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Organ Transplant Tourism

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1. Introduction

1. Organ transplantation is the best and frequently the only lifesaving treatment for end-stage organ failure. The number of transplants performed worldwide has steadily increased, amounting in 2016 to 135,860 solid organ transplants, including 89,823 kidney transplants (of which 40,2% were donated by living kidney donors) (Global Observatory on Donation and Transplantation 2018). However, the need for transplants is also increasing, with the annual demand for transplants estimated to be between 2-2.5 million patients. Whereas previously it was estimated that transplant activity covered 10% of the global need, it is now estimated that only 5-6 % of those who need a transplant may get one (Matesanz 2017).
2. Disparity between the need and supply of organs has resulted in patients circumventing the prohibition of commercialisation in their home countries by going abroad to buy an organ in countries where this prohibition is poorly enforced or where transplant legislation is marred by loopholes. This practice was first reported in the late 1980s and has since been consistently and uniformly condemned by intergovernmental organisations such as the World Health Organization and the Council of Europe and by professional organisations such as the World Medical Association and The Transplantation Society.
3. According to broad estimates by the World Health Organization (WHO), transplantation of organs purchased from destitute populations in low-income countries accounts for up to 10% of all transplant activities performed worldwide (Shimazono 2007). However, this statistic is more than 10 years old, and in the light of increased mobility, growing and ageing populations, and the globalisation of unhealthy lifestyles, including an epidemic of diabetes, this number might well be much higher. Due to its illegal and dynamic nature, the exact extent of transplant tourism is unknown. To get a clearer picture, more collaboration and research are urgently needed.
4. Travel for transplantation may be legitimate and even necessary when the home country does not offer transplant services and the recipient travels with the donor to receive those services abroad. Alternatively, travel may be appropriate when the recipient and the donor are related but live in different jurisdictions due to migration. However, as defined in the 2018 update of the Declaration of Istanbul, travel for transplantation becomes “transplant tourism”, and thus unethical, if it involves: (1) trafficking in persons for the purpose of organ removal; (2) organ trafficking; or (3) use of transplant resources that undermines the country’s ability to provide transplant services for its own population (Declaration of Istanbul, update 2018). Let us briefly consider these three aspects.
5. “Trafficking in persons for the purpose of organ removal” occurs when, with the aim of having a person’s organ removed, that person is recruited, transported, transferred, harboured or received by making use of “the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability, or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person.” Since 2000, an international criminal law framework addressing trafficking in persons for the purpose of organ removal has been elaborated by the UN (Protocol to Prevent, Suppress and Punish Trafficking in Persons 2000), the Council of Europe (Convention on Action against Trafficking in Human Beings 2005), and the EU (Directive 2011/36/EU). The great majority of cases of transplant tourism involve organ sellers who have been subjected to trafficking in persons.
6. “Organ trafficking” occurs when an organ has been illicitly removed, either because it was removed without valid consent or authorisation or if it was removed in exchange for financial gain to the donor or a third person. A variety of acts relating to illicit organ removal, such as the transportation, manipulation, and transplantation of the illicitly removed organ; the solicitation or recruitment of donors or recipients for financial gain; and the offer of any undue advantage to, or request by, a healthcare professional, public official, or employee of a private sector entity to facilitate or perform such illicit removal or transplantation, are also considered organ trafficking. The international criminal law framework addressing organ trafficking was elaborated by the Council of Europe (Convention against Trafficking in Human Organs 2015) to solidify the principle of non-commercialisation of the human body through criminal sanctions and to overcome the limitations of the framework of trafficking in persons. More specifically, the criminal law framework on organ trafficking also allows the prosecution of transplant tourism in cases where the organ was removed from a living person who had adequately consented but had been paid, or where the organ was illicitly removed from a deceased person. Moreover, where it overlaps with the framework on trafficking in persons, the framework on organ trafficking allows easier prosecution of transplant tourism, because it does not require proof that specific illicit means had been used to obtain a paid organ transplant (López-Fraga et al. 2014).
7. In addition to cases that constitute outright trafficking in persons or organ trafficking, transplant tourism occurs when domestic transplant resources are used to the benefit of foreigners to an extent that is detrimental to the transplant needs of the local population. This may, for instance, involve the allocation of organs from deceased

donors to foreigners who are prioritised over residents, or the priority use of the few available transplant centers and transplant professionals by wealthy patients from abroad.

2. The characteristics of organ transplant tourism

8. Transplant tourism is fuelled by the demand of desperate patients who are willing to pay large sums of money to obtain a kidney or, less frequently, a liver lobe from a living donor.¹ Transplant tourism typically involves the movement of recipients from high- and middle-income countries to low-income countries where the vulnerable and impoverished serve as organ source and where the surgical procedures are undertaken. However, recently other forms of transplant tourism, that involve trafficking in persons or organ trafficking, have emerged. For instance, recipients and organ sellers may travel from the same country to the country of destination where the surgery is undertaken; they may travel from different countries to the country of destination where the surgery is undertaken; or the organ seller may travel to the country where the recipient and the transplant centre are located (Shimazono 2007). As a rule, transplant tourism takes place within authorised transplant systems that exist in the countries of origin. In those cases, local transplant professionals and even hospitals may be knowingly and willingly involved in these illegal activities, or, alternatively, the recipient and the organ seller may have found a way to deceive established screening mechanisms. Only very rarely, transplant tourism occurs completely outside of the scope of the country of destination's legitimate transplantation programs, for instance in private houses or hotel rooms (Jabri 2017).

9. Australia, Canada, Japan, South Korea, the United States and countries in the Middle East and Western Europe have been identified as the main countries of origin of transplant tourists (López-Fraga et al. 2017). Recently, due to a rapid expansion of dialysis programs in some parts of Africa and Asia, transplant tourists from additional countries, including Nigeria, have come onto the scene (Okafor 2017). Common destinations include Bangladesh, Bolivia, Brazil, China, Colombia, Costa Rica, Egypt, India, Iraq, Lebanon, the Republic of Moldova, Pakistan, Peru, the Philippines, Sri Lanka, Turkey and Vietnam (López-Fraga et al. 2017). The most recent anecdotal reports indicate that transplant tourism is currently rampant in India, Pakistan, Egypt and Lebanon (BBC 2017; Fatima et al. 2017; Haider 2017; Khan 2018; Sunny 2017), and continuing at a considerable scale in China, Sri Lanka and Turkey (ARTE 2017; Bhardwaj 2017; Chang 2018; Chu 2018; TRT World 2017; TV Chosun 2017). As a result of war and natural catastrophes, transplant tourism has recently also emerged in countries such as Iraq, Nepal and Yemen (Asia Foundation 2015; Baghdad Post 2017; Maher 2016; MEE 2017) and is increasingly targetting refugees (e.g. from Syria and Sub-Saharan Africa) in countries such as Egypt, Lebanon and Turkey (Baraaz 2018; Forsyth 2017; Gregory 2017; Irvine 2018; Putz 2013).

