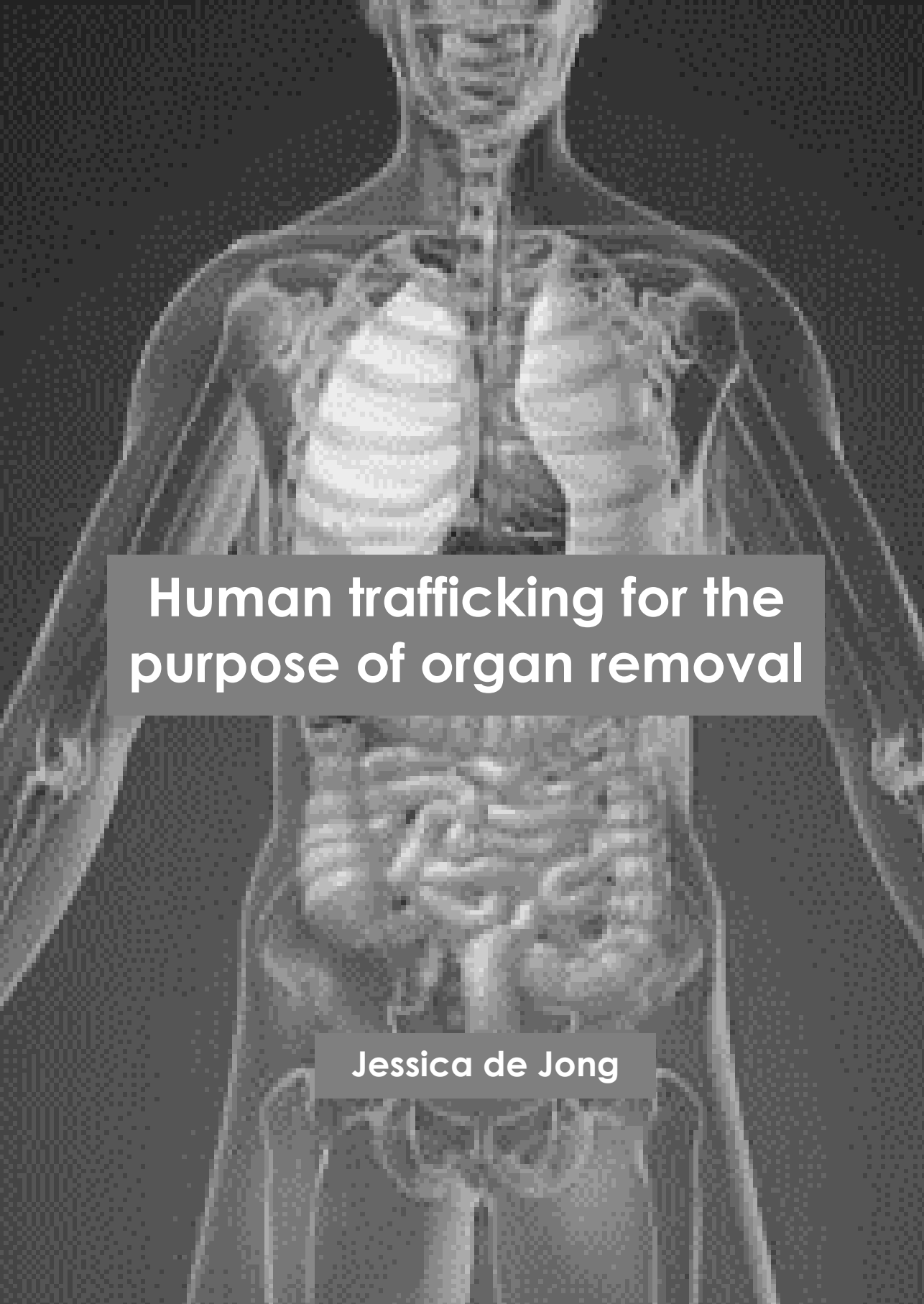

Human trafficking for the purpose of organ removal

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Human trafficking for the purpose of organ removal

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List of abbreviations

COFS	Coalition for Organ-Failure Solution
DoI	Declaration of Istanbul on Organ Trafficking and Transplant Tourism
EULEX	European Union Rule of Law Mission in Kosovo
FBI	Federal Bureau of Investigation
ISN	International Society of Nephrology
NGO	nongovernmental organization
NOTA	National Organ Transplant Act
OSCE	Organization for Security and Co-operation in Europe
TTS	International Transplant Society
TVPA	Trafficking Victims Protection Act
UNMIK	United Nations Interim Administration Mission in Kosovo
UNODC	United Nations Office on Drugs and Crime
UNOS	United Network for Organs Sharing
WHO	World Health Organization
WMA	World Medical Association

Introduction

"On the 4 of November 2008, X, a Turkish national, was stopped at Pristina airport after passing through passport control en route *to Istanbul. […] X told the Kosovo Police that he had traveled to Kosovo to 'donate' his kidney. X was immediately examined by a medical practitioner at the airport who stated he was in poor medical condition and was not capable of traveling to Istanbul. The Prosecution submits that this was standard practice following transplants at the Medicus clinic. Victims would be discharged and sent back to their home countries as soon as possible after the operation, they had served their purpose, with no documentation for follow up treatment or concern for their future wellbeing. Following this examination, X was immediately taken to the hospital for urgent medical treatment. He provided the police with preliminary information that he had recently undergone surgery and his kidney had been removed for human organ transplant to an unknown person at the Medicus clinic."*

Special Prosecution Office of the Republic of Kosovo, 16 April 2013
Closing statement of the prosecutor, p. 36

The first successful human organ transplant was performed in 1954 in the United States; a 23-year old man received a kidney from his healthy identical twin brother (Altman, 2004). Over the past decades, organ transplantation has become a standardized medical procedure highly improving the quality of, or even save patients' lives. An organ transplant can be performed with an organ from a deceased donor (postmortal donation) or a living donor (living donation). A living donor can be genetically (for instance, a parent) or emotionally (a friend) related or can be unrelated to the recipient (anonymous donation). Organs which can be transplanted after death include lungs, liver, pancreas, small bowel, heart and kidneys.[1] Transplantable organs from living donors include one kidney, half of a liver and the lobe of one lung. The kidney is the most often donated and transplanted organ. Although living liver and living lobe donation are possible, these forms of donation involve greater risks than living kidney donation and are therefore far less common. In 2015, as many as 92.911 patients were transplanted worldwide, with living as well as deceased donors. Of these, 61.609 (66 percent) included kidney transplants (EDQM, 2016). Despite the

[1] There are several ways to obtain consent for postmortal organ donation. In general, there are two options: a system of explicit consent (opting in) or a system of presumed consent (opting out). In an explicit consent system, the donor him- or herself must authorise postmortal organ removal. For organ removal in presumed consent systems, it is sufficient that the deceased person has not objected to it during life; consent is presumed (Coppen, 2010).

increasing number of transplants being performed all over the world, with the aging of populations and growth in heart and vascular diseases, the number of people known to have organ failure is growing exponentially (Francis & Francis, 2010). Currently, the activity of transplantation worldwide is less than 10 percent of the global need (GODT, 2013). For each of the aforementioned organs waiting lists exist. Kidney transplant waiting lists grow most prominently (Shafran, Kodish & Tzakis, 2014). At the end of 2015, over 180.000 patients were actively waiting for a kidney transplant worldwide, whilst over 11.000 people registered on national waiting lists died waiting for a kidney that year (EDQM, 2016).[2]

Due to medical technological innovations of the mid-twentieth century, in particular the development of immosuppressant drugs which prevent organ rejection after transplantation, recipients and donors no longer had to be relatives but could be biologically and geographically distant. Consequently, transplant activities were expanded, saving the lives of many people (Waldby & Mitchell, 2007). Since the early 1980s, the demand for transplantable organs has started to outpace the supply (Cho, Zhang & Tansuhaj, 2009); especially in countries where religious or cultural considerations inhibit organ donation (Rothman et al., 1997). In response to the organ shortage, in 1987 the World Health Organization declared that organs should be donated without financial gain (World Health Assembly, 1987). Although the commercial trade in human organs has long been the subject of rumours and unconfirmed reports, over the past fifteen years journalists and scientists have indicated that the trade occurs worldwide. To date, the buying and selling of human organs is prohibited worldwide, except for Iran where a governmental regulated system is in place.

