



Presentation on the Current Status of Organ Donation and Transplantation Around World – With the Dilemma of Organ Trafficking and Transplant Tourism



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Organ transplantation, one of the medical miracles of the twentieth century, has prolonged and improved the lives of hundreds of thousands of patients worldwide. The many great scientific and clinical advances of dedicated health professionals, as well as countless acts of generosity by organ donors and their families, have made transplantation not only a life-saving therapy but a shining symbol of human solidarity. Yet these accomplishments have been tarnished by the trafficking in human beings who are used as sources of organs and of patient-tourists from rich countries who travel abroad to purchase organs from poor people.

These two pictures contrast the reality of organ transplantation in 2016.

On the left, Doctor Joseph E. Murray is receiving the Nobel Prize in Medicine for his contribution in kidney transplantation. The nobility of his contribution is conveyed by acknowledging the benefit of organ transplantation in restoring individuals to well-being.

On the right, bonded laborers are shown with their scars following kidney removal. They are hoping to release themselves from such bondage having parted with a kidney – sold to affluent individuals who can come to Pakistan for illegal transplantation.

The picture on the right of organ trafficking is not isolated to Pakistan. Thousands have sold their kidneys in the Philippines. The buyers are rich Americans, Saudis, Canadians, and Israelis who have connections and resources to travel to Manila.

Trafficking occurs in several ways. Sometimes organ donors themselves are moved from their place of residence to another country where their kidney (or, less frequently, a portion of their liver) is removed and transplanted into a waiting patient. Thus, for decades, patients from Europe and the Middle East have travelled to Turkey, and in the past decade to the former Yugoslavia, where unemployed young men from countries in southeastern Europe, such as Moldova and Romania, who had been lured with the promise of a job, become their kidney suppliers. Similar activities led to young Brazilians being the source of kidneys transplanted to foreign patients in a South African hospital in the early years of this century.

In 2004, the New York Times reported the dimension of these illegal sales. This picture describes a complexity of kidney transplantation that is been overcome by a broker system that will transport a vendor donor from Recife, Brazil to a hospital in Durban, South Africa so that a woman from Brooklyn New York can undergo the transplant. The arrangements are done from an individual residing in Israel.

The World Health Organization has long known of these organ sales as a human rights abuse.

At the Eighth Plenary Meeting of the World Health Assembly, 22 May 2004, A57/VR/8. WHA57.18 the WHO urged Member States: (1) to implement effective national oversight of procurement, processing and transplantation of human cells, tissues and organs, including ensuring accountability for human material for transplantation; (2) to cooperate in the formulation of recommendations and guidelines to harmonize global practices in the procurement, (3) to consider setting up ethics commissions to ensure the ethics of cell, tissue and organ transplantation; (4) to extend the use of living kidney donations when possible, in addition to donations from deceased donors; and (5) to take measures to protect the poorest and 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.

As a result, the international Transplantation Society (TTS) and the WHO formed a very strong alliance to combat organ trafficking and transplant tourism. As a result of worldwide consultations that were conducted by the WHO and TTS, it became evident that 10% of the organ transplants performed annually around the world were being done illicitly. The countries performing these illegal organ transplants became known to be widespread including the United States, China and India. The collaboration of WHO and TTS set out to prohibit commercial organ transplantation, to define transplant tourism and organ trafficking and place the responsibility of protecting the poor from harm and exploitation to the transplant professionals themselves.

On April 30, 2008, The Transplantation Society (TTS) and the International Society of Nephrology (ISN) convened in Istanbul, Turkey a Summit Meeting of more than 150 representatives of scientific and medical bodies, government officials, social scientists, and ethicists from around the world to take a stand on the urgent and growing problems of organ sales, transplant tourism, and trafficking in organs. The meeting adopted the "Declaration of Istanbul on Organ Trafficking and Transplant Tourism", which has since been endorsed by 130 medical societies, government bodies, and other groups involved with organ transplantation.