10. The modus operandi of trafficking networks engaged in transplant tourism has been revealed in a number of field studies and reports (Budiani-Saberi et al. 2014; Budiani-Saberi & Mostafa 2011; Columb 2017; Council of Europe/United Nations 2009; Lundin 2015; Mendoza 2010; Moazam et al. 2009; Moniruzzaman 2012; OSCE 2013; Pascalev et al. 2016a; Pearson 2004; Scheper-Hughes 2011). As compared to other forms of trafficking, such as trafficking for sex or labour exploitation, trafficking that occurs in transplant tourism requires the involvement of the medical profession and of healthcare facilities, often results in a very serious violation of the physical integrity of the victim and may be exceptionally complex, both in terms of operational structure and geographical scope. There is an enormous discrepancy between what the recipient has to pay (between \$100,000 and \$200,000) and what the organ seller eventually receives (between \$1,000 and \$10,000), which depends on the local availability of destitute sellers and on the difficulties in arranging and performing the illicit activities in the light of possible law enforcement response. Brokers and collaborating healthcare professionals make huge profits, which makes transplant tourism one of the most lucrative illegal activities (Haken 2011).

11. One of the most disturbing findings of these field studies and reports is that organ sellers invariably come from the poorest strata of society and only co-operate because of their desperate financial situation and because they are misled about the nature of the surgery and the consequences of giving up an organ. Their position of extreme vulnerability, lack of alternatives and lack of education is ruthlessly exploited. For medical reasons, organ sellers between 20 and 40 years of age are preferred; they are predominantly male, except in India (Budiani-Saberi & Karim 2009; Chattopadhyay 2018; Pascalev et al. 2016a). Organ sellers are recruited through advertisements in local newspapers, on the Internet, by scouts working for recruiters, or they may present themselves directly to persons or medical facilities known to be involved. Due to their precarious situation, organ sellers generally have no real choice but to submit to the violation of their physical integrity. Studies highlight that a huge majority later express serious regrets, stating that they would not have agreed if they had been properly

¹ Note that transplant tourism to receive an organ from a deceased donor (including vital organs, such as a heart) is very exceptional, and has been reported almost exclusively with regard to China.

informed and if their situation had not been so hopeless (Budiani-Saberi & Delmonico 2008). In addition, fraud, deception, intimidation and coercion are frequently used to force recruited organ sellers to co-operate and to dissuade them from engaging law enforcement officials. Moreover, organ sellers are further exploited in that the sum that they eventually receive is generally much less than what had been promised, if money is paid at all. There is even some anecdotal evidence of blatant organ theft from persons undergoing unrelated surgery, from patients in psychiatric institutions, and from persons abducted for their organs (Baraaz 2018; Chaudhary 1992; Scheper-Hughes 2002).

12. Transplant tourists who seek a transplant abroad may arrange the contact with the organ seller and the transplant professionals themselves. This scenario is most likely for patients who had earlier migrated from, or have a close cultural affinity with, the destination country (Ambagtsheer et al. 2014; van Balen et al. 2016). These patients may use local advertisements or personal acquaintances in the country of destination to engage with the local black market in organs. Alternatively, transplant tourists often rely on transplant 'package deals' that include travel and accommodation expenses, payments to the broker and the organ seller and coverage of the medical procedure. These deals are offered by transplant centres and brokers operating in international trafficking rings, and contacted through dedicated websites or through contact persons in the country of origin (López-Fraga et al. 2017; Muraleedharan et al. 2006; Pascalev et al. 2016a).

13. Studies point out that, in addition to organ sellers and patients seeking to obtain an organ, transplant tourism requires the involvement of a variety of other actors, whose roles may not always be clearly delineated, and who may form a part of a specialised and organised criminal group or, alternatively, of ad hoc mobile networks operating without any clear criminal structure (Budiani-Saberi 2014; Council of Europe/United Nations 2009; López-Fraga et al. 2017; OSCE 2013; Pascalev et al. 2016a; UNODC 2015). Patients wishing to obtain an organ are connected with an organ seller by brokers who co-ordinate and facilitate the commercial transplant and arrange the price. Usually, these brokers co-ordinate logistics, such as recruiting transplant surgeons and other healthcare personnel, arranging travel and accommodation, preparing fraudulent documents, and making medical arrangements.

14. Organ sellers are identified by local recruiters or may approach them on their own initiative. Recruiters often have the same socio-economic background as the persons whom they want to recruit, and are sometimes former victims, on occasion even acting under coercion from trafficking networks. Recruiters may work on their own or as a part of local networks, they engage informants and scouts, are paid a commission for every successful recruit, and sometimes also act as enforcers who use threats or force to ensure that a recruited organ seller goes through with the donation.

15. Several categories of healthcare professionals may be implicated in transplant tourism, including transplant surgeons and anaesthesiologists, nephrologists or hepatologists, nursing staff, and lab technicians and technical personnel to perform ancillary medical tests. Depending on the circumstances of the case and of the technical organisation of the medical interventions, these healthcare professionals may or may not be aware that they are involved in an illicit transplant activity.

16. In addition, the success of these illicit activities often depends upon the support of a range of facilitators, which may include directors of transplant units, administrators of medical and testing facilities, corrupted members of law enforcement and public officials who facilitate illegal entries, arrange forged documents, or turn a blind eye on the illegal operations of transplant clinics. Other types of support may be provided by so-called minders, who accompany the recruited organ seller and may act as enforcers, and by translators, drivers, travel agencies, insurance companies, etc.

