

DIRECTORATE-GENERAL FOR EXTERNAL POLICIES  
POLICY DEPARTMENT



# Trafficking in human organs

DROI



## STUDY

# Trafficking in human organs

### ABSTRACT

The commercial trade in human organs, including trafficking in persons for organ removal has developed into a global problem. This report describes the current situation regarding international organ trafficking, committed often by transnational criminal networks. It zooms in on the role of traffickers, international brokers, health professionals, and the recipients and suppliers. To combat and prevent organ commercialism and trafficking, a legal framework for the criminalisation of trafficking offences, and tailor-made law enforcement instruments have been developed by a number of international organisations. A number of recent trafficking cases in which European citizens were involved, have been analysed in detail to highlight the different forms of organ trafficking and to demonstrate how investigation and prosecution can result in an effective justice response to these crimes. The efforts of the EU and other European organisations, such as the Council of Europe or the OSCE, to develop binding legal instruments and formulate policy actions to step up law enforcement and legal cooperation in the combat against trafficking in organs, are described. The report concludes with observations and recommendations for the EU to prepare next steps in successfully fighting and preventing trafficking in organs and organ commercialism.

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## 1 Glossary and acronyms

CDPC	Council of Europe European Committee on Crime Problems
CDPTO	Council of Europe European Committee on Organ Transplantation
CoE	Council of Europe
COFS	Coalition for Organ Failure Solutions
DICG	Declaration of Istanbul Custodian Group
DOI	Declaration of Istanbul
ECHR	European Convention of Human Rights
ELPAT	European Platform on Ethical, Legal and Psychosocial Aspects of Transplantation
EP	European Parliament
EU	European Union
EULEX	European Union Rule of Law Mission in Kosovo
Europol	Europol European Union law enforcement agency
Eurostat	European Union statistical office
GODT	Global Observatory on Donation and Transplantation
HTOR	Human Trafficking for Organ Removal
GRETA	Group of Experts on Action against Trafficking in Human Beings
HOTT	European Commission funded project on Human Organ Trafficking for Transplantation
ILO	International Labour Organization
Interpol	International Criminal Police Organization
IOM	International Organization for Migration
ISN	International Society of Nephrology
NGO	Non-Governmental Organization
OHCHR	Office of the High Commissioner for Human Rights
OSCE	Organization for Security and Co-operation in Europe
OTC	Organs, Tissues and Cells
THB	Trafficking in Human Beings
THBOR	Trafficking in Human Beings for the purpose of Organ Removal
TTS	The Transplantation Society
UN	United Nations
UN.GIFT	United Nations Global Initiative to Fight Human Trafficking
UNHCR	United Nations Commissioner for Refugees (UN Refugee Agency)
UNICEF	United Nations Children's Fund

UNMIK	United Nations Interim Administration Mission in Kosovo
UNODC	United Nations Office on Drugs and Crime
UNTOC	United Nations Convention against Transnational Organized Crime
UN Women	UN Entity for Gender Equality and the Empowerment of Women
WHA	World Health Assembly
WHO	World Health Organization
WMA	World Medical Association
XDOT	Expose and Disrupt Organ Trafficking Tool

## 2 Executive summary

This study explores the phenomenon of trafficking in human organs in its global context. It describes the current situation of trafficking in human beings for the purpose of organ removal as well as the policies, the legal instruments and actions that have been adopted at both the EU and international level to combat and prevent this serious crime. From the trafficking cases that have been investigated and prosecuted in recent years, lessons can be learned by the EU for more effective law enforcement in the future.

### **Global spread of trafficking**

Before 2000, the problem of trafficking in human organs (mainly kidneys) was primarily limited to the Indian subcontinent and Southeast Asia. Recipients of these organs came mainly from the Gulf States, Japan and other Asian countries. The EU and the USA issued sporadic reports about patients travelling overseas to obtain kidneys. However, since the year 2000 trafficking in organs has seemingly started to spread globally, to a large extent driven by Israeli doctors and patients who explore opportunities to seek transplantation in Eastern European countries and Russia. Today, partly as a result of tougher law enforcement against trafficking in Eastern Europe, the Philippines and on the Indian subcontinent, organ commercialism and trafficking of human beings for the removal of organs (THBOR) has started shifting to Latin America, North Africa and other regions where the economic crisis alongside social and political instability create opportunities for traffickers.

### **Different forms of trafficking in organs**

The term 'trafficking in organs' groups together a whole range of illegal activities that aim to commercialise human organs and tissues for the purpose of transplantation. It encompasses the trafficking of persons with the intent to remove their organs (THBOR); transplant tourism where patients travel abroad seeking an (illegal) transplant with a paid donor; and trafficking in organs, tissues and cells (OTC), which refers to commercial transactions with human body parts that have been removed from living or deceased persons.

### **Criminalisation of trafficking in organs**

The crime of trafficking in human beings (THB) was already defined by the UN Palermo Protocol in 2000, and this definition has since then become widely accepted in the international legal framework against trafficking, including the 2008 EP Resolution on Policy actions at EU level, the 2011 EU Directive on preventing and combating trafficking in human beings and protecting its victims, and the 2014 Council of Europe Convention against trafficking in Human Beings. Under these frameworks the trafficking in human beings for the removal of organs is treated as a subcategory of THB, and is consequently classified as a criminal offence. In 2008 the Declaration of Istanbul has further defined 'trafficking in organs' and 'transplant tourism', and its Custodian Group has made important efforts to raise awareness among health professionals and transplant organisations, while at the same time also undertaking successful attempts to curb organ trafficking in countries like the Philippines, Israel and Colombia by supporting new legislation. The WHO has estimated in 2007 that around 5-10 % of all kidney and liver transplants performed globally are conducted with illicitly obtained organs and/or commercial 'donors'. This amounts to at least 5 000 illegal transplants and this number seems to be increasing.

### **Modus operandi of organ traffickers**

By studying recently prosecuted trafficking cases, better knowledge has been acquired about the composition and operation of criminal networks dealing in organ trafficking. In particular the role of brokers and health professionals is pivotal to the 'success' of the trafficking network. Analysis of these cases has provided insight into the modus operandi of traffickers, but also into the background and fate of organ suppliers (victims) and recipients. Data collection on the financial aspects of organ trafficking has made it clear that the criminal proceeds from trafficking and illegal transplants are considerable. This demonstrates that money is the ultimate driving force behind this crime. Unfortunately it also means that trafficking is in fact maintained by the money flow coming from patients. The data concerning suppliers and recipients of illicitly obtained organs also shows that illegal transplants carry considerable risk – medical, psychological, social and economic risks – to both groups.

### **Legal Framework against organ commercialism and organ trafficking**

In the legal framework developed for combating and preventing the illegal removal and transplantation of human organs and tissues, two different aspects are crucial: the commercialisation of human organs and the trafficking of human beings for the purpose of organ removal. Chapter 6 of this report gives an overview of the existing international and European legal framework against commercialisation of human organs and tissues. The selling and buying of human organs (and body parts) is banned practically around the world and this prohibition is part of every transplant law (and made punishable). In Chapter 7 the international and European legal framework against trafficking in human beings (THB) is reviewed and analysed. Both international and European organisations have been active during the last ten years in developing binding legal instruments to make possible effective law enforcement against traffickers. The EP Resolution 'Policy actions at EU level', the EU Directive on preventing and combating trafficking in human beings and protecting its victims (2011/36/EU), and the CoE Convention on action against Trafficking in Human Beings, adopted in 2005, all have made important contributions. An important aspect of this legal framework is that it states that organ removal in the context of human trafficking always constitutes a criminal offence, even when the 'victim' has given consent.

### **Lessons learned from prosecution of actual trafficking cases**

Chapter 8 describes the true face of organ trafficking in Europe and beyond, by presenting and analysing four recent cases, where law enforcement has resulted in prosecution and conviction of the perpetrators. These cases clearly demonstrate the transnational character of trafficking networks, and the modus operandi of the traffickers. At the same time a lot has been learned about the loopholes and pitfalls that confront law enforcement officers when investigating and prosecuting such cases: the lack of cooperation between countries involved, the absence of a legal basis for extradition of defendants, and the difficulty to have people act as witness for the prosecution. These cases also demonstrate the problems that arise over the question whether organ suppliers (sellers) should be held criminally liable or rather treated as victims. The same kinds of questions are also relevant when one intends to prosecute recipients of trafficked organs and health professionals who have knowingly or unknowingly facilitated illicit organ transplants. In addition to these four cases, a complete overview of prosecuted trafficking cases is presented in the annex to this report.

### **European response to trafficking in organs**

In Chapter 9 the European response to trafficking in organs is presented and analysed, in particular the policy options and action plans that have been agreed and pursued by relevant organisations.

The policies and law enforcement instruments developed by the European Union, the Council of Europe and the OSCE are presented in detail. On the one hand, an important conclusion here must be drawn that, in spite of demonstrable progress in the investigation and prosecution of trafficking cases, and improved cooperation between countries involved, there is still no comprehensive legally binding instrument that covers all forms of trafficking in organs and that enables law enforcement in all situations. A recent development is the new CoE Convention against Trafficking in Organs that has been approved by the Committee of Ministers on 9 July 2014. This law enforcement instrument is different from its predecessors as it shifts the focus of criminalisation from the trafficking in human beings to the illicit removal of human organs from either living or deceased persons. In this way a wider range of offences and illegal acts fall under its scope. This may fill some important gaps in the currently existing legal framework. On the other hand, the CoE Convention also shows some flaws that may affect its effectiveness and binding power. On 25 March 2015 the new Convention was opened for signature for all CoE member states, as well as other countries.

### **Conclusions and recommendations**

In the final Chapter 10 a number of observations and lessons learned on the topic of trafficking in organs and its challenges are summarised. A series of recommendations are presented for next steps to be taken by the EU in its battle against trafficking in organs. These recommendations are mostly practical in nature and aim to make law enforcement against traffickers more effective.

## 3 Introduction

### 3.1 Objective

The objective of this study is to give an updated overview of the situation concerning the trafficking in human organs, both internationally and in the European Union. The focus is on the current knowledge concerning the scope of organ trafficking, the modus operandi of individuals and criminal organisations involved in trafficking, and the position and consequences for both the persons who are being trafficked for the removal of their organs (victims), and the recipients of these organs. Also the responsibility and potential liability of health professionals and institutions in the context of organ trafficking are analysed. Furthermore, the legislative and other responses to human organ trafficking from international organisations, the EU institutions as well as NGOs in the field of combating and preventing human trafficking are reviewed. Special attention is given to the role of international and European organisations for criminal investigation and law enforcement. Finally, the current international and EU policy actions aiming to combat and prevent trafficking in organs are critically reviewed; and possible steps and strategies are considered.

### 3.2 Approach and methodology

In this study the trafficking in human organs is analysed in the context of two different – but closely related – phenomena, namely:

- a) The persistent and global shortage of human organs for transplantation, where many patients spend years waiting for a transplant; and many of them die while on the transplant waiting list. This situation makes some patients take desperate steps, including unethical and illegal actions, to obtain a life-saving organ;
- b) The trafficking in human beings, where vulnerable persons are exploited, sometimes under force, to provide ‘services’ to other individuals who pay for these services to the traffickers (including forced labour, slavery, sexual acts, prostitution, illegal immigration, child adoption, and also organ removal), with the objective of making financial profit.

These phenomena set the scene for the rise of the global trafficking in human organs and allow organ transplants to be performed outside the established legal systems of donation and transplantation, where the main aim is not the relief of suffering, provision of high quality medical care and enhancing quality of life, but solely the financial profit. To acquire insight into the scale and scope of global trafficking in human organs, the author has drawn on a desk study of the (scarcely) available data contained in official reports (i.e. WHO data, Global Observatory on Donation and Transplantation, academic reports and media reports, including investigative journalism).

An important issue is the variation in definition of the term ‘trafficking in organs’. Most recent documents and reports give this term a broad scope that includes different ways in which human body parts are illicitly obtained and distributed. However, it is important to distinguish between ‘trafficking in human beings for the removal of organs’ (THBOR) and the broader term ‘trafficking in organs, tissues and cells’ (OTC), that includes trafficking of human body parts from both living and deceased persons. The relevant documents (UN Palermo Convention, Council of Europe Conventions and Recommendations, EU Directives, Communication and Resolution) are analysed to see how these differences are handled. Important up-to-date information on the modus operandi of different actors in organ trafficking, and on the role and operation of criminal networks involved in trafficking, was gathered thanks to the author’s involvement in the HOTT Project, an ongoing EU funded study of trafficking in organs. Data on the actual investigation, unravelling, prosecution and legal proceedings against organ traffickers was collected by analysing a number of high-profile trafficking cases, some of which were included in the HOTT study (including the Medicus case in Kosovo, the Netcare case in South Africa, the Gurgaon case in India). The

HOTT Conference, held in November 2014 in The Hague, the Netherlands, also gave the opportunity to consult with representatives from international law enforcement and policing organisations (including Europol and Interpol), on aspects of criminal investigation, prosecution and international co-operation and legal assistance in the field of combating trafficking in organs. Finally, special attention is given to the most recent and comprehensive approach to combat and prevent trafficking in human organs, namely through the CoE Convention against Trafficking in Human Organs. This Convention was adopted on 9 July 2014 and was subsequently opened for signature in March 2015 (at the occasion of the CoE Conference in Santiago de Compostela, Spain, 25 March 2015). This document is analysed, comparing its scope and approach in the light of the Policy Actions that were proposed in the EP Resolution of 2008 on organ donation and transplantation: Policy actions at EU level.

### 3.3 Substantive scope

The commercialisation of the human body and its parts is prohibited by all relevant international and EU law documents, as well as in national legislations of member states (e.g. WMA Convention, WHO Guiding Principles, CoE Biomedicine Convention). From this it follows that trafficking in human organs also includes the illicit commercialisation of human tissues and cells that can be used for either therapeutic implantation or the preparation of medicinal products. Indeed, many documents include in the trafficking of organs the trafficking of tissues and cells (referred to as 'trafficking in OTC'). However, the ways in which human tissues and cells are illicitly obtained and distributed open up very different forms of trafficking: very large scale operations, high profits, different stakeholders, and different modus operandi. This study focuses almost exclusively on trafficking in organs (kidney, liver), although some observations are made concerning tissues. The focus on organs does not imply, however, that the trafficking of human tissues and cells should be considered a less alarming and urgent problem. But it deserves a separate study.

A second issue that is not analysed in detail in this report is the use of executed prisoners as organ donors in China, the commercialisation of these organs and the perverse connections between the judicial system and the transplant system. Although the way in which the organs that become available are offered to foreign patients resembles trafficking in organs to some extent, the solutions are not to be found in stricter law enforcement. Changing these practices will rather depend on (political) pressure from the international transplant community, internal reform of the Chinese health care and transplant system, and human rights reform.

## 4 A short history of global trafficking in organs

The first reports on commercial trade in human organs date from the 1980s and concern the selling of kidneys by poverty stricken Indian citizens to foreign patients, especially from the Middle East. It was reported that around 80 % of all kidneys that were procured for transplantation in Indian hospitals were transplanted into patients coming from the Gulf States, as well as Malaysia and Singapore<sup>1</sup>. A first scientific report appeared in the *Lancet*, and revealed that 131 kidney patients from the UAE and Oman had travelled to Bombay, together with their doctors, and were transplanted there with kidneys from local paid 'donors'. The authors were not so much concerned about the commercialism, but more about the fact that many of the recipients had post-operative complications<sup>2</sup>. This took place before the passage of the Indian Transplantation of Human Organs Act in 1994, which outlawed the selling and buying of human organs. But also after 1994 there are consistent reports of foreign patients travelling to India in search of a paid kidney donor: Goyal reported on over 300 citizens of Chennai who illicitly sold a kidney in the period 1994-2000<sup>3</sup>. Even from developed countries where, it is claimed, no overt payment for organs is made, there is data that financial incentives may have influenced organ allocation: American and European transplant surgeons during the 1980s have solicited wealthy foreign patients to come to their transplant centres for a priority transplant. It was reported that in the United States in 1984 around 300 kidneys were transplanted into non-residents<sup>4</sup>. Similar allegations were made by the Bellagio Task Force who reported that Belgian and Austrian transplant centres did not always exchange available organs with collaborating foreign centres, but required foreign patients to come to their centres, in order to raise their incomes<sup>5</sup>. Early evidence of EU citizens travelling abroad to obtain organs was provided by an article in the *British Medical Journal* in 1996, in which it was described that two German patients had died of post-transplant complications, after having been transplanted in India. It was stated that at least 25 German patients were known to have obtained kidneys abroad. The article requested 'suitable legislation to prevent such incidents'<sup>6</sup>. A high profile case of organ trafficking was reported in 1988 in the UK, when it was discovered that a kidney had been removed from a Turkish peasant in a London private clinic run by a well-known nephrologist. The Turkish 'donor' had been recruited through advertisements in Istanbul newspapers, promising a fee of GBP 2 000-3 000. When travelling to London, these donors carried a letter of introduction saying that they were going to support and care for a relative who was to undergo transplantation. There were no criminal charges against the perpetrators, but the nephrologist and three other doctors involved in this case (as well as similar other cases) were struck off the register by the General Medical Council. This case speeded up the passing of the UK Human Organ Transplant Act (1989), which made organ trafficking a criminal offence<sup>7</sup>. Another case involving the UK concerned a Turkish company (Trans Transplantsyon) that offered UK citizens and other foreign patients to have a kidney transplant in India or Russia for a fee of GBP 22 000. The company was said to have been already in operation on the Continent for six years, facilitating 400 successful transplants, and planning to set up an office in London<sup>8</sup>.

<sup>1</sup> Price, D., *Legal and ethical aspects of organ transplantation*, Cambridge Press, 2000.

<sup>2</sup> Salahudeen AK., Woods HF., Pingle A., et al., High mortality among recipients of bought living-unrelated donor kidneys. *Lancet*, 1990; 336: 725-8.

<sup>3</sup> Goyal M., Metha RL., Schneidermann LJ. et al., *Economic and health consequences of selling a kidney in India*, *JAMA* 2002; 288: 1589-1593.

<sup>4</sup> Porter S., *Organ transplants: Questions and Controversy*, *The New Ethics*, 1984; 80: 33-37.

<sup>5</sup> Rothman D., et al., The Bellagio Task Force on Transplantation: Bodily Integrity, and the International Traffic in Organs, *Transpl Proc* 1997, 29: 2739-2741.

<sup>6</sup> Karcher H., German doctors protest against organ tourism, *BMJ* 1996; 313: 1282.

<sup>7</sup> Price D., Mackay R., *The trade in human organs*, *New Law Journal* 1991; 1272 (Part I) and 1307 (Part II).

<sup>8</sup> The Sunday Times, 11 May 1997.

An important aspect of most of the above mentioned cases of organ trafficking and commercialism is that the reports rely to a great extent on media reports and investigative journalism, which makes it difficult to analyse the events in more detail. On these early cases no police investigation reports exist nor has there been any prosecution.

Things started to change in the period after 2000. The Israeli nephrologist Michael Friedlaender reported in 2002 that over 80 Arab Israeli patients had travelled to Iraq to obtain a kidney transplant from a paid donor. However, Jewish Israeli patients were not able to go to Iraq (or other Arab countries), and transplant surgeons from the centre in Tel Aviv as a solution (circumventing Israeli law) made arrangements to go together with their patients to Estonia, Bulgaria, Turkey, Georgia, Romania and Russia to perform kidney transplants from paid unrelated donors<sup>9</sup>. They charged their patients USD 200 000 for such service. It is reported that at least 26 patients were transplanted in this way. This arrangement was made semi-official through the Veterans Health Organisation, run by the Ministry of Defence, and was facilitated by the health insurance companies. This has been the beginning of the extensive involvement of Israeli recipients as well as transplant physicians in organ tourism and trafficking in the Eastern European region<sup>10</sup>. Further evidence of trafficking in organs, especially in the Eastern European region came out of a fact-finding mission of the special rapporteur Mrs. RG Vermot-Mangold to the Parliamentary Assembly of the Council of Europe in 2003. She exchanged views with a representative of Europol and visited Moldova in October 2002<sup>11</sup>. The report stated that trafficking in human beings (especially women and children) was already deemed a serious problem in Moldova, targeting the impoverished rural population. Trafficking in human beings for organ removal, though still small scale, appeared to be on the increase. Several dozen young men, aged between 18 and 28 years, had been taken to Turkey, where - in rented hospital facilities - a kidney was removed and transplanted, sometimes using coercion or force. These victims were paid around USD 2 500-3 000, but sometimes did not get the full amount promised. From the interviews and research it came out that this was not an operation confined to Moldova, but that 'donors' had also been recruited in the same way from neighbouring Ukraine, Bulgaria, Romania, Russia and Georgia. The operation was run by a well organised network, consisting of brokers, local recruiters, doctors and specialised nursing staff. There appeared also to be strong links with the police and customs, which were open to corruption. Following this report, the Parliamentary Assembly called on the Council of Europe to develop a European strategy for combating trafficking in organs, by drafting an additional protocol to the European Convention on Action against Trafficking in Human Beings.

At the beginning of 2000, two other European countries were found to be involved in the trafficking of human tissues. The State Forensic Medical Centre in Riga (Latvia) from 1994 to 2003, delivered human tissue material to the German company Tutogen, that paid 'compensation' to the Forensic Centre. Over the 10 year period tissues were taken from at least 400 deceased persons. When relatives of the deceased found out that the tissues were retrieved and sold without any valid consent, they informed the police who started a criminal investigation. In 2005 the Security Police concluded that no one was guilty, as the Latvian law was unclear about human rights protection, and the determination of a deceased person's last will<sup>12</sup>. In 2006 the case was reopened, and recently in 2015, the European Court of Human Rights ruled that taking and selling the tissues without consent, constituted a violation of articles 3 and 8 of the European Convention of Human Rights (degrading treatment, lack of respect to private life), and that

<sup>9</sup> Friedlaender MM., The right to sell or buy a kidney: are we failing our patients?, *Lancet*, 2002; 35: 971-73.

<sup>10</sup> Scheper-Hughes., N., Parts unknown, *Undercover ethnography of the organ trafficking underworld*, *Ethnography* 2004; 5: 29-73.

<sup>11</sup> Council of Europe, Parliamentary Assembly, Trafficking in organs in Europe: Report by Mrs. Ruth-Gaby Vermot-Mangold (Doc. 9822, 3 June 2003).

<sup>12</sup> Olsena S., A Latvian case: The removal of tissue from 400 deceased persons, In: W.Weimar and M.A. Bos: Organ transplantation: Ethical, Legal and Psychosocial Aspects, Towards a common European Policy, Pabst 2008.

Latvia was to pay financial compensation to the relative of a deceased person<sup>13</sup>. A second case involving the abuse of human tissues, took place in the Czech Republic, where, in the period 2003-04 in the hospital in Brno employees of the local tissue bank sold skin grafts to a foreign (Dutch) company for a total of USD 340 000. Six employees were charged with organ/tissue trafficking; the prosecution took 3.5 years and the defendants faced prison sentences<sup>14</sup>.

