transplants for they tend to paint it in such fabrication that it is often seen as a fairytale or urban myth not worth being studied. The public often views the black market in mystic terms while Scheper-Hughes found that in her research, the black market is a very real thing at effects a great deal of people.

While recording the victims of the market, she found the perpetrators who work in the system and keep the market lucrative. She claims that buyers, sellers, and even the surgeons play a role. Though she believes the surgeons are often let off the hook for their involvement in the black market. Her biggest argument against the existence of the black market is the exploitations of the poor and

marginalized individuals. While tracing the black-market chains she often sees them lead to poor communities and therefore directs her attention to “addressing an uncanny dimension of the usual story of race and class hatred to which we have become so accustomed” (Scheper-Hughes, Wacquant, 2002: 31). She brings in her research of countries like Guatemala and Peru who are trafficking children bodies for organ harvesting and even cites seeing a parent sell a child for such matters. She also looks to Asia and the practice of executing prisoners for organ use.

While she was on the task force, she pushed for an independent surveillance to watch to flow of body parts that happen both in the donor market as well as the black market. Yet, some organizations such as UNOS (United Network on Organ Sharing), which has been purposed in the United States, wants the system to have a self-regulation standards (Scheper-Hughes, Wacquant, 2002: 33). She claims that in “today, kidney transplants have spread from a small number of privileged medical centers in the First World to every continent, producing in its wake a global ‘scarcity’ of transplantable organs” which causes the need for a much more scruple surveillance (Scheper-Hughes, 2004: 33). In this same article, she backs up this demand by referencing South Africa and the lack of a patient waiting list. When she questions a doctor, he pulls out a note book with a few names penciled in. This just reiterating the fact that those only selected worthy by each individual doctor would receive an organ on a need and/or lucrative basis. She sees that the “new developments in transplant tourism have exacerbated older divisions between north and south, core and periphery, haves and haves-nots, spawning a new form of commodity fetishism in demands by medical consumers for a quality product- ‘fresh’ and ‘healthy’ kidneys and part-livers purchased from living bodies” (Scheper-Hughes, 2004: 34). Like in Africa, it is who can afford the kidney and who can produce the kidney, whether black market or not.

Cultural Influence on Organ Exchange

Her second point is focused on the different cultures and their beliefs around living donors. In her article “The Tyranny of the Gifts: Sacrificial Violence in Living Donor Transplants” she explores different scenarios in which culture influences the type of living organ donation. She travels to the United States and finds the ideologies around donation being a woman’s job. She uses an anecdote where she talks to a man who needed bone marrow and sees that he does not hesitate to put his sister’s life on hold while she donates to him. It was expected of her to stop her very fulfilled life to help her brother. Yet, it wouldn’t be like this if it was the other way around. He even brushed off the fact that he was inconveniencing her life by saying it was just what families do, even though his relationship with his sister was estranged. On the other hand, in Japan they do not often take organs from relatives for it is a gift they cannot pay back. There is no equivalent gift to give the donor so they feel indebted to the donor for their gift. It is much more preferred for the people in this culture to buy an organ or to get it from a deceased donor. Another cultural difference is in the slums of Banong Lupa, Manila. Scheper-Hughes found that fathers selling kidneys is seen by the culture as self- sacrifice of a loving father. Many times, these kidneys are being sold to supply the family with basic necessities, but was viewed in a positive light of the men being protective provider.

Conclusion

In synopsis, she believes that the global market and exchange of organs should be regulated and monitored to protect the marginalized individual in poor community and prevent bodily exploitation. She doesn't believe in the complete shut down and banning of the underground organizations for certain culture rely on the buying and selling of organs for moral reasons. She also sees the living donor system to be a personal exploitation of individuals through moral reasons and not better or worse than the global organ market.

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Characterization of the International Organ Trade

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Introduction

Commodifying organs and other body parts have largely been taboo among the global community; this enforces the internationally accepted altruistic nature that organ donations prompt. Despite these sentiments, the international trade in organs has taken root and persists today. The global organ trade exists in two spheres: the legal market, where organ trade is permitted and actively acknowledged by the government (e.g. Iran), and the illegal market, where most trade of organs happens and is legislatively banned by judiciary institutions and code. There is legislation in almost all countries that effectively criminalizes the trade of organs making this kind of trade have a substantial presence in the illicit markets. The only country that permits the buying and selling of organs in a legal market is Iran, although other countries have entertained the idea of setting up something similar. Characterized by the supply and demand of human organs, altruism and the ethical dilemmas, and the social and geographical divide, the international organ trade continuously provides a setting that increasingly causes debates over the ethical implications.

Supply and Demand of Human Organs

The main drive for this market is an increasingly high demand for organs for transplants and their lack of availability. This scarcity of organs is in part caused by the increasing growth in the availability of medical technologies that provide transplantation services across the world (Scheper-Hughes, 2002). Increasing use of medical technologies and number of people affected by organ diseases is directly responsible for the high demand. This is a global lack of donors that plagues the organ availability in both low-income and high-income countries. The World Health Organization conducted a study that found that only ten percent of people in need of a kidney, the body part with the highest demand, is able to receive one (The Economist, 2008). This statistic sheds light on the reality that people seeking organs, specifically kidneys, face.