3. The effects of organ transplant tourism

17. Studies on transplant tourism indicate that, even apart from their exploitation, organ sellers suffer from very negative post-operative consequences (Ghahramani et al. 2012; Goyal et al. 2002; Naqvi et al. 2008; Sajjad et al. 2008; Tong et al. 2012). Their hope of paying off crippling debts and securing a minimum level of subsistence by selling an organ quickly proves illusory. Few, if any, organ sellers manage to improve their financial situation in the medium term. Within a couple of years, most of them are back in significant debt and, in addition, they also experience a significant decline in household income because their physical condition has deteriorated as a result of the organ removal and this prevents them from sustaining the demands of hard physical labour. A large majority of organ sellers even report that their health worsened significantly, due to pre-existing compromised health conditions, a lack of post-operative care and a continuing unhealthy lifestyle or environment. Because of their inability to pay for medical assistance many, in time, suffer organ failure, which is most likely to lead to early death. Furthermore, these studies indicate that the organ sellers also suffer from severe stigmatisation and social isolation and many also report depression and anxiety.

18. Medical reports of the health status of returning transplant tourists emphasise that transplant tourism frequently also negatively affects the interests of the recipients (Anker & Feeley 2012; Inston et al. 2005; Tsai et al. 2011; Yakupoglu et al. 2010). Compared to transplantation within the regulated domestic system, transplant tourists run significantly higher risks of mortality and morbidity. More in particular, data reveal a higher frequency of complications, due to a higher incidence of unconventional, occasionally even life-threatening infections, resulting in a significantly lower survival rate of the graft and the patient. This poor outcome is caused by a variety of factors, including inadequate pre-transplantation health screening of organ sellers, worse initial health of the recipients, who are generally older or sometimes even excluded from their domestic waiting list for medical reasons, substandard medical facilities and medical aftercare, and compromised follow-up when they return home, as a result of the lack of intelligible medical documentation. Combined with the financial sacrifices that they have made to obtain an organ, transplant tourists thus run a real risk of being exploited themselves.

19. Transplant tourism not only negatively affects the interests of organ sellers and recipients, but it also results in major costs that have to be borne by third parties. For instance, both the lost productivity of organ sellers and the possible medical costs exceeding their financial ability will have to be shouldered by their family and the local communities (Jafar 2009; Turner 2009). In addition, the emergence of a black market in organs will impede the development of a legitimate local transplant system that would allow the local residents a reasonable chance of obtaining an organ (Kelly 2013). Undoubtedly, widespread distrust in the local transplant system and even in the medical profession, and the awareness that organs are available for sale, will make the population reluctant to consent to post-mortem organ donation or to consider altruistic living organ donation (Kahn & Delmonico 2004; Rothman & Rothman 2006).

20. Negative externality concerns equally apply to the country of origin of the transplant tourist in that the medical problems that recipients may experience as a result of their illicit transplant will need to be addressed by the domestic health care system. In addition, significant public health risks may arise when transplant tourists return with severe infectious diseases, including antibiotic-resistant bacteria, blood-borne viral infections and invasive fungal infections (Babik & Chin-Hong 2015; Hill 2011; Tomazic et al. 2007). Moreover, physicians will be forced to bear responsibility for the medical treatment of returning transplant tourists (Bramstedt & Xu 2007). Transplant tourism may also have detrimental effects on the efforts of the country of origin to further develop its own organ transplant programs and to attain self-sufficiency in transplantation, since governments may feel less responsible if citizens can relatively easily obtain organs abroad (Abouna 1993; Budiani-Saberi 2009).

4. Organ transplant tourism in Europe

21. The magnitude of transplant tourism in Europe (either as a region of origin or as a region of destination of transplant tourism) is difficult to estimate. However, the data that are available indicate that this truly problematic issue currently is not a major phenomenon, certainly as compared to the involvement of other regions in the world. In what follows, the findings of case reports, academic studies and intergovernmental activities will be presented.

22. The following cases of transplant tourism – involving trafficking in persons and/or organ trafficking where a European country or a European citizen was affected – have been reported:

- a. State v. Netcare Kwa-Zulu Limited (South Africa) (2001-2003): Romanian citizens trafficked to Durban, South Africa, to sell a kidney (Allain 2011; Telegraph 2010).
- b. Turkey (2001-2002): Moldovan citizens trafficked to Istanbul, to sell a kidney (OCCRP 2011; OSCE 2013).
- c. Bulgaria (2004-2006): Russian and Georgian citizens trafficked to Sofia to sell a kidney (Pancevski 2006).
- d. Turkey (2004-2005): nine Bulgarian citizens trafficked to a private clinic in Turkey to sell a kidney (Associated Press 2005; OSCE 2013).
- e. Ukraine (2006-2007): Israeli citizens trafficked to Donetsk to sell a kidney (Eyadat 2007; OSCE 2013).
- f. Medicus case (Kosovo^{2*}) (1998-2008): at least 24 victims, including nationals of Belarus, Israel, Kazakhstan, Republic of Moldova, Russia, Turkey and Ukraine trafficked to Pristina to sell a kidney to recipients, including nationals of Germany and Poland. Trafficking network headed by Turkish and Kosovo* transplant surgeons (Pajazit 2018).
- g. Shalimov Institute case (Azerbaijan & Ukraine) (2009): at least 13, possibly 100 victims, including nationals of Belarus, Moldova, Russia, Ukraine and Uzbekistan trafficked to Baku, Kyiv or Quito

² *All reference to Kosovo, whether to the territory, institutions or population, in this text shall be understood in full compliance with United Nations Security Council Resolution 1244 and without prejudice to the status of Kosovo.

- (Ecuador) to sell a kidney. Illegal transplants performed by Ukrainian surgeons (Prosecutor General's Office 2010; Smith et al. 2011).
- h. Costa Rica (2013): Costa Rican citizens trafficked to San José (Costa Rica) to sell a kidney to recipients, including 4 Greek citizens (AFP 2017; ICR 2014; Fieser 2013).
 - i. Israel (2012-2014): several victims, including nationals of Azerbaijan and Ukraine, trafficked to Istanbul to sell a kidney (Ehrlich 2018).
 - j. Spain (2014): attempted organ trafficking targeting immigrants, including a Romanian citizen, with the aim of selling a liver segment to a Lebanese man. Plot foiled by Spanish authorities (Dunham 2014; Goodman 2014; Rada 2014).
 - k. Spain (2015): attempted organ trafficking targeting a Moroccan immigrant, with the aim of selling a kidney to a member of a Serbocroatian gang. Plot foiled by Spanish authorities (The Independent 2015).