After the year 2000, around 2 000 pieces of information on trafficking in organs, which had been scant before, became more prominent. An important role in this was played by the organisation Organs Watch, founded by anthropologist/investigator Nancy Scheper-Hughes. The discovery and criminal prosecution of a number of high profile recent trafficking cases has increased the insight and knowledge of how trafficking in organs operates (Medicus case, Netcare case, Gurgaon case – see chapter 8). The Declaration of Istanbul on Organ Trafficking and Transplant Tourism established in 2008 and the work of its Custodian Group, brought pressure on a number of countries and governments to effectively change their legislation and ban trafficking in organs. As a consequence, trafficking in organs has decreased in a number of countries. However, trafficking operations have now shifted to other countries and new routes have been opened. According to recent information from the UN Office on Drugs and Crime (2014) around 0.3 % of all reported persons trafficked are trafficked for organ removal, and some 50 countries around the globe are in some way involved in trafficking in organs<sup>15</sup>. In Europe, the Council of Europe and the European Union, through the European Parliament, are actively developing new strategies to combat and prevent what is now considered a criminal offence on a global scale.

Recently there have been media reports that trafficking in human beings, including for the purpose of organ removal, may be increasing in Europe because of the economic and financial crisis<sup>16</sup>. Also it is documented that there is an increase of organ offers over the internet and in newspaper advertisements (solicitation), in particular in Southern Europe and Russia. Serious, but as yet unconfirmed reports have been circulating recently on the alleged trafficking of organs from refugees in the Syrian conflict, and their being offered on the Lebanese and Turkish 'black market' in organs<sup>17</sup>. Other alarming reports point to a shift of organ trafficking operations to countries in Latin America (Costa Rica, Panama, Peru),<sup>18</sup> which led to a meeting of judicial officials from Central America and the Dominican Republic in June 2012. Finally there is recent evidence of THBOR networks in Vietnam-China, and Cambodia-Thailand<sup>19</sup>.

<sup>13</sup> European Court of Human Rights, press release on ECHR 005 (2015). See also: [www.coe.int/t/dghl/monitoring/execution](http://www.coe.int/t/dghl/monitoring/execution).

<sup>14</sup> <http://www.radio.cz/en/section/crime/six-charged-in-organ-trafficking-case-at-brno-hospital>.

<sup>15</sup> UNODC Global Report on Trafficking in Persons, 2014. Vienna/New York.

<sup>16</sup> The New York Times, June 28, 2012, 'Black market for body parts spreads among the poor in Europe'. BioEdge, 9 June 2012, 'European crisis boosts illegal trade in body parts, [www.bioedge.org](http://www.bioedge.org).

<sup>17</sup> Spiegel online International, November 12, 2013, 'Lebanese black market: Syrian refugees sell organs to survive'. Global Research, February 8, 2014, 'Organ smuggling: Turkish hospitals traffic injured Syrian citizens' organs. [www.globalresearch.org](http://www.globalresearch.org).

<sup>18</sup> La Prensa, Insight Crime, 19 July 2012, 'Organized crime in the Americas. Desperation, lack of donors drives organ trafficking in Latin America' [www.insightcrime.org](http://www.insightcrime.org).

<sup>19</sup> South China Morning Post (Agence France-Presse, 27 October 2014, 'Cambodia-Thailand kidney trafficking case sparks fears of new organ market', [www.scmp.com](http://www.scmp.com). Tuoi Tre News, 7 March 2013 'Human trafficking on the rise in Vietnam: police warns', [www.tuoi-trenews.vn](http://www.tuoi-trenews.vn).

## 5 Current situation concerning organ trafficking

In this chapter the nature of trafficking in organs is analysed in its different forms. The relation to trafficking in human beings and the legal status as criminal offence involving organised crime networks are explained. Its current scope and geography is described. The role of relevant stakeholders in trafficking is analysed and also the financial aspects of trafficking. The modus operandi of organ traffickers is described on the basis of recent prosecuted cases.

### 5.1 The many faces of trafficking in organs

The general term 'trafficking in organs' covers a whole range of illicit activities that aim to commercialise human organs and tissues that are needed for therapeutic transplantation. Although transplantation medicine has seen enormous advances over the last decades and the number of transplants performed has grown to around 115 000 globally<sup>20</sup>, this covers only the needs of around 15 % of all patients on the waiting list. There is no doubt that the resulting structural shortage of legally obtained organs is the main cause of trafficking in organs.

In the extensive literature on trafficking in organs one finds different terms and definitions for these phenomena, describing different but sometimes partly overlapping activities. These definitions also refer to different legal and policy frameworks.

#### ***Trafficking in Human Beings for Organ Removal (THBOR)***

The trafficking in persons for the purpose of organ removal is clearly defined in the Palermo Protocol to the UN Convention against Transnational Organized Crime<sup>21</sup>. Article 3a states that: 'Trafficking in persons shall mean the recruitment, transportation, transfer, harbouring or receipt of persons, 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 or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs.'

This extensive definition is widely used by all organisations active in the field of combating and preventing human trafficking, such as UNODC and OSCE<sup>22</sup>. It is also included in the 2005 Council of Europe Convention on Action against Trafficking in Human Beings.

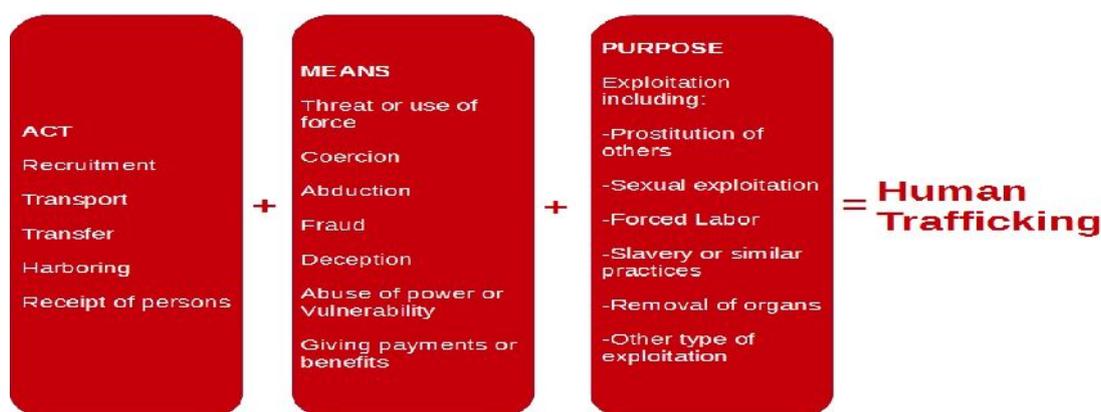
In the Palermo Protocol THBOR is thus defined as a specific form of trafficking in persons (THB), in which internationally operating networks through deception and coercion lure or compel persons in acute poverty into selling an organ. As such it focuses specifically on the victims of trafficking, in the case of organ removal the supplier of the organ. In the context of organ transplantation this refers to a living person. From a legal point of view THBOR constitutes, like all other forms of trafficking of persons, a violation of the fundamental human rights and the dignity of the individual, and is thus defined as a criminal offence, typically committed by transnational organised crime networks.

In order to be defined as 'trafficking in persons' and to carry criminal liability, the act must comply with a strict set of criteria (see figure 1).

<sup>20</sup> Global Observatory on Donation and Transplantation, Newsletter Transplant vol. 19, no.1, 2014

<sup>21</sup> United Nations, Protocol to prevent, suppress and punish trafficking in persons, especially women and children, supplementing the UN Convention on Transnational Crime Res 53/111, 2000.

<sup>22</sup> United Nations Office on Drugs and Crime: Global Report on trafficking in persons 2012; Organization for Security and Cooperation in Europe: Trafficking in human beings for the purpose of organ removal in the OSCE Region, 2013.

**Figure 1: Criteria for defining human trafficking**

Source: UN Palermo protocol, 2000

The scheme above means that in order to be classified as human trafficking, and thus as a criminal act, the removal of an organ would have to be the result of (one or more of) the mentioned acts and means. The Palermo Protocol emphasises that, in case of trafficking, any agreement or consent on the side of the victim is irrelevant and invalid since it is obtained under pressure. The Palermo Protocol created for the first time a legal binding instrument against trafficking in persons (including for organ removal).

### **Organ Tourism or Transplant Tourism**

Another term that is widely used in the context of trafficking in organs is 'organ tourism' or 'transplant tourism'. In contrast to THBOR it focuses more on the recipient of a commercially obtained organ: the patient who travels abroad in search of an (illegal) transplant. This term is not uniformly defined nor widely used in official documents. The 2008 Declaration of Istanbul<sup>23</sup> (DOI) has proposed the following definition of 'transplant tourism':

'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 devoted to providing transplants to patients from outside a country undermine the country's ability to provide transplant services for its own population.'<sup>1</sup> (see paragraph 6.3.3 for background on DOI).

The assumption is often that in transplant tourism the organ is obtained through a more or less overt financial transaction with the supplier ('vendor'), who has consented willingly to having his kidney removed. There would be no need for force, coercion or deception to obtain the organ. These vendors are usually impoverished local inhabitants, and are not transported across boundaries. Strictly following the THBOR definition, transplant tourism would not meet all the criteria for trafficking and fall outside the description of the crime. However, on the basis of the knowledge gained from numerous cases of transplant tourism, it appears there is considerable overlap between transplant tourism and THBOR. In view of the poverty and vulnerability of the vendor, the consent for organ removal cannot be seen as based on autonomy and a voluntary decision; deception and fraud in the payment are frequent, and brokers and recruiters target specific vulnerable populations. Also the lack of post-operative care for the vendor strengthens the element of exploitation.

<sup>23</sup> The Declaration of Istanbul on Organ Trafficking and Transplant Tourism (convened by The Transplantation Society and International Society of Nephrology in Istanbul, Turkey, April 30 – May 2, 2008. See also par. 4.9.

### **Trafficking in Organs, Tissues and Cells (OTC)**

Trafficking in OTC may be defined as: 'The handling of any human organ, tissue or cell obtained and transacted outside the legal national system for organ transplantation'. In contrast to THBOR, the term 'trafficking in OTC' focuses on the trafficking of human body parts deriving from either living or deceased persons (donors). This kind of trafficking has a wide scope: it may occur as buying and selling of organs/tissues from living persons, but also as stealing organs/tissues from deceased persons (at autopsy, in the morgue). It is clear that this form of trafficking does not fall under the definition of trafficking in persons, as described in the UN Palermo Protocol. Consequently it is not an act punishable as a crime in the sphere of trafficking of persons (THB). However, trafficking in OTC does imply the selling and buying of body parts (organs), and as such falls under the universal prohibition of gaining profit from the human body and its parts (commodification and commercialisation), which is prohibited and punishable under international conventions<sup>24</sup>, as well as under national transplant legislation.

### **Some observations and conclusions**

Trafficking in persons for organ removal (THBOR) is a crime where the exploitation of an individual is the central aspect (a combination of three elements: action, means and purpose has to apply in order for the crime to be constituted). The definition is precise and uniform, and the framework widely used. Trafficking in OTC is a crime where the organ and its use are the central elements (illegally removed organs (and tissue and cells) from either living or deceased persons are entered into the regular legal transplant system). So far there has been no precise and uniform definition of trafficking in OTC. From a legal/criminal perspective it appears that sanctions for committing trafficking in persons are more severe than for violation of the prohibition on gaining profit from the human body. For an effective strategy against all forms of trafficking in organs, it is necessary to have at one's disposal a uniform and legally binding instrument that includes both THBOR and trafficking in OTC elements. The Declaration of Istanbul has attempted this approach, but it is not a legally binding instrument. As will be described later, the CoE Convention against Trafficking in Human Organs, that was finalised in July 2014 and opened for signature end of March 2015, has also taken this approach<sup>25</sup>.

## **5.2 Scope of trafficking in organs**

The development of organ transplant medicine over the last 25 years has been so rapid that transplants are now literally performed around the globe. In 2012 over 114 000 transplants have been done in 109 countries, of which some 70 % (77 800) are kidney transplants (from both living and deceased donors)<sup>26</sup>. These numbers include commercial transplants from paid donors. However it is difficult to determine the true extent of trafficking in organs, as reliable data is absent due to the clandestine nature of trafficking. Another reason may be that 'such trafficking has not yet received priority attention or close scrutiny from member states until now' as the UNODC Secretary-General remarked in his 2006 report<sup>27</sup>. In 2012, and again in 2014, the UNODC published its Global Report on trafficking in persons, based on official information coming from law enforcement agencies around the world concerning suspected, investigated and prosecuted cases of trafficking<sup>28</sup>. The report states that trafficking in persons for organ removal (THBOR) has been reported in 16 countries, in all regions around the globe (the report states that

<sup>24</sup> Council of Europe, Convention for the protection of human rights and dignity of the human body with regard to the application of biology and medicine (CETS No. 164, 1997), and its Additional Protocol (CETS No. 186, 2001). WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation, revised version, 2010. WMA statement on Human Organ Donation and Transplantation, revised version 2006.

<sup>25</sup> Council of Europe Convention against Trafficking in Human Organs. CM92013479 final, of 9 July 2014.

<sup>26</sup> GODT, Newsletter Transplant 2014 vol 19, September 2014.

<sup>27</sup> UNODC CCPGJ, Report of the Secretary-General on preventing, combating and punishing trafficking in human organs, 2006.

<sup>28</sup> UNODC Global Report on trafficking in persons, 2012.

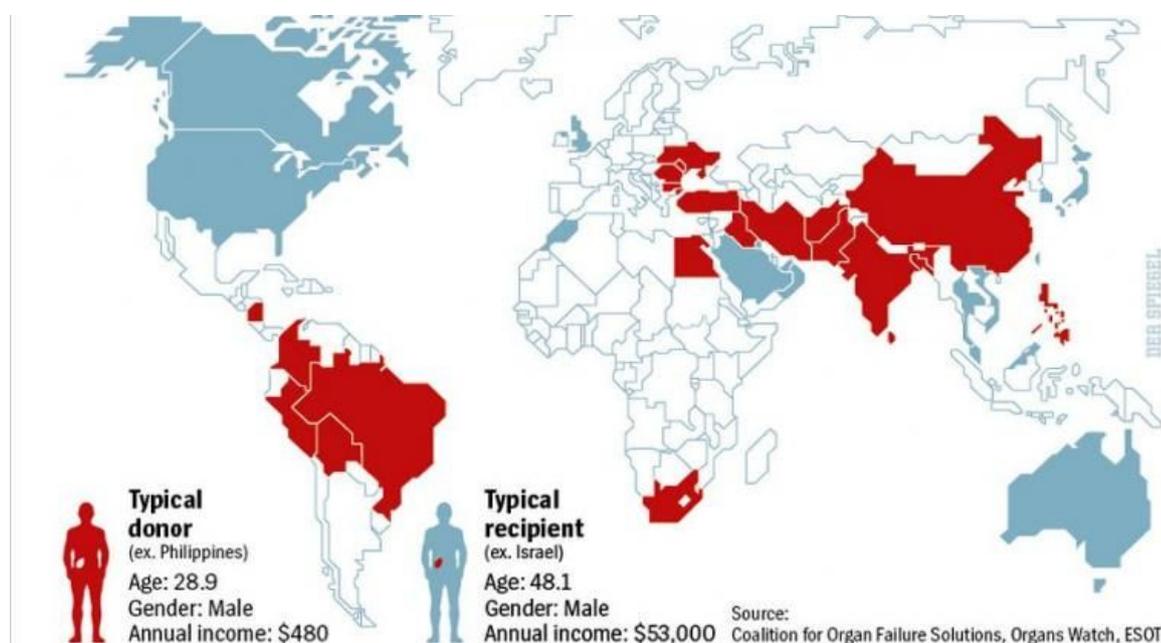
about 50 victims of THBOR were detected during the 2010-2012 period in Europe and Central Asia). It was estimated that trafficking for organ removal accounted for 0.3 % of all detected human trafficking cases. A small proportion, but with a wide geographical spread. However, since this number is based on detected cases only, it is most probably underestimated.

In 2007 the World Health Organization, assessed based on data from member states around the world that 5 to 10 % of kidney transplants are performed annually with organs from commercial donors (3 400-6 800 in 2007)<sup>29</sup>.

Recently the WHO Office has confirmed that an estimate of at least 5 000-7 000 annual commercial kidney transplants is more realistic. Although there was a temporary drop in 2006-07, the number has been growing ever since and the organ trade has shifted from former 'hubs' (e.g. Pakistan, the Philippines and Israel) to new countries, such as Costa Rica, Colombia, Egypt, Vietnam and Lebanon. Recent local reports on trafficking around the world have been published on the website of the Declaration of Istanbul Custodian Group<sup>30</sup>. For the European Region, recent data on trafficking in persons has been presented in the 2014 Eurostat Report<sup>31</sup>. Over 30 000 registered victims of THB have been reported in the 28 member states (in the 2010-2012 period); the breakdown for type of exploitation is as follows: 69 % sexual exploitation, 19 % forced labour, and 12 % other forms of exploitation (including trafficking for organ removal and child selling). There is however no detailed information on the number of THBOR cases, in total or per country.

Figure 2 shows the global spread of trafficking in organs, distinguishing organ-importing countries (origin of recipients) from organ-exporting or 'destination' countries (origin of organ suppliers).

**Figure 2: Global scope of trafficking in organs**



Source: Der Spiegel

<sup>29</sup> Shimazono Y., The state of the international organ trade: a provisional picture based on integration of available information, Bulletin of the World Health Organization, 2007; 85.

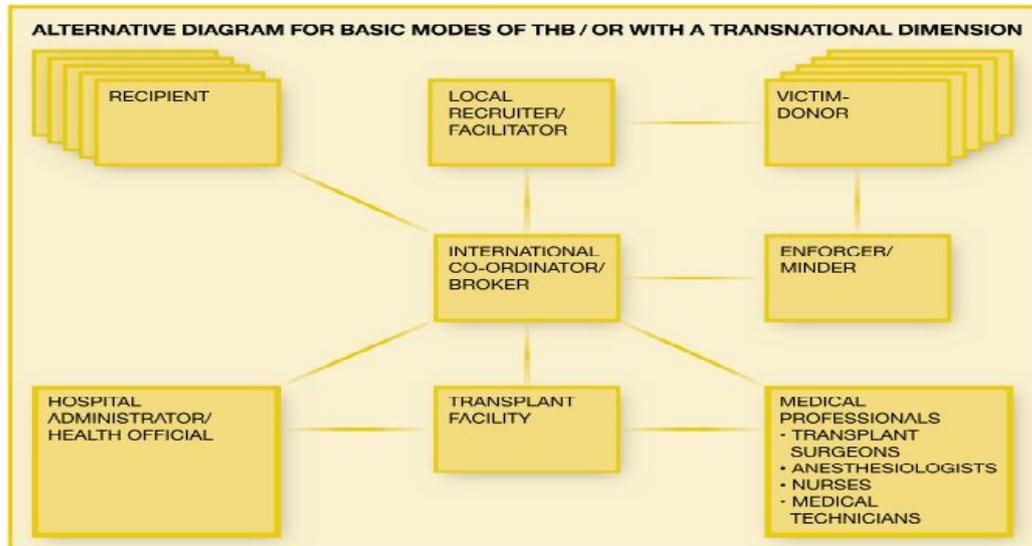
<sup>30</sup> DICG: [www.declarationofistanbul.org](http://www.declarationofistanbul.org).

<sup>31</sup> Eurostat, Statistical working papers: Trafficking in human beings, European Union, 2014 edition.

### 5.3 Stakeholders in trafficking operations

Trafficking (THBOR) networks show a wide variation in size, division of labour between the actors, and geographical scope. However, in practice in all networks there are essential roles and tasks that should be fulfilled and conditions that are required, for the operation to be successful. Figure 3 gives a schematic picture of a trafficking network.

**Figure 3: Diagram of THBOR network with transnational scope**



Source: OSCE report 2013

Emphasising the transnational character of THBOR, each box may represent a function located in a different country. In the following sections, the roles of different actors and stakeholders in the network are described.

#### **Brokers**

A criminal network that specialises in trafficking in organs (THBOR) is usually led by an international co-ordinator, who is generally also the person who established the network. The often used term 'broker' has no uniform definition, but the description used by Yea<sup>32</sup> is an apt one: 'an intermediary between a kidney buyer and seller who connects the two using his/her knowledge of medical personnel and facilities that engage in illegal transplantations. The broker's key asset in this market is his/her greater knowledge of other stakeholders to whom the seller does not have direct access.' The broker is the one who makes the strategic decisions for operating the network, and is generally also the person with whom potential recipients come first in contact with (through internet or word of mouth) in their search for an organ. In most networks the main role of the broker is to establish and regulate the supply of recipients, to channel all payments, and to oversee the matching logistics with the potential organ suppliers<sup>33</sup>. In larger transnational networks there may be more than one broker. Brokers often see themselves as business executives who negotiate and set the price of the transplant package offered to the recipient, and set the fee for the organ supplier (in the most profitable way for the network). In some cases brokers are doctors/surgeons themselves, or directors of hospitals or tissue-matching laboratories. Actual

<sup>32</sup> Yea S., Trafficking in part(s): The commercial kidney market in a Manila slum, the Philippines, *Global Social Policy*. 2010; 10:358-75.

<sup>33</sup> In the Rosenbaum case, the broker referred to himself as the 'matchmaker', who – as head of a Jewish charity – brought recipients and donors together.

prosecution cases against criminal trafficking networks and their brokers have shown that the more the broker acts as an international 'business executive' the greater the chance of engaging in trafficking in persons (THBOR), targeting vulnerable people as potential sellers, and exploiting these victims.

### ***Local recruiters and other facilitators***

Brokers should be distinguished from local recruiters: persons who are employed to find or identify the actual organ sellers/suppliers. Recruiters (or scouts) are usually operating within one country or a specific geographical area (such as a Philippines slum or a refugee camp). Recruiters are sometimes involved in other forms of human trafficking (sexual exploitation, forced labour). In some cases they are (corrupt) local police officers, but more often they have been former organ sellers themselves. Recruiters are usually paid per successful recruit, resulting in a transplant. Trafficking also depends on other facilitators who collaborate within the network: 'minders' accompany the recipients during their travel and while they are lodged in hotels/safe houses waiting for the transplant; 'enforcers' make sure that the organ sellers/suppliers go through with the contract; drivers take care of 'safe' transport of the recipients in the foreign country. Also important are interpreters who facilitate the communication with recipients/suppliers with local doctors and hospital staff.

### ***Medical professionals and local hospitals***

Crucial to the trafficking network is the collaboration with medical professionals and local transplant hospitals and matching laboratories. To perform the organ removal and transplant operations one needs surgeons, nephrologists/hepatologists and anaesthesiologists. Additionally, nurses and lab technicians are involved.

In some cases, the illicit transplants have been performed by doctors who were employed by, or even were themselves the co-ordinators of the trafficking network (e.g. the Medicus case). In other cases, the broker/co-ordinator of the network has to contract local hospitals and medical staff, who are open to a lucrative – but illegal – deal (e.g. in Turkey, the Philippines). In more rare cases, the transplants are performed in hospitals in developed countries, where hospital staff and executives have no idea that these are in fact illicit transplants, making use of paid non-related donors (e.g. the Rosenbaum network in the USA presented the donors as genetically related or emotionally related family volunteers).