A capitalistic society, like the United States, would normally propose a market solution to remedy this economic problem but due to the taboo nature of commodifying body parts it poses an ethical dilemma. The only country that uses a market solution to solve their shortage of organs is Iran. Since the implementation of a market solution in 1988, Iran effectively eliminated their waiting list for kidney transplants in 1999 (Ghods, 2014). Currently, there are over 100,000 individuals waiting to receive an organ in the United States (UNOS, 2017). As described by Nasser Karimi and Jon Gambrell of the Associated Press (2016), Iran's system works as follows: "A person needing a kidney is referred to the Dialysis and Transplant Patients Association, which matches those needing

a kidney with a potential healthy adult donor. The government pays for the surgeries, while the donor gets health coverage for at least a year and reduced rates on health insurance for years after that from government hospitals.” Critics of Iran’s system say it can exploits the poor people in the country, the commodification of human organs is also not supported by the World Health Organization. The benefit of Iran’s system is that it solves the supply/demand question while also providing monetary and insurance compensation for donors (Ghods, 2014). The lack of people willing to donate, available organs, and the high amount of people in need of transplantations fuel alternative ways of obtaining organs, such as purchasing them on the black market.

Altruism and the Ethical Dilemmas

The concept of altruism dominates the global organ trade. In almost all instances, to legally obtain an organ, such as a kidney, it must be altruistically donated by someone else. There is no form of compensation for the donor other than the benefit of doing a good deed. The altruistic donation of organs simply does not meet the need for organs. Therefore, compensating someone for their donation serves as an incentive to increase more donations giving life to more people, but this is not without ethical dilemmas. “Millions of people are suffering, not because the organs are not available but because "morality" does not allow them to have access to the organs (Kishore, 2005).” Is being compensated for a “donation” of an organ a violation of human dignity and does it go against core principles of providers? This ethical dilemma is still debated by scholars liked Nancy Scheper-Hughes and R. R. Kischor. Scheper-Hughes (2005) states that compensation for a kidney donation is a win-win for both the receiver and giver because it searches for a libertarian, consumer-oriented resolution of the conflict between “non-maleficence (“do no harm”) and beneficence (the moral duty to perform good acts) (62).” Kischor (2002) goes more for a bioethical standpoint by arguing that “any act done to save the life of a human being or to liberate him from suffering cannot be construed as contrary to human dignity (363).” Arguments against compensation, say that it unfairly targets the low-income individuals to make a sacrifice that is potentially life-threatening. With this noted, the international organ trade is also characterized by a social and geographical divide.

Social and Geographical Divide

The supply and demand for human organs is a significant part of the international organ trade. This characterization often also depicts the global socioeconomic and geographical divide in organ procurement. Due to the shortage in supply of organs, people from high-income countries are searching in low-income countries for organs. The organs are flowing from poor donors, usually in the global south, to the wealthier recipients in the global north (Ludin, 2015). This geographical framework coincides with the socioeconomic status of those who donate their organs. Susan Ludin (2015), an ethnographer who researched the global organ trade in her book *Organs For Sale: An Ethnographic Examination of the International Organ Trade*, writes,

“The organs come from poor countries in Eastern Europe, the Middle East, South America, Asia, and various countries in Africa. The recipients are inhabitants of richer countries such as Sweden, Israel, the United States, Germany, Great Britain, Saudi Arabia, Australia, and Japan. Little surprise that it is people from wealthy social groups who buy organs and the most vulnerable people in the poor countries who are the sellers. It is a complicating factor that the operations are often performed in another country – in the Philippines, Latin America, or some Eastern European country, for example (6).”

The trade in human organs is encompassed in almost every country, and often is obtained through an illicit economic promise of monetary compensation in the form of cash payments or payment of medical bills. This type of compensation falls under the illicit sphere of organ trade. It also takes advantage of the fact that many people willing to give up an organ in the low-income countries are often in situations where they need economic support. Lundin (2015) writes, “what weighs most heavily are the economic conditions. It is poverty that leads to desperate efforts to earn money (13).” The geographical and socioeconomic divide in the givers and takers of the organs, especially in the illicit market of human organs, is clear.

Conclusion

International organ trade is characterized by the three concepts of supply and demand for human organs that is increasingly hindered by altruism and the ethical dilemmas and clearly depicts the divide in social and geographical differences between low- and high-income countries. These three things play an essential role in how organs are obtained and the legality of human organ trade. With the sole exception of Iran, the international organ trade happens mostly in the illicit setting where monetary compensation for organs and organ trafficking have come to dominate the narrative of this market. The illicit nature that it produces, unfortunately, makes solid data increasingly hard to find. The international organ trade is a market that seeks to help find a solution to the global demand of organs.

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