23. In order to have a better view on transplant tourism in Europe, the Committee on Organ Transplantation (CD-P-TO) of the Council of Europe has recently established a network of National Focal Points, designated by member States. The role of these National Focal Points is, *inter alia*, to perform data collection on patients having received a kidney transplant abroad and having returned home to receive follow-up care.³ To that end, a dedicated International Database on Travel for Transplantation was launched in June 2017. Data collection has been performed on patients having received a kidney transplant abroad during the year 2015. 20 member States participated in this data collection exercise. Of these, only 11 countries (Bulgaria, Spain, United Kingdom, Georgia, Greece, Hungary, Croatia, Latvia, Romania, Russian Federation, Turkey) reported a total of 60 patients who had received a kidney transplant abroad. Nine countries (Belarus, Cyprus, Finland, Lithuania, Republic of Moldova, Poland, Portugal, Serbia, Slovenia) reported that they had not identified any case. Preliminary analysis of these 60 cases shows that 15 involved transplant tourism (in accordance with the third element of the definition outlined above), in that patients had received a kidney from a deceased donor but had not been properly referred for transplantation abroad, thus potentially impairing the transplant capacity of the destination country. In addition, another 25 cases might have involved transplant tourism, in that the patients appeared to have received a living kidney transplant under circumstances that could be consistent with trafficking (CD-P-TO 2018).

24. Additional information can be found in an academic study performed in the nephrology and transplant departments of three major university hospitals in Europe (Lund University, Sweden; University of St. Cyril and Methodius, “the former Yugoslav Republic of Macedonia”; and Erasmus MC University Hospital, Rotterdam, The Netherlands), interviewing patients with renal disease who had travelled abroad for a kidney transplant. The study indicates that, according to an informal list compiled by physicians in Sweden approximately 40 patients most likely had travelled abroad for commercial organ transplantation. Moreover, from the University of St. Cyril and Methodius, the only center that performs transplants in “the former Yugoslav Republic of Macedonia”, 35 patients are known to have travelled abroad to buy kidneys, predominantly to Pakistan, India and Egypt. In the study, 22 patients who traveled from “the former Yugoslav Republic of Macedonia”/Kosovo*, the Netherlands, and Sweden for paid kidney transplantations between years 2000 and 2009 were interviewed. 7 of these patients went to their country of origin and were able to organise their transplantations by arranging help from family and friends abroad. The costs varied from €5,000 to €45,000 (Ambagtsheer et al. 2014; van Balen 2016).

25. These scarce data indicate that only few European patients travel abroad to buy an organ and that this mainly concerns transplant tourism to countries outside of Europe. Moreover, transplant tourism by non-European citizens, involving trafficking in persons or organ trafficking, to European transplant centers seems to be largely absent. This will be due to the fact that many European countries have well-functioning transplant systems that can to a large extent cater for the transplant needs of the population, and that comprehensive transplant regulations and screening procedures are in place that minimise the chances that transplant centers become implicated in trafficking activities. Nevertheless, as indicated by the case law, in a few countries illicit activities by private transplant hospitals have proven to be difficult to eradicate. Moreover, as pointed out above, it should be

³ Note that the network of National Focal Points builds on Resolution CM/Res(2013)55 on Establishing Procedures for the Collection and Dissemination of Data on Transplantation Activities outside a Domestic Transplantation System, and on Resolution CM/Res(2017)2 on Establishing Procedures for the Management of Patients Having Received an Organ Transplant Abroad Upon Return to Their Home Country to Receive Follow-up Care. Its role is not restricted to data collection, but also to: (1) increase awareness among Health Authorities and healthcare professionals on transplant-related crimes; (2) elaborate national protocols and codes of conduct to provide an adequate framework to prevent, detect and report transplant-related crimes; (3) act as a reference person to exchange and disseminate information at both national and international level on transplant-related crimes; and (4) help establish multidisciplinary synergies and a multi-agency approach to ensure an effective fight against transplant-related crimes. See CD-P-TO 2018.

taken into account that anecdotal reports point out that refugee populations, at least in Turkey, seem to be a target for illicit organ removal, and that cases involving undocumented migrants have sporadically also come into view.

26. In addition to organ transplant tourists who have engaged in activities that involve trafficking in persons or organ trafficking, a new phenomenon raises concern in some European countries with very successful deceased organ transplant programs. This phenomenon involves patients from abroad who make use of loopholes in the legislation to access the domestic waiting list, thereby possibly impairing the ability of countries to provide transplant services to their own populations. For instance, cases have been reported of foreign patients who travelled to Spain (e.g. the Renibus case involving patients from Bulgaria) with false employment contracts, making them eligible for health services, and who managed to receive kidney transplants (TN 2016). Moreover, a number of non-residents in other communities in Spain reportedly also managed to circumvent the regular allocation procedure and get on the waiting list. To safeguard the viability of successful deceased organ transplant programs in some European countries, some experts have proposed to require a minimum residency period to be able to access the waiting lists, except for emergencies (Matesanz 2017).

5. Organ transplant tourism in China

27. Compared to western countries, China has a transplant system that is fairly recent and has undergone significant changes in the last couple of years. A system of regulatory oversight of organ transplantation was established in 2006 and transplant legislation adopted in 2007. In 2007 it was acknowledged that more than 90% of transplanted organs were obtained from executed prisoners (Huang 2007). In response to international pressure to stop this practice and to align itself with the international guidelines issued by the WHO (Danovitch et al. 2011; Delmonico 2013), initiatives were undertaken to reform the transplant system, with the sustained support from the international community and with the help of dedicated transplant professionals from the West (Huang 2008a; Huang 2008b). As a result, in October of 2014, the Hangzhou Resolution was promulgated, in which China committed itself to terminate its dependence upon organs from executed prisoners and to prohibit organ trafficking and transplant tourism, building on the 1995 law banning organ sales and on a 2007 Notice issued by the Ministry of Health giving Chinese citizens priority in transplantation (Huang et al. 2008a).