A difficult question is to what extent medical personnel, nurses, lab technicians and others in a transplant hospital that is contracted by a trafficking network to perform illicit transplants are actually aware that they are engaging in criminal acts and are seen as accessories (e.g. in the Netcare case). It is even more complicated to establish to what extent doctors in European or American hospitals can be held criminally liable for facilitating organ trafficking or transplant tourism, when they counsel or prepare their patients for trying to have a transplant abroad (see law enforcement par. 8.4).

### ***The role of corruption***

Corruption is an essential ingredient and prerequisite for trafficking in organs. The trafficking in persons (THBOR) for the purpose of organ removal on a larger scale would not be possible without the assistance of corrupt police officials, customs officers, officials giving out visa and travel documents, and sometimes officials in the health administration who issue false licenses to hospitals and doctors (see the Medicus case). In some cases networks have close links with existing organised crime groups who are engaged in 'traditional' human trafficking (prostitution, sexual exploitation, forced labour)<sup>34</sup>.

<sup>34</sup> OSCE Report, 2013.

### ***The background of organ buyers/recipients***

In contrast to the suppliers of organs (victims of THBOR), there has been surprisingly little academic study or media attention for the recipients who travel abroad in search of an illegal transplant. They are not systematically reported to the health care system in their home country, although their treating nephrologist/hospital will know the circumstances. The confidentiality rules in medicine, as well as the fact that most recipients of bought organs are aware of the fact that they have committed an illegal act (although they avoid the term 'crime'), makes it difficult to trace and interview these recipients.

The anthropologist Nancy Scheper-Hughes has given a very general indication of the background of recipients: 'From North to South, from poor to rich, from young to old'<sup>35</sup>.

From existing trafficking cases there is more detailed information on the background and motives of recipients:

- Long waitlists and waiting times (enhancing the risk of dying on dialysis)
- Not being admitted to the waitlist or being de-listed because of health condition
- Seeking a pre-emptive transplant (before starting dialysis)
- Not wanting to ask relatives for a live donation
- No possibility of or access to transplantation in the home country (e.g. African countries)
- Belonging to an ethnic minority in the country of residence; having the idea that one has better access to a transplant in the country of origin, or the possibility of a better-matched kidney<sup>36</sup>
- No difference has been observed between recipients of organs retrieved through THBOR and from transplant tourism.

Although it has been reported that not all patients who travel to obtain a purchased kidney are necessarily rich, or necessarily come from a rich background, their economic situation is generally markedly better than that of the organ suppliers<sup>37</sup>. Another undeniable fact is, that it is the recipients who provide the funds that make trafficking in organs possible and 'drive the business'.

### ***Characteristics of organ suppliers/victims***

There is a vast literature on the background and characteristics of organ suppliers (sellers) that explains their motives for giving up an organ. The general characteristics are:

- Coming from poor developing countries (often indicated as 'organ-exporting countries'<sup>38</sup>), or belonging to a part of the population living below poverty line
- Being in a position of vulnerability (being poor, an illegal immigrant, a refugee)
- Lack of basic medical knowledge, not aware of potential health consequences of having a kidney removed
- Low education level, being illiterate

<sup>35</sup> Scheper-Hughes N., *Neo-cannibalism: the global trade in human organs*, Hedgehog Rev, 2002; 381: 16.

<sup>36</sup> Cronin A., Solving the kidney transplant crisis for minority ethnic groups in the UK: Is being transplanted overseas the answer?, in: W. Weimar, MA Bos (Eds.): *Expanding the European Platform*, 2011, p. 62-72.

<sup>37</sup> In the recent past insurance companies in some countries would fully reimburse overseas transplants, irrespective of the illicit mode of organ removal (e.g. Israel, the Netherlands).

<sup>38</sup> The most often named are: India, Pakistan, China, the Philippines Bangladesh, Ukraine, Kazakhstan, Russia, Iraq, Jordan, Egypt, Romania, Moldova, Kosovo, Turkey, Israel, Brazil, Colombia, Peru and Bolivia.

- Young age group (18-30 years), mostly males
- Often lured into organ removal by fraud and deception, or coercion
- From a home country that lacks a legislative system to effectively prohibit and prosecute trafficking in persons, high level of corruption.

In general the organ supplier is not considered to be a participant in the trafficking network, but is seen as a victim of exploitation, who needs care and protection<sup>39</sup>.

## 5.4 Modus operandi of organ traffickers

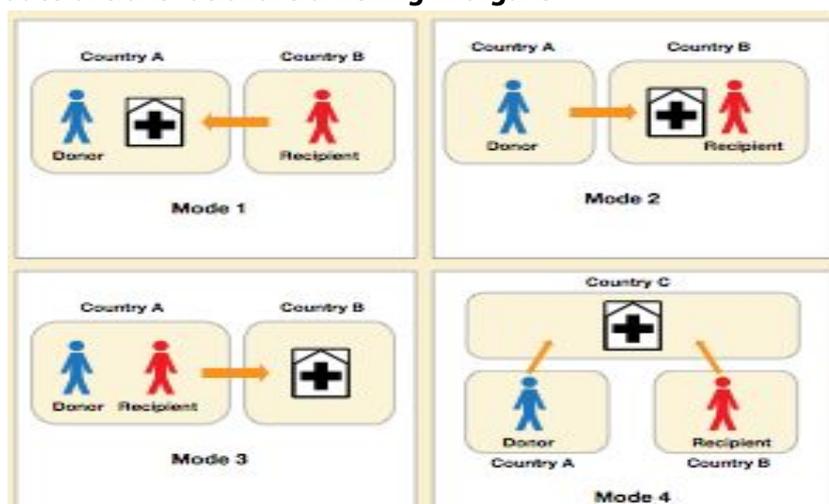
A description of the modus operandi of an organ trafficking network is already implied in the definition of 'organ trafficking' as proposed by the Declaration of Istanbul (and derived/adapted from the UN Palermo Protocol):

'The recruitment, transport, transfer, harbouring 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 receiving by, a third party of payments or benefits to achieve the transfer or control over the potential donor, for the purpose of exploitation by the removal of organs for transplantation<sup>40</sup>.

As can be seen this definition covers both THBOR and transplant tourism, as well as trafficking in organs from deceased persons.

The transnational character of trafficking in organs is represented in figure 4 that schematically depicts the different modes of movement of both recipients and organ suppliers between countries. Mode 1 shows a recipient travelling from country A to country B, where the organ supplier and the transplant centre are located. Mode 2 shows an organ supplier travelling from country A to country B, where the recipient and the transplant centre are located. Mode 3 shows a situation where both recipient and organ supplier from country A travel to country B, where the transplant centre is located. Mode 4 shows a situation where the recipient from country A and the organ supplier from country B, both travel to country C where the transplant centre is located.

**Figure 4: Modes of transnational trafficking in organs**



Source: Shimazono WHO 2008

<sup>39</sup> Gunnarson M, Lundin S., The complexities of Victimhood: Insights from the Organ Trade, Somatechnics, 2015 (in press).

<sup>40</sup> Declaration of Istanbul on organ trafficking and transplant tourism, 2008.

As can be deduced from the above scheme, the operation of a trafficking network is essentially dependent on the travel of both recipients and suppliers, which calls for careful logistics, including: travel documents (flight tickets, visas, passports); ground/air transportation and accommodation; forged/fraudulent consent declarations and identity documents; financial transactions (mainly in cash); timely blood and tissue typing; obtaining recipients medical record.

An important issue is the observation that for both the recipient and the organ supplier the preparation of both the removal and the transplant must be done well in advance, so that the recipient and the supplier stay as short as possible in the country where the transplant is to be performed. This is done to diminish the risk of detection of the operation: in many cases both the recipient and the supplier are discharged and sent back home within a week, with grave risks to their health.

Further information and details on the actual modus operandi of organ traffickers is presented in Chapter 8 where some recent cases are described in detail.

## 5.5 Financial aspects of trafficking in organs

There can be no doubt that the aim of organ traffickers is material gain rather than delivering safe and good quality medical care, although it is claimed by some that commercial transplants do relieve the shortage of transplantable organs. The huge profit from illicit transplants is also achieved with a relative small risk of prosecution for the perpetrators. The US based Institute for Global Financial Integrity, in its 2011 report, presented a rough estimate that organ trafficking may generate illegal profits in the range of USD 600 million to USD 1.2 billion per year<sup>41</sup>. In the following section the financial consequences for organ suppliers (vendors), as well as recipients are analysed; also an estimate of the illegal profits made by the traffickers is presented.

### **Payments to organ suppliers**

The amounts of money paid to organ suppliers (victims of trafficking) show great variation across the globe. Media reports as well as police investigation in several prosecuted cases has yielded credible information. Table 1 presents some of this data.

**Table 1: Average amounts of money promised/paid for illicitly obtained kidneys**

Country of origin	Amount received	Source
<b>India</b>	USD 1 400	Goyal
Goyal	USD 1 740 - USD 2 400	Naqvi, Moazam
<b>The Philippines</b>	USD 2 300 - USD 6 300	Padilla, Awaya
<b>Bangladesh</b>	USD 1 400	Moniruzzaman
<b>Colombia</b>	USD 1 700	Mendoza
<b>Brazil</b>	USD 3 000	Netcare case
<b>Romania</b>	USD 6 000	Netcare case
<b>Moldova</b>	USD 2 500 - USD 3 000	Vermot-Mangold, Lundin
<b>Israel</b>	USD 20 000	Netcare case
<b>Turkey</b>	USD 10 000 - USD 20 000	Medicus case
<b>Israel</b>	USD 10 000	Rosenbaum case

<sup>41</sup> Haken J., *Transnational crime in the Developing World*, Washington DC: Global Financial Integrity, 2011.

The amounts above originate from studies and surveys where a sizable number of vendors (30-300) could be interviewed. In most cases the amount that was actually received by the vendors, was 25 to 50 % lower than the sum that was initially promised. The cash payment was usually done in instalments: an initial payment at the time of recruitment and the final payment after the transplant had been performed. Individual cases are reported where the vendor received no payment at all, because of costs of travel, lodging and documents that had to be paid back.

### **Sums paid by organ recipients**

Patients who are in search of illicitly obtained organs (buyers) must expect to be charged very considerable amounts by the brokers/traffickers who provide such 'services'. Reports by the CoE and the WHO mention black market prices for kidneys ranging from USD 100 000 to USD 200 000<sup>42</sup>.

A literature study by the HOTT Project consortium found however, that the actual amounts of money paid by recipients vary extensively<sup>43</sup>. Table 2 shows this data.

**Table 2: Actual payments made by organ buyers**

Country of origin	Transplanted in	Organ	Amount (mean)	Source
Turkey	Iraq/India	kidney	USD 20.000	Erikoglu
Egypt	China	liver	USD 40 000-USD 75 000	Abdeldayem
Pakistan	Pakistan	kidney	USD 7 300	Rizvi
Foreign	Pakistan	kidney	USD 25 000	Rizvi
Turkey	Egypt	kidney	USD 35 000-USD 40 000	Yakupaglu
Korea	China	kidney	USD 42 000	Kwon
Korea	China	liver	USD 63 000	Kwon
Israel, USA	S.Africa	kidney	USD 100 000-USD 120 000	Netcare case
USA	USA	kidney	USD 120 000 - USD 160 000	Rosenbaum case
Germany/Israel	Kosovo	kidney	USD 108 000	Medicus case

In some cases (Pakistan, Iraq, Philippines) the recipients are offered 'transplant packages' covering the payment to the organ vendor, surgery, hospital stay and immunosuppressive drugs. In other cases recipients would have to make additional payments for travel, tests, documents and accommodation.

### **Profits gained by traffickers**

The existing data on the proceedings in trafficking in organs is very incomplete and does not give good insight into the money flows involved in this operation. However, what is clear from the cases that have been investigated and prosecuted, is that the (international) brokers are pivotal to the trafficking network and consequently stand to receive the highest profits (more than 50 % of the sums paid by recipients). It is usually these brokers who fix the price for the illegal transplant, as well as the 'fee' for the organ supplier, dependent on his insight into the 'market' and the circumstances of the recipients.

In most cases the recipients pay directly the brokers, who are their first contacts; in some cases payments have also been made to the hospital or doctor. What is also clear from the investigated cases, is that the

<sup>42</sup> Vermot-Mangold, RG., *Trafficking in organs in Europe*, Report to the CoE Parliamentary Assembly, 2003, and WHO Bulletin, 2004; 82: 639-718.

<sup>43</sup> HOTT-Project, Combating trafficking in persons for the purpose of organ removal, see [www.hottproject.com](http://www.hottproject.com).

broker has to spend money on local recruiters, people who accompany the recipient during his travel and stay ('minders'), pay bribes to police and custom officers, and of course has to pay the hospital/surgeon. From many reports on trafficking cases, one issue stands out, namely that the level of corruption in a country is an important prerequisite for successful trafficking. In the India Gurgaon trafficking case (see chapter 8) the central broker had bribed his way out of prison several times, paid extortion money to local mafia, and was finally arrested in Nepal while on the run carrying more than USD 200 000 in cash for bribes<sup>44</sup>.

Table 3 sums up the information coming out of a selected number of trafficking cases that were investigated and prosecuted.

**Table 3: Proceeds of trafficking in organs**

Case	Payments by recipients	Fees paid to supplier	Nr. of transplants	Comments
<b>Gurgaon, India</b>	USD 37 500- USD 60 000	USD 400 – USD 1 200	500-600 (estimate)	trafficking over a ten year period
<b>Rosenbaum case, USA</b>	USD 120 000- USD 160 000	USD 25 000	3 cases identified and charged	trafficking over the 2001-08 period
<b>Netcare case, South Africa</b>	USD 120 000	USD 6 000- USD 20 000	109 cases identified and charged	trafficking over the 2001- 03 period
<b>Medicus case, Kosovo</b>	USD 108 000	USD 20 000- USD 30 000	24 cases identified and charged	trafficking over the 2005-08 period
<b>Shalimov Institute case, Ukraine</b>	USD 100 000	USD 10 000- USD 15 000	25 cases identified, estimate 100 cases	trafficking over the 2009-10 period

From this information it becomes clear that trafficking in organs can become a multimillion dollar business, and that such an operation can go on for several years before being detected. Although in the above cases the main perpetrators were sentenced to pay considerable fines, the criminal proceeds of their trafficking were not always traced and seized.

## 5.6 Risks of organ trafficking: to suppliers, recipients

### **Health risks to suppliers**

The existing reports on THBOR make it very clear that traffickers chose their organ suppliers from the most vulnerable populations. Also the experiences of these victims during the trafficking event, based on witness reports, show that the traffickers have little consideration for their victims' wellbeing. From the available reports and surveys where the suppliers of trafficked organs have been interviewed concerning their experiences, it comes out that most of them are left to care for themselves once the organ removal and transplant have been performed and the final payment for their services has been made. Many suppliers are aware that selling a kidney is illegal and punishable and therefore will not go to the police or other authorities in case of problems; in some cases they are threatened by local recruiters to prevent them from making complaints. Apart from having their human rights violated, suppliers also face many other serious consequences of their having lost a kidney. Reports show that most suppliers do not benefit economically from having sold a kidney in the long run; energy loss, pain and health complications lead

<sup>44</sup> Discover Magazine, April 2010, 'The Downfall of India's kidney kingpin'.

to deterioration of health, loss of a job and relapse into debt and poverty<sup>45</sup>. Most victims have no access to post-op care or check-up. There are frequent reports of depression and shame, and in some societies being an organ seller carries social stigma<sup>46</sup>. Problematic is the fact that in many cases of THBOR and transplant tourism, the organ suppliers cannot be traced to see if help is needed.

### **Health risks to recipients**

Whereas the evidence that selling a kidney in the context of a trafficking operation leads to serious health and social risk for the organ seller (victim) is overwhelming, things are less clear for the recipients of commercial transplants. Data on the outcome of overseas commercial transplants in recipients from western countries are scarce and give a diffuse picture that is not easy to interpret. Sajjad et al. conducted a systematic review of 29 studies in 2008, and compared the medical outcomes of both recipients (buyers) and suppliers (sellers)<sup>47</sup>. Their conclusion is that most studies show that the outcomes of transplants received abroad by patients from developed countries (USA, Canada, Australia, Turkey, UK) are (moderately to seriously) worse than those of transplants performed in the patients' home countries (post-operative complications, graft and patient survival). Transplants performed in India and Pakistan showed the worst results; those performed in China and the Philippines did not give significantly inferior results. Transplants performed over the 1990–00 period showed worse outcomes than transplants done after 2000. Complications that recipients reported are: surgical complications, postoperative hernia, wound infections, donor-derived infections (HIV, Hepatitis B, CMV, fungal infections), acute myocardial infarction, steroid diabetes, and also a higher risk of acute rejection, inferior graft and patient survival. An additional problem in treating post-transplant complication is the fact that the documentation from the overseas transplant centre is usually lacking in detail; donor information is often totally absent.

A striking observation is that there is very little information on the outcome of commercial transplants in European patients who travelled abroad. This may be because the numbers per country are relatively small and there is no systematic follow-up of commercial transplants. Exceptions are reports from the UK<sup>48</sup> and Macedonia<sup>49</sup>, that show that the risk associated with overseas transplants (Pakistan, India) is three times as high as for transplants performed in the home country. Because of the risk of post-transplant complications, sometimes even death, recipients of trafficked organs are also seen by some as victims of trafficking in organs. In general however, their fate is not comparable to the hardship and suffering of the organ suppliers.

<sup>45</sup> Goyal M., Mehta RL. et al., *Economic and health consequences of selling a kidney in India*, J Am Med Assoc 2002; 288: 1589-93. Naqvi S., Ali B. et al., *A socioeconomic survey of kidney vendors in Pakistan*, Transplant Int. 2007; 20: 034-9. Paguirigan MS., *Sacrificing something important: the lived experience of compensated kidney donors in the Philippines*, Nephrol Nurs J. 2012; 39: 107-17. Budiani-Saberi, D. et al., *Care for commercial living donors: the experience of an NGO's outreach in Egypt*, Transplant Int. 2011; 24:317-23.

<sup>46</sup> Lundin S., *Organ economy: organ trafficking in Moldova and Israel*, Public Underst Sci. 2012; 21: 226-41. BBC News, 'Moldova's desperate organ donors', 21 May 2003. Codreanu I., Codreanu N. et al., *The long-term consequences of kidney donation in the victims of trafficking in human beings for the purpose of organ removal*, Transplantation 2010: 90. Vermot-Mangold RG., *Trafficking in organs in Europe* CoE 2003, Doc. 9822.

<sup>47</sup> Sajjad I, Baines LS, et al., *Commercialisation of kidney transplants, a systematic review of outcomes in recipients and donors*. Am J of Nephrol 2008; 28: 744-54.

<sup>48</sup> Cronin A, Johnson R et al., 'Solving the kidney transplant crisis for minority groups in the UK: Is being transplanted overseas the answer?', *Organ Transplantation: Ethical, Legal and Psychosocial Aspects. Expanding the European Platform*, W. Weimar, M. A. Bos, J. J. V. Busschbach (Eds.), 2011.

<sup>49</sup> Ivanovski N et al., *The organ shortage in the Balkans. Pakistan – the new hope on the horizon?*, *Organ Transplantation: Ethical, Legal and Psychosocial Aspects. Expanding the European Platform*, W. Weimar, M. A. Bos, J. J. V. Busschbach (Eds.), 2011.

## 6 The ethical and legal framework against organ commercialism

### 6.1 Introduction

In the past decades a number of international and European standards have been developed to create a comprehensive ethical and legal framework, consisting of guidelines and binding legal instruments, that make it possible to a) prohibit commercialisation of human body parts, and b) combat and prevent trafficking in human beings (THB), including for the removal of organs, and protect and assist victims of trafficking. International organisations, such as the United Nations General Assembly, the World Health Organization, the World Medical Association, as well as The Transplantation Society and the International Society of Nephrology (in the joint Declaration of Istanbul), all have made important steps to help curb the growing problem of trafficking in human beings, including human trafficking for the removal of organs. The same holds true for European organisations such as the EU, the Council of Europe and the OSCE. The joint Council of Europe/United Nations study 'Trafficking in organs, tissues and cells and trafficking in human beings for the purpose of the removal of organs' of 2009<sup>50</sup> gives an excellent overview of these conventions, resolutions and recommendations. In this chapter the focus will be specifically on the main contributions to the ethical and legal framework for the prohibition of commercialisation. The following chapter 7 aims at describing the legal framework for combating trafficking in human beings (THB), and the contributions of different international and European organisations. Chapter 6 will illustrate the modus operandi of trafficking networks by analysing a number of high-profile trafficking cases that relate directly or indirectly to Europe. These concrete case-studies will also serve to highlight the problems and challenges of law enforcement agencies in their action to combat and prevent trafficking in organs. Finally, in chapter 9 the European response to trafficking in organs will be outlined, and the specific European legal and policy framework analysed in more detail.

### 6.2 Ethical and legal framework against organ commercialism

The success and growth of organ and tissue transplantation worldwide stimulated the awareness that organ shortage would remain a universal problem, which prevents many patients from receiving the benefits of transplantation. A serious consequence of this shortage is that many patients will not have access to the waiting lists for transplantation, and worse still, that a considerable number of patients on the waiting list will die every year without ever getting transplanted. Deaths that are, to a certain extent, avoidable if sufficient organs were available. It is calculated that every day around 12 EU citizens and 18 US citizens die while waiting in vain for an organ. It is not surprising therefore, that the desperation of patients waiting for transplants may lead to different forms of organ commercialism, whereby organs and tissues (from living and deceased persons) are bought and sold, which leads even to the trafficking of human beings for the purpose of removing their organs. And in a world where huge economic disparity exists, this also leads to tragic inequity in the access to transplantation medicine. This in turn leads to global organ commercialism where poor and vulnerable individuals and populations are exploited to the benefit of the more wealthy citizens of the developed world.

To find an adequate response to organ commercialism, we have to go back to the basic bioethical framework underpinning organ and tissue donation and transplantation as it developed since the 1950s. This framework deals with the morally acceptable retrieval of organs, fair distribution of organs, equal access to the waiting list, among others. Key values in these processes are: respect for individuals, autonomy, human dignity, ensuring informed consent and voluntariness. From these core values it follows that efforts to bridge the gap between demand and supply of organs must not include the

<sup>50</sup> CoE/UN Joint study on Trafficking in organs, tissues and cells and trafficking in human beings for the purpose of the removal of organs. Directorate General of Human Rights and Legal Affairs, Council of Europe, 2009.

commercial trade in organs and tissues. For this particular reason international and European organisations have developed ethical and legal standards that prohibit organ commercialism.