Organ trafficking is the recruitment, transport, transfer, harboring or receipt of living or deceased persons or their organs by means 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 to, or the receiving by, a third party of payments or benefits to achieve the transfer of control over the potential donor, for the purpose of exploitation by the removal of organs for transplantation.

Transplant commercialism is a policy or practice in which an organ is treated as a commodity, including by being bought or sold or used for material gain.

Travel for transplantation is the movement of organs, donors, recipients or transplant professionals across jurisdictional borders for transplantation purposes. Travel for transplantation becomes **transplant tourism** if it involves organ trafficking and/or transplant commercialism or if the resources (organs, professionals and transplant centers) devoted to providing transplants to patients from outside a country undermine the country's ability to provide transplant services for its own population.

Principles of the Declaration of Istanbul

1. National governments, working in collaboration with international and non-governmental organizations, should develop and implement comprehensive programs for the screening, prevention and treatment of organ failure, which include:

- a. The advancement of clinical and basic science research;
- b. Effective programs, based on international guidelines, to treat and maintain patients with end-stage diseases, such as dialysis programs for renal patients, to minimize morbidity and mortality, alongside transplant programs for such diseases;
- c. Organ transplantation as the preferred treatment for organ failure for medically suitable recipients.

2. Legislation should be developed and implemented by each country or jurisdiction to govern the recovery of organs from deceased and living donors and the practice of transplantation, consistent with international standards.

- a. Policies and procedures should be developed and implemented to maximize the number of organs available for transplantation, consistent with these principles;
- b. The practice of donation and transplantation requires oversight and accountability by health authorities in each country to ensure transparency and safety;
- c. Oversight requires a national or regional registry to record deceased and living donor transplants;

d. Key components of effective programs include public education and awareness, health professional education and training, and defined responsibilities and accountabilities for all stakeholders in the national organ donation and transplant system.

3. Organs for transplantation should be equitably allocated within countries or jurisdictions to suitable recipients without regard to gender, ethnicity, religion, or social or financial status.

a. Financial considerations or material gain of any party must not influence the application of relevant allocation rules.

4. The primary objective of transplant policies and programs should be optimal short- and long-term medical care to promote the health of both donors and recipients.

a. Financial considerations or material gain of any party must not override primary consideration for the health and well-being of donors and recipients.

5. Jurisdictions, countries and regions should strive to achieve self-sufficiency in organ donation by providing a sufficient number of organs for residents in need from within the country or through regional cooperation.

a. Collaboration between countries is not inconsistent with national self-sufficiency as long as the collaboration protects the vulnerable, promotes equality between donor and recipient populations, and does not violate these principles;

b. Treatment of patients from outside the country or jurisdiction is only acceptable if it does not undermine a country's ability to provide transplant services for its own population.

6. Organ trafficking and transplant tourism violate the principles of equity, justice and respect for human dignity and should be prohibited. Because transplant commercialism targets impoverished and otherwise vulnerable donors, it leads inexorably to inequity and injustice and should be prohibited. In Resolution 44.25, the World Health Assembly called on countries to prevent the purchase and sale of human organs for transplantation.

a. Prohibitions on these practices should include a ban on all types of advertising (including electronic and print media), soliciting, or brokering for the purpose of transplant commercialism, organ trafficking, or transplant tourism.

b. Such prohibitions should also include penalties for acts – such as medically screening donors or organs, or transplanting organs – that aid, encourage, or use the products of, organ trafficking or transplant tourism.

c. Practices that induce vulnerable individuals or groups (such as illiterate and impoverished persons, undocumented immigrants, prisoners, and political or economic refugees) to become living donors are incompatible with the aim of combating organ trafficking, transplant tourism and transplant commercialism.

Although the Declaration was widely disseminated in medical journals and online beginning with a seminal article published in *The Lancet* on July 5, 2008. TTS and ISN were determined that the Declaration would be more than merely a statement reported in the medical literature. Therefore, in 2010, they created the Declaration of Istanbul Custodian Group (DICG) as a means of actively promoting, sustaining, and monitoring the implementation of the Declaration's principles.