28. The Hangzhou Resolution also announced measures to promote altruistic deceased organ donation and transparency in organ allocation through a national computerised waitlist and matching system, to standardise the quality of organ transplantation by reducing the number of transplant hospitals from more than 600 to 169, to establish scientific registry systems for organ transplantation, and to increase regulatory oversight (Huang et al. 2014). In 2014 it was also proclaimed that China was implementing a new national program for deceased organ donation and that all transplant hospitals would be required to stop using organs from executed prisoners as of January 2015 (Dai & Xu 2015; Huang et al. 2015a; Huang et al. 2015b; Xiang et al. 2016). As a result, the beginning of a new era for organ transplantation in China, in full compliance with the WHO Guiding Principles on Organ Transplantation and with the Declaration of Istanbul, was heralded (Fleck 2012; Sun et al. 2014). At the same time, it was acknowledged that there still was a lot of work to optimise the transplant system, mainly because of cultural attitudes related to bodily integrity and to the concept of brain death (Guo 2018; Hu & Huang 2015; Weiye et al. 2017; Wu et al. 2018).

29. A recent report indicates that, as a result of these structural changes, the deceased organ donation rate in China has dramatically increased from 0.03 per million population in 2010 to 3.71 per million population in 2017. Whereas in 2016 4,080 persons had donated an organ after death, leading to 13,263 transplants, 5,135 persons donated an organ after death in 2017, resulting in more than 16,000 transplants (Guo 2018; Global Observatory on Donation and Transplantation, China data summary 2016).

30. China's announcements of its huge progress have not been uniformly well-received by international observers. Transplant professionals working outside of China emphasise that transplant tourism to China has not been eradicated. Anecdotal reports indicate that there are still patients from South Korea and the Gulf Region, but also from Chinese communities in the West, who are travelling to China for a commercial transplant (Chang 2018; Chu 2018; Ruohan 2018; TV Chosun 2017). In response, leading transplant experts, affiliated with The Transplantation Society and the Declaration of Istanbul Custodian Group, have issued statements that the reports of China's entry into a new era of transplantation are misleading or at least premature (Declaration of Istanbul Custodian Group 2014; Delmonico et al. 2014a; García-Gallont 2015; Jha 2015; Martin & Tibell 2015; Wei et al. 2014). An Open Letter was published, addressed to the Chinese President, expressing grave concern about the continuation of the use of organs from executed prisoners and imploring the President to put an end to corruption in Chinese transplant practice and to enforce the official government policy (Delmonico et al. 2014b).

31. More specifically, the Chinese authorities and transplant community were urgently requested to be fully transparent about Chinese transplant practice, to accept and promote the legal determination of death by neurologic criteria (i.e. brain death), to improve voluntary deceased donation rates by training transplant co-ordinators and physicians within intensive care units, and to develop transplant registries with proper oversight and accountability. Concern was raised about allegations that organ removal from executed prisoners had actually not ended but had been considered as voluntary deceased donations, either with the “consent” of the prisoner or with family approval at the time of execution. Moreover, it was feared that deceased organ donation rates were boosted by providing families of a deceased person large sums of money in return for their approval (Allison et al. 2015a & 2015b; Chapman 2015; Danovitch & Delmonico 2015a; Danovitch & Delmonico 2015b; Lavee & Jha 2015; Li et al. 2015; Martin & Tibell 2015; O’Connell et al. 2016). Despite their skepticism, most of these experts maintain a stance of guarded optimism, emphasising that only through the unwavering support from the international community will China be able to complete the ethical reform of its transplant system. Members of the Declaration of Istanbul Custodian Group travel to China on a regular basis to visit transplant centers suspected of being involved in transplant tourism, urging local and national authorities to eradicate remaining transplant tourism.

32. By contrast, some critics are much more skeptical. They suggest that it might well be that China is transplanting many more organs than it officially wants to acknowledge and that an additional source of organs exists, consisting of prisoners of conscience, such as Falun Gong practitioners, and other minority groups such as Uighur Muslims, Tibetans and Christians, killed in secret prisons for their organs, which are subsequently transplanted in military hospitals. These critics call for an immediate stop to all forms of executions for organ removal and they ask for complete transparency by allowing on-site inspections of all Chinese transplant centers by internationally respected organ transplant professionals (Paul et al. 2017; Paul et al. 2018; Rogers et al. 2016; Rogers et al. 2017; Sharif et al. 2014; Sharif et al. 2016; Trey et al. 2016; Trey & Matas 2017). These statements are based on personal testimonies and undercover documentaries and on reports presented by the authors David Matas, David Kilgour and Ethan Gutmann, who allege that, on the basis of their own calculations, China is transplanting between 60,000 to 100,000 organs a year, predominantly harvested from prisoners of conscience (Gutmann 2014; Kilgour et al. 2016; Matas 2017; Matas 2017).

33. Recently, Chinese authorities were one of the driving forces behind the establishment of the WHO Task Force on Donation and Transplantation of Human Organs and Tissues. This Task Force was created in June 2018 in order to advise and assist the WHO and Member States in disseminating and implementing the WHO Guiding Principles in a way that would ensure ethical practices in organ and tissue donation and transplantation worldwide (WHO Task Force 2018). The Task Force is expected to provide China and other countries struggling with transplant tourism with international support for the sustainable development of ethical organ donation and transplantation. It is hoped that, in this way, China will finally be successful in eradicating transplant tourism.

6. Policy responses to organ transplant tourism

34. Building on earlier statements condemning transplant tourism and on ethical guidelines on organ donation and transplantation issued by organisations such as the World Health Organization, the Council of Europe, the World Medical Association, and The Transplantation Society, proposals to directly address transplant tourism have been following in quick succession since the 2004 WHO Resolution on Human Organ and Tissue Transplantation and the WHO-commissioned report on The State of the International Organ Trade that was subsequently published by Shimazono in 2007 (Shimazono 2007).