## 6.3 International standards and legal framework against organ commercialism

### 6.3.1 World Health Organisation

Between 1987 and 2010 the WHO (and its World Health Assembly) has been working towards ethical standards in the field of human organ and tissue donation and transplantation. In 1991 the first version of the Guiding Principles on Human Organ Transplantation was adopted: focusing on key issues such as free and voluntary informed consent and non-commercialisation of human organ and tissues<sup>51</sup>. These Guiding Principles were updated in 2008, elaborating the prohibition of sale or purchase of organs, and emphasising the relation between organ sales and human trafficking. In 2010 a revised version of the Guiding Principles has been published, which has adopted 'measures to protect the poorest and vulnerable groups from transplant tourism and the sale of organs and tissues.' The revised Guidelines called for special attention to the international trafficking in human organs and tissues<sup>52</sup>. The WHO standards and principles provide guidance to countries' health authorities and health professionals, but they are not legally binding in character.

### 6.3.2 World Medical Association

As early as 1985 the World Medical Association (WMA) had issued a Statement on Live Organ Trade<sup>53</sup>, stating the WMA 'condemns the purchase and sale of human organs for transplantation, and calls on governments to take effective steps to prevent the commercial use of human organs.' And in October 2000 the World Medical Association (WMA) adopted its Statement on Human Organ Donation and Transplantation. It promoted a policy based on ethical principles to give guidance to medical associations, physicians and other healthcare providers in issues relating to organ donation and transplantation. One of the key topics was the universal principle of non-commercialisation of human organs. Paragraph 30 of the WMA Statement said: 'Payment for organs must be prohibited. A financial incentive compromises the voluntariness of the choice and the altruistic basis for organ donation. Furthermore, access to needed medical treatment based on ability to pay is inconsistent with the principles of justice. Organs suspected to have been obtained through commercial transaction must not be accepted for transplantation. In addition, the advertisement of organs in exchange for money should be prohibited.' In October 2006, the WMA General Assembly revised its Statement and reiterated its prohibition of commercialism<sup>54</sup>. The WMA Statement aims to provide guidance to all health professionals, both individual and as members of medical associations, but has no legally binding character.

### 6.3.3 The Declaration of Istanbul and the DICG

The Declaration of Istanbul (DOI) is not a legally binding treaty or law enforcement instrument either, but essentially a statement aiming to guide the professional behaviour of physicians and health care institutions<sup>55</sup>. It provides a set of moral principles to govern organ donation and transplantation in general, as well as practice proposals to combat, curb and prevent human organ trafficking<sup>56</sup>. It derives its

<sup>51</sup> WHO, World Health Assembly. Resolution WHA42.5 on 'preventing the purchase and sale of human organs', and Resolution WHA44.5 on 'Guiding principles on human organ transplantation', 1991.

<sup>52</sup> WHO 2010, Revised Guiding Principles on Human Cell, Tissue and Organ Transplantation. Resolution WHA63.22.

<sup>53</sup> WMA Statement on Live Organ Trade, 1985.

<sup>54</sup> WMA Statement on Human Organ Donation and Transplantation, adopted by the 52nd WMA General Assembly in Edinburgh, October 2000.

<sup>55</sup> Danovitch GM, Chapman J et al., *Organ trafficking and transplant tourism: the role of global professional ethical standards – The 2008 Declaration of Istanbul*. Transplantation, 2013; 95: 1306-12.

<sup>56</sup> Steering Committee of the Istanbul Summit, Organ trafficking and transplant tourism and commercialism: the Declaration of Istanbul, Lancet 2008; 372: 5-6.

authority through the voluntary adherence by professional medical and governmental bodies to its principles. In this respect it has been likened to the Declaration of Helsinki on research involving human beings that was adopted by the World Medical Association in 1964. The voluntary nature of the DOI does not, however, preclude the incorporation of its principles into national legislation and regulations. The immediate cause for establishing the DOI in 2008, was the growing awareness, around 2005, that human organ trafficking had become a global phenomenon that threatened to defile the public and professional image of transplant medicine. And indeed, organ trafficking had over a period of two decades changed from a hidden illicit activity into a widespread visible activity that involved thousands of illegal transplants per year, using organs from poor, vulnerable and poorly compensated 'donors', originating mainly from Pakistan, India, Egypt, the Philippines, China and Colombia. In reaction to this, the Transplantation Society, together with the International Society for Nephrology (ISN), developed the DOI as a guidance statement. At the same time the DOI Custodian Group (DICG) was established with the task to promote and uphold the DOI principles in every possible way. As from January 1, 2015, the DOI has been endorsed by 111 organisations, including the Ministries of Health of Ecuador, Malaysia, and South Africa, the Council of Europe European Committee on organ transplantation (CD-P-TO), and the United Network for Organ Sharing of the United States (UNOS). The DICG was established to foster transparency in transplant practice, promote education on organ donation and transplantation, and encourage all endorsing organisations to adhere to the DOI principles. DICG will also withhold academic recognition from transplant professionals who do not adhere to the DOI principles (e.g. by refusing publication of their articles in transplant journals). In the first 5 years since the DICG was established, it was instrumental in inducing several countries to initiate and implement major changes in organ donation and transplantation policy and practice, where before they were known as 'trafficking hubs' (Pakistan: new legislation in 2010; India: amendment to the THOA law in 2008; China: some positive steps towards abandoning the use of executed prisoners as donors, ban on organ transplants in foreign patients; the Philippines: the 2008 ban on foreign recipients receiving kidneys from Filipino donors; Egypt: the 2010 law against transplant tourism (but commercial transplants are resumed after political changes); Israel: the 2008 law no longer allows reimbursement of foreign transplants; Colombia/Latin America: substantial drop in transplants for foreign recipients)<sup>57</sup>. The effect of 5 years of DOI was analysed and assessed at a Review Meeting in April of 2013 in Doha (Qatar)<sup>58</sup>. It was concluded that 'persistent actions by DICG and the endorsing organisations have resulted in tangible changes in both medical practice and governmental policies.'

## 6.4 European ethical and legal framework against organ commercialism

### 6.4.1 The 1978 Council of Europe Resolution

In 1978 the Committee of Ministers of the CoE adopted the Resolution (78)29 'on harmonisation of legislation of member states relating to removal, grafting and transplantation of human substances'<sup>59</sup>. This Resolution prohibited any human substance from being offered for profit, either from living persons (art. 9), or from deceased persons (art. 14). This Resolution dealt with issues such as informed consent for (living and deceased) donation, and respect for anonymity of donors and recipients. It sets out these principles to be implemented in the domestic legislation of EU member states, but it is not legally binding and formulates no provisions on sanctions.

<sup>57</sup> Delmonico FL., The implications of Istanbul Declaration on organ trafficking and transplant tourism, *Curr Opin in Organ Transplantation*, 2009; 14: 116-9.

<sup>58</sup> The Doha Communiqué of the Declaration of Istanbul Custodian Group, April 14, 2013.

<sup>59</sup> Council of Europe, Committee of Ministers. Resolution (78)29 on 'Harmonisation of legislations of member states relating to removal, grafting and transplantation of human substances'. (adopted 11 May 1978).

## 6.4.2 Conclusions of the Third Conference of European Health Ministers

In November 1987 the European Health Ministers convened in Paris to discuss further measures for the protection of human rights and freedoms in relation to health and medical care<sup>60</sup>. The ministers elaborated the principles already set out in the 1978 Resolution and laid the foundation for the future CoE Convention on Biomedicine. The main conclusion was that there was a need to protect individual rights and freedoms, to avoid commercialisation of organs and transplantation, to develop policies for informing the general public and to promote European co-operation in this field. These conclusions sent out a clear political message to the member states, but did not have any binding power.

## 6.4.3 The Council of Europe Convention on Human Rights and Biomedicine

After a considerable period of preparation and negotiation finally the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine – in short the Convention on Human Rights and Biomedicine – was adopted in 1997<sup>61</sup>. The focus of this landmark piece of international legislation was to guarantee every citizen's integrity, rights and fundamental freedoms in relation to biology and medicine. Article 2 sets out the basic principle of respect for human dignity ('The interests and welfare of the human being shall prevail over the sole interest of society or science'). Key issues were the requirement of free and informed consent, strict requirements for organ and tissue removal from living donors, and the prohibition of financial gain in relation to human body parts and substances. Article 21 says: 'The human body and its parts shall not, as such, give rise to financial gain'. Finally, in article 25, member states must provide in their legislation for appropriate sanctions in case of violation of the Convention's provisions. Member states that have signed and ratified this Convention are legally bound by it.

## 6.4.4 Additional Protocol to the CoE Convention

The year 2002 saw the publication of the Additional Protocol to the Convention on Human Rights and Biomedicine, concerning transplantation of organs and tissues of human origin<sup>62</sup>. This Protocol guarantees the protection of individuals specifically in the field of organ donation and transplantation. Some key notions are: the equitable access to transplantable organs, the principle of solidarity in organ exchange, the traceability of organs and tissues, the informed consent regarding donation by living and deceased persons, the prohibition of financial gain from organs, and the allowance of compensation to donors for reasonable costs. In the field of international exchange of human organs, the distribution of organs should be based on solidarity among participating countries; also the traceability of these organs must be ensured for health reasons (transmissible diseases), as well as to prevent trafficking. Article 22 of the Protocol for the first time refers directly to the prohibition of organ trafficking, as a form of making financial gain from the human body, but also as unacceptable violation of human rights by exploiting vulnerable individuals. Finally, the Additional Protocol formulates appropriate sanctions to any infringement of these provisions. As the Additional Protocol is to be regarded as an addition to the 1997 Convention, its articles are part of this Convention and have the same binding power.

Additionally to the CoE Convention a range of Recommendations of the CoE Committee of Ministers have been issued on topics directly related to organ donation and transplantation, including the management of organ donor registers (Rec (2003)12), kidney transplantation from unrelated living donors (CM/Res (2008)6), and the role and training of professionals responsible for organ donation

<sup>60</sup> Conclusions of the 3rd Conference of European Health Ministers, Paris, 16-17 November 1987.

<sup>61</sup> Council of Europe. Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine. (CETS no.186), Oviedo, 4 April 1997.

<sup>62</sup> Council of Europe. Additional Protocol to the Convention on Human Rights and Biomedicine, concerning Transplantation of Organs and Tissues of Human Origin. (CETS No. 186), Strasbourg, 24 January, 2002.

(donor coordinators) (Rec (2005)11). Of particular importance for this study is the Recommendation Rec (2004)7 on organ trafficking<sup>63</sup>. The main message of this Recommendation to the member states is that 'Member states should protect the dignity and identity of all persons and guarantee without discrimination their fundamental rights and freedoms with regard to organ and tissue transplantation. Member states should make it clear to all that organ trafficking exploits human beings and is illegal, and should take all possible measures to prevent organ trafficking.' The focus here is on prevention, which should be achieved by: improving organ and tissue availability (self-sufficiency); assuring traceability of human organs and tissues; prohibiting payments; better use of legal instruments; information to the general public; and full international co-operation.

This overview shows that the ethical, legal and policy framework around the concept of non-commercialisation of human organs and tissues is firmly rooted in international and European conventions and protocols that have provided non-binding guidelines, as well as legally binding instruments to prohibit commercial transplants. The concept of non-commercialism is evidently closely connected to the fight against and the prevention of organ trafficking. Chapter 7 will give an overview of the legal and policy framework concerning trafficking in human beings, including the removal of organs.

<sup>63</sup> CoE Recommendation REC (2004)7 of the Committee of Ministers to member states on organ trafficking. 19 May 2004.

## 7 The legal and policy framework against trafficking in human beings (including the removal of organs)

### 7.1 Introduction

In this chapter the focus is on the legal framework against trafficking in human beings (THB). From a moral perspective trafficking in human beings is (almost) universally recognised as an infringement of the fundamental rights and dignity of the individual. At the same time, from a more legal perspective, it also represents a serious form of transnational organised crime. Taken together these arguments explain why the act of trafficking in human beings is widely criminalised, both on the basis of international legal instruments and in domestic legislation. It is therefore not surprising that the original UN Convention against Transnational Organised Crime<sup>64</sup>, was accompanied by an Additional Protocol, focusing on trafficking in human beings. This Additional Protocol was the first multilateral treaty that explicitly and specifically recognised human trafficking for organ removal as a practice to be criminalised and punished.

### 7.2 United Nations Palermo Protocol

The United Nations Palermo Protocol is an addition to the UN Convention against Transnational Organised Crime of May 2000<sup>65</sup>. Its full title is: 'Protocol to prevent, suppress and punish trafficking in persons especially women and children', which makes it crystal clear that it is focused on trafficking of human beings (THB). The Protocol gives a comprehensive definition of THB in article 3(a), and includes trafficking for the removal of organs as a form of exploitation of persons (see paragraph 3.2 for full text of the definition). As it has been described before, the key notion in this protocol provides that in order for 'trafficking in human beings' to be recognised as organised crime it must entail all of three elements: an action (recruitment, transport), the means used to achieve that action (deception, fraud, coercion), and the purpose (exploitation in case of organ removal)<sup>66</sup>. Because of its wide definition and scope of what constitutes 'trafficking in human beings', this Protocol has been adopted by other international and European organisations as the cornerstone for law enforcement measures against human traffickers.

#### ***Weakness of the Palermo Protocol***

Although it has served as a good instrument to define the concept of trafficking of human beings for the purpose of organ removal (THBOR) in law enforcement, the Palermo Protocol also has an inherent weakness. The Protocol was established primarily to respond to the threat posed by transnational organised crime networks dealing in human trafficking. However, from the perspective of illicit organ removal and transplantation in general, it is by no means always clear that suspected commercial transplants comply with the notion of 'trafficking' and that these acts fulfil the three criteria. For instance, in cases of transplant tourism involving Filipino organ sellers, it may be difficult to prove that these sellers were actually trafficked (e.g. use of force); therefore these organ sales (although illegal) will not easily be classified as THBOR, and charged as a trafficking offence (under the terms of the Palermo Protocol or national anti-trafficking legislation). Doing this would make these cases much harder to investigate and prosecute.

<sup>64</sup> UN Convention against Transnational Organised Crime, Palermo December 2000.

<sup>65</sup> UN Protocol to prevent, suppress and punish trafficking in persons, especially women and children, supplementing the UN Convention against transnational organised crime (Palermo Protocol), 2000.

<sup>66</sup> UNODC. United Nations Convention against Transnational Organized Crime and the Protocols thereto, Vienna 2004.

### 7.3 Council of Europe Convention on Action against Trafficking in Human Beings

The CoE Convention on Action against Trafficking in Human Beings of 2005 has basically adopted the definition of THB already established by the UN Palermo Protocol and includes the removal of organs as a form of THB<sup>67</sup>. An important element in this Convention is that organ removal in the context of human trafficking constitutes a criminal offence, irrespective of whether or not the 'victim' has given consent. The fact that one or more of the 'means' have been used to obtain an organ (see paragraph 3.1), vitiates any consent. Although generally following the Palermo Protocol, the CoE Convention has some important additions. In an Explanatory Report to the Convention (2005), it is explained that 'the abuse of a position of vulnerability means abuse of any situation in which the person involved has no real and acceptable alternative to submitting to the abuse. The vulnerability may be of any kind, whether physical, psychological or economic.' In other words, it includes abusing the economic insecurity or poverty of persons who hope to improve their own lot and that of their family by agreeing to have a kidney removed. In this sense the CoE Convention demonstrates a more victim-centred approach (stemming from human rights) to human trafficking. Also in its articles, it shows more emphasis on obligations to protect trafficking victims (Arts. 10-17). However, it should be noted that protection and assistance to the victims is contingent on whether in criminal proceedings the 'trafficking' can be proven. In summary, the Convention has an anti-trafficking framework that is limited in scope, in that it does not cover all aspects of organ commercialism. This Convention is binding for all member states that have signed and ratified it.

### 7.4 European Union

In the 2002 EU Council Framework Decision on combating trafficking in human beings, the EU aimed to strengthen and complement the already existing instruments available to combat trafficking in human beings<sup>68</sup>. The central view is that 'trafficking in human beings is a crime against the person with a view to the exploitation of that person'. The definition of 'trafficking in human beings' focuses explicitly on trafficking for the purpose of forced labour or sexual exploitation (art. 1). EU member states must punish any form of recruitment, transportation, transfer or harbouring of a person who has been deprived of his/her fundamental rights, in the mentioned situations. Penalties provided for by national legislation must be 'effective, proportionate and dissuasive' (a maximum penalty of no less than 8 years of imprisonment). Although this Framework Decision in general follows the definitions and criteria of the Palermo Protocol, and criminalises trafficking in human beings, it does not mention THB for the purpose of organ removal. This Framework Decision is legally binding for all member states.

The Council Framework Decision 2002/629/JHA has been replaced in time by Directive 2011/36/EU on 'preventing and combating trafficking in human beings and protecting its victims'<sup>69</sup>. This Directive adopts a much broader concept of what should be considered 'trafficking in human beings' and also covers trafficking in human beings for the purpose of organ removal. It is described in more detail in Chapter 9, which reviews the current European response to trafficking in organs, including the relevant and recent legal instruments.

<sup>67</sup> Council of Europe, Convention on action against trafficking in human beings, (CETS 197) 2005.

<sup>68</sup> EU Council Framework Decision 2002/629/JHA of 19 July 2002 on combating trafficking in human beings, (OJL 203).

<sup>69</sup> Directive 2011/36/EU on preventing and combating trafficking in human beings and protecting its victims, of 5 April 2011 (replacing Council Framework Decision 2002/629/JHA).

## 8 Organ trafficking and law enforcement in Europe and beyond: actual cases

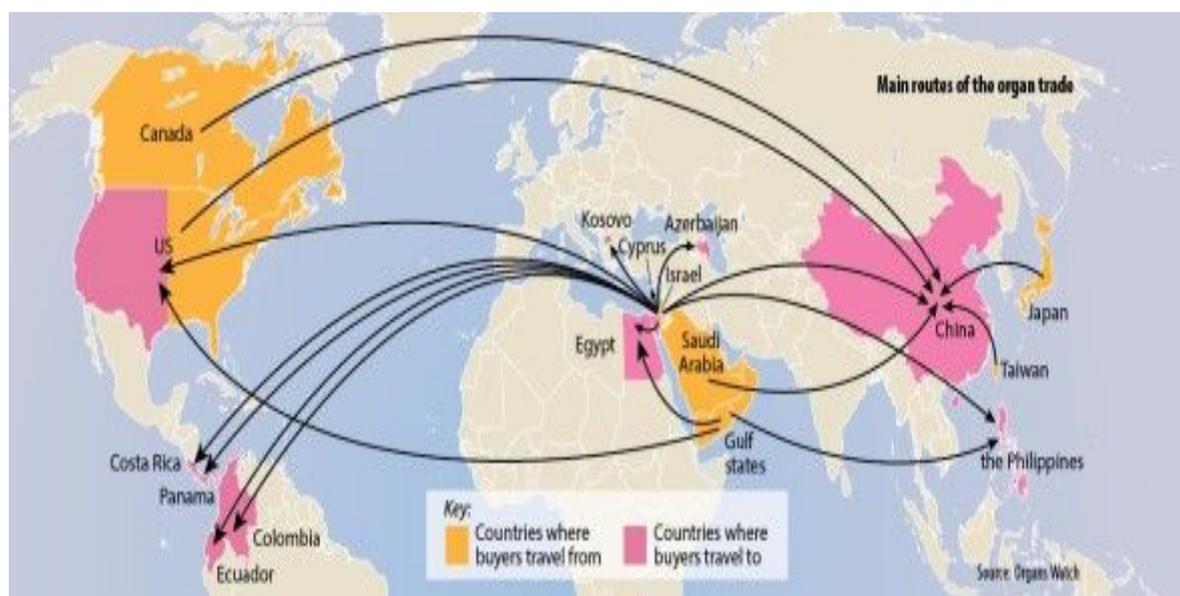
### 8.1 Introduction

In this chapter a number of high-profile trafficking cases, that relates directly or indirectly to Europe, will be analysed in somewhat greater detail, to illustrate the modus operandi of trafficking networks. These are all cases that have been detected, investigated and prosecuted. This will also serve to highlight the problems and challenges of law enforcement agencies in their action to combat and prevent trafficking in organs<sup>70</sup>. These four cases do not represent the entire list of organ trafficking cases that have been reported, investigated and prosecuted, and where European criminal networks or individual citizens (as organ suppliers or recipients) were involved. A more extensive list of trafficking cases is shown in the Annex. Apart from these investigated and prosecuted cases, there are numerous incidents involving persons, who were suspected of being involved in organ trafficking for the purpose of organ removal. However, in these cases there was insufficient evidence of trafficking on which further investigation and prosecution could be started. A number of 'incidents' of this type recently reported by the Dutch police will be briefly analysed in this chapter (see paragraph 6.5).

### 8.2 Trafficking routes

From the cases that have been investigated, a clearer view has emerged of the routes that recipients and organ suppliers have followed (see figure 5).

**Figure 5: Main routes in transnational organ trafficking networks.**



This figure brings out the already mentioned observation that trafficked organs generally go from the poor to the wealthy, and from the East and South to the West. It also shows the important role of Israel seen until recently as an 'organ importing or demand country'.

<sup>70</sup> For this chapter use has been made of a case report study, based on fieldwork interviews, prepared by the HOTT Project (3rd deliverable November 2014).

## 8.3 Four cases of trafficking in organs

### 8.3.1 The Gurgaon trafficking network, India

The Gurgaon organ trafficking case counts among the most extensive trafficking scandals worldwide<sup>71</sup>. This operation came to light in January 2008 when local police arrested several people who were accused of recruiting poor pavement dwellers in Moradabad and dealing in illegal transplant activities. The initial investigation led to the industrial township Gurgaon, near Delhi, where the key-figure in the operation was Amit Kumar, who owned a residential building and a guesthouse in that part of the town. The police raided the building that turned out to be a private – clandestine – clinic and found several people on the premises, three of them being patients that were recovering from kidney removal surgery and five foreigners (three Greek citizens and an Indian couple resident in the USA). Amit Kumar and two of his associates (his brother Jeevan and medical doctor Upendra Aggarwal) escaped being arrested after they had been tipped-off by local police. In view of the scale and nature of the scandal, the investigation was handed over to the Indian Bureau of Investigation (CBI). The Gurgaon court issued arrest warrants for the Kumar brothers. In cities close to Delhi, two more hospitals and ten laboratories were found to be involved in the illegal transplant activities. CBI alerted Interpol, who issued an international Red Alert notice for the Kumar brothers. Jeevan Kumar was arrested soon after in Mumbai; Amit Kumar was arrested by special police early February 2008 in a wildlife park in Nepal. As he was carrying a considerable amount of cash with him, he made an unsuccessful attempt to bribe the police for his release. He denied all involvement in criminal activity.