To increase ethical organ donation by living related donors, the DICG encourages countries to adopt means to cover donors' financial costs, which now discourage donation. It also works with the World Health Organization to encourage ministries of health to develop deceased donation to its maximum potential, toward the goal of achieving national self-sufficiency in organ transplantation so that patients do not travel to foreign destinations to undergo organ transplantation using kidneys and partial livers purchased from poor and vulnerable people. Success in combatting human trafficking for organ removal and organ trafficking will be greatly enhanced through organizations like the DICG forging strong relationships with human rights

The precepts set forth in the "WHO Guiding Principles" (2010) align very well with the efforts of the DICG to work with countries to ensure that their laws and regulations reflect the goals of the Declaration of Istanbul. For example, WHO Guiding Principle 5 states that:

Cells, tissues and organs should only be donated freely, without any monetary payment or other reward of monetary value. Purchasing, or offering to purchase, cells, tissues or organs for transplantation, or their sale by living persons or by the next of kin for deceased persons, should be banned.

The prohibition on sale or purchase of cells, tissues and organs does not preclude reimbursing reasonable and verifiable expenses incurred by the donor, including loss of income, or paying the costs of recovering, processing, preserving and supplying human cells, tissues or organs for transplantation.

The firm commitment of bodies such as the WHO and the DICG to uncompensated donation has been challenged in recent years by some groups in wealthy countries, where most patients have access to treatment for end-stage organ failure and the resulting large demand for organs for transplantation is not met by the existing system of voluntary, unpaid donation. They have argued that a regulated system of financial incentives would close the gap in organ donations or, somewhat more modestly, that the long-standing prohibitions on organ purchases in laws such as the National Organ Transplant Act (NOTA), which was adopted by the US Congress with bipartisan support in 1984, should be modified to allow “pilot trials” of such incentives. The editorial board of the *New York Times* cited the work of the DICG when it rejected such a change in the law.

Instead of providing financial “benefits” to organ donors, the *Times*, like the DICG, favors removing the ancillary costs of donating – such as lost wages, travel and housing expenses to undergo donor-screening and the surgery itself – from the shoulders of organ donors. The need to pay such costs, which may average as high as \$6000 is a disincentive that lowers the rate of donation, especially among people of limited means. NOTA actually permits reimbursing such costs, leaving organ donation a financially neutral act, but adequate mechanisms are not in place to make sure this occurs. Potential living organ donors – and the next of kin of deceased donors – should neither be motivated by financial rewards nor deterred by financial burdens.

For the past decade, the country with the largest number of transplant tourists – and the resulting neglect of the needs of its own people – has been China, which differs from other countries where organ trafficking occurs in having relied principally on executed prisoners as the source of organs for transplantation. The procurement of organs involves a commercial transaction, but the money has gone to brokers and people in the prison system rather than to the donor. The DICG has worked diligently to persuade Chinese officials to discontinue the use of organs from executed prisoners. The number of hospitals catering to transplant tourists has been reduced and promises have been made to develop other sources of organs, but thus far it is not clear whether these efforts will fully eliminate the human rights abuses involved in relying on prisoners.

One very powerful tool used by the DICG to push Chinese colleagues to stop using organs from executed prisoners (and other transplant professionals from relying on trafficked organs) has been its ability to persuade many medical societies to disallow presentations at their congresses and publications in their journals that involve transplants derived from organ sales or from executed prisoners. Being denied the connections and the recognition that follow from visibility in such venues has led Chinese physicians and researchers to pressure their government to remove this blot on their collective professional standing internationally.

Much remains to be done to prevent human trafficking for organ removal and organ trafficking. The DICG will continue to work toward that goal, encouraged by the successes it has had, which have been widely recognized, such as by a private audience in 2014 with Pope Francis, who endorsed the principle of “financial neutrality” in organ donation. Further progress will depend not only on continued collaboration with existing partners in governments, medical institutions, and nongovernmental organizations, but on forging strong new relationships with human rights organizations and experts who are experienced in fighting all forms of illegal trafficking.