35. Crucially, in response to these initiatives The Transplantation Society and the International Society of Nephrology – the two main international professional organisations in the field of transplantation and nephrology – joined forces to combat unethical practices in organ transplantation. In 2008, they convened an International Summit on Transplant Tourism and Organ Trafficking in Istanbul, attended by more than 150 representatives of medical and scientific organisations from 78 countries. This Summit resulted in the Declaration of Istanbul on Organ Trafficking and Transplant Tourism, a professional code of practice which has since been endorsed by numerous transplant associations and which suggests strategies to ethically increase the donor pool and to prevent commercial organ transplantation and transplant tourism (Steering Committee of the Istanbul Summit 2008).

36. To enhance compliance with the principles set out in the Declaration, the Declaration of Istanbul Custodian Group was established in 2010. Its goals include awareness raising among national governments, regulatory authorities and healthcare institutions about the need to develop policies to prevent and combat commercial transplantation and transplant tourism. The Declaration of Istanbul Custodian Group quickly became an important professional network whose members assist in improving practices and exposing trafficking networks. In addition,

it developed a patient brochure that is available in many languages and explains the medical risks and legal consequences of commercial transplantation and transplant tourism (DICG, Patient Brochure). The Declaration of Istanbul was updated in 2018 to address the new realities, mainly by strengthening its appeal to national authorities to harmonise and improve their criminal law provisions in the light of the criminal law framework on organ trafficking, introduced by the Council of Europe Convention against Trafficking in Human Organs.

37. As a result of the combined efforts of the WHO and the Declaration of Istanbul Custodian Group to mobilise professional opinion, encourage health ministries and assist transplant centres and national medical societies, national transplant systems and regulations have been greatly improved in many countries vulnerable to trafficking and transplant tourism, such as Colombia (2010), Egypt (2011), India (2008), Pakistan (2010), and the Philippines (2008/2009), and in several of the main countries of origin of transplant tourists, such as Israel (2010), Japan (2010), and Saudi Arabia (2007). Changes that have been implemented focus on a wide range of issues, including strengthening the prohibition of organ commercialism and unconsented-to organ removal, guaranteeing equitable allocation of organs, promoting donation from deceased persons, restricting unrelated living donation and transplant services to foreign nationals, focusing on national self-sufficiency in transplantable organs, observing transparency, traceability and accountability in transplantation, improving vigilance, quality and safety in procedures, providing reimbursement of actually incurred costs, prohibiting insurance reimbursement of illegal transplant services, and providing follow-up care to living donors.

38. These efforts at establishing ethical donation and transplant systems, reducing the organ shortage and curtailing the demand for transplant tourism have been greatly helped by several backing initiatives. One of the most important is the Madrid Resolution on Organ Donation and Transplantation, adopted at a summit convened in 2010 by the WHO and the Spanish National Transplant Organisation with the support of the European Commission and The Transplantation Society (Participants to the Third WHO Global Consultation 2010). In line with the WHO Guiding Principles on Human Organ Transplantation, that had been updated that same year, and the Declaration of Istanbul, this Resolution calls upon governments to pursue national or regional self-sufficiency in transplantation. Stressing that countries should progress toward the goal of meeting patients' needs based on the resources obtained within the country, the Resolution discourages low-income countries from allowing (paid) organ donation to foreigners and encourages high- and middle-income countries to establish adequate transplant programmes rather than allowing their citizens to seek organs abroad. Models to ethically increase domestic organ donation were developed in several countries, such as Qatar (Alkuwari et al. 2014).

39. Importantly, in September 2017 the General Assembly of the UN adopted Resolution 71/322, containing a list of recommendations aimed at strengthening and promoting effective measures and international co-operation on organ donation and transplantation, so as to prevent and combat trafficking in persons for the purpose of organ removal and trafficking in human organs (United Nations Resolution 71/322). An updated Resolution, including additional action points, is expected to be adopted by the General Assembly by the end of 2018. In addition and as indicated, at the level of the WHO a Task Force on Donation and Transplantation of Human Organs and Tissues was established in June 2018. Moreover, in February 2017 a Summit on Organ Trafficking and Transplant Tourism was organised by the Pontifical Academy of Sciences, bringing together major experts in the field. The resulting Statement, endorsed by Pope Francis, called upon governments, healthcare professionals and also religious leaders to encourage ethical organ donation and to condemn trafficking in persons for the purpose of organ removal, organ trafficking, and transplant tourism (Statement of the Pontifical Academy 2017).

40. In addition, several important regional initiatives were taken. For instance, in 2008, the Asian Task Force on Organ Trafficking, a group of local and international experts, alarmed by the prevalence of illicit transplant activities in Asia, issued its Recommendations on the Prohibition, Prevention and Elimination of Organ Trafficking in Asia (Asian Task Force on Organ Trafficking 2008). These recommendations stressed the importance of implementing the measures outlined above, in an attempt to help local authorities in the prevention and elimination of illicit practices. Similarly, in 2007, at a WHO Regional Consultation on Developing Organ Donation from Deceased Donors, transplant professionals of North Africa and the Middle East issued a statement endorsing the development of deceased donor programmes and opposing organ sales and organ tourism (Delmonico 2007). Since many of these countries are considered to be important countries of origin of transplant tourists, the significance of this statement cannot easily be overestimated. As a result of these initiatives, several countries of origin and countries of destination of transplant tourists examined their transplant practices and regulations, which, as indicated above, resulted in updated transplant laws and criminal codes.

41. In this regard, mention should also be made of the Action Plan on Organ Donation and Transplantation (2009-2015) presented by the European Commission in 2008. Its aim was to strengthen co-operation between EU member States to increase the availability of organs, enhance the efficiency and accessibility of transplantation systems, and improve the quality and safety of organs. Priority Actions for increasing organ availability included

the maximisation of deceased donation to its full potential and exchange of good practice and the establishment of registries in the field of living organ donation. To support the implementation of the Action Plan, Directive 2010/53/EU was adopted. Its importance lies in the requirement of EU Member States to establish an extensive regulatory framework aimed at protecting living donors and monitoring and improving organ donation and transplantation to minimise risks and reduce organ failure (Van Assche et al. 2015).