According to the police investigators, the trafficking network had been in operation for at least seven years and around 400-500 transplants may have been carried out<sup>72</sup>. The majority of recipients had been Indian kidney patients, but since 2005 more and more foreign recipients had been transplanted (from the USA, the UK, Canada, Australia, Saudi Arabia, and Greece). Amit Kumar, who was seen as the main broker ('king-pin' in Indian newspapers), had a house in Canada, from where he directed his international activities. The organ suppliers were recruited in at least eight Indian states, also with the help of local recruiters and hospitals. These suppliers were mostly urban pavement dwellers or unemployed rural peasants who were approached on the labour market, where they were looking for work. The 'kidney scouts' promised the men a job. They were all young men (aged between 20 and 35 years old), although it was found out during the trial that Kumar had also brought Nepali women to Delhi as suppliers. When it came out that the job offer was a scam, the potential suppliers were offered USD 1 000 to USD 2 500 to give a kidney; they were medically examined and kept in safe-houses until the transplant was performed. However, in many cases there had been no consent from the supplier and the kidney had been removed under threat of force. Private hospitals around Delhi taking care of the recipients during their recovery proved that a number of doctors had been involved and had taken profit. In the office of Kumar letters of 48 foreign patients were found inquiring about the possibility of a transplant.

The charges filed against the Kumar brothers and the close associates included: causing grievous bodily harm, wrongful confinement and criminal conspiracy. During the trial a number of surprising facts came to light. Neither of the Kumar brothers had ever had any medical training, but they had performed hundreds of transplants and organ removals. It also came out that Amit Kumar and his brother had been previously arrested four times for dealing in illegal organ trade in several other states; each time they had been released on bail. There were connections between the organ traffickers and the (corrupt) police, but also with the Indian urban mafia, to whom Kumar paid extortion money. During the trial of the Gurgaon case, it came out that Amit Kumar and some of his associates were also involved in illegal transplants in

<sup>71</sup> Infochange Public Health, Will the law against organ sale remain a moral victory? [www.infochangeindia.org](http://www.infochangeindia.org), 2009.

<sup>72</sup> The Sydney Morning Herald, March 2, 2010. [www.smh.com.au](http://www.smh.com.au).

the town of Faridabad, where three Turkish organ recipients had died because of medical negligence. In March 2013, a CBI special court convicted five of the ten defendants, acquitting the other five. Amit Kumar and medical doctor Upender Dublesh were sentenced to seven years imprisonment and a fine for criminal conspiracy, criminal intimidation, running a clandestine hospital facility without a licence and forgery of documents<sup>73</sup>. Included in that sentence were 4.5 years imprisonment for organ trade and four years for removing organs without valid consent. A lab technician and two local recruiters were also sentenced to 4.5 years imprisonment. Three of the organ suppliers (victims) were paid a financial compensation, because they had acted as witnesses for the prosecution. The Court gave as a reason for the high sentences that there had been a very serious breach of trust in the medical profession. One of the lawyers defending the accused had tried to convince the Court that the recipients should be considered guilty as well, but this plea was rejected. The US and Greek nationals that were found in the guesthouse on Kumar, were finally sent home as there was not enough evidence against them (they had not yet been transplanted).

Some observations:

This case demonstrates very clearly the ingredients for an organ trafficking network to operate successfully: extreme poverty, entrenched corruption, desperate (but rich) patients on dialysis, and the possibility for transnational operation. It also shows that the lack of police cooperation between Indian states made it possible for the principal broker to operate for more than ten years, working under different aliases without ever being punished. Corruption and a close nexus with the local police and mafia ensured that he could avoid arrest. There was a decisive role for the Indian Central Bureau of Investigation and Interpol to secure the arrests and get the prosecution going. In fact, this case was the first in India where the accused were actually prosecuted and sentenced, although a number of similar organ trafficking cases had been detected before. Kumar has also been charged for money laundering, while making investments (e.g. real estate, Bollywood film industry) in several countries (including India, Canada, Hong Kong and Australia). International investigation into the matter is still going on.

### 8.3.2 The Netcare trafficking network, South Africa

Investigations in this case started in 2003, when the police received various signals that illegal transplants were taking place at St. Augustine's Hospital, part of the Netcare chain, in Durban. One of these signals came from American anthropologist and founder of Organs Watch, Nancy Scheper-Hughes, whereas the other signal came from a local whistle-blower. A background investigation was first started.

Whenever an organ supplier was stopped at the airport, the police had to act openly. A search warrant was obtained to inspect and search the transplant premises, where all relevant files, including patient records and surgery reports, were confiscated. In another search at the blood bank all documents related to cross-match tests for potential organ suppliers were also taken. The documents showed indisputably that letters saying that recipients and organ suppliers in these transplants were blood-related, were forged. On the basis of this evidence arrests were made of an organ broker, a local coordinator, medical professionals at the hospital and an interpreter. Evidence and statements were obtained proving that at least 109 illegal transplants had taken place at the hospital, involving organ suppliers from Israel, Romania and Brazil, and recipients from a range of countries with the majority of recipients coming from Israel. The network consisted of a central broker (from Israel), local recruiters in Brazil who arranged transport, travel, visas, preparatory blood tests, etc. and local assistants in South Africa, who acted as chaperons and interpreters. The money flow was essentially coming from recipients to the main broker, who in turn handed money down to the hospital/surgeons and co-workers. Recipients were expected to

<sup>73</sup> ZeeNews March 22, 2013. [www.zeenews.india.com](http://www.zeenews.india.com). The Hindustan Times, 23 March 2013. [www.hindustantimes.com](http://www.hindustantimes.com).

pay up-front, whereas the suppliers were paid only after the operation had taken place. Charges were brought against the Netcare Corporation (owner of the hospital), two transplant coordinators, four surgeons, the nephrologist and an interpreter. In the end six people were been convicted (four surgeons and two transplant coordinators), but were eventually released on bail and the prosecution stopped in 2012 (because of the long delay in the case). The Netcare Corporation was fined, but criminal charges against the CEO of Netcare were withdrawn after a plea agreement had been reached.

Some conclusions:

The main legal complication in this case was the fact that at the time of the investigation and trial, South Africa did not have any legislation in place to specifically prohibit trafficking in persons for the purpose of organ removal (THBOR). Both the Human Tissue Act, and the Prevention of Organised Crime Act were not applicable and well-suited to the case. An essential loophole was that buying an organ or receiving payments by authorised health institutions was not illegal. Thus, the charges against Netcare and the defendants were specified as: fraud, forgery, unlawful acquisition, use or supply of human tissue, use or possession of proceeds from unlawful activities, and illegal receipt of payments by minors. Also, the long duration of the case (almost ten years) led the court to decide on a permanent stay of the judicial proceedings. The main broker from Israel could not be brought to trial; he was initially arrested in Israel on a charge of tax evasion and subsequently released on bail. He finally fled the country and was eventually arrested in Germany on the basis of an international arrest warrant, but was later released. The Brazil recruiter received a nine-year prison sentence in Brazil but escaped while on leave in 2009; in 2013 he was arrested in Rome on the basis of an international arrest warrant and extradited to Brazil in 2014.

### 8.3.3 The Medicus trafficking network, Kosovo

The illegal transplant activities at the Medicus Clinic in Priština, Kosovo first attracted attention in October 2008 when the Kosovo police and the Immigration service noticed foreigners arriving at the airport carrying letters of invitation to the Medicus Clinic for the treatment of heart conditions. The Medicus Clinic was not particularly renowned for treating this disease. Subsequently, in November 2008, three persons who turned out to be an Israeli organ broker, an organ supplier on his way back to Istanbul and a third person who turned out to be the brother of the recipient to whom the supplier had given his kidney were stopped at the airport. The supplier was questioned, but was found to be in a very poor health condition. He confessed to having had his kidney removed. Upon this, the Medicus Clinic was searched by local police, the Department of Organised Crime and UNMIK International police. The recipient of the kidney was actually present at the clinic. The director and the owner of the clinic were arrested, and all records and computers seized. UNMIK police took over the lead in the investigation from the local police because of the sensitive political situation in Kosovo.

During the investigation and prosecution it was established that the owner of the Medicus Clinic (an urologist) had already in 2005 made contacts in Turkey to set up the trafficking network. In the following years a Turkish transplant surgeon was contracted to perform transplants in Priština and was granted a licence by the Kosovo Ministry of Health in 2008. The MOH also approved a licence for the Medicus Clinic to perform transplants, in spite of the fact that the Kosovo health law prohibited organ transplants. In 2008 at least 24 organ suppliers were recruited in foreign countries (Israel, Moldova, Russia, Ukraine, Kazakhstan and Belarus) and transported to Kosovo. These suppliers were matched to 24 recipients (from Ukraine, Israel, Turkey, Poland, Canada and Germany) and the transplant took place. The nationality of nine suppliers and five recipients could not be traced. All suppliers had to sign a document saying that they donated their kidney voluntarily to a relative or altruistically to a stranger, without any payments. They were given only short time to agree and had to sign false declarations in the local language without explanation of the content. After 4-5 days the suppliers were discharged and sent on their way home. Suppliers were promised in advance a 'fee' of up to USD 30 000. A number of them received only part of

the money and some nothing at all. They were promised the remainder of the money on condition that they themselves would recruit other 'donors'. In total six suppliers testified at the trial.

The recipients contacted the main brokers through word of mouth, and payments for the transplant were agreed for a total of USD 108 000, to be paid in advance in instalments or in cash at the arrival at the clinic. Most recipients would fly to Priština via Istanbul and were often escorted. They were issued letters of invitation for undergoing medical treatment at the Medicus Clinic to show at the airport immigration desk. Some were instructed to tell they were on travelling for leisure. After the transplant surgery they were discharged after a short period and were given information on their treatment to present to doctors in their home countries.

When the EU Rule of Law Mission (EULEX) was deployed in Kosovo, the prosecution of the trafficking case was handed over to EULEX. The investigation was complicated by the fact that the Kosovo political elite was under suspicion of being involved in the trafficking (e.g. the MOH having given out a licence to the clinic and the surgeon). Another problem was that no official search warrant had been issued at the time of the clinic search by the police. Also, the actual legal assistance and logistic support by the local court administration proved extremely difficult and challenging. From an international legal point of view making requests for legal assistance proved complex because the autonomous status of Kosovo was not unanimously recognised by all countries (e.g. cooperating with Russia was nearly impossible). Later on in the prosecution, once the relations with foreign specialists were firmly established, international cooperation became smooth.

In April 2013 the defendants were found guilty of trafficking in persons and organised crime, the owner of the clinic was also found guilty of unlawful exercise of medical care. Other charges, such as abuse of official position, inflicting grievous bodily harm, fraud and forging documents were rejected. Sentences included imprisonment up to eight years and a EUR 10 000 fine. Two other defendants were acquitted. However, after their initial arrest in 2008 the main broker (Israeli) and the Turkish surgeon left Kosovo, and in 2010 they became the subject of an International Wanted Notice of Interpol. The surgeon was later (2011) arrested in Turkey but released on bail in Istanbul, and remains on the Interpol list. The Israeli broker was finally arrested in Israel in 2012 on the basis of the Interpol warrant, and accused of separate organ trafficking acts. Their prosecution and sentencing in the Kosovo case now depends on their extradition.

Some conclusions:

The Medicus case shows that successful prosecution in a suspected trafficking case depends very much on timely investigation and arrests, and seizure of all relevant documents. In this case the analysis of the anaesthetists' operation logs proved decisive. Prosecution by EULEX was based from the start on charges of trafficking in persons and organised crime. A number of suppliers and recipients could be traced and their statements taken. Suppliers were considered victims of exploitation, fraud and coercion, and some of them acted as witnesses for prosecution. An initial stumbling block was the establishment of international legal cooperation (requesting legal assistance) involving numerous countries. Finally, the prosecution of some of the main culprits was frustrated because their extradition did not prove possible.

### 8.3.4 The Rosenbaum trafficking network, USA

The detection of this trafficking case followed in the wake of an FBI undercover operation (Operation Bid Rig) against tax evasion and corrupt public officials in New Jersey on the suspicion of money laundering in the local Jewish community. This operation was launched already in 1999, but only in 2008 did the FBI investigators hit on the trafficking operation after one of the suspects became an FBI informant. He put the FBI on the trail of the main organ broker Rabbi Levy Izhak Rosenbaum. In another undercover operation Rosenbaum was approached by an FBI agent with a request to facilitate a kidney transplant for a family member. Rosenbaum agreed to find a matching 'donor' who would be presented to the

transplant centre as a close relation, in order to pass the screening procedure. To this end fraudulent identity papers would have to be forged. The procedure would be performed at the cost of USD 160 000 to the recipient (half paid up-front and the other half shortly before the transplant). The FBI made the first payment to the bank account of a charitable organisation in Brooklyn, shortly after the FBI undercover operation resulted in the arrest of 44 people, including Rosenbaum.

During the prosecution it was established that Rosenbaum had acted as an organ trafficking broker already since 2001. He contacted his associates in Israel to locate suitable suppliers, based on blood/tissue matching. Suitable 'donors' would be looked after during the pre-transplant screening procedure. Rosenbaum would coach the recipient in the USA to make up a cover story to mislead the hospital staff performing the screening.

Initially both the recipients and the suppliers came from Israel under the flag of the Jewish charity organisation that Rosenbaum had established. Later on the recipients were mainly US citizens from orthodox Jewish communities in New Jersey and New York. The suppliers were Israeli nationals (mainly impoverished immigrants to Israel from Eastern Europe).

On 27 October 2011 Rosenbaum pleaded guilty on three counts of violating US legislation concerning the prohibition of commercial transaction involving human organs, and one count of violating US legal code concerning taking part in conspiracy (because of his criminal activities during the undercover operation). Rosenbaum was finally sentenced to 30 months imprisonment and confiscation of the criminal proceeds of the three transplants that had been proved (as well as the USD 10 000 payment that the FBI undercover agent had made).

Some observations:

The prosecution did not file charges against the recipients or suppliers, but instead had some recipients act as witnesses for the prosecution. Their reasoning was that both were under a certain amount of distress and psychological pressure, both due to their health condition and to a condition of desperate poverty. Also, there may have been a subtle psychological nudging of suppliers to fulfil their obligation (mitzvah) towards the recipients, in the context of the Jewish orthodox tradition. A legal hurdle in this case, that prevented charges involving other than the identified three trafficking case was the fact that the criminal charges were limited to what had happened in the context of the undercover operation. Another limitation was that violations under federal law could only be charged in relation to activities done in New Jersey. Finally Rosenbaum could not be charged and convicted for human trafficking, as the prosecution had not actually traced a single supplier at the time Rosenbaum pleaded guilty. When later on, close to the day of the verdict, one supplier was traced and heard, the prosecutor concluded that coercion (a requirement for human trafficking) was not evident. These legal complications led to a sentence that in light of human trafficking for organs was surprisingly mild. An alarming lesson provided by this case is that it proved relatively easy to mislead the screening procedure in the hospitals that were chosen by the recipients to perform the transplants. Nevertheless, the investigation did not find any evidence suggesting that the hospitals or surgeons were in any way implicated in the trafficking.

#### 8.4 Legal challenges in the prosecution of organ traffickers: general observations

There are a number of lessons to be learned from the above presented cases that are illustrative of trafficking in organs around the globe. In particular it is useful to focus on the legal challenges that law enforcement agencies face when considering prosecuting organ traffickers. In general law enforcement

authorities 'should be prepared to commit a lot of time, intelligence, effort and resources in order to successfully combat organ traffickers'<sup>74</sup>.

### ***Absence of applicable legislation***

In some cases the national legislation on organ transplants as well as the Penal Code is not updated to include trafficking in persons for organ removal (THBOR) as a form of (organised) crime. In the Netcare case the prosecution was hampered by the lack of suitable legislation and they had to resort to charges of fraud, unlawful acquisition and use of human tissues, as well as unlawful payments. This led to relatively light sentences. In many countries, including EU member states, the loopholes in national legislations should be amended and adapted to include criminalisation of THBOR.

### ***Flexibility of trafficking networks***

Due to the transnational nature of trafficking in organs, the key players in such operation can easily switch their base from one country to another, making it difficult for prosecutors to investigate cases and arrest perpetrators. Several Israeli brokers (e.g. in the Kosovo case) have repeatedly escaped prosecution in this way and started their operations again in a different country.

### ***International police and judicial cooperation***

The very fact that THBOR involves criminal networks that operate on a transnational scale, presents additional challenges to law enforcement agencies. Once the network has been uncovered, the investigation will spread over several countries, and even continents. This in itself is not different from the problems that occur in trafficking in persons and other types of transnational crime. The usual situation is that the country where the transplants have taken place takes the lead in the investigation and prosecution (see Medicus and Netcare cases). However, in the Moldova case (see Annex) it was the country where the majority of organ suppliers came from, while the transplants took place in Turkey. If the investigation and prosecution are taken up in a developing country (e.g. Bangladesh or the Philippines) or a country with an unstable political situation and low resources (e.g. Kosovo) the capacity for a large-scale investigation may not be present. To tackle this, the prosecution may request legal assistance from other countries when a link with that country in the trafficking network has been established (e.g. in the Medicus case legal assistance was sought with over a dozen countries). This procedure is very time-consuming and complex, and some countries may not even respond to such a request.

Another hurdle is the fact that a transnational crime network means that the law enforcers are confronted with different national jurisdictions, so that prosecution and investigation run up against the limits of their legal authority. This is particularly the case when there is the need to ask for extradition of (fugitive) members of the trafficking network who are in hiding in another country (often the main broker). However, extradition is only possible on the basis of mutual agreements between countries. If extradition is not possible, it often results in fugitive defendants being released on bail or the case dropped because the other country has no reason to detain them (e.g. lack of evidence). This has been the case in the Medicus case, where the Turkish and Israeli defendants could not be brought to trial in Kosovo.

All this points to the most urgent priority in transnational trafficking cases: the need for international police and legal cooperation. If such cooperation is not established from the start of the investigation and prosecution process, there is a risk that the case will fail because of a fragmented approach. This cooperation however is not self-evident: problems can arise when the other party is involved in the

<sup>74</sup> Holmes P., Manual for law enforcement officers on detection and investigation of trafficking related crimes, Kyiv, 2009, p. 471.

trafficking operation to a lesser extent (e.g. being the home country of some of the recipients or suppliers); in such a case a country may feel no priority to cooperate. For instance, the interest to take legal action in some countries where the suppliers in the Medicus case came from was initially – for both political and financial reasons – not overwhelming. If it had not been for EULEX taking over the case from the local Kosovo police, the prosecution would probably have halted. On the other hand there have recently been a number of cases where international cooperation has been quite successful (e.g. Rosenbaum case, Costa Rica case, Medicus case, Shalimov Institute case and Netcare case, see Annex)<sup>75</sup>.

There is also an important role for international police cooperation, for instance through Europol and Interpol. International arrest warrants issued in some cases have been successful in apprehending some of the key perpetrators (e.g. broker Amit Kumar in the Gurgaon case, and Brazil recruiter Gedaliah Taub<sup>76</sup> in the Netcare case).

An important element in international cooperation is information sharing. By collecting and sharing information on the modus operandi of organ traffickers, names of criminal collaborators, and trafficking routes, among others, networks already in operation may be detected and new trafficking networks prevented. The NGOs Organs Watch, COFS and DICG are all active in collecting and sharing such information around the world. Europol and Interpol are involved in the development of ‘indicators of human trafficking’, to help local police, immigration officers and border control officers recognise and detect illicit trafficking operations (see paragraph 7.3). An example is the development of the XDOT tool: an online reporting tool to collect, standardise and assist with the analysis of case reports, as well as examine linkages and patterns around the activities of HTOR abuses<sup>77</sup>. The ongoing HOTT Project, funded by the European Commission is making a valuable contribution by collecting and analysing such data making it available for exchange<sup>78</sup>.

### **Financial evidence**

Both the Rosenbaum case and the Gurgaon case demonstrate that police investigation should also focus on the money flows that are part of an organ trafficking operation. ‘Follow the money’ is a very useful, but sometimes neglected start for collecting criminal evidence. Trafficking networks have a need for money laundering operations, often in the form of investments in real estate, to make use of the proceeds of illegal transplants. Sometimes this leads to connections with traditional organised crime.

### **Corruption**

Situations where there is widely spread and firmly entrenched corruption, involving local police, customs and officials in the health authority or even government create additional difficulties to start in depth investigation and prosecution in trafficking cases. This is clearly shown in the Gurgaon and the Medicus cases, as well as in the Costa Rica case. In such cases the solution is often to hand the prosecution over to specially trained and trustworthy specialists, such as the Central Bureau of Investigation, FBI, Europol and Interpol.

### **Treatment of victims**

The organ suppliers in human trafficking cases are almost never considered as ‘culprits’, but rather as ‘victims’. International and national anti-trafficking legal frameworks set forth the rights to protection,

<sup>75</sup> In the Netcare case American anthropologist Dr. N. Scheper-Hughes has been instrumental in uncovering the link between South Africa and Brazil, which made legal cooperation possible.

<sup>76</sup> The Times of Israel, ‘Israeli arrested in Rome for organ trafficking’ [www.timesofisrael.com](http://www.timesofisrael.com), 9 June 2013.

<sup>77</sup> XDOT: eXpose and Disrupt Organ Trafficking. COFS <http://cofs.org/home/awareness/cofs-news/>.

<sup>78</sup> The HOTT project final report will become available end of 2015.

support, and access to justice and related services to be provided to trafficked persons<sup>79</sup>. This includes victims of THBOR. In relation to the prosecution of organ trafficking, suppliers are sometimes willing to act as witnesses for the prosecution (Medicus case, Gurgaon case), provided they are well protected. Their testimony can provide key evidence to get traffickers convicted.

### ***Position of recipients in organ trafficking***

Like organ suppliers, the recipients of illegal trafficked organs are seldom considered as ‘perpetrators’ in a trafficking operation, and almost never prosecuted. Their position however, is distinctly different from that of the victims of THBOR. It is their money that is the prime driving force behind trafficking in organs. Also, the buying of organs, and facilitating (e.g. through payments) that others are coerced into having an organ removed, is almost universally prohibited in national legislation and international (legally binding) conventions. Although patients who (intend or attempt to) buy organs in their home country commit an illegal and criminal act and may be prosecuted under the national legislation, this is generally not legally possible, when the illegal/criminal act is committed in another jurisdiction. In principle, the country where the organ buyer is a national/resident could claim the so-called extraterritorial jurisdiction (ETJ). This means that a government has the legal ability to exercise authority beyond its normal geographical borders. This means in practice that nationals of a country who commit an illegal/criminal act in another country could be prosecuted in their home country for what they did abroad, provided that the act is considered a criminal act in both countries (an example is the use of ETJ in the prosecution of European citizens for committing sexual abuse of children in South East Asia). This approach has also been advocated by some in the case of THBOR<sup>80</sup>. In December 2013 Canada has de facto introduced new legislation that creates extra-territorial jurisdiction for trafficking in persons including for the purpose of organ removal<sup>81</sup>. The Declaration of Istanbul Custodian Group has established a special Working Group on EJT<sup>82</sup>. In practice however, prosecution in organ trafficking cases does focus primarily on the brokers and other key perpetrators, and does not target recipients. Recipients may be heard as witnesses. A more preventive approach is to actively discourage potential ‘organ tourists’ by providing information on the risks of illegal transplants (for both recipient and supplier) and making a moral appeal not to treat other people’s organs (especially the poor of this world) as commodities and exploit vulnerable populations<sup>83</sup>. The DICG has issued a special brochure intended for kidney patients on the waiting list, warning against the medical, ethical and legal risks of organ tourism<sup>84</sup>.