Although there is no reliable data about the scope of the trade (Council of Europe & United Nations, 2009), patients' global search for potential donors has generated a highly profitable black market (e.g. Ambagtsheer, Zaitch & Weimar, 2013; United Nations, 2006) and has led to the exploitation of donor victims,[3] desperately willing to sell their organs (Scheper-Hughes, 2000). In 2000, the United Nations established the first legal instrument to define and prohibit human trafficking, in which organ removal is explicitly recognized as one of the purposes

[2] The active waiting list only includes patients who are transplantable and are not eligible for a transplant with a kidney from a living donor; they do not wish to ask family or friends to donate a kidney or have not (yet) found a suitable voluntary donor. Most patients are not waitlisted because they are considered unsuitable for transplantation (Krishnan et al., 2010) or because their country does not offer a transplantation program (Ambagtsheer et al., 2014a).

[3] In the literature, many different terms are used to refer to people who provide an organ for an illegal transplantation, including donors, sellers, vendors, providers, commercial living donors, compensated kidney donors, and victims. In this thesis, I refer to people who provided an organ as *donors* or, if there is evidence of exploitation by traffickers, I refer to them as *donor victims* – not 'just' victims, because (as I will argue in chapter 5) patients who buy an organ could be exploited and therefore be victims of organ trafficking as well as donors.

of exploitation (2000c). For a trafficking offence to be established there must be evidence of an illicit act (i.e. recruitment) and an illicit means (i.e. coercion) for the purpose of exploitation (i.e. organ removal) – an offence which is referred to by the prosecutor quoted above. A clear distinction needs to be made between the buying and selling of human organs and human trafficking for the purpose of organ removal. In situations in which organs are purchased and sold (hereafter referred to as *organ trade*), it is often not evident whether these commercial transactions are voluntary or whether illicit acts and means are applied for the purpose of exploitation (hereafter referred to as *organ trafficking*).

Due to the complex nature of the activities, which require compatible patients[4] and donors, transplant surgeons and an operating theatre, organ trafficking is said to require globally active and well-organized networks (Scheper-Hughes, 2011; UN.GIFT, 2008; Vermot-Mangold, 2003; Yea, 2010). However, despite the proliferation of legislation worldwide, only a few cases have appeared at the judicial level. Literature supporting the claim of the involvement of organized criminal groups is scarce. There is a critical lack of evidence-based research (Columb, 2015), in particular regarding the methods of actors involved through which the organizational model of the criminal activities could be explored.

This study aims to contribute to criminological research in terms of describing and explaining organ trafficking by providing an answer to the following central research question: *How does the interaction between the organ trade prohibition and the demand and supply of human organs for transplantation shape the mechanisms and organizational model of organ trafficking?* In order to provide an answer for this research question, the following sub-questions are defined: Why is the trade in human organs criminalized? What are the effects of the criminalization? What are the global and local causes for the phenomenon to occur? What is the modus operandi of the actors involved in organ trafficking? How do they consider the nature of their activities and justify their behaviour? How can the crime's organizational model be defined?

In order to answer these research questions, I chose to analyse criminal cases by studying court documents and interviewing mainly law enforcement officials, i.e. police officers, prosecutors and defense lawyers. For this study, three cases were selected: 1) the world's first, and so far only conviction of a hospital group in facilitating illegal organ transplants in South Africa in 2010; (2) the USA's first, and so far only conviction of an organ broker in 2011; and (3) the world's first, and so

[4] Similar to donors, in the literature a range or different terms are used to refer to people who obtain an organ for an illegal transplantation, including patients, recipients, buyers and purchasers. In this thesis, I refer to individuals who need an organ transplantation as patients and within the context of (the preparation of) an illegal organ transplant as recipients.

far only conviction of medical professionals found guilty of human trafficking for the purpose of organ removal in Kosovo in 2013. As in each of these cases several actors such as brokers,[5] recipients and donors were Israeli, it was essential to travel to Israel – in addition to traveling to South Africa, the United States of America and Kosovo – in order to thoroughly examine the three criminal cases.

In the first chapter of this thesis, the qualitative research design, validity and triangulation, ethical issues and limitations of this study are described. Chapter 2 focuses on the establishment of the international instruments that prohibit the organ trade and organ trafficking. Which legislation has been developed? Who were the moral entrepreneurs who advocated the need for criminalization, for what reasons and what are the arguments against the organ trade prohibition? To what extent is the legislation implemented, violated and enforced in the countries studied – South Africa, the United States, Kosovo and Israel – and what are its effects? In chapter 3, the empirical studies that have been published to date regarding the scope and mechanisms of the phenomenon are discussed. It shows that the majority of the existing studies are either *medical*, as physicians wrote about the medical outcomes of commercial transplants conducted by their patients abroad, or *anthropological* by nature, as scholars and nongovernmental organizations (NGOs) described the experiences and socio-economic consequences of organ selling from the donors' perspectives. Consequently, in the literature little information is revealed about the mechanisms and organizational model of organ trafficking, as well as the purposes with which the perpetrators become involved and justify their illegal activities. Chapter 4 introduces theoretical concepts through which the phenomenon could be approached. Within this theoretical framework, chapter 5 provides in-depth information about the modus operandi of the actors by addressing the key elements of the human trafficking definition (the use of illicit acts and means with the purpose of exploitation), after which the organizational model of organ trafficking is defined. Finally, the thesis ends with a conclusion.

[5] In the literature, brokers are usually referred to as those who arrange or facilitate commercial organ transplants. There are many almost similar terms in existence, such as middleman, connector, agent, fixer, facilitator, professional and private co-ordinator. Brokers are usually seen as being involved in a wider range of activities rather than just the recruitment, by being the link between recipients, donors and surgeons. For this, brokers need to be well-connected and are often linked up with hospitals and other health care facilities (UNODC, 2015).

1. Research and analysis process

It is challenging to gain access to hidden populations; groups of people who reside outside of mainstream society and are involved in clandestine activities (Watters & Biernacki, 1989). Their activities frequently go unrecorded and remain concealed due to illegality. Most researchers try to overcome this difficulty by searching for a key informant; a central figure who supports the researcher to contact and conduct research within the hidden population. In exploring the trade in organs, researchers have used multiple key informants and assistants, such as brokers, donors (e.g. Moniruzzaman, 2012), transplant clinics and physicians (e.g. Ambagtsheer et al., 2014a), local governments representatives (e.g. Naqvi et al., 2008), NGOs (e.g. Moazam, Zaman & Jafarey, 2009), human rights workers, journalists and documentary filmmakers (Scheper-Hughes, 2004).

As a criminologist employed by the Dutch National Police, it would have been even more difficult to gain the trust of people involved in illegal activities. But because of my position with the police, under the right conditions, police officers and prosecutors would most likely not be reluctant to disclose confidential information. Moreover, I have not encountered studies that address the mechanisms of organ trafficking through the analysis of criminal cases, although the information available with law enforcement authorities sheds a light on the entire human trafficking process, from recruitment to exploitation. My position with the police and the relevance of their intelligence led me to focus on law enforcement officials with organ trafficking experience as key informants. As an associated partner of the HOTT project – an international research project into human trafficking for the purpose of organ removal[6] – part of my data has been collected with other researchers, some of them from different disciplines. Below, this study's research (paragraph 1.1) and analysis methods (1.2), its validity and triangulation (1.3), ethical issues (1.4) and limitations (1.5) are discussed in detail.

[6] The HOTT project, which started in November 2012 and ended in October 2015, was commissioned by the European Commission and coordinated by the Erasmus MC in the Netherlands. Its objectives were to increase knowledge, raise awareness and improve the non-legislative response. The main findings are published in five deliverables: 1) a literature review, 2) a prosecuted cases report, 3) a report on patients who traveled overseas for alleged illegal transplants, 4) indicators to help with the identification of human trafficking for organ removal and 5) recommendations to improve the non-legislative response. All deliverables can be downloaded from www.hottproject.com.

1.1 Research methods

This paragraph describes this study's research methods, which consisted of desk research (paragraph 1.1.1), case studies, which were conducted through semi-structured interviews and the analysis of court documents and case-related documentaries (1.1.2) and the attending of two expert meetings on human trafficking for the purpose of organ removal (1.1.3). The use of this many different data sources (data triangulation) strengthens this study's internal validity.

1.1.1 Desk research

The desk research mainly consisted of a literature research. As empirical studies into the organ trade and organ trafficking are limited, I also searched for reports from (non)governmental organizations about the phenomenon.