42. In a similar way, at the level of the Council of Europe, attempts to implement and harmonise ethically appropriate organ donation and transplantation programmes have been greatly inspired by the Convention on Human Rights and Biomedicine (1997) and its Additional Protocol concerning Transplantation of Organs and Tissues of Human Origin (2002). Recommendations have recently been made to optimise ethically appropriate organ donation and transplantation programmes as a way to reduce the organ shortage, including in Resolution CM/Res(2013)56 on the Development and Optimisation of Live Kidney Donation Programmes. Moreover, collaborative efforts to address the organ shortage and improve access to transplant health services in Council of Europe member States have been initiated, for instance through the Council of Europe Black Sea Area Project, assisting member States in the Black Sea area (Armenia, Azerbaijan, Bulgaria, Georgia, Republic of Moldova, Romania, Turkey, Ukraine, and the Russian Federation) through the development of safe and ethical donation and transplantation programs, resulting in a significant increase of the total donation rates (Arredondo et al. 2018).

43. In addition to improving transplant regulations and practices through professional collaboration, several international organisations have started to look specifically into the challenges raised by organ trafficking and trafficking in persons for the purpose of organ removal. For instance, the Organization for Security and Co-operation in Europe conducted an analysis of trafficking in persons for the purpose of organ removal within the OSCE region, with due attention to the relevant, but very limited case law (OSCE 2013). Similarly, in 2015, the United Nations Office on Drugs and Crime published an assessment toolkit to assist authorities and NGOs in detecting and identifying victims of trafficking in persons for the purpose of organ removal, aimed at improving victim protection measures (UNODC 2015). In addition, an international research project on “combating trafficking in persons for the purpose of organ removal” – known as the HOTT project and funded by the European Commission – was undertaken in 2012 and presented its findings in 2015. It included a comprehensive literature review that shed new light on the *modus operandi* of networks involved in trafficking in persons for the purpose of organ removal (Pascalev et al. 2016a).

44. Importantly, at the level of the Council of Europe, the Convention against Trafficking in Human Organs was adopted in 2015. It entered into force on 1 March 2018 and is currently ratified by 5 member States and signed by an additional 18 member States. As indicated, the Convention closes the main loopholes left by the international criminal law framework on trafficking in persons for the purpose of organ removal and will be of crucial importance in the fight against the most egregious forms of transplant tourism. Crucially, the adoption of the Convention has in many Council of Europe member States resulted in a harmonisation and comprehensive revision – in several countries with a view to the ratification of the Convention – of the domestic criminal law provisions on illicit organ removal.

7. Remaining challenges

45. Taking into account that the desperation of patients suffering from organ failure is fuelling the demand that drives transplant tourism, it is vital that the main causes of the need for organs are addressed. However, prevalence of end-stage kidney disease is expected to rise sharply in the next decade, with worldwide use of renal replacement therapy projected to more than double (to 5.4 million persons) by 2030 (Liyanaage et al. 2015). If this projected evolution materialises, the demand for organs will soar, making it more likely that transplant tourism will significantly increase rather than abate. It is therefore essential to develop and implement population-based prevention strategies, focussing on encouraging a healthy lifestyle and on providing quality universal healthcare, so as to prevent as much as possible the emergence of diseases and conditions that may result in organ failure.

46. Relatedly, it should be emphasised that progress toward national self-sufficiency remains the best strategy to prevent transplant tourism in the long term. In addition to sustained efforts to prevent and treat organ failure, national self-sufficiency should be pursued by maximising donation from the deceased and by ensuring that living donors may donate only under circumstances that are adequately protective. The observation that in several EU countries (e.g. Belgium, Croatia; Spain) organ shortages are low and recently seem to have stabilised, indicates that the organ shortage can be effectively addressed by resorting only to ethical means. However, for a variety of economic, political and cultural reasons, deceased organ donation programmes are virtually non-existent in many countries (e.g. India, Japan, Pakistan, the Philippines, South Korea) and even in whole regions (e.g. Africa, Middle

East) (Global Observatory 2018). These countries should be encouraged and, where necessary, assisted in developing deceased organ donation programmes to better cover the transplant needs of their population.

47. Developing a successful deceased organ donation programme depends on the implementation of several elements: a) the legal acceptance of the criterion of brain death⁴; b) essential hospital infrastructure, including intensive care units and HLA labs; and c) a comprehensive mechanism of donor identification, through detection by intensive care physicians and through engagement with families by specialised donor co-ordinators (whereby organ donation is considered an integral part of end-of-life care) (Domínguez-Gil et al. 2011; Domínguez-Gil et al. 2017a; Escudero et al. 2015; Matesanz et al. 2011; Matesanz et al. 2017). However, in many countries major concerns still exist about bodily integrity and the legal acceptance of brain death, which automatically has as a consequence that potential deceased donors are not identified. Additional barriers to initiating successful deceased organ donation programmes are: a) lack of trust in the medical profession and in the healthcare system in general; b) absence of affordable immunosuppressants; and c) diversion of financial burdens onto the deceased donor's family, who may be asked to bear some of the costs associated with the medical preparation of the donor and with the organ recovery. It will be necessary to overcome these barriers before a successful deceased organ donation programme can be developed. This may be a real challenge, in that it will require a major change in attitudes and considerable efforts on the part of governments to provide the appropriate structure and to develop an adequate funding model for donation and transplant activities and for immunosuppression, against the background of inadequate resources and many competing public health priorities.

48. In order to guarantee that the development of deceased donation programmes does not lead to increased inequity – as currently seems to be the case in several countries, including India (Jha 2018) – preferential access to organs by wealthy locals and foreigners and tampering of waiting lists by private hospitals must be avoided through the establishment of centrally-governed computerised waiting lists, that allocate organs in conformity with objective, non-discriminatory, externally-justified and transparent rules, guided by clinical criteria and ethical norms. Moreover, to guarantee equity in access, deceased organ donation and transplantation programmes need to be implemented foremost in public hospitals and made subject to universal health coverage.

49. In the absence of progress towards self-sufficiency, the biggest challenges are raised by transplant tourists who abuse possibilities of living organ donation in the countries of destination. It should be pointed out that preliminary findings on the impact of regulatory improvements and ethical transplant capacity building in some countries considered to be trafficking hubs for transplant tourists (e.g. the Philippines, possibly also China) or countries of origin of transplant tourists (e.g. Israel, Qatar) indicate that transplant tourism to or from these regions has decreased considerably (Danovitch et al. 2013; Martin et al. 2016). By contrast, some countries remain hubs for transplant tourism even after their legislation was strengthened (e.g. India, Pakistan) and other countries (e.g. the Philippines) have managed to curtail transplant tourism but still have significant problems with intra-state trafficking (de Castro 2013). Most susceptible to transplant tourism are those countries where both very high levels of living organ donation exist – especially where this involves living unrelated organ donation and where transplantation mainly takes place in private hospitals (where profit motives prompt the smooth approval of transplantation) –, and transplant practice is poorly monitored and transplant legislation poorly enforced.