### ***The position and responsibility of medical professionals***

Illegal organ removal and transplantation cannot possibly be performed without the assistance and expertise of health professionals, including surgeons, nephrologists, anaesthesiologists, nurses and lab technicians. Apart from cases where the main broker was a surgeon and performed the transplants himself (as in the Medicus and Gurgaon cases), these health professionals employed by the network will be fully aware of the fact that they are accomplices in a criminal act. This central role of health professionals is well recognised as an aspect of THBOR that distinguishes it from other trafficking cases. In both national and international legislation on organ trafficking, the professional duty of doctors and other medical staff to care for patients (recipients and suppliers) is emphasised, and being involved in

<sup>79</sup> OSCE, 2013 report. Addressing victims’ rights and needs in practice.

<sup>80</sup> Budiani-Saberi D (COFS), human trafficking for organ removal (HTOR): A call for prevention, protection, prosecutions and investigation.

<sup>81</sup> See Criminal Code of Canada, s.279.01-s.279.04 (<http://laws-lois.justice.gc.ca/eng/acts/C-46/page-146.html#docCont>).

<sup>82</sup> DICG, 2014. How to address organ trafficking? Point of view of the DICG.

<sup>83</sup> Gill JS, Goldberg A, et al., Policy statement of Canadian Society of Transplantation and Canadian Society of Nephrology on Organ Trafficking and Transplant Tourism, Transplantation, 2010; 90: 817-20.

<sup>84</sup> DICG. Thinking of buying a kidney? STOP.

trafficking and illegal transplants is considered a grave violation of professional duties and moral principles that undermines the general trust in medical practice. In several trafficking cases surgeons and other health professionals have pleaded that they were not aware of the fact that recipients and suppliers were not actually blood-related, and that they trusted the (forged) documents declaring this relationship. The same goes for written consent forms and declarations stating that no payment was made. However, most prosecutors in trafficking cases have not accepted such attempts to deny responsibility, and have confirmed the criminal liability of health professionals<sup>85</sup>. Sometimes the investigation in trafficking cases is hampered because doctors will make an appeal to confidentiality principles, and refuse to divulge information concerning recipients/suppliers. But in other cases doctors have been valuable witnesses and sources of information for the prosecution.

Apart from health professionals who are directly involved in illegal transplants and the preparation and execution of organ trafficking, there are other categories of health professionals who are more indirectly involved:

- Doctors and nurses employed by (private) hospitals, who rent out their facilities to trafficking networks
- Lab technicians performing tissue matching procedures in authorised facilities, who are not aware of the illegal nature of the transplants
- Doctors who take care of the post-transplant recovery of recipients, but are not part of the criminal network
- Doctors in countries of origin of the transplant tourists who perform preparatory tests and/or counsel their patients on being transplanted abroad

It is plausible that these health professionals are not always aware of the fact that they are 'used' in a criminal trafficking operation, or are unintentionally facilitating THBOR and illegal transplants. In a number of trafficking cases (e.g. Gurgaon, Rosenbaum case) these health professionals have not been charged or were acquitted.

The international transplant community has recently made important efforts to formulate and promote ethical principles and guidelines for health professionals on how to deal with suspected cases that may point to illegal activities. The Declaration of Istanbul Custodian Group is active in raising awareness among health professionals in order to prevent them from getting unintentionally involved in facilitating transplant tourism, or being accused of 'aiding and abetting' THBOR<sup>86,87</sup>.

## 8.5 Suspected cases of organ trafficking

In the past decade approximately a dozen cases of THBOR in Europe, or involving European citizens have been investigated and prosecuted (see Annex). However, there is an unknown number of cases where police, border control or immigration officers have been confronted with potential cases of trafficking in persons, and where organ removal could have played a role. These cases often do not carry sufficient and convincing signals that justify further investigation, and these officers may not be well acquainted with this form of human trafficking. As a result, these suspected cases will not lead to any prosecution and conviction. So far there is no systematic (international) registration of such cases and no international cooperation for follow-up.

<sup>85</sup> In the Medicus case, the main prosecutor labelled these arguments 'willful blindness'.

<sup>86</sup> Codreanu I, Renal Foundation, Moldova. Medical professionals responsibilities in preventing organ trafficking, 2014.

<sup>87</sup> Martin DE., *How to address organ trafficking* – Point of view of the DICG, 2014.

In December 2014 the National Information Service of the Dutch Police published a study report on trafficking in organs and trafficking in human beings for the purpose of organ removal<sup>88</sup>. It is reported that between 2005 and 2013 at least five crime reports have been made by the Dutch police involving foreign nationals who complained to have been threatened with organ removal. Two people declared that they had been trafficked to the Netherlands for the purpose of organ removal, in one case under threat of force. Three others declared they had come to the Netherlands seeking asylum or work; once in the Netherlands the job was not available and the smugglers demanded the debts to be paid off by giving up a kidney. In none of these cases there were sufficient indications or evidence of human trafficking, reason why no further investigation was started. Other cases have raised suspicions that the Netherlands could be involved as a transit country for people trafficking for the purpose of organ removal. In 2005 border control/immigration officers at Schiphol International Airport questioned a Pakistani physician (transplant surgeon) travelling accompanied by three minors holding Pakistani passports that turned out to be fake. The man was arrested on suspicion of human trafficking, potentially for the purpose of organ removal. Further questioning revealed that the boys were Afghani nationals living in a refugee camp in Pakistan. They declared that their final destination was the UK, where they would work or go to school. In spite of strong suspicions and indications it could not be proven that the boys were smuggled for the removal of their organs, or that they were coerced in any way. In appeal the Pakistani doctor was convicted to 16 months imprisonment for person trafficking, and possession of false identity papers. The Afghani boys requested asylum in the Netherlands, but subsequently left for an unknown destination. Similar cases have been reported in several other European countries.

<sup>88</sup> Dutch Police, National Unit, Information Service. De Jong J. Organ trafficking and trafficking in human beings for the purpose of organ removal. An explorative study into the involvement of the Netherlands and Europe, December 2014.

## 9 Current European response to trafficking in organs: policies and action points

### 9.1 Introduction

In this chapter the current European response to the increase of trafficking in organs will be reviewed and analysed in more detail. In particular the recommendations, resolutions and legislative instruments developed by the EU, the Organization for Security and Co-operation in Europe (OSCE), and the Council of Europe (CoE) will be highlighted.

### 9.2 European Union

The EU has a long track record of legislative initiatives to deal with the quality and safety of organ/tissue donation and transplantation, and the trafficking in human beings, including for the removal of organs. These legal instruments will be discussed here briefly, with special focus on the strategy and actions related to trafficking in human beings, and trafficking in organs in particular.

#### 9.2.1 Setting standards of quality and safety in organ and tissue donation

Already in 2004 the European Parliament and the Council had adopted a Directive aiming at setting standards of quality and safety for the process of donation of human tissues and cells<sup>89</sup>. During the preparation of this Directive it was recognised that the donation of human organs is a process that shows much similarity to the donation of tissues and cells and raises comparable issues. However, the decision was made that these two areas should be covered by separate instruments, because of some fundamental differences. This Directive was followed by Commission Directive 2006/17/EC that aimed at implementing a number of technical procedures for the procurement of tissues and cells, in particular procedures related to reducing the risk of disease transmission and other adverse effects during donation and transplantation<sup>90</sup>.

#### 9.2.2 Towards an EU strategy plan on organ donation and transplantation: Action Plan

In May 2007 the European Commission laid the foundation for a comprehensive strategy by adopting a Communication on 'Organ donation and Transplantation: Policy Actions at EU level', to be presented to the European Parliament and the Council<sup>91</sup>. This Communication outlined the role and importance of organ transplantation over the past 50 years. It described the scientific and clinical progress, and the benefits that patients with end-stage organ failure can have through transplantation. It further focused on areas where improvements are particularly necessary. These challenges included: 1) the prevention of transplant risks, in particular transmission of donor-derived diseases, by establishing strict safety requirements; 2) relieving the organ shortage by increasing the donor pool; 3) fighting and preventing organ trafficking, which is seen as a serious ethical and political concern. The Action Plan underlines the value of EU-wide action in these fields, and identified three priority action areas: a) increasing the quality and safety of organs; b) improving organ availability; and c) increasing the efficiency and accessibility of national transplant systems. To address these issues more attention should be given to the following fields of action:

<sup>89</sup> Directive 2004/23/EC of 31 March 2004 on setting standards of quality and safety for the donation, procurement, testing, processing, preservation, storage and distribution of human tissues and cells (OJL 102, 7.4.2004).

<sup>90</sup> Commission Directive 2006/17/EC of 8 February 2006 implementing Directive 2004/23/EC of the European Parliament and of the Council as regards certain technical requirements for the donation, procurement and testing of human tissues and cells (OJL 38/40, 9.2.2006).

<sup>91</sup> Communication from the Commission to the European Parliament and the Council on "Organ Donation and Transplantation: Policy Actions at EU level" (COM (2007) 275 final).

1. developing a framework (and binding criteria) for quality and safety of organ donation and transplantation;
2. better cooperation between member states in organ allocation and exchange;
3. improving organ availability (e.g. by decreasing family refusals); raising public awareness of donation, e.g. by continuous education;
4. addressing organisational aspects, e.g. improving the national donation and allocation systems;
5. fighting organ trafficking and monitoring trafficking incidents in the EU and worldwide (actions based on the EU Charter of Fundamental Rights, art. 3).

Two priority actions were already announced: an action plan on strengthened co-operation between the member states, and developing a new EU Directive on the quality and safety of organs. In December of that same year the Council adopted its conclusions on the proposed policy actions, which were in line with the aforementioned Communication. The momentum for developing an EU wide strategy on organ donation and transplantation was further increased by a motion adopted by the European Parliament asking for an EP Resolution. On 22 April 2008 the Parliament adopted its Resolution on Organ Donation and Transplantation: Policy Actions at EU Level<sup>92</sup>.

### 9.2.3 The 2008 EP Resolution 'Policy actions at EU level'

This important piece of EU policy setting focuses on two key areas: a) the development of quality and safety requirements for the whole process of organ donation, allocation and transplantation across the EU, and b) legal and other measures to combat and prevent illegal commercial organ transplants and human trafficking for organ removal. The preamble to this Resolution stated that, while there is a steady increase in the need for transplants, there is no corresponding increase in the number of donors, which leads to a chronic organ shortage and growing waiting lists, as well as patients dying on the waiting list. This shortage must be considered an important root cause of the rapid development of organ trafficking, commercialism and transplant tourism, although there is a lack of data to understand this link. The Resolution confirms that trafficking in organs is a serious violation of fundamental human rights and dignity and is becoming an increasing global as well as a European problem. It also points out that commercial transplants present a health risk to both the donors and the recipients. Furthermore, it criticises certain member states for failing to ratify international and European conventions against THB. The main part of the Resolution focuses on the need for a Directive to ensure quality and safety requirements for organ donation and allocation across the EU to be implemented into national legislation of the member states. The EP points out that the EU member states are responsible for their national legal system for organ donation (opt-in or opt-out), but underlines the basic principle that organ donation stays strictly non-commercial. In total 60 action points are identified and described. Action points 1-48 relate to increasing the quality, safety and supply of transplantable organs, and ask for a comprehensive legislative framework and instruments to meet these targets.

Action points 49-59 focus specifically on organ trafficking. The main proposals for action here are the following:

- The need to ensure that organ donations stay strictly non-commercial (action point 21)
- Adopt strict legal provisions relating to donation from unrelated living donors, in order to exclude illicit organ selling or coercion of donors (action point 23)

<sup>92</sup> European Parliament Resolution of 22 April 2008 on Organ Donation and Transplantation: Policy Actions at EU Level (2007/2210 (INI)).

- Develop a code of conduct setting out rules whereby organs donated by (deceased) EU donors may be allocated to non-EU residents (action point 32)
- To avoid - in communication concerning organ donation - using economic terminology which suggests that organs may be treated as a commodity of the internal market (action point 38)
- To universally ban and fight the practice of organ and tissue trafficking (action point 50)
- Mechanisms of traceability should be put in place to prevent illicitly retrieved organs from entering the EU (action point 51)
- Measures should be taken to prevent transplant tourism, and to protect the poorest and most vulnerable groups and individuals from becoming trafficking victims (action point 52)
- Member states are urged to amend their criminal codes to ensure prosecution of perpetrators of organ trafficking, including medical staff involved in illegal organ transplants (action points 53 and 54)
- Potential recipients of trafficked organs and tissues must be actively discouraged from travelling overseas (transplant tourists), among others by making EU citizens criminally liable for commercially obtaining organs outside the EU (extraterritorial jurisdiction) (action point 53)
- Member states should take measures to prevent health professionals from facilitating organ and tissue trafficking (when referring patients to overseas transplant centres) (action point 54)
- Health insurance providers should be prohibited to promote organ trafficking by reimbursing costs incurred in undergoing illicit transplants (action point 54)
- Law enforcement agencies as well as medical staff should be trained to recognise organ trafficking, and report all cases to the police (action point 55)
- Member states are urged to sign and ratify relevant European and international conventions against human trafficking, where in default (action point 56)
- Europol is criticised for not providing up-to-date data on organ selling and trafficking, and is urged to improve monitoring of such cases (action point 57)
- The Action Plan on THB should be updated and measures to specifically combat organ trafficking included (action point 58).

Some observations:

This Resolution is meant to firmly set the agenda for future policy actions but does not have a binding character itself. There is no denying that this Action Plan is very comprehensive and also very ambitious in its aims to improve the quality and safety of organ donation and transplantation, strive for self-sufficiency of member states in meeting their need for transplantable organs, make more effective use of available organ sources, and promote cooperation amongst the member states to achieve all this. The EP is also aware of the fact that failure to meet the demand for organs in the EU region will perpetuate and further increase the risk of organ trafficking and organ tourism. A long-term strategy should be developed to eliminate social and economic inequalities between the EU and the poor regions of the world, as this is the root cause of organ trade and transplant tourism. National anti-trafficking legislation should be toughened up. What catches the eye is that this Resolution advocates a very strict line against (potential) recipients of trafficked organs (transplant tourists): they should be held criminally liable and

prosecuted, if necessary by applying extraterritorial jurisdiction (ETJ). The same strict approach is taken towards health professionals facilitating organ trafficking and tourism and towards insurance providers (intentionally or unintentionally) facilitating transplant tourism. The EP further advocates that all cases of trafficking or transplant tourism be reported to the police. It must be remarked that so far practically no national legislation in the EU contains or supports such actions, and that reporting recipients of commercially obtained organs to the police is widely considered a breach of medical confidentiality among health professionals.

#### 9.2.4 Directive on standards of quality and safety of human organs

On 8 December 2008 the Commission presented a proposal for the requested Directive on standards of quality and safety of human organs intended for transplantation<sup>93</sup>. In the introduction it is stressed that organ transplantation is the best option and most cost-effective treatment for end-stage organ failure, reason why this treatment modality should be available for all EU patients in need of it. To achieve the best outcome of available donor organs, dedicated efforts must be made to ensure the highest quality and safety of donated transplantable organs. The increase of available organs is also linked to the fight against trafficking in organs. However, it is stressed that the Directive will not have combating trafficking as a prime objective.

On 7 July 2010 the EP and the Council have finally adopted and published the long-awaited Directive on standards of quality and safety of human organs intended for transplantation<sup>94</sup>. This Directive is primarily aiming to ensure the availability of high quality human organs for transplantation, with a minimum of risk to the health of recipients and living donors, and the maintenance of a reliable and transparent system for obtaining and allocating these organs to patients in the member states; all this while maintaining the ethical standards.

As already stated, this Directive does not explicitly focus on combating or preventing trafficking in organs as such; and thus is not intended as a legal instrument to increase or enhance law enforcement against such illegal/criminal activities. In the Preamble (point 7) it is stated that:

'Unacceptable practices in organ donation and transplantation include trafficking in organs, sometimes linked to trafficking in persons for the purpose of the removal of organs, which constitutes a serious violation of fundamental rights and, in particular, of human dignity and physical integrity. This Directive, although having as its first objective the safety and quality of organs, contributes indirectly to combating organ trafficking through the establishment of competent authorities, the authorisation of transplant centres, the establishment of conditions of procurement and systems of traceability.'

From the articles it becomes clear that the implementation of the objectives outlined in this Directive is the responsibility of the individual member states, and in particular the national competent authorities. Art. 17 defines the obligations of these competent authorities, which includes monitoring organ exchange with third countries, organ exchange/import, and ensuring traceability of imported organs (Chapter V). Although the Directive does not mention anywhere the combat against or prevention of trafficking in organs, it can be assumed that national competent authorities - while overseeing and regulating organ exchange with third countries - should also monitor and register potential trafficking incidents. Nevertheless the Directive cannot be seen as a practical legal instrument in the fight against trafficking in organs.

<sup>93</sup> Commission proposal for a Directive on standards of quality and safety of human organs intended for transplantation (COM(2008) 819 final).

<sup>94</sup> Directive 2010/45 (53)/EU on Standards of quality and safety of human organs intended for transplantation.

### 9.2.5 EU Directive on preventing and combating trafficking in human beings

On 5 April 2011 the European Parliament and the Council adopted Directive 2011/36/EU on preventing and combating trafficking in human beings and protecting its victims.<sup>95</sup> This Directive confirms again that THB is a serious crime, and a gross violation of fundamental human rights. It makes a firm statement that preventing and combating trafficking in human beings is a priority for the Union and the members. The Directive encompasses all forms of trafficking in persons, and focuses in particular on its victims and the element of exploitation. In point 11 of the preamble it is stated that the Directive adopts 'a broader concept of what should be considered trafficking in human beings than under the former Framework Decision 2002/629/JHA, and therefore includes additional forms of exploitation'. Within the scope of such a broad definition of trafficking fall in particular the exploitation of begging, including the use of a trafficked dependent adult or child, illegal adoption and forced marriage, that all comply with the constitutive elements of THB; and also trafficking in human beings for the purpose of organ removal fits this broad definition.

A new element in this Directive is that it defines a maximum penalty of (at least) five years of imprisonment for THB (art. 4.1); this maximum penalty increases to ten years when the crime is committed (art. 4.2) against a particularly vulnerable person (e.g. a child), takes place in the framework of a criminal organisation, endangers the life of the victim, and is committed by use of serious violence. In art. 5 is laid down that legal persons can also be held criminally liable for trafficking offences (in particular persons who have a leading position within the legal person). Art. 6 defines sanctions against legal persons, which include fines, judicial supervision and temporary or permanent closure of establishments. In addition, art. 7 formulates that national competent authorities can seize and confiscate proceeds from trafficking offences.

This Directive stipulates in art. 8 that no prosecution and no penalties will be imposed on victims of trafficking for being involved in criminal activities, as they have been compelled to do so. Art. 9 stipulates that member states have a duty to start investigation and prosecution of trafficking offences, irrespective of the crime being reported by the victim, or in case the victims retracts a statement. In art. 10 the member states are directed to take measures to establish their jurisdiction over trafficking offences: 1) when the offence is committed on their territory, and 2) when it is committed by one of their nationals (outside its territory). The Directive further defines the rights of victims to receive assistance and support, and protection during criminal investigation and proceedings (in particular when the victim is a child). Finally the Directive stipulates in art. 18 and 19 that member states must take appropriate measures to prevent trafficking crimes (by education, awareness raising campaigns etc.), and assign national rapporteurs for organ trafficking (assess trends, collect statistics, measure effects of anti-trafficking actions, etc.).

Directive 2011/36/EU does not apply exclusively to THBOR but includes trafficking offences in the broadest sense. However, its importance for THBOR is that it defines very clearly the general legal/judicial response to THBOR and underlines the need for victim protection and prevention of trafficking in organs. The Directive is legally binding for all member states.

Some observations:

This Directive shows clearly that the EU has over the past decade stepped up its efforts to fight human trafficking, while also strengthening its focus on prevention and protection of trafficking victims. It is a clear sign of the continued commitment of the EU to confront the problem of trafficking. The Directive

<sup>95</sup> Directive 2011/36/EU on preventing and combating trafficking in human beings and protecting its victims, and replacing Council Framework Decision 2002/629/JHA.

offers a comprehensive legal instrument to address human trafficking (THB)<sup>96</sup>. It should be noted however, that this Directive does not apply to offences relating to trafficking in organs, tissues and cells (OTC), deriving from deceased persons, as this does not involve trafficking in live persons.

### 9.2.6 The EU Commission Communication on Eradication of THB (Four-year Strategy Plan)

In June 2012 the European Commission sent a Communication to the European Parliament, the Council, European Economic and Social Committee and the Committee of the Regions, in which the overall, long-term strategy for combating and preventing trafficking in human beings was summed up, and key priorities for the period 2012-16 were identified<sup>97</sup>. This Communication underlines the need for a comprehensive and integrated strategy and effective instruments, and sums up the EU action and initiatives taken so far. Important is the identification and explanation of five key priorities of the strategy:

- a) Identifying, protecting and assisting victims of trafficking;
- b) Stepping up the prevention of trafficking in human beings;
- c) Increasing prosecution of traffickers;
- d) Enhancing coordination and cooperation among key actors and policy coherence;
- e) Increasing knowledge of and effective response to emerging concerns related to all forms of trafficking in human beings.

One of the initiatives announced in this four-year Strategy Plan is to develop a model for an EU-wide Referral Mechanism, which will link national referral mechanisms. Its aim will be to improve identification and referral of victims of trafficking and ultimately better protect and support them. The Commission also plans to publish a report in 2016 on measures which have proved effective in discouraging the demand for trafficking and may subsequently propose a new EU legislation to implement such measures. Several EU member states have already developed and implemented such referral and identification systems (e.g. the UK National Referral Mechanism (NRM), German Federal Office for Migration and Refugees Study)<sup>98-99</sup>.

The Four Year Strategy Plan does not specifically mention trafficking of human beings for organ removal (THBOR), nor does it outline any initiatives or priorities specifically focused on trafficking in human organs. However, the five key priorities that were identified are all relevant to this field, in particular developing tools for identification of victims.

### 9.2.7 The 2014 mid-term Review of the Action Plan on Organ Donation and Transplantation

In April 2014 the European Commission published a Working Document on the mid-term review of the Action Plan on Organ Donation and Transplantation (2009-2015): Strengthened Cooperation between member states<sup>100</sup>. This very informative document provides an overview of all actions and progress that has been made so far on the issue of improving organ availability in the EU, ensuring the quality and

<sup>96</sup> In November 2011 a group of six UN agencies (UNODC, UNHCR, OHCHR, UNICEF, ILO and UN Women) have published a joint UN Commentary on the EU Directive, which aims to support the efforts of EU member states to transpose the Directive into national legislation.

<sup>97</sup> Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions. The EU Strategy towards the Eradication of Trafficking in Human Beings 2012-2016. (COM (2012) 286 final), of 19 June 2012.

<sup>98</sup> UK National Crime Agency (NCA). National Referral Mechanism (NRM), established in 2009.

<sup>99</sup> German Federal Office for Migration and Refugees, Study on Identification of victims of trafficking in human beings in international protection and forced return procedures. (German National Contact Point for the European Migration Network, 2013).

<sup>100</sup> European Commission, Commission Staff Working Document SWD(2014) 147 final of 25 April 2014, on the mid-term review of the Action Plan on Organ Donation and Transplantation (2009-2015): Strengthened Cooperation between member states.

safety of organs intended for transplantation, and promoting cooperation between member states in the area of cross-border organ exchange. However, no specific information is provided on any substantial progress in the field of combating and preventing trafficking in organs, other than reporting that Eurostat<sup>101</sup> intends to monitor and provide EU-wide data on organ trafficking (action point 7.3), and that the EC has funded the HOTT project under the Prevention of and Fight against Organised Crime Program. The HOTT project aims, among others, at establishing a list of indicators to help identify illegal trafficking activities. The Working Document further mentions cooperation with the Council of Europe, and inclusion of monitoring in Directive 2010/53/EU, making it a responsibility for national competent authorities.

### 9.2.8 Europol and Eurojust initiatives against Trafficking in Human Beings

Europol was established in 1993 as the law enforcement agency of the European Union. It serves as the EU centre for expertise in a wide field of law enforcement, it collects and analyses data on criminal activities both within the EU and outside for the purpose of combating and preventing crime. It also supports high level investigations in such areas as criminal money laundering, terrorism, cybercrime and trafficking crimes. An important aspect is initiating and supporting cooperation between police forces in the EU member states, e.g. by providing data on organised crime networks. An effective instrument for international law enforcement is the European Arrest Warrant (EAW), established in 2002<sup>102</sup>. A key area of interest is smuggling of migrants and human trafficking<sup>103</sup>. In the past the trafficking in organs was outside the jurisdiction of Europol, but more recently this crime area has come within its scope of attention<sup>104-105-106</sup>. Europol is also one of the associated partners in the EU-funded HOTT Project on Combating trafficking in persons for the purpose of organ removal.

Eurojust (the European Union's Judicial Cooperation Unit, established in 2001) has signed in October 2011, together with Europol, a Joint Statement to address trafficking in human beings in a coordinated, coherent and comprehensive manner. This joint effort includes assistance to member states to increase the number of THB investigations and prosecutions and to coordinate cross-border action to bring human traffickers to justice efficiently. In this context Eurojust has taken the initiative to develop a strategic project entitled 'Eurojust's action against trafficking in human beings'<sup>107</sup>. One of the issues is the relatively small number of actual THB prosecutions, and actions to improve this situation.

Summary conclusion concerning EU initiatives in the field of trafficking in organs:

As far as Directives and Resolutions by the EU are concerned, these bodies have made important contributions to tackling THBOR, by establishing a general strategy and framework for legal and judicial response to trafficking offences (THB). It should be noted, that whereas the EU sets out this general strategy and legal framework, it is the final responsibility of the individual member states to transpose these instruments into the national legislation and act accordingly in responding to THB crimes. Finally, although this framework is well-suited to deal with THBOR, the available legal instruments are not yet tailored to other forms of trafficking in organs, such as transplant tourism and trafficking in OTC.

<sup>101</sup> The 2013 Eurostat Report on Human Trafficking does not provide any specific information on trafficking in human organs, other than stating that this crime is included in the category 'other forms of trafficking'.

<sup>102</sup> Council Framework Decision of 13 June 2002 on the European Arrest Warrant and the surrender procedures between Member States (2002/584/JHA) O.J. 2002, L 190/1, replacing the 1957 European Convention on Extradition (ECE).

<sup>103</sup> Europol. Knowledge Product: Trafficking in Human Beings in the European Union. 1 September 2011.

<sup>104</sup> Europol Review. General report on Europol activities, 2013.

<sup>105</sup> Europol Conference: Trafficking in Human Beings – Europol perspective (Barcelona, 22 October 2013).

<sup>106</sup> Europol. Knowledge Product: Trafficking in Human Organs – Europol Perspective, 2010.

<sup>107</sup> Eurojust. Strategic project on "Eurojust's action against trafficking in human beings". Final report and action plan, October 2012.

The issue also becomes more in the forefront of the attention of two EU agencies dealing with law enforcement and judicial cooperation: Europol and Eurojust.

### 9.3 OSCE policy framework to combat trafficking in human beings

The OSCE Action Plan to Combat Trafficking in Human Beings was adopted in 2003 and revised in 2005<sup>108</sup>. This action plan broadly followed the definitions and position set out in the UN Palermo Protocol to the 2000 UN Convention against Transnational Organized Crime. Its main purpose is the definition and description of all forms of trafficking in human beings (THB), and the criminalisation of THB. As in the UN Protocol, trafficking in human beings for the purpose of organ removal (THBOR) is enumerated as a form of THB. In 2008 the OSCE adopted another policy document that focused on the criminal justice response to THB<sup>109</sup>. This document provided more detailed statements and proposals on law enforcement against traffickers and protection of victims of THB:

- All forms of THB must be criminalised in national legislation and perpetrators shall not enjoy impunity
- Cooperation between all law enforcement and judiciary bodies must be promoted
- Training on combating trafficking should be included in the curriculum for law enforcement officers
- Assistance must be provided to victims of THB (accommodation, medical and psychological care, legal counselling)
- Investigation into THB should not be dependent on reporting by victims
- Victims have a right to compensation and to claiming damages
- There must be increased cooperation between national law enforcement and international bodies (Europol, Interpol)
- Measures to disrupt trafficking networks must be intensified, including by means of investigating money laundering and financial transactions.

In 2013 the OSCE adopted an Addendum to the 2005 Action Plan aimed to provide an updated toolkit to the participating states in order to combat all forms of THB<sup>110</sup>. This Plan focused strongly on law enforcement actions at national level, based on the 3P's approach (Prosecution, Prevention, Protection). The main recommendations are:

- Criminalisation and prosecution of all forms of THB must be fully implemented in national legislation
- Criminal justice response against traffickers and their accomplices must be intensified
- Financial investigation in THB cases must be intensified, including tracing, freezing and confiscating of proceeds of THB. These seized proceeds are to be used to fund anti-trafficking initiatives or to compensate victims

<sup>108</sup> OSCE Permanent Council, Decision No. 557/Rev. 1. OSCE Action Plan to Combat Trafficking in Human Beings (Vienna, 2005).

<sup>109</sup> OSCE, Decision No. 5/08, 2008. Enhancing criminal justice responses to THB.

<sup>110</sup> OSCE Permanent Council, Decision No. 1107/corr.1 (6 December 2013). Addendum to the OSCE Action Plan to Combat Trafficking in Human Beings – one decade later.

- Better transparency and accountability in THB investigation and prosecution (capacity building and training for law enforcement officials, anti-corruption regulations)
- Better prevention of THB through: targeted awareness-raising and public education; increased capacity for monitoring, detecting, investigating and disrupting all forms of THB
- Promotion of awareness of THBOR by developing partnerships with health care and medical professionals, transplant organisations and relevant NGOs
- Training programmes for social workers, labour inspectors, airline staff, health workers on THB related issues
- Trafficked persons must be recognised as victims of THB and they must always be treated in a manner that respects human rights
- Victims should not be penalised but given social, medical and legal assistance
- Primary responsibility for combating THB lies with individual states, but there is need for cooperation at international and regional level
- Cooperation should include: collaboration between law enforcement authorities and the private sector (banks, credit card companies) to combat money laundering; collaboration between countries of origin, transit and destination, e.g. by creating joint investigation teams.

These action plans and recommendations show that the OSCE is very much focusing on the practical aspects of combating THB, including THBOR. In 2013 the OSCE did an analysis and evaluation of its own effectiveness and results to combat and prevent THB for organ removal, as well as gave credit to the contributions of others.<sup>111</sup> In a landmark report the Special Representative and Coordinator for combating THB summed up the developments in the OSCE region related to the combat against THBOR, such as the building up of a legal framework, capacity for investigation and prosecution, acquiring insight into the modus operandi of traffickers, justice response and the actual outcome of recent cases of THBOR. This report focuses for the first time exclusively on THB for the purpose of organ removal, and shows that important progress has been made in law enforcement against these traffickers. In a number of countries prosecution for THBOR was started for the first time and resulted in convictions of traffickers. It also shows that international cooperation still has a long way to go, and that individual countries do not give high priority to THBOR incidents and cases, if the illegal acts are not committed on their national territory. The report in its conclusions gives very useful recommendations for future action against THBOR.

## 9.4 Council of Europe

In 2008 the Council of Europe adopted its Convention on Action against Trafficking in Human Beings<sup>112</sup>. This convention aimed to prevent THB, to protect victims, to prosecute traffickers, and to promote coordination of national actions and international cooperation. The progress from the convention and implementation into national legislation is monitored by a Group of Experts on Action against THB (GRETA). On 5 February 2015, approximately 43 (out of 47 members) countries have ratified this convention (Belarus was the first non-member state to sign; Turkey has signed but not yet ratified). A year later, in 2009, the Council of Europe issued a Recommendation 'Towards a CoE Convention to combat

<sup>111</sup> OSCE 2013, Office of the Special Representative and Co-ordinator for combating Trafficking in Human Beings. Report: Trafficking in Human Beings for the purpose of organ Removal in the OSCE Region: Analysis and Findings.

<sup>112</sup> CoE Convention on Action against Trafficking in Human Beings CETS No. 197, of 1 February 2008.

trafficking in organs, tissues and cells of human origin<sup>113</sup>. This convention aimed to be the first international legally binding instrument to combat trafficking in organs in the broadest sense, and is open for the signature and ratification of both member and non-member states of the CoE. Instrumental in drafting this Convention was the CoE Committee of Experts on Trafficking in Human Organs, Tissues and Cells (PC-TO)<sup>114</sup>.

The Draft CoE Convention against Trafficking in Organs was approved by the European Committee on Crime Problems (CDPC) in December 2012<sup>115</sup>, and subsequently agreed by the CoE Parliamentary Assembly in 2013<sup>116</sup>. The CoE Committee on Social Affairs, Health and Sustainable Development had already given their comments and amendments in the month prior to the approval by the Parliamentary Assembly<sup>117</sup>. The Committee on Legal Affairs and Human Rights followed a month later<sup>118</sup>. Both Committees supported the draft convention, but also had the following criticisms:

- The draft convention was too much focused on the criminal aspects of organ trafficking without adequate consideration of prevention and cooperation
- There should be more attention to organ shortage as the root cause of trafficking
- Parties to the convention have a free hand in deciding whether or not to punish donors (suppliers) and recipients involved in trafficking
- There is no provision to eliminate the 'dual criminality rule' in prosecuting organ traffickers; this could encourage transplant tourism
- There is no follow-up reporting requirement for parties
- There are too many opt-out clauses in the convention: too much compromise
- There is need for an additional protocol relating to human tissues and cells.

Taking these critical remarks and amendments on board, the CoE Convention against Trafficking in Human Organs was finally adopted by the Committee of Ministers on 9 July 2014<sup>119</sup>. The new Convention is open for signature as from 25 March 2015, at the end of a planned international conference on organ trafficking to be held in Santiago de Compostela (Spain), 25-26 March 2015.

In the following paragraphs the content and key articles of the Convention will be analysed and commented on in detail.

### **Chapter I: Purposes, scope and use of terms**

In article 1 the purposes of the Convention are summed up as follows: a) to prevent and combat the trafficking in human organs by criminalisation of certain acts; b) to protect the rights of victims of

<sup>113</sup> CoE Recommendation 2009(2013): Towards a CoE convention to combat trafficking in organs, tissues and cells of human origin.

<sup>114</sup> The CoE Committee of Experts on Trafficking in Human Organs, Tissues and Cells (PC-TO), was set up by the Committee of Ministers, and worked under the authority of the European Committee on Crime Problems (CDPC). See Terms of Reference on <http://www.coer.int/PC-TO>.

<sup>115</sup> CoE, European Committee on Crime Problems. Draft Council of Europe Convention against Trafficking in Human Organs (CDPC 2012) 21, of 7 December 2012.

<sup>116</sup> CoE Parliamentary Assembly. Draft Council of Europe Convention against Trafficking in Human Organs (Doc. 13338) of 22 October 2013.

<sup>117</sup> CoE Committee on Social Affairs, Health and Sustainable Development. Committee opinion on the Draft Convention (Doc. 13289 of 30 September 2013).

<sup>118</sup> CoE Committee on Legal Affairs and Human Rights. Committee opinion on the Draft Convention (Doc. 13354 of 8 November 2013).

<sup>119</sup> CoE Convention against Trafficking in Human Organs. Committee of Ministers, Document CM92013)79 final of 9 July 2014.

trafficking in organs; and c) to facilitate cooperation at national and international levels on action against trafficking.

Article 2 sets out the scope of the Convention and defines some key terms. According to art. 2.1, the Convention 'applies to the trafficking in human organs for purposes of transplantation or other purposes, and to other forms of illicit removal and illicit implantation'.

Article 2.2 defines 'trafficking in human organs' as: 'any illicit activity in respect of human organs' (as prescribed in articles 4, 5, 7, 8 and 9 of the Convention). While 'human organ' is defined as 'a differentiated part of the human body, formed by different tissues, that maintains its structure, vascularisation and capacity to develop physiological functions with a significant level of autonomy'.

Comments:

The opening articles of the Convention demonstrate clearly how this instrument diverges from the existing legal framework that focuses on 'trafficking in human beings for the removal of organs' (THBOR). In the Convention the key concept is the 'illicit removal of organs' from either a living or a deceased person, which is not limited to persons (organ suppliers) who are trafficked. Art. 2.2 defines 'human organ' in such a way that it rules out tissues and cells of human origin.

### **Chapter II: Substantive Criminal Law**

Article 4 is again a key element of the Convention as it defines what is 'illicit removal of human organs'. Parties to the Convention shall establish as a criminal offence under their domestic law, when committed intentionally, the removal of human organs from living or deceased donors:

- a) where there was no valid consent of the living or deceased donor, or when the deceased donation was not authorised under domestic law;
- b) where the living donor, or a third party, has been offered or has received financial gain;
- c) where, in the case of a deceased donor, a third party has been offered or has received financial gain.

In addition art. 4.4 stipulates that a party to the Convention can establish as a criminal offence under its domestic law any removal of human organs from living or deceased donors that is performed outside the framework of its domestic transplant system, or performed in breach of essential national principles or rules in transplantation.

Comments:

This article makes clear that the Convention has a very broad scope going beyond the criminalisation of organ removal in the context of human trafficking. The removal of any organ from a living or deceased person is deemed 'illicit', when valid consent is absent, and/or a financial gain has been offered or received in exchange for the organ removal. In this way the Convention tries to fill important gaps in the current legal framework that focuses primarily on THBOR.

In art. 5 the Convention defines as a criminal offence the act of illicitly removing organs for implantation or other purposes than implantation.

In art. 6 any implantation of organs outside of the domestic transplant system, or violating the essential principles of national transplant legislation, is defined as a criminal offence.

Comments:

These articles broaden the scope of criminalisation under this Convention: separate from 'illicit organ removal', also 'illicit use' of these organs is defined as a criminal offence. And this use is not limited to implantation, but can also relate to commercial use e.g. to prepare medicinal products.

Article 7 of the Convention establishes as a criminal offence a number of acts, related to illicit obtainment of organs:

- a) the solicitation and recruitment of an organ donor or a recipient, carried out for financial gain to either this person or a third party;
- b) promising, offering or giving any undue advantage (money or otherwise) to healthcare professionals, healthcare officials, or private sector officials, with the purpose of performing or facilitating the removal or transplantation of an illicitly obtained organ;
- c) requesting or receiving any undue advantage (money or otherwise) by healthcare professionals, its public officials or private sector officials, with the purpose of performing or facilitating the removal or transplantation of an illicitly obtained organ.

Comments:

This article defines as a separate criminal offence the illicit solicitation, recruitment, and the offering and receiving of financial (or other) gain by different actors.

In article 8 the Convention defines as a criminal act the following acts:

- a) preparation, preservation, and storage of illicitly removed human organs;
- b) transportation, transfer, receipt, import and export of illicitly removed human organs.

Comments:

This article allows to prosecute a number of accomplices of trafficking in human organs, who assist brokers and health professionals performing illegal removals and transplants.

Article 9 establishes as a separate criminal offence 'aiding or abetting' the commission of any of the above mentioned criminal offences; as well as any intentional attempt to commit any of these offences.

In article 10 the Convention describes that countries shall take such legislative or other measures as may be necessary to establish jurisdiction over any offence established in accordance with the Convention, when the offence is committed:

- a) in its territory;
- b) on board a ship flying the flag of the country;
- c) on board an aircraft registered with the country;
- d) by one of its nationals;
- e) by a person who habitually has residence in its territory.

Parties to the Convention can make certain reservations or exceptions to the applications of these rules. Special legislative measures need to be taken by a country in case an alleged offender is present on its territory but will not be extradited to another country, for reasons of nationality.

Articles 11, 12, 13 and 14 relate to: corporate liability of legal persons and its representatives; effective, proportionate and dissuasive sanctions, including imprisonment, closure of a hospital, or seizure of criminal proceeds; aggravating circumstances (abuse of power, serious damage to or death of the victim; criminal organisation, previous convictions, victim is a child).

### **Chapter III: Criminal Procedural Law**

This chapter (articles 15, 16, and 17) deals with the initiation and continuation of criminal proceedings against organ traffickers; effective criminal investigation and prosecution; and need for cooperation in cases of requests for extradition and mutual legal assistance.

Comment:

The Convention states that, in case where a party to the Convention does not have a treaty with a country requesting extradition to that country, it can consider the Convention as a legal base to make possible that extradition.

#### **Chapter IV: Protection measures**

This chapter ([articles 18, 19, and 20](#)) deals with measures to protect victims of trafficking in organs, safeguarding their rights and interests, and offering witness protection.

#### **Chapters V: Prevention measures**

Articles [21 and 22](#) set out measures for prevention of trafficking in organs at both the national and the international level. This includes establishing transparent domestic systems for retrieval and transplantation of human organs, equitable access to transplantation for patients, awareness-raising addressed to both the general public as well as health professionals about the unlawfulness and risks of trafficking in organs.

The final **Chapters V – IX** deal with procedural and formal aspects of implementing and effectuating the Convention.

Overall comments and critical remarks:

This Convention is intended to be complementary to the already existing international legal framework and instruments that criminalise trafficking in human beings for the purpose of organ removal (e.g. UN protocol, EU Directive and Action Plan, OSCE Recommendations etc.). Whereas these frameworks are primarily focusing on trafficking in human beings, the CoE Convention is the first legal instrument to exclusively target trafficking in human organs. As it is stated in the Preamble, the Convention aims to achieve its objectives 'through the introduction of new offences supplementing the existing international legal instruments in the field of trafficking in human beings for the purpose of the removal of organs.' While the current legal instruments focus on the trafficking of (living) persons for organ removal (THBOR), the CoE Convention takes illicit removal and illegal handling of human organs as its prime target for combating trafficking in organs. This considerably widens the range of criminal offences that can be prosecuted: illicit organ removal from both living and deceased persons, other use of illicitly obtained organs than implantation, transnational transportation of illicitly obtained organs irrespective of an element of human trafficking. This is particularly important as trafficking in persons is often difficult to prove by prosecutors (all three components of THB must be proven)<sup>120</sup>. Under the current legal instruments for combating THBOR one cannot prosecute commercial transactions involving the organs from deceased persons, living persons whose organs have been removed in their home country and are transported elsewhere, or organs that have been legally obtained but are diverted to illegal use (e.g. in patients who are not eligible to receive organs under a national allocation scheme, to transplant facilities who serve transplant tourists). The CoE Convention also clearly targets brokers and their accomplices, even when not involved in human trafficking; corrupt officials and health professionals who knowingly handle illicitly obtained organs; and medical professionals who remove organs from deceased persons knowing there was no valid authorisation, or a payment/financial inducement was offered. This Convention intends to combat illegal and unethical transplant practices that still often escape prosecution.

<sup>120</sup> Lancet Comment: A needed Convention against trafficking in human organs, 2014, 383: 2187-89.

Although this Convention has the ambition and the possibility to tackle a broader range of offences involving the illicit use of human organs than the currently existing legal framework, there are also some serious shortcomings that may hamper its implementation. These concern the following aspects:

**Terminology and scope:** Although in the Preamble there is a reference to the UN Trafficking Protocol, the definition of 'trafficking' in the Convention is totally different. The Convention defines 'trafficking in human organs' as 'any illicit activity in respect of human organs'. Here the link with the UN Protocol is unclear, as the Convention makes no clear distinction between organ sales in the context of transplant tourism and trafficking of persons for the removal of organs. The term 'trafficking' itself is not clearly defined.

**Criminalisation:** The Convention criminalises the illicit removal of organs mainly on the basis of a lack of informed consent, and/or the exchange of money. By putting so much emphasis on the aspect of financial gain, other unacceptable conditions such as trafficking of persons using force, fraud or deception, seem to be neglected. To put the sale of an organ on the same level as trafficking of a person to remove his organs is, from a criminal perspective, problematic. From a legal perspective, the Convention defines 'selling an organ' as an illegal act and therefore a trafficking crime. However, the question of whether these 'organ sellers' should actually be prosecuted is ultimately left to individual states. On the other hand art. 19 of the Convention describes the legislative and other measures to protect the rights of 'victims' of trafficking crimes. It is not clear from the Convention under what conditions an organ supplier/seller becomes a victim: this means that organ sellers will generally be considered criminally liable, unless there are reasons to see them as victims.

**Opt-out clauses:** The Convention formulates in art. 30 that states, at the time of signing and ratification, can reserve the right not to apply certain articles of the Convention (e.g. art. 1.a, criminalising organ removal without consent; art. 9.3, criminalising intentional attempt; art. 10 on jurisdiction rules). These reservations may have a detrimental effect on the extent to which parties/states will feel bound by the Convention.

## 10 Conclusions and recommendations

### 10.1 Summary conclusions

In the preamble to the Declaration of Istanbul (DOI) it is stated that 'organ transplantation can be counted among the medical miracles of the twentieth century, in that it has prolonged and improved the lives of hundreds of thousands of patients worldwide. It is not only a great scientific breakthrough, but – because of the acts of generosity by organ donors and their next-of-kin – also an outstanding symbol of human solidarity'. However, the trafficking in organs that has started approximately 30 years ago and has since developed into a global phenomenon is now threatening to seriously damage the positive public image of organ donation and transplantation. Again in the words of the Declaration of Istanbul: 'The legacy of transplantation must not be the impoverished victims of organ trafficking and transplant tourism, but rather a celebration of the gift of health by one individual to another.'

These solemn words have motivated many transplant organisations, medical societies and health professionals worldwide (110 by 1 January 2015) to endorse the DOI and consider once again effective measures to combat and prevent the trafficking in organs in their domestic countries and raising awareness amongst their members. Also, in the past two decades, international and European organisations, and law enforcement agencies have worked hard to develop legal and ethical policy frameworks to be able to tackle trafficking in organs in its different forms, and find a suitable criminal justice response to disrupt and curb this global threat. The growing list of trafficking cases that have been investigated and (successfully) prosecuted in the past eight years shows that we are more effectively rising up to the challenge.

In this final chapter the main conclusions from this report will be summed up, and – where possible – recommendations for future steps will be made.

#### ***The root cause of trafficking: organ shortage***

There can be no doubt that trafficking in organs is caused by, and will persist, because there is a worldwide shortage of donor organs available for transplantation. Individual countries as well as international organisations and the EU are putting a lot of effort into trying to achieve a level of self-sufficiency in organ donation and transplantation, by such measures as promoting public awareness, to improve the willingness to donate, and fostering international cooperation and exchange of organs. However, this is not going to succeed in the short run.

Another aspect that deserves better consideration is that the developed societies (North America, Europe, Australia, Gulf States) must be more aware that they bear a heavy responsibility for the fact that trafficking in organs continues, because it is mainly the citizens of their countries that seek to obtain kidneys (and other organs) abroad. The fact that the trafficking and illegal transplants to a large extent (but not exclusively) take place in third world developing countries and target impoverished vulnerable populations, does not give wealthy developed countries the moral excuse to look the other way and stay idle. It is in fact the money coming from recipients that drives and sustains the whole trafficking business. As the ethnologist and trafficking researcher Nancy Scheper-Hughes has remarked: it is ethically unacceptable that we allow a world cut in two, where a wealthy minority of the globe's inhabitants use the poor majority as a source of spare body parts.

#### ***The scope of trafficking in organs***

Over the past decades there have been ample debates over the definition and scope of trafficking in organs. International organisations, such as the UN, and also the EU, the Council of Europe and the OSCE have focused primarily on the trafficking of human beings for the purpose of organ removal (THBOR). This is understandable, as trafficking in persons (for sexual exploitation, prostitution, forced labour etc.) has over the past decades become a growing global and also a European problem, and the development

of a suitable legal framework and effective law enforcement instruments has been primarily targeted towards this crime. However, in practice it has been shown that THBOR does by no means cover the whole phenomenon of trafficking in organs and that some forms of trafficking (e.g. organs from living and deceased persons that have already been removed, illicit organ removal without force or coercion, trafficking in human tissues and cells) are often overlooked and escape prosecution. The CoE Convention against trafficking in human organs, that has been adopted recently and is opened for signature since early 2015, aims to avoid these loopholes and may provide a much needed legal instrument to complement the existing more THBOR-focused instruments. The next biggest challenge will be the implementation of the recent legal instruments into national laws.

### ***Focus on combat and prevention of THBOR***

Despite a certain measure of success in detecting and disrupting trafficking networks, it cannot be denied that an unknown number of attempts at THBOR still goes on undetected. In other suspected cases there is not enough evidence to start criminal investigation and prosecution. A recent report by the Dutch National Police<sup>121</sup> has shown that the number of detected or suspected cases may be just the tip of the iceberg, and that police and border control/immigration officers often lack the knowledge and skills to recognise potential THBOR cases. One should also be aware that, as Europe already has taken stringent measures to combat trafficking in persons, in many cases European countries will not be the final destination of THB but rather places of transit. The 2012 UNODC report on Global Trafficking in persons has shown that a number of EU member states are the so-called THB hubs for smuggling persons into destinations outside the EU. This calls for additional training of law enforcement officials and development of effective indicators to recognise potential THB.

Another approach to the prevention of trafficking in organs should be to provide information concerning the potential risks of commercial transplants: research has shown that suppliers of commercial kidneys face serious health and social consequences as a result of their kidney removal. This calls for better awareness-raising and educational programs in potential target populations (young, unemployed, impoverished). The risk of becoming targeted by criminal organisations as a potential organ supplier has increased, also in Europe, because of the current financial and economic crisis. Better cooperation with national and international NGOs (e.g. IOM) is needed to get these education programs off the ground.

### ***More attention to the role of health professionals in organ trafficking***

For good reasons the main target of law enforcement authorities in trafficking cases are the leaders of trafficking networks, in particular the main broker(s). At the same time, as reality has shown, these criminals are the hardest to catch and prosecute, because they operate globally and may easily change countries. However, it is a fact that organ trafficking networks cannot function without the essential participation of medical specialists (surgeons, nephrologists, and anaesthesiologists), nurses and lab technicians. Also, there is the involvement of hospitals and private clinics where the transplants take place. Health professionals who are employed by and intentionally operate within the trafficking network should be considered criminals, and punished as such. However, the penalties for health professionals who are involved in illegal organ transplants are often quite low, because national transplant legislations usually only look at unlawful profit making. The THB aspect is dealt with under the Penal Code, and results in much tougher sanctions. Actual prosecution cases over the years have shown that the responsibility and role of health professionals in criminal networks has not always been given due attention, and this has led to relatively low sentences or even acquittal. New legislation on the other

<sup>121</sup> De Jong J., *Orgaanhandel en mensenhandel met het oogmerk van orgaanverwijdering. Een verkennend onderzoek naar de betrokkenheid van Nederland en Europa, Politie, Landelijke eenheid*, 2014.

hand has emphasised the criminal liability of legal persons, such as hospitals, in trafficking offences and has toughened up the penalties (as in the Netcare and the Medicus case).

Apart from being directly involved in trafficking in organs, health professionals may also contribute indirectly and unintentionally to illegal transplants, e.g. by preparing their patients for seeking a transplant abroad, counselling them, performing blood and tissue tests, providing their medical records etc. In this way they actually facilitate transplant tourism, although usually with the best of intentions for their patients' health. However, this behaviour should not be tolerated and medical associations must emphasise the responsibility that doctors have, not only for their patients, but also towards the suppliers of the kidneys who face serious health consequences. This issue of professional ethics should be introduced in the medical training of surgeons and nephrologists, and (inter)national transplant societies should promote discussion among transplant centres on the duties and ethical principles during pre- and post-transplant care of recipients. On this issue, DICG, ISN and Eurotransplant have taken initiatives to engage health professionals in a debate on professional responsibilities and a code of conduct.

### ***How to deal with organ suppliers and recipients of illegal transplants?***

Currently there is a wide difference of opinion among states concerning the question whether a person who sells an organ (with or without his consent) should be prosecuted for committing a criminal offence, or whether this person should always be treated as a 'victim' of a trafficking offence. Most national laws define the selling of an organ as a criminal act, for which the perpetrator can be prosecuted and penalised. On the other hand, in actual prosecution cases the organ suppliers/sellers are almost always considered victims and do not face prosecution and punishment, but are offered assistance and protection (e.g. when the act as witness for the prosecution). Most legal instruments do not make a clear distinction between organ sellers (e.g. a person who offers an organ for money on the internet, without the context of a trafficking network), and organ suppliers who become ensnared in a trafficking operation (through coercion, fraud or deception).

Likewise the position of recipients of illicitly removed organs also poses a problem in law enforcement. Under (inter)national legislation the buying of organs is universally prohibited and criminalised. This means that patients who engage in solicitation (requesting an organ and offering payment) risk sanctions. However, there is as yet no system or obligation for doctors to report returning transplant tourists to the police or health authorities. On the contrary, most doctors would consider such reporting as a breach of professional confidentiality. In view of the fact that many recipients of illegally obtained organs experience serious complications and health risks, many would see these recipients as victims of trafficking rather than as perpetrators. Some advocate that the fact that a patient has obtained an illegal organ abroad should be included in his medical record (for medical reasons), but not reported to authorities. Others have proposed that recipients of illegally obtained organs should be penalised by withholding reimbursement for the transplant. Some countries (e.g. Canada) however are taking steps to take legal action against these recipients by introducing extraterritorial jurisdiction that makes it possible to prosecute them for committing a criminal act abroad. Again, the current legal instruments do not clearly define under which conditions organ buyers/recipients may not be criminally liable.

### ***Law enforcement and criminal proceeds***

It has repeatedly been demonstrated that organ traffickers are primarily motivated by making money. And several prosecuted cases have demonstrated that the profits from trafficking in organs can be huge. At the same time the illegal money flows offer an opportunity for law enforcers to crack down on a trafficking network by following the money flows from the organ buyers to the brokers (who often are involved in money laundering). Seizure of criminal proceeds and confiscation of goods and real estate acquired with money coming from trafficking offences is a justified measure and may be an effective deterrent for potential traffickers.

### ***Legal framework and criminal justice response against trafficking in organs***

The past 20 years have seen a lot of efforts being made to create a legal framework that is suitable for tackling trafficking in organs. The UN Protocol, the Council of Europe Convention and the EU Directive and the EU Action Plan on organ donation and transplantation have succeeded in laying a solid basis for law enforcement against THBOR, including prevention and protection of victims. The OSCE and Europol<sup>122</sup> recommendations and guidelines have also contributed to successful investigation and prosecution in recent trafficking cases. However, what is lacking until now is a truly international binding legal instrument that criminalises all forms of trafficking in organs, especially cases where there is illegal removal of organs, but no trafficking in persons. The recently adopted CoE Convention against trafficking in organs, that is open for signature since March 2015, covers 47 European countries but is also open for non-CoE member states to join, may provide this 'missing link' in the legal framework, and offer complementary possibilities for effective criminal justice response. This Convention has a broad scope where it comes to criminalising 'illegal acts in respect to human organs', and offers targeted legal instruments, but it also shows some flaws that may weaken its effectiveness.

### ***The limitations of a criminal response to trafficking in organs***

In the past two decades a lot of effort has been put into developing an effective criminal response to confront the growing menace of trafficking in human organs. To a certain extent these efforts have also been successful, as witnessed by the increasing number of prosecuted cases lately. However, it would be a serious mistake to narrow down the problem that confronts us to the issue of trafficking of human beings for organ removal (THBOR) alone, and to assume that the best way to combat this is a criminal law response. First of all the problem, as we have seen, is much broader than trafficking and involves different forms of organ commercialism: organ sales (solicitation and commercial exchange) by individuals; transplant tourism without the trafficking aspect; removing (stealing) organs and tissues from deceased persons without their consent and offering these for sale. Secondly, what is often neglected is the fact that organ trafficking and commercialism is also a violation of basic human rights, which calls for a different legal response. Thirdly, at the basis of organ commercialism and trafficking is a 'global organ crisis' where there is an ever increasing gap between supply and demand/need. Organ commercialism and the emergence of criminal trafficking networks are some of the consequences, also caused by socio-economic and cultural factors. The example of the Philippines shows that acute financial difficulties, or even the ambition to improve the living standards of one's own family, can be the driving forces behind organ commercialism without a trafficking context. In other words: selling an organ as such does not constitute trafficking. The consequence of this is that prevention of trafficking in organs should also focus on the causes of organ commercialism: alleviating poverty, creating employment, enhancing education levels, curbing corruption, etc. Finally, the prevention of commercialism is also dependent on achieving better self-sufficiency in organ availability, through increased organ donation from deceased donors (DCD donors, extended criteria donors), as well as from living donors (unrelated donors, altruistic donors).

### ***A warning***

The combat against trafficking in organs and illegal transplants has been relatively successful in recent years, in Europe as well as in other parts of the world. However, there is a downside to this success: better investigation and tougher prosecution, combined with more effective prevention, have not made trafficking in organs disappear. It rather causes traffickers and brokers to shift their operations to other countries and continents, where widespread corruption and political instability create a good breeding ground for trafficking (e.g. parts of Latin America, North Africa and South East Asia). New target

<sup>122</sup> Europol, Trafficking in human beings in the European Union, Knowledge product, 2011.

populations are illegal immigrants, inhabitants of refugee camps and those who are badly hit by the economic crisis. Only increased international cooperation in law enforcement; and also joint efforts to increase the supply of legally retrieved organs for transplantation will bring progress.

## 10.2 Recommendations

The following are recommendations for the European Union to take a series of next steps and actions to combat and prevent trafficking in organs. Where relevant the European Parliament is addressed to take specific actions.

### 10.2.1 Continue priority actions to increase organ availability

The root cause of trafficking in human organs is still the gap between the need for transplantable organs and the actual numbers that come available. Within the EU there are huge differences between states regarding the actual numbers of organs that are donated for transplantation, and in the length of the waiting lists. Most countries still have a long way to go to reach a state of self-sufficiency. Actions to combat and prevent trafficking in organs should therefore not only focus on improving law enforcement against traffickers, but also on increasing organ availability. There are a number of potential approaches that could be considered by the EU in order to support member states in increasing the availability of transplantable organs:

- *increase deceased donation to the full potential.* There are several actions on the country level that have shown to be successful in increasing the number of available organs. The training and appointment of transplant donor coordinators is one of the success factors behind the so-called Spanish Model. However, in a number of EU member states (in the southern and Balkan region) the numbers of coordinators are still insufficient. Another approach is the introduction of DCD donation (donation after circulatory death). In many countries the number of brain dead donors (DBD) is structurally decreasing; countries like the UK, the Netherlands, Belgium, and Spain are now compensating for the lack of DBD donors by introducing DCD donation. But, still the majority of member states rely only on DBD donation. A third approach is the use of innovative machine preservation techniques to improve the quality of retrieved organs (especially from extended criteria donors) and reduce the discard rate because of ischemic damage. The EU is already funding the COPE trial (machine preservation)<sup>123</sup>. The EU can support its member states by encouraging them to establish national action plans for increasing deceased donation and monitor the progress (see the 5-year Action Plan of the UK<sup>124</sup>).
- *increase living kidney donation.* Several member states have considerably improved their kidney transplant rate by increasing the number of living donor kidney transplants (UK, the Netherlands, Sweden). This involves allowing unrelated and altruistic living kidney donation. The EU-funded EULOD project has provided good information on best practices and legal requirements for increasing living donation. The EU can support the implementation of these guidelines throughout the EU.
- *raising public awareness and knowledge on donation.* Increasing public awareness of the positive aspects of organ donation and transplantation should be a continuous effort (see the loss of public trust after the German transplant scandal). One way to increase public awareness and increase the knowledge on donation and transplantation among members of the general

<sup>123</sup> Consortium for Organ Preservation in Europe (COPE), funded by Seventh Framework Programme, 2013.

<sup>124</sup> 1<sup>st</sup> Report of the UK Organ Donation Taskforce (ODT), January 2008.

public is to introduce tailor-made education programmes at the primary and secondary school level (the Netherlands has conducted very promising pilot studies in this field). The EU can support the development and implementation of such education programs throughout the EU.

The EU should ensure it maintains a broad focus on the issue of trafficking and commercialisation of human organs, not only from the perspective of law enforcement but also by striving to increase the full potential of organ donation and transplantation. The European Parliament should align itself with this broad focus.

### 10.2.2 Speed up the implementation of anti-trafficking policy in national law

In a number of EU member states the implementation of EU Directives and Conventions is lagging behind. Countries should make better and accelerated efforts to implement European Directives and Conventions against trafficking in organs into their domestic law. There is also a need for harmonisation of national laws on the aspect of criminalisation of trafficking offences and applying sanctions (in transplant laws as well as in penal codes). The EU should encourage the national competent authorities to monitor this process more strictly. Where relevant member states who have not yet done so, should be encouraged to complete ratification of international treaties relevant to fighting THB (for organ removal). The Commission is to monitor the progress of the implementation of EU legislation, the European Parliament should exercise its power of scrutiny over the Commission by stressing to the Commission the importance of swift and full implementation of the relevant legislation.

### 10.2.3 Legislation should cover all forms of illegal organ removal

For an effective response against the illicit removal and use of human organs, the domestic legislation should criminalise the whole range of offences related to trafficking in organs: trafficking in persons for the purpose of organ removal, as well as illicit removal and commercialisation of organs from both living and deceased persons. The EU, with the support of the national competent authorities, should initiate a study on the quality of current domestic legislation of member states.

### 10.2.4 Recipients are morally and criminally liable

Whereas suppliers of organs in trafficking cases are generally considered to be victims and given due assistance and protection, the recipients of these organs must be held morally responsible for aiding and abetting trafficking in organs, and stronger measures must be taken to discourage and deter transplant tourism. Currently, in law enforcement against organ trafficking, there is no consensus on the legal position of these recipients. The general approach is to hold recipients criminally liable in cases where the victims suffer serious health damage. The EU should encourage a (Horizon 2020) study to better define the moral and legal position of recipients in organ trafficking.

### 10.2.5 Focus more on role of health professionals

Trafficking in human organs and commercial transplants could not take place without the cooperation and involvement of health professionals. However, current anti-trafficking legislation and law enforcement is not always clear when these health professionals are criminally liable and when not. The EU should encourage that more attention by law enforcement (such as Europol and Eurojust) should be given to the role of health professionals as accomplices in criminal trafficking networks. Stronger sanctions (fines, striking off the medical register, imprisonment) against health professionals who perform illegal transplants will act as deterrent. On the other hand, health professionals should be counselled how to avoid becoming accomplices by (unintentionally) facilitating patients to seek an overseas transplant.

### 10.2.6 Develop a Code of Conduct for health professionals

The EU should encourage European medical associations and transplant societies to develop a Code of Conduct for health professionals and transplant centres on how to deal with patients who intend to travel abroad to obtain an organ, and when they return for post-transplant care. This could take the form of a joint study with The European Society of Organ Transplantation (ESOT) and other professional medical associations on the responsibility of transplant professionals. Some interesting initiatives in this respect have already been taken in Canada<sup>125</sup> and by the DICG (e.g. patient brochure STOP).

### 10.2.7 Collect data on transplant tourists

So far there is hardly any reliable data from the EU member states, and at EU level, on the number of patients who acquire a transplant outside the framework of the domestic transplantation system. The EU should encourage the national competent authorities to collect this data. From the safety point of view (e.g. donor-derived communicable diseases, infections) it would be advisable to enter the fact that a patient has obtained an organ abroad into his medical record. The EU should also encourage Eurostat to provide more data specifically on organ trafficking and transplant tourism in its report on Trafficking in Human Beings in the EU.

### 10.2.8 Improve the organ traceability system

Countries must ensure that the traceability system for human organs is so tight that no illicitly obtained/removed organ can enter the domestic transplant system undetected and unaccounted for. The EU, with the help of the national competent authorities, should monitor the effectiveness of this system.

### 10.2.9 Prohibit reimbursement of illegal transplants

Until recently health insurance agencies in several EU member states were reimbursing illegal transplants performed overseas. This reimbursement of illegal transplants performed abroad is unacceptable and must be legally prohibited. The EU, with the support of the national competent authorities, should set up a monitoring system to ensure that only overseas transplants from legally obtained organs are reimbursed (e.g. from genetically or emotionally related family members).

### 10.2.10 Seize criminal proceeds of trafficking

The EU should encourage that (inter)national law enforcement (Europol, Eurojust) against organ traffickers has the legal instruments to seize the criminal proceeds of trafficking in organs. Following the proposal by Europol, these proceeds can be used to increase the training and expertise of anti-trafficking forces, or may be used to compensate victims of trafficking.

### 10.2.11 Develop indicators for recognising trafficking incidents

National and international law enforcement agencies should make efforts to develop practical indicators for recognising signals of (attempted) trafficking in organs. The EU should encourage that the outcome of the EU-funded HOTT Project will become available to training and education programmes for law enforcement officers.

<sup>125</sup> J.S. Gill et al., Policy Statement of the Canadian Society of Transplantation and Canadian Society of Nephrology on Organ Trafficking and Transplant Tourism, 2010.

### 10.2.12 Prohibit solicitation

Solicitation for selling and buying organs through the internet and social media is becoming a huge threat to the regular domestic donation and organ allocation system, and is difficult to control. This solicitation is also increasing fast into a cross-border phenomenon, linking recipients (potential buyers) to willing organ sellers. The EU should encourage member states to develop effective barriers against (on-line) solicitation to buy or sell human organs. The EU should initiate and fund an EU-wide study on this topic.

### 10.2.13 Develop a legal framework for tissues and cells

There is as yet no suitable EU legal framework to effectively address trafficking and commercialisation of human tissues and cells, which is a growing problem. The EU should encourage the development of such a legal framework. The European Parliament, on the basis of its right of legislative initiative (laid down in article 225 TFEU), should invite the Commission to put forward a proposal on this topic.

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## Annex: Recent cases of trafficking in organs

The following table lists the recent cases of trafficking in organs that have been investigated and prosecuted (Europe and international):

**Table 4: recent cases of trafficking in organs**

Period*	Name of case/country of prosecution	Alleged nr. illegal transplants	Other countries involved**
2001-2004	Moldova <sup>126</sup>	≥ 18 cases (transplants in Istanbul)	Israel, Turkey
2003-2013	Netcare, South Africa <sup>127</sup>	109 cases	Israel, Brazil, Romania
2004-2006	St. Ekaterina Hospital, Bulgaria <sup>128</sup>	≥ 20 cases	Russia, Georgia, Israel
2005-2006	Bulgaria <sup>129</sup>	9 cases (transplants in Ukraine)	Turkey
2006-2007	Israel (Michael Zis case) <sup>130</sup>	≥ 4 cases	Ukraine
2007-2008	Ukraine (Michael Zis case) <sup>131</sup>	Not specified, attempts	Israel
2008-2013	Medicus case, Priština, Kosovo <sup>132</sup>	≥ 30 cases	Belarus, Canada, Israel, Poland, Russia, Ukraine, Turkey, USA, Kazakhstan, Germany
2008-2013	Gurgaon, Delhi, India <sup>133</sup>	500-600 cases	India, Greece, Turkey, Nepal, Canada, UK, US
2009-2010	Azerbaijan Int. University Medical Center <sup>134</sup>	13 cases	France, Israel, USA, Ukraine
2010-2013	Shalimov Institute, Ukraine; transplants in Ukraine and Azerbaijan <sup>135</sup>	25 cases (estimated 100 cases)	Azerbaijan, Belarus, Kosovo, Moldova, Russia, Uzbekistan, Ecuador, Israel
2008-2012	Rosenbaum case, USA <sup>136</sup>	≥ 3 cases	Israel
2011-2014	Egypt <sup>137</sup>	60 cases (estimate several hundreds)	Sudan, Jordan, Eritrea, Ethiopia, Somalia

<sup>126</sup> Letter from the Permanent Representative of Moldova to the OSCE Special Representative and Coordinator for Combating Trafficking in Human Beings of 16 August 2012.

<sup>127</sup> HOTT Project 2014, Trafficking in Human Beings for the purpose of organ removal: A case study report.

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<sup>132</sup> HOTT Project 2014, Trafficking in Human Beings for the purpose of organ removal: A case study report.

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<sup>137</sup> Coalition for Failed Organ Solutions (COFS), Report on Sudanese victims of organ trafficking in Egypt, 2011. [www.cofs.org](http://www.cofs.org). Wall Street Journal, December 12, 2011. Trafficking in organs said to rise in Egypt. [www.wsj.co](http://www.wsj.co).

<b>2011</b>	Sydney, Australia (1st case) <sup>138</sup>	1 case (attempt)	Philippines
<b>2013-2014</b>	Costa Rica <sup>139</sup>	13 cases	Costa Rica, Colombia, Mexico, Israel
<b>2012</b>	United Kingdom (1st case) <sup>140</sup>	1 case (attempt)	Somalia

\* Start of investigation and prosecution till sentence

\*\* Countries of origin of organ suppliers and brokers

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