For the literature research, I was able to use the results of the search from February till May 2013 performed by Lund University[7] and the Erasmus MC University Hospital Rotterdam[8] for the purpose of the first deliverable of the HOTT project; a literature review. The search by Lund University and the Erasmus MC University Hospital Rotterdam had focused on academic articles regarding the organ trade and organ trafficking from a wide range of perspectives, published since 2000 and accessible in English through online database services. After having removed duplicates and excluded records on blood, cell, tissue, sperm, eggs and bone marrow, the search led to over one thousand unique publications. These were imported in the analysis tool QSR*NVIVO (version 10),[9] as well as the relevant 'new' references from their reference lists. I further updated the content of NVIVO by adding two recent prominent publications and their 'new' references: "Trafficking in human beings for the purpose of organ removal in the OSCE region: Analysis and Findings" (OSCE, 2013) and "Assessment Toolkit: Trafficking in persons for the purpose of organ removal" (UNODC, 2015), and by searching for additional academic articles published since 2013 through the three online databases PubMed, Scopus and Web of Science in January 2016.

[7] Lund University performed a literature search in the online databases EbscoHost databases, Library of Congress, Catalog OAlster, PubMed, Scopus and Web of Science. In consultation with the HOTT project team members the following key words were used: 'commercial transplants', 'buying organs', 'kidney sales', 'organ trade', 'organ trafficking', 'organ tourism', 'organ brokers', 'organ trafficking chain', 'organ sales', 'selling organs', 'trafficking in persons for the purpose of organ removal' and 'transplant tourism'.

[8] The Erasmus MC University Hospital Rotterdam performed a literature search in the databases Embase, Scopus, Web of Science, Medline OvidSP and Cochrane central for which similar search strings were used based upon the key words gathered by Lund University.

[9] NVIVO is a qualitative data analysis computer software package. It has been designed for qualitative researchers working with rich text-based and/or multimedia information, where deep levels of analysis are required.

1.1.2 Case studies

Case studies are regularly used as a research design in criminological research. A case study is a detailed, intensive study of the way a research object (an individual, a phenomenon, a network, et cetera) manifests itself in social reality. The researcher typically uses multiple information sources to sketch and understand the complexity of 'the case' (Leys, Zaitch & Decorte, 2010). With the aim of acquiring in-depth knowledge to describe and explain the mechanisms of the phenomenon, three organ trafficking cases were selected for this study. From November 2012 until October 2013, I traveled to four countries to study three criminal cases: extensive police investigations and prosecutions of criminal networks which operated in various countries, bringing patients in need of kidney transplants together with donors, with the help of legal actors such as physicians and insurance companies. The criminal cases in South Africa and Kosovo have been studied together with other researchers of the international HOTT project.

1. South Africa, Durban (23 November - 3 December 2012) – Netcare case

In 2010, after seven years of police investigation, South Africa's largest private hospital group, Netcare, pleaded guilty for performing 109 illegal kidney transplants from 2001 to 2003 in St. Augustine's hospital in Durban. It concerned the world's first (and so far, only) conviction of a hospital group in facilitating at least 224 illegal organ transplants in Netcare's hospitals in Durban, Cape Town and Johannesburg. The police investigation focused on the at least 109 illegal transplants performed in Durban. Almost all recipients came from Israel. Initially, the donors were recruited in Israel, however lo[illegible] Brazilian and Romanian donors were recruited because their kidneys could be obtained at a much lower cost. An Israeli and Brazilian broker have been imprisoned in Brazil for their involvement. Between 2004 and 2012, the Netcare case was unduly delayed by many procedural and jurisdictional problems. Besides the hospital group Netcare, five individuals were convicted for their involvement in the illegal transplants; it concerned an Israeli recipient, two brokers (one of them had been brokering transplants in Netcare's hospital in Johannesburg as well), a translator and a nephrologist.[10] In 2012, four transplant surgeons and two transplant coordinators were granted a permanent stay of prosecution by the court, halting further legal process in the trial. The Durban High Court Judge accepted the defense's argument that the case exceeded the statute of limitations and the accused had already suffered enough damage to their professional standing, incomes and reputation. An Israeli broker, Ilan Perry,[11] had been the subject

[10] Nephrology is a medical specialty that concerns itself with the study of dialysis and kidney transplantation.

[11] Within this thesis, the defendants in the criminal cases are not mentioned by name, except for some criminal actors whoes identity is more than obvious as they are well-known because of their

of an Interpol Red Notice. He was arrested in Germany, but extradition proceedings to South Africa failed. After his release, he returned to Israel where he has been charged and acquitted for tax evasion.[12]

2. The United States, New York (18 - 22 March 2013) – Rosenbaum case
In 2009, a criminal network was uncovered facilitating illegal transplants in United States' hospitals. Through a FBI undercover operation, the main suspect – Izhak Rosenbaum, an Israeli native who resided in the United States – admitted to brokering kidneys over a 10 year period between recipients and donors from Israel and the United States, by collaborating with brokers and service providers such as blood banks in both countries. In 2011, this led to the first (and so far, only) conviction of a broker in the United States, as Rosenbaum pleaded guilty to brokering three illegal kidney transplants.

3. Republic of Kosovo, Pristina (16 - 20 September 2013) – Medicus case
In 2013, an EU-led court in Kosovo[13] convicted five medical professionals for carrying out at least 24 illegal kidney transplants at the Medicus clinic in Pristina in 2008. This is the world's first (and so far, only) conviction of medical professionals found guilty of human trafficking for organ removal and organized crime. Donors were recruited in Israel and abroad and were of Israeli, Turkish, Russian, Ukrainian, Moldovan, Kazakh or Belarussian nationality. Apart from a few recipients from Canada, Ukraine, Poland, Turkey and Germany, the majority of the recipients came from Israel. Two local former government officials were acquitted. To date, the Turkish transplant surgeon Yusuf Sonmez is subject of an Interpol Red Notice. The whereabouts of the surgeon are claimed to be unknown.[14] Three Israeli brokers who recruited

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controversial reputation; it concerns the Israeli transplant surgeon Zaki Shapira, the Israeli brokers Ilan Perry, Moshe Harel and Izhak Rosenbaum and the Turkish transplant surgeon Yusuf Sonmez. They are all mentioned by name in numerous media articles and some appeared openly in one of the documentaries included in this study. Therefore, it makes no sense to anonymize these individuals in this thesis.

[12] Until May 2008, Israel had not implemented legislation with regard to the trade in organs.

[13] Following the Kosovo War (1998-1999) a mandate of the United Nations Interim Administration Mission in Kosovo (UNMIK) was established by the UN Security Council. This mandate required the UN to take over the administration and political process in Kosovo. Kosovo declared independence in February 2008 and it has been recognized as a sovereign state by more than 100 UN Member States since. In 2008, the UN Secretary-General instructed the Head of UNMIK to facilitate European Union preparations to undertake an enhanced operational role in Kosovo in the rule of law area. In December 2008, the European Union Rule of Law Mission in Kosovo (EULEX) was deployed throughout Kosovo. The high profile Medicus case proceedings took place under the auspices of EULEX (Ambagtsheer et al., 2014b).

[14] As will be described below, however, the filmmakers of *Tales from the Organ Trade* spoke with the Turkish surgeon in his apartment in Istanbul while being a fugitive from justice. Furthermore, the filmmakers of *Organ Traders* spoke with the Turkish state prosecutor for the Medicus case who explained that Yusuf Sonmez is not under arrest, but "after his initial release the decision was made

recipients and/or donors and handled the financial and logistic arrangements for the transplant surgery in Kosovo are currently under criminal investigation in Israel; including Moshe Harel, who in August 2016 pleaded guilty to charges under the Israeli Organ Transplant Act, as did the Israeli transplant surgeon Zaki Shapira. A fourth broker has been convicted for related activities in Ukraine, where he is serving a prison sentence.

4. *Israel, Tel Aviv and Jerusalem (6 - 14 October 2013)*
Many of the brokers, recipients and donors in the Netcare, Rosenbaum and Medicus case are Israeli natives. For a thorough understanding of these Israeli managed global organ trafficking networks, the Israeli context has been studied through examining the criminal methods and enforcement measures which took place in relation to the three criminal cases by conducting interviews with law enforcement officials, transplant professionals, a health insurance company and (defense lawyers of) recipients in Israel.

Visiting these four countries made it possible to talk to key informants and access data that could not have been acquired through desk research, such as a defense's pre-sentence memorandum and a sentencing hearing transcript. The interviews in South Africa, Kosovo and Israel, I conducted with other team members of the HOTT project, which strengthens this study's internal reliability.

It is important to note that the crime is not restricted to these four countries.[15] In 2012, through a request for information via Europol's Dutch Desk, the UNODC Human Trafficking Case Law Database[16] and media reports, I discovered that police investigations into the organ trade and/or organ trafficking have been taking place in Australia, Brazil, Bulgaria, China, Germany, Greece, Finland, India, Jordan, the Netherlands, Moldova, Pakistan, Singapore, Turkey, Ukraine and the United Kingdom as well.[17] There are several reasons for not including these countries in this study. First, it turned out to be difficult to receive confidential

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to keep Sonmez under the Judicial Court's control but not under arrest." This supports the claim of Scheper-Hughes that organ trafficking is "a protected crime" by state institutions (2016: 255).

[15] According to the United Nations Office on Drugs and Crime (2012: 38-39), the phenomenon is less marginal than the amount of officially recorded victims would have us believe. "Trafficking for the removal of organs may appear to be limited, as it accounts for less than 0,2 per cent of the total number of detected victims. Nonetheless, during the reported period, cases or episodes of trafficking for organ removal were officially reported by 16 countries. [...] In addition, it appears that all regions are affected by trafficking for organ removal."

[16] The UNODC developed the Human Trafficking Case Law Database as a public online tool to increase the visibility of successful prosecutions, identify global patterns, and promote awareness of the crime. The database currently consists of about 1,200 cases from ninety countries, with fourtheen cases concerning organ/tissue removal (UNODC, 2015).

[17] More recently, an OSCE publication (2013) revealed that police investigations took place in Azerbaijan. And from 2014 on, media reports indicated criminal investigations in Spain (Goodman, 2014; Sahuquillo & Duva, 2014), Costa Rica (Melendez, 2014) and Egypt (BBC News, 2016).

police information via official channels from many of the countries mentioned.[18] Secondly, some police investigations are related to the Netcare or Medicus case.[19] And thirdly, some criminal cases have not been brought to trial (yet),[20] which means that the information available could be limited and not proven.

The three case studies have been conducted through semi-structured interviews and the analysis of case-related court documents and documentaries. These research methods will be described in detail below.

1.1.2.1 Interviews

In-depth interviews, mainly with people who were directly involved in the investigation and prosecution of the crime, were the primary method to acquire detailed knowledge about the mechanisms and organizational model of organ trafficking. The interviews took place using a uniform, semi-structured questionnaire. The form of a semi-structured interview was chosen since it accommodates flexibility (Beyens & Tournel, 2009); it allows specific issues to be addressed in more detail, depending on the type of respondent and country in question. The interviews broadly covered the following themes: the legislation and health care system of the countries in question; the purpose and geographical scope of the criminal networks; the actors involved, their modus operandi and the networks' structure; various aspects of the criminal investigations (such as international collaboration and financial investigation); and respondents' moral points of view towards the phenomenon.

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[18] Upon inquiry with the police liaison bureau in the Netherlands and/or the Dutch liaison officer posted in the countries mentioned, it turned out to be difficult or impossible to receive police information from China, Finland, India, Jordan, Moldova, Pakistan, Singapore and Ukraine via official police channels. Although Greece was willing to share information, it turned out that their case was related to the case in India, the Gurgaon case. Greece was one of many countries where brokers and recipients in the Gurgaon case came from, the main activities of the criminal organization, the kidney transplants, occurred in India (personal communication with two police officers in Athens, May 2013).

[19] The case in Brazil is related to the Netcare case, as it was targeted at the brokers who recruited poor Brazilians willing to sell a kidney in South Africa. The South African police traveled to Brazil to interview some of these donors. Furthermore, Scheper-Hughes' fieldwork in Brazil (2007; 2009) provides rich additional information about the Brazilian case, as she interviewed the head of the criminal organization and one of the donors who traveled to Durban. The case in Turkey is related to the Medicus case in Kosovo, as one of the surgeons accused, Yusuf Sonmez, is from Turkey.

[20] In Australia, the patient accused of organ trafficking died during the police investigation (O'Brien, 2012). In a Bulgarian case, proceedings were stopped due to insufficient evidence (OSCE, 2013). In Germany, three police investigations into the organ trade are still ongoing (e-mail communication with a Bundeskriminalamt police officer, January 2016). In the Netherlands, from 2005 to 2013, the police received five reports in which foreign people stated to have been threatened with organ removal in the Netherlands. The reports contained insufficient evidential basis for prosecution (De Jong, 2015). In the United Kingdom, two victims of organ trafficking were identified, but the cases have not been brought to trial (personal communication with a police officer of the Serious Organised Crime Agency, Birmingham, February 2013).

An important method for finding respondents was through snowball sampling. The first points of access were the lead prosecutors and/or lead police investigators of the Netcare, Rosenbaum and Medicus cases. They were my key informants. Before and during the visits in the countries in question, they played an important role in 'recruiting' other respondents involved in fighting the crime, defending the accused or with knowledge about the situation regarding organ donation and transplantation in the countries in question. These key informants were not only of importance in finding other respondents, but even more in gaining their trust and in gently urging them to contribute to the study. Because of the sensitive topic, many of whom I approached on own initiative either kindly refused to the interview request or did not reply to my messages at all.

From November 2012 till December 2013, I held in-depth interviews with 45 respondents: law enforcement officials, defense lawyers, medical professionals, ministry representatives and (inter)national organization representatives, such as health insurance companies and donation and transplantation organizations. Appendix 1 provides an overview of the respondents, listed by number (R1-R45). All respondents were approached via telephone and/or e-mail. Prior to the interview they received an information sheet, which described the purpose of the study and presented the name(s), affiliation(s) and contact details of the interviewer(s). The sheet emphasized that data would be used anonymously and kept strictly confidential. The meetings with the respondents usually took place in their offices. Several interviews were held with more than one person and some were interviewed more than once, because of the comprehensive and complicated nature of the criminal cases. Three interviews were conducted with the help of an interpreter. Most conversations lasted for 1,5 to 2 hours, some shorter but some even longer. The interviews were recorded, if permitted by the respondents, and transcribed verbatim. Due to the sensitive nature of the topics, during eight interviews respondents did not want to be recorded. During those interviews notes were taken and processed immediately after the interview. All respondents received the interview transcript and were able to correct or nuance any misrepresentations or misinterpretations, which makes it likely that the transcript accurately states their view (reliability), although evasive and socially desirable answers need to be taken into account.

During my fieldwork, I encountered several difficulties and unexpected events and twists. First of all, although it was not my main focus, I did try to gain access to the recipients and donors involved in the criminal cases, which turned out to be (practically) very difficult. Often their identity was not revealed to me, and, more importantly, most of them were not in the visited country anymore; they lived abroad, had been flown in for the illegal organ transplant and were sent back home afterwards. For this reason, law enforcement authorities had

experienced many difficulties themselves in tracking them down for a statement. In the end, I did accomplish to interview two Israeli recipients who underwent an illegal kidney transplant abroad, one of them in a Netcare hospital in Durban, South Africa. Secondly, dozens of people approached were not willing to participate. Some of them kindly refused to the interview request, but many did not respond to phone calls and e-mail messages at all. This included judges, medical facilities, medical professionals and defense lawyers of transplant surgeons and brokers. One judge agreed at first, but then cancelled the interview on short notice, because of the ongoing trial of the case. Thirdly, for some respondents the criminological focus of the study seemed to be a reason to not participate in the study in an elaborate manner. When approached for an interview, two defense lawyers asked to be called back several times before they wanted to make an appointment. One of them, the lawyer of a broker, was interested in my personal point of view before agreeing to an interview. He kept on asking if I was in favour or against the prohibition of the organ trade. According to him, the law needed to be changed and he was interested in contributing to the study if that meant an opportunity to influence the public opinion. I repeatedly explained to him that although my thesis would address the pros and cons of legalizing the purchase and sale of organs, my main focus would be the mechanisms of organ trafficking. In the end, he did consent to an interview, but he was clearly not willing to talk and replied to all my questions about the case with short answers. However, he did send me home with a copy of the defense's 94-pages pre-sentence memorandum. The other, an Israeli lawyer who had advised a number of brokers about where in the world they could perform transplants without breaking the law, did consent to an interview after several requested phone calls as well, but was initially, equally unwilling to give detailed answers to the questions. The turning point was a remark made by my co-interviewer halfway through the interview, who shared her personal opinion by saying that the purchase and sale of organs should be regulated and decriminalized. After this remark the lawyer was suddenly very open with us. By that point he even provided us with names and telephone numbers of people we should talk to, for instance someone who bought a kidney and who he described as 'a specialist that knows more than anybody else about this thing'. During the interview he even arranged a meeting for us with 'the world expert' on the topic; a lawyer of a surgeon involved in illegal kidney transplants. However, this meeting was cancelled on very short notice, an hour before the meeting was about to take place. It was obvious that defense lawyers were reserved in contributing to the study, and the ones who did contribute used multiple neutralization techniques to emphasize their clients were not guilty (Sykes & Matza, 1957). They justified their clients' actions by calling them 'lifesavers' and denied the existence of victims. Another meeting which required several attempts to be arranged and during which the respondent was very cautious,

was an interview with a representative of the Ministry of Health in Kosovo. As an employee of the Ministry had been one of the accused in the Medicus case, a Ministry representative was only willing to talk after having received permission from the Minister of Health. During the interview, he was joined by an interpreter, a legal officer of the Ministry, who took active part in the conversation on his own initiative. Another situation which could be related to the criminological focus of the study was that one of the respondents, a recipient, during the interview suddenly denied having bought an organ abroad, although having spoken about it with one of the present interviewers on an earlier occasion. However, an opposite situation occurred as well. During an interview with a defense lawyer, he suddenly asked to pause the recorder, because he wanted to share something off the record: the whereabouts of one of the accused, a fugitive from justice, who had called him to ask him to represent him in court.

1.1.2.2 Court documents

Many respondents provided official court documents, which form an important additional primary source for the case studies. The documents were either sent via e-mail or given in person. The documents which were received via e-mail before the relevant interviews took place were carefully read in advance, so the interview could be entirely aimed at clarifying and deepening the topics. The 31 court documents received from respondents are listed by number (D1-D31) in Appendix 2. It concerns indictments, affidavits, a defense lawyer's open letter, a sentencing hearing transcript, a defense's pre-sentence memoranda, plea sentence agreements, closing statements, judgments and appeals.

1.1.2.3 Documentaries

Visual data, such as photo's or movies, is rarely used in traditional criminological research. However, visual material forms an important contribution to the discipline of criminology, because it represents, or reflects upon, a part of the social reality and influences people's behaviour and ideas (VanderVeen, 2010). In this study, four documentaries that disclose valuable information about the Netcare, Rosenbaum and Medicus case are included as a secondary source, in addition to the interviews and the case's court documents:

1. Special Assignment, *Medical Greed!*, 21 March 2011[21]
   Medical Greed! focuses on the Netcare case by interviewing several actors involved in the case: Rogelio Bezerra, who was arrested in South Africa after selling his kidney; former police captain Ivan Bonifacio, who was the head of the Brazilian criminal organization that recruited donors; and transplant surgeon John Robb, who was indicted for performing the illegal transplants.

[21] *Medical Greed!* was provided to me on a cd-rom by a key informant of the Netcare case study.

2. Al Jazeera, *Organ Traders*, 20 December 2012[22]
Organ Traders presents an investigation into the human organ trade in Kosovo, Turkey and Israel. The documentary focuses on the Medicus case by interviewing Cem Sofuoglu, the defense lawyer of the Turkish transplant surgeon Yusuf Sonmez; Mordechai Tvizin, the lawyer of the Israeli broker Moshe Harel; Lufti Dervishi, co-owner of the Medicus clinic; Linn Slattengren, who is Dervishi's defense lawyer; and the case's prosecutor, Jonathan Ratel.

3. HBO, *Tales from the Organ Trade*, 14 April 2013[23]
Tales from the Organ Trade explores the legal, moral and ethical issues of the black organ market by interviewing brokers, surgeons, patients and donors. The filmmakers spoke to several actors involved in the Medicus case: Jonathan Ratel, the prosecutor; the Israeli transplant surgeon Zaki Shapira and the Turkish transplant surgeon Yusuf Sonmez, both involved in the illegal transplants in Kosovo and other places; and the Canadian recipient Raul Fain, who traveled to Kosovo for an illegal kidney transplant.

4. RTÉ One, *What in the World*, 24 December 2013[24]
What in the World focuses on the black organ market following trade routes in the United States of America, Europe and the Middle East. The documentary pays attention to the Rosenbaum case: Assistant U.S. Attorney Mark McCarren and anthropologist Nancy Scheper-Hughes provide information about the case and about broker Izhak Rosenbaum.

It must be emphasized that the documentaries were made by others and for other purposes than the study in question. They represent part of the reality in a specific context and moment in time and can be the result of reactivity; people can behave differently because they are being filmed (VanderVeen, 2010). In determining their validity and reliability, the content of the documentaries included have been cross-checked with the interviews and court documents. The documentaries are of great value for this study, because some of the filmmakers succeeded to speak with transplant surgeons and brokers who have (almost) never agreed to an interview before. Sometimes the circumstances are questionable though. Ivan Bonifacio only wanted to contribute to *Medical Greed!* through an off-camera interview for which he demanded huge sums of

[22] Several respondents of the Medicus case study referred to the documentary *Organ Traders*, which can be watched online via <www.aljazeera.com/programmes/peopleandpower/2012/12/201212198161347766 0.html>.
[23] Upon request, the documentary *Tales from the Organ Trade* was provided to the HOTT project team members by the producer, Ric Esther Bienstock.
[24] *What in the World* was brought to my attention by anthropologist Nancy Scheper-Hughes. The documentary can be watched online via <www.rte.ie/player/us/show/10236585>.

money (TVSA Team, 2011). The filmmakers of *Tales from the Organ Trade* spoke with Yusuf Sonmez in his apartment in Istanbul while he was a fugitive from justice, which was the reason he could not be tracked down by the filmmakers of *Organ Traders*. Like the defense lawyers I interviewed, it seemed that the motivations of these actors to contribute to a documentary was to publicly state they did nothing wrong by saving lives. Lastly, the documentaries underline the value of law enforcement officials as key informants in this study, as many filmmakers were not able to (profoundly) speak with prosecutors and police officers. In *Organ Traders* it is stated that the Israeli police was not willing to talk and that it took several weeks before the interview with the Medicus case prosecutor was permitted by his superiors, who monitored the conversation in which the filmmakers were only allowed to ask a few pre-arranged questions.

1.1.3 Expert meetings

In December 2013, after having completed a literature review and three case studies on organ trafficking, I was invited to participate at an United Nations expert meeting in Vienna, Austria, to contribute to an assessment tool kit for human trafficking for the purpose of organ removal. It was a two-day meeting attended by around 30 experts from national governments, medical institutions, non-governmental organizations as well as academia. During the meeting, various presentations were given and the phenomenon was discussed in detail. Afterwards, I received the recording of the meeting, which enabled me to take the full content of the expert meeting into account for this study.

In November 2014, I attended the HOTT project Writers Conference, hosted at the Europol Headquarters in The Hague, the Netherlands. Around 30 international experts were invited there to formulate recommendations on human trafficking for the purpose of organ removal. The recommendations were aimed at (a) ethical and legal obligations of healthcare providers, (b) protecting victims, (c) improving cross-border collaboration in criminal cases, and (d) enhancing partnerships between transplant professionals and law enforcement. Afterwards, for the purpose of this study, I received the recording of the meeting. The formulated recommendations were presented the next day at the international symposium 'Trafficking in Human Beings for the Purpose of Organ Removal', also hosted at the Europol Headquarters in The Hague. The primary aim of the symposium was to inform key stakeholders about the incidence and nature of the crime by sharing the evidence-based research results of the HOTT project. The symposium was open to all interested parties including law enforcement, human trafficking rapporteurs and experts, human rights NGOs, international organizations, EU officials, health organizations and transplant professionals. Over 200 participants from 35 countries attended the HOTT project symposium.

Because of the international multi-disciplinary approach, the meetings were very informative. Participants had many different opinions about the ethical and legal obligations of medical professionals, about what counts as true consent for donation given the pressures of familial relations and economic desperation of donors, and about whether compensation for living donors is acceptable and justifiable and will effectively influence the black market in organs. Some discussions were intense and often led to even more unanswered questions.

1.2 Data analysis

After the data collection, the data was thematically analysed with support of QSR*NVIVO software (version 10). First, the case study materials were imported in the analysis tool: the interview transcripts, court documents and documentary transcripts. Secondly, in order to ensure anonymity, the names of the respondents and of the people mentioned in the interviews and court documents were coded; the respondents were labelled according to Appendix 1. And thirdly, for the coding process of the content of the data, a list of nodes was defined based upon the research questions which were formulated in the introduction. The coding structure was fine-tuned until data saturation was reached. This study's analysis strategy is both deductive, by predefining nodes based upon the research questions, and inductive, as I derived additional nodes during writing this thesis with regard to the relevant theoretical concepts (see chapter 4).

1.3 Validity and triangulation

As Lecompte and Goetz wrote, establishing validity "requires determining the extent to which conclusions effectively represent empirical reality and assessing whether constructs devised by researchers represent the categories of human experience that occur" (1982: 32). They further noted that "internal reliability refers to the extent to which scientific observations and measurements are authentic representations of some reality. […] External reliability addresses the issue of whether independent researchers would discover the same phenomena or generate the same constructs in similar settings" (ibid).

My research methods consisted of desk research, participant observation and case studies, which were conducted through semi-structured interviews and the analysis of court documents and case-related documentaries. The triangulation of this many different data sources contributes to the internal validity and reliability and therefore strengthens this study's scientific value (Maesschalck, 2010). The internal reliability is further enhanced by teamwise conducting and

discussing a large part of the interviews for this study with other researchers of the HOTT project. Furthermore, all respondents received the transcript of the interview and were able to correct or nuance any misrepresentations or misinterpretations. This method makes it likely that the transcript accurately states their view, although reluctant and socially desirable answers need to be taken into account. The quotes that are extensively used throughout the text to present the explanations and interpretations of the respondents should not be interpreted as "scientific truths" though (Decorte & Zaitch, 2010).

Concerning the external reliability, it is important to note that the prosecution of the illegal activities studied may have caused a displacement effect in terms of the methods of criminal networks, which means the modus operandi and theoretical framework described are not by definition one-to-one transferable to other organ trafficking cases. As Maesschalck (2010) explains, not being able to generalize outside the research population is inherent to qualitative research. However, qualitative research does allow to describe a case very thoroughly ("thick description", a concept introduced by Geertz in 1973), as I have done here, which means others are able to judge to what extent the conclusions drawn from the specific cases are applicable to other cases (Firestone, 1993).

1.4 Ethical issues

There are several ethical issues related to criminological research. In preparing and processing the interviews conducted for this study, which were mainly held with people who were directly involved in the investigation and prosecution of organ trade and organ trafficking, the issues of informed consent, confidentiality of data and anonymity of respondents were continuous concerns.

The principle of informed consent implies that the respondents should be given all the information needed to make an informed decision about their participation in the study. Informed consent ranges from ensuring that the respondent is fully aware that he or she is participating in a research project to providing insight into the actual research process and its possible implications (Bryman, 2004; May, 2011; Noaks & Wincup, 2004). As I described in paragraph 1.1.2.1, prior to each interview all respondents received an information sheet which described the purpose of the study and presented the name(s), affiliation(s) and contact details of the interviewer(s). The information sheet emphasized that the data would be used anonymously and kept strictly confidential. Prior to the interviews, I discussed with each respondent whether the interview was to be recorded and I promised that the recording and transcript would not be shared with anyone else without their permission and that no

personal details would be mentioned in my thesis and other publications. Furthermore, while respondents openly spoke about the identity of the main suspects whoes full names were stated in the court documents, they were often reluctant in stating the names of others involved, which resulted in the preferable situation that I was often not aware of their identities.

1.5 Limitations of the study

This study has several limitations. First, it must be emphasized that the findings have an incomplete and changeable character. Human trafficking is often hidden from law enforcement authorities. The criminal activities take place in secret or have the appearance of legality. Victims do not want or dare to make themselves known, or may not realize that they are victims. The international character of human trafficking and the principle of medical confidentiality further impede the detection and investigation of the criminal activities. And as human trafficking for the purpose of organ removal is a relatively unknown form of human trafficking, the responsible authorities lack knowledge and experience which makes it more difficult for them to recognize and investigate the crime, as became clear during the interviews. In addition, the police investigation and judicial prosecution of illegal activities could cause a displacement effect in terms of locations and methods of operation, which means the modus operandi described in this thesis could be (slightly) changed today.

Secondly, the primary objective of police investigations is to gather evidence against suspects. Despite international co-operation, the law enforcement officials interviewed were often not able to gather as much information about the suspects who lived abroad as the local defendants. Concerning the selection of respondents, many of (the representatives of) the people involved were reluctant to be interviewed, and the ones that agreed were not always willing to actually talk. This (forced) selectivity could have resulted in a fragmented picture of the mechanisms and business model of organ trafficking.

2. Prohibition, violation and enforcement

In the 1980s, with the purpose of eliminating all potential risks associated with the buying and selling of human organs, the rising demand for organs available for transplantation has led to the establishment of international instruments prohibiting the organ trade; despite the absence of any reports about actual organ purchases and sales at the time. Trading in human organs was seen as morally and ethically improper. Developing a more efficient deceased donor organ program and raising more awareness among potential donors was believed to provide enough transplantable organs to face the narrow shortage (House of Representatives, 1984). To date, however, the number of patients with kidney failure continuous to increase and despite the almost universal prohibition journalists and scholars have indicated that the trade in organs occurs worldwide. New reports of illegal organ transactions appear on a regular basis while prosecution rates generally remain low (Columb, 2015) or cause the illegal activities to become more hidden or shift to other countries (Shimazono, 2007; Van Dijk, Ambagtsheer & Weimar, 2011). This development raises the question whether a prohibition of the trade is (still) effective. In studying the underground banking phenomenon, Borgers (2009) argued that the effectiveness of the prohibition of underground industries (risk model) seems rather low, even if the ban is combined with an active investigation and prosecuting policy. Prohibition could not only result in more efforts to hide illegal practices from the authorities (Razavy, 2005), underground industries have also proven to be able to recover after state authorities' interventions (Perkel, 2004; Schramm & Taube, 2003).

As policies that were intended to prevent exploitation by prohibiting the organ trade failed, compensating donors has recently re-emerged as a possible solution to solve the shortage of organs available for transplantation (Working Group on Incentives for Living Donation, 2012). Scholars argue that concern over exploitation of the poor should lead to regulation of the purchase and sale of organs, not its continued prohibition (Matas, 2004; Taylor, 2006). This approach, in which underground industries are permitted provided that certain requirements are met (assimilation model), is viewed as a suitable option regarding the underground banking industry (Borgers, 2009) and illegal markets such as gambling, narcotic drugs and prostitution. If the demand for certain illegal goods and services remains high, it will be very difficult to restrain these markets by means of repressive action, whereas regulation may result in less crime and social disorder and fewer health problems (Spapens & Rijken, 2015).

This chapter describes the establishment, violation and enforcement of international instruments which prohibit the organ trade and organ trafficking. Paragraph 2.1 gives an overview of the instruments that have been developed aimed at the organ trade (2.1.1), organ trafficking (2.1.2) or both practices (2.1.3) and its underlying arguments. Whilst a consensus prevails that organ trafficking should remain universally prohibited, in paragraph 2.2 it is explained that, as the international proclamations aimed at the prohibition of the organ trade do not address several pivotal concerns, an all-encompassing prohibition of the trade is not justifiable under all circumstances. The main arguments against the trade's prohibition are presented – a debate that continues until today and revolves around the questions whether the use of incentives would increase the supply of organs and would be ethically justifiable – after which the need for an evidence-based approach of the trade's regulation is addressed. Finally, paragraph 2.3 discusses to what extent and in what way the international enactments are implemented, violated and enforced in the countries related to the three case studies of this thesis: South Africa, the United States, Kosovo and Israel.

2.1 The prohibition and its influence

2.1.1 WHO's Guiding Principles

In the late 1970s and early 1980s, after effective immunosuppressant drugs had been developed to prevent organ rejection after transplantation, the prospect of lifesaving transplants became a possibility for patients in need of an organ and transplant waiting lists worldwide started to grow. In 1983, the United States Congress held its first hearings on how to solve the organ shortage. At the first hearing, physician Dr. Jacobs, medical director of the private organization International Kidney Exchange, proposed that the government would provide an incentive for living kidney donors, many of whom would come from developing countries, and for families of deceased donors to increase the number of kidneys available for transplantation in the United States: "My proposal is that they decide what they want to do with their body. Every American has the independent right, assuming they can make an intelligent, informed decision, to make it, fully protected, in our system. That's up to the individual" (House of Representatives, 1984: 246). A few weeks before the Congress' hearing, Dr. Jacobs wrote an article in the *USA Today* in which he suggested that his organization would act as a broker in the commercial organ trade for a US$5,000 fee (Jacobs, 1983). In reaction to Dr. Jacobs' proposal, professional after professional testified before the Congressmen that there was no need to even consider organ sales, the shortage could be solved with cadaver organs, supplemented by altruistic living kidney donations. Some strongly urged Congress to also ban the purchase and sale of human organs on moral grounds. Dr.

Terasaki, president of the International Transplant Society (TTS), wrote on behalf of the three main American transplant societies that they "strongly condemn the recent scheme for commercial purchase of organs from living donors. This completely morally and ethically irresponsible proposal is rejected as abhorrent by all members of the Transplantation Societies" (House of Representatives, 1984: 316). In response to Dr. Jacobs' plan and the professionals' testimonies that a national regulated deceased donor organ program would suffice (Fry-Revere, 2014), the Congress passed the National Organ Transplant Act (NOTA) of 1984. The law prohibits paying for human organs, imposing a potential fine of US$50,000 and a maximum sentence of five years in prison for offenders.

Following the United States' lead, the World Health Organization (WHO), the world's authority in matters of public health, has taken significant steps to regulate organ transplantation. In 1987, the World Health Assembly, WHO's supreme decision-making body, passed its first resolution on the topic, claiming that the trade in organs is "inconsistent with the most basic human values and contravenes the Universal Declaration of Human Rights" and requesting research for the purpose of developing appropriate transplantation guidelines (World Health Assembly, 1987: 1). In 1991, the resolution led to the *WHO Guiding Principles on Human Cell, Tissue, and Organ Transplantation* (hereafter referred to as Guiding Principles), which were updated in 2010. Principle 5 states that organ purchase should be banned. Organs should be "donated freely, without any monetary payment or other reward of monetary value." As payment for human organs "is likely to take unfair advantage of the poorest and most vulnerable groups, undermines altruistic donation, and leads to profiteering and human trafficking. Such payment conveys the idea that some persons lack dignity, that they are mere objects to be used by others" (World Health Organization, 2010: 5). An expression of gratitude that cannot be assigned a value in monetary terms is allowed. The Guiding Principles also aim to prohibit commercial solicitations. Principle 6 forbids to advertise the need for, or availability of, organs with the purpose of offering or seeking financial gain or comparable advantage, because it targets organ brokers and direct purchasers (ibid).

The WHO's Guiding Principles, although not legally binding, have influenced professional medical codes and practices around the world, as well as legislation, as is evident from the content of the Council of Europe's Additional Protocol to the Convention on Human Rights and Biomedicine concerning Transplantation of Organs and Tissues of Human Origin (2002), which prohibits the trade by declaring that "the human body and its parts shall not, as such, give rise to financial gain or comparable advantage" (article 21) and that "organ and

tissue trafficking[25] shall be prohibited" (article 22).[26] To date, every country has implemented the prohibition into its domestic laws, with the exception of Iran.

After the Islamic Revolution, Iran's relationship with Eurotransplant[27] collapsed and Iran didn't have the infrastructure or resources to develop a cadaver organ program, so a system based solely on living donation evolved (Fry-Revere, 2014). In 1988, a governmental regulated procurement system was introduced. Iranian nationals who wish to donate a kidney can refer to a government institution who matches them to a prospective recipient.[28] Brokers, it is claimed, remain uninvolved (Ghods & Savaj, 2006). From the government, a donor receives a standard payment (the equivalent of US$1,000), one year health insurance and an exemption from Iran's mandatory two-year military service for men (Fry-Revere, 2014). Many donors also receive a gift from their recipient.[29] The amount of this gift is considered a private matter that is not interfered with (Simforoosh, 2007). In order to ensure donors will receive the promised payment, recipients have to put the promised amount into escrow with the NGOs who have been formed to carry out the governmental regulated procurement system (Fry-Revere, 2014).[30] As several prominent religious leaders in Iran claim that under Islamic law it is acceptable to gain from something that has value, "it became acceptable to sell kidneys, particularly because, like blood, they have a use outside the body that does no long-term harm to the seller." But because it is impossible to place a price on the gift of life and as often both parties are in desperate need – one at risk of dying and the other at risk of financial ruin – the relationship between both parties is framed in terms of exchanging gifts, rather

[25] As the Council of Europe's Protocol deals with the prohibition of the organ trade and not with human trafficking for organ removal, 'organ trafficking' refers to the trade in organs.
[26] Furthermore, the Charter of Fundamental Rights of the European Union (2000/C 364/01), in article 1 on human dignity and article 3 on the right to the integrity of the person, refers to the prohibition on making the human body and its parts as such a source of financial gain.
[27] Eurotranplant is a non-profit organization that facilitates the allocation and cross-border exchange of deceased donor organs between its member countries.
[28] Since 1992, Iran does not allow foreigners to purchase a kidney from, or sell a kidney to, an Iranian. Foreigners are welcome if they bring a donor from their own nationality (paid or unpaid), but they need to pay for the organ transplantation in Iran themselves. Before the law of 1992, medical tourism created an incentive to favor high-paying foreign recipients over Iranians, whose treatment is paid for at a lower government rate (Fry-Revere, 2014).
[29] In 2009, Iranian donors on average received a total amount of five million Iranian toman; a standard amount of one million toman from the government and on average four million tomar from their recipient. With an exchange rate of approximately one thousand toman for one dollar, donors received the equivalent of US$5,000. For most Iranian citizens $5,000 is more than a year salary, as in 2009 the average income in Iran was a little over $3,000 per year. Once average income, standard of living and purchasing power are considered, the amount which Iranian donors are paid comes closer to something between $15,000 and $30,000. Moreover, donors in Iran receive goods and services (such as health insurance vouchers, job placement services and dental care) in addition to a monetary payment. When those additional benefits are included, the average purchase power of a donor's compensation is closer to $45,000 (Fry-Revere, 2014).
[30] Under Islamic law, a promise (binding decision) of reciprocal gifting is legally enforceable (ibid).

than a commercial transaction, "to avoid either the donor or the recipient from running afoul of the prohibition against exploitation" (ibid: 99).

2.1.2 Palermo Protocol

In 2000, the *United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children* (otherwise known as the Palermo Protocol), supplementing the United Nation Convention against Transnational Organized Crime, was established. The Palermo Protocol is the first international legal instrument that defines and prohibits human trafficking and explicitly recognises human trafficking for the purpose of organ removal as a practice that should be criminalised. The purposes of the Palermo Protocol are to "prevent and combat human trafficking" and "protect and assist the victims of such trafficking, with full respect for their human rights". The definition of human trafficking is written down in article 3(a) of the Protocol (United Nations, 2000c: 2):

> "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 […] the removal of organs."

The definition includes three key elements; an act (what is done), a means (how it is done) and a purpose (why it is done), being exploitation.[31] Under international law, all three elements must be present. The only exception is when the victim is a child. According to article 3(c), the 'acts' and 'purpose' elements are sufficient to establish the crime of child trafficking, no 'means' need to be involved.[32] Furthermore, article 3(b) emphasizes the consent – consent is the ethical cornerstone of all medical interventions and therefore of particular relevance for the issue of organ removal (UNODC, 2015) – of the victim to the intended exploitation shall be irrelevant where any of the listed means have been used. In other words, a donor's consent to organ removal is inapplicable when it is obtained through threat or use of force, coercion, abduction, fraud, deception, abuse of power or a position of vulnerability (United Nations, 2000c).

[31] What follows is that, in order to fulfill the definition, it is not necessary for law enforcement officials to demonstrate whether perpetrators have made any financial or material profit.
[32] In addition to the Palermo Protocol, the United Nations Optional Protocol on the sale of children, child prostitution and child pornography (2000) to the Convention on the Rights of the Child (1998) criminalizes "offering, delivering or accepting, by whatever means, a child for the purpose of transfer of organs of the child for profit" (article 3(1)(a)(i)).

The Palermo Protocol is a binding convention that requires States to criminalize human trafficking (United Nations, 2000c). The Protocol and its definitions have been widely embraced by the international community, which is evident from the content of the *Council of Europe Convention on Action against Trafficking in Human Beings* (CETS No. 197) of 2005 and the *Directive 2011/36/EU of the European Parliament and the Council of 5 April 2011 on preventing and combating trafficking in human beings and protecting its victims*, in which the Palermo Protocol's definition have been adopted. However, over the past decade it has become evident that important concepts of the definition are not clearly understood and, therefore, are not being consistently implemented and applied. In particular, the intentions of the drafters of the Protocol are unclear with respect to 'abuse of a position of vulnerability'; one of the means through which individuals can be exploited. The drafting history of the Protocol explains that 'abuse of a position of vulnerability' is to be understood as referring to "any situation in which the person involved has no real and acceptable alternative but to submit to the abuse involved." This is a circular definition, as it is not clear what 'real and acceptable alternative' actually means or how it is to be applied in practice (UNODC, 2013). In the UN Model Law against Trafficking in Persons, developed to assist States in implementing the provisions contained in the Palermo Protocol, it is explained that open-ended terms like 'the abuse of a position of vulnerability' speaks to the definitional flexibility that States are granted when prosecuting suspected cases of human trafficking (UNODC, 2009).[33] A United Nations issue paper regarding the 'means' within the definition of human trafficking further explains that 'abuse of a position of vulnerability' is broadly understood by practitioners to encompass among vulnerable factors poverty, gender, age and illness. The existence of vulnerability is best assessed on a case-by-case basis, taking into consideration the personal, situational and circumstantial situation of the alleged victim. The paper also finds that evidence of this means has been relevant to establishing other means, such as deception and fraud, as well as to resolution of any issues over apparent consent (UNODC, 2013). Another concept of which the intentions of the drafters of the Palermo Protocol are unclear is 'coercion'. The UN Model Law against Trafficking in Persons addresses this concept by giving a few examples of definitions. For instance, the "use of force or threat thereof, and some forms of non-violent or

[33] "'Abuse of a position of vulnerability' shall mean taking advantage of the vulnerable position a person is placed as a result of (i) having entered the country illegally or without proper documentation, (ii) pregnancy or any physical or mental disease or disability of the person, including addiction to the use of any substance, (iii) reduced capacity to form judgements by virtue of being a child, illness, infirmity or a physical or mental disability, (iv) promises or giving sums of money or other advantages to those having authority over a person, (v) being in a precarious situation from the standpoint of social survival, or (vi) other relevant factors" (UNODC, 2009: 9). The Commentary explains that many other definitions of abuse of a position of vulnerability are possible, including elements such as abuse of the economic situation of the victim (UNODC, 2009).

psychological use of force or threat thereof." Non-violent or psychological forms include, for instance, "any scheme, plan or pattern intended to cause a person to believe that failure to perform an act would result in serious harm to or physical restraint against any person", "abuse or any threat linked to the legal status of a person" and "psychological pressure" (UNODC, 2009: 11).

The decision to include the removal of organs in the Palermo Protocol was made very late in the negotiations. Although Argentina proposed the inclusion of "extraction of body organs or organic tissue" during the first session of the Ad Hoc Committee on the Elaboration of a Convention against Transnational Organised Crime (United Nations, 1999: 4), it took until the ninth session before it was decided to include the removal of organs as a form of exploitation in the Protocol "for purposes of further discussion" (United Nations, 2000b: para 12), most likely because of the lack of available empirical information on the topic. Unlike other exploitative purposes specifically referred to in the Protocol, human trafficking for the purpose of organ removal was not previously considered in international law and as such had no prior legal definition (Columb, 2015). The Palermo Protocol does not define the concept either. It was only in a background paper prepared by the Secretariat of the Conference of Parties of the Convention that it was explained that trafficking in tissues or cells is not covered by the Protocol (United Nations, 2011: para 9). This illustrates the lack of consideration given to this issue prior to its inclusion (Columb, 2015).

2.1.3 Declaration of Istanbul

In 2008, the International Society of Nephrology (ISN) and the TTS convened in Istanbul to establish the *Declaration of Istanbul on Organ Trafficking and Transplant Tourism* (hereafter referred to as DoI). This is the first universal document, drawn up by and targeted at transplant professionals and societies, that defines and condemns transplant tourism, in addition to the organ trade and organ trafficking. In Istanbul, more than 150 representatives of scientific and medical organizations, government officials, social scientists and ethicists from 78 countries around the world attended the conference. Lundin, who was one of the attendees, explained that there were different views on how to control the black market in organs. "A majority advocated altruistic donation while a minor group recommended a state-sanctioned organ trade. To increase altruistic donation, 'we must inform people about the importance of donating.' Protests such as 'you can't educate people to be altruistic' were ignored, as were statements like 'donations are only relevant in welfare states' and 'poor people can't afford being altruistic'" (Lundin, 2012: 10). The DoI states that the buying and selling of organs targets impoverished and otherwise vulnerable donors and thereby violates the principles of equity, justice and respect for human dignity. Besides organ trade and organ trafficking, the DoI is the first universal document

that prohibits transplant tourism, which is defined as travel for transplantation that involves "organ trafficking and/or transplant commercialism or if the resources (organs, professionals and transplant centres) devoted to providing transplants to patients from outside a country undermine the country's ability to provide transplant services for its own population" (DOI, 2008: 2). Delmonico, the former president of the TTS and one of the founders of the DoI, further explains that organ trade, organ trafficking and transplant tourism "threaten to undermine the nobility and legacy of transplantation worldwide because […] the vulnerable in resource-poor countries are exploited for their organs as a major source of organs for the rich patient-tourists" (Delmonico, 2009: 116). Despite its non-binding character, the influence of the DoI is significant. Over one hundred transplant organizations endorse it (Danovitch & Al-Mousawi, 2012). To promote and monitor the implementation of the declaration, in 2010 the Declaration of Istanbul Custodian Group had been established, consisting of experts from various professional and geographical regions (UNODC, 2015).

Similar to the DoI, more recently the *Council of Europe Convention on Trafficking in Human Organs*, which was adopted in 2014, calls for a broad prohibition of the organ trade.[34] The Council of Europe Convention points to legal loopholes in existing legislation, which "only address the scenario where recourse is had to various coercive or fraudulent measures to exploit a person in the context of the removal of organs, but do not sufficiently cover scenarios in which the donor has – adequately – consented to the removal of organs or – for other reasons – is not considered to be a victim of trafficking" (Council of Europe, 2015: 2).

2.1.4 Differentiating organ trade from organ trafficking

The international instruments discussed above either prohibit the organ trade (WHO's Guiding Principles), organ trafficking (Palermo Protocol) or both (DoI). These instruments correctly define the differentiation between organ trade and organ trafficking and they advocate equally repressive, punitive responses to both crimes. For this reason, Ambagtsheer and Weimar (2012) argue that these international instruments wrongly conflate organ trade and organ trafficking to constitute one and the same problem, while policies aimed at suppressing illegal markets work differently from policies addressing the harms associated with trafficking. Therefore, the grounds for the prohibition of the organ trade may not be as obvious as these declarations imply. According to the Bellagio Task Force – a working group composed of transplant surgeons, organ procurement specialists, human rights activists and social scientists, which closely examined the

[34] The Council of Europe's Convention on Trafficking in Human Organs deals with the prohibition of the organ trade and not with human trafficking for the purpose of organ removal. Therefore, 'trafficking in human organs' refers to the trade in human organs.

issue of organ commercialism – the principles of the organ trade prohibition are written down in one or two brief sentences without supporting arguments. "To the framers of the resolutions condemning organ sale, the practices seemed so corrupt and demeaning, the commercialism so rampant, that the reasons for a blanket prohibition appeared self-evident" (Rothman et al., 1997: 5). While a consensus prevails that organ trafficking should remain universally prohibited (Ambagtsheer, Zaitch & Weimar, 2013; Sándor et al., 2012), since the 1990s, scholars have argued that an all-encompassing prohibition of the trade is not justifiable under all circumstances (Friedlaender, 2002; Radcliffe-Richards, 2004).

2.2 Debating the organ trade's prohibition grounds

The debate on the universal prohibition of the trade in human organs revolves around the questions whether the use of incentives would increase the supply of organs available for transplantation, and whether a legal incentive system would be ethically justifiable (e.g. Abouna, Sabawi, Kumar & Samhan, 1991; Gill et al., 2013; Matas, 2008; Radcliff et al., 1998; Rippon, 2012; Working Group on Incentives for Living Donation, 2012). Most proponents of incentives rely on two core empirical claims: (i) a legal program of incentives for living donation would result in an overall increase in supply of organs for transplantation (Becker & Elias, 2007) and (ii) in a legal program, the harms associated with illegal organ markets could be avoided (Hippen, 2005). Before discussing both claims, I will first address the debate surrounding the shortage of organs available for transplantation.

2.2.1 Addressing the organ shortage

In the literature available, there is far from any consensus about why there is a shortage of human organs for transplantation (see Pascalev et al., 2013). In the debate surrounding this issue, it is necessary to distinguish between those who target the low supply and those who target the high demand of organs. First of all, many views exist on what may cause the low supply of organs for transplantation. Some see it as an informational and organizational problem (Waldby & Mitchell, 2007); there is not an efficient system in place for informing citizens about the life-saving capacity of organ transplantation and for confronting them with the decision of whether to donate their organs or not. Others claim that the potential of deceased donation is not fully utilized. Not every country performs deceased donor transplants, especially developing countries that lack suitable legislation and infrastructure (Akoh, 2011). Moreover, because of cultural and religious taboos, deceased donation has long been almost non-existent in several countries, causing severe organ shortage. In Middle Eastern countries, for example, Islamic teachings discourage and in certain areas even prohibit cadaveric organ