50. Moreover, as a result of political turmoil, war, natural catastrophe, the refugee crisis, and mass migration, new countries (e.g. Nepal) may quickly become favourite countries of destination and new groups of vulnerable persons (e.g. migrants; refugees) may become targets. Partly in response to these developments, human rights NGOs and transplant experts call for comprehensive outreach programs and better victim support with specific attention to the most vulnerable categories of the population (Budiani-Saberi & Columb 2013; Pascalev 2016b). Many international legal instruments, such as the Council of Europe Convention on Action against Trafficking in Human Beings and the Council of Europe Convention against Trafficking in Human Organs require the implementation of extensive measures to identify, protect and assist the victims of these crimes.

⁴ Organ transplantation can only be successfully performed when organs have been, and remain, properly perfused. Interruption of blood supply (ischemia) causes a shortage of oxygen needed for the cellular metabolism. Since ischemia time, which is associated with significant mortality and morbidity post-transplantation, should be kept as short as possible, persons who have been diagnosed with irreversible loss of brain functioning but whose blood flow is maintained (or supported through mechanical ventilation) are the ideal organ donors. The criterion of brain death was therefore developed largely in response to transplant needs (President's Commission 1981). From 2006 onwards, donation after circulatory death (DCD) was introduced, allowing an additional category of persons to donate. In DCD, patients suffering from devastating injuries for whom the decision has been made to remove life support and for whom consent or authorisation for organ donation is obtained, are brought to the operating room, where life support is withdrawn. When the heart stops and there continues to be no circulation for, depending on the local protocol, 2 to 5 minutes, the patient is pronounced dead and the transplant team enters the operating room (Manara et al. 2012).

51. Importantly, transplant tourism is a dynamic phenomenon, with patients finding their way to other parts of the world when in certain countries laws become properly enforced. Similarly, innovative forms of transplant tourism emerge to exploit existing loopholes. For instance, patients may travel to a country that offers transplant services to foreigners and falsely present a prospective ‘donor’ as a relative. Alternatively, ‘donors’ may even move in with the family of the recipient for weeks, or the recipient and ‘donor’ may bring along their own translators, as sophisticated strategies to circumvent screening mechanisms for detecting trafficking (Chan 2012). Several suggestions have been made to better prevent and combat transplant tourism in the light of persistent and new manifestations. Some of these recommendations aim at strengthening monitoring and enforcement. The main measures that have been identified in this respect are: a) the creation of a national transplant agency to organise, co-ordinate and supervise all donation and transplantation activities and to ensure equitable organ sharing; b) mandatory and transparent collection and reporting of data on donors and recipients; c) accreditation of transplant hospitals, made dependent upon data collection and oversight; d) closing of legal loopholes; and e) close collaboration between monitoring bodies, professional organisations, and law enforcement agencies.

52. Other recommendations focus on tightening the transplant authorisation procedure, by enhancing the quality of ethics committees, by establishing clear protocols to more thoroughly verify identification documents and individual declarations, and by updating psychosocial screening guidelines for living donation in ways that are better suited to the needs of developing countries or developing transplant programs. More specifically, healthcare professionals and authorities should be provided with guidance to assist them in identifying cases of transplant tourism by focusing on specific “red flags” during the evaluation of prospective donors and recipients, especially where it concerns non-resident living donors. These indicators may include stories that are memorised or mechanically recited, fearful behaviour by the potential donor, absence of a common language or culture, inability to produce official documentation proving the required relationship between the donor and the recipient, and residence in a country where the recipient could have accessed local living donor transplant services (Domínguez-Gil et al. 2017b; Lentine 2017). Particularly important will be informing and training healthcare professionals about their roles in recognising, preventing, and combatting transplant tourism.

53. As an additional measure, it has recently been suggested that the countries of origin, which generally have more resources at their disposal, should take the lead in preventing and prosecuting transplant tourism. This may be achieved by applying extraterritorial jurisdiction in an attempt to strengthen the enforcement of existing laws governing transplant-related crimes across national boundaries (Martin 2016). Another proposal concerns establishing a duty on the part of healthcare professionals to report detected or suspicious cases of trafficking and transplant tourism to law enforcement agencies, which, however, may not always be easy to reconcile with obligations of medical confidentiality (Ambagtsheer et al. 2015; Martin 2016). Relatedly, it is proposed to develop a global registry of transnational transplant activities in conjunction with a standardised international referral system for legitimate travel for transplantation. This would allow flagging prospective or completed transplant cases involving foreigners when no details of prior registration are available (Domínguez-Gil 2018; Martin 2016). As a possible first may be considered the recent launch, mentioned above, of a dedicated International Database on Travel for Transplantation under the auspices of the Council of Europe and the establishment of a network of National Focal Points in Council of Europe member States.

54. Finally, to get a clearer view of transplant tourism and to better detect, prevent and combat this phenomenon in a way that does not solely rely on international networks of transplant experts, it is essential to strengthen partnerships between all relevant stakeholders, so as to arrive at a harmonised and integrated approach. This would require making the fight against transplant tourism a priority action and increasing collaboration at the international level between global actors (e.g. UNODC; UNCHR; WHO; Interpol), regional actors (Council of Europe; Europol), professional actors (e.g. World Medical Association; The Transplantation Society; the International Society of Nephrology; the Declaration of Istanbul Custodian Group), and NGOs working in the field. Only in this way may transplant tourism be successfully addressed in the light of current and future challenges.

Affiliations

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[Disclaimer: This expert memorandum was prepared by Kristof Van Assche in his personal capacity. Possible opinions expressed in this memorandum are the author's own and do not necessarily reflect the view of the committees and groups of which he is a member.]

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[Disclaimer: Please note that, because of the clandestine nature of the acts described, not all statements and allegations made in some newspaper articles, reports, and documentaries can be independently verified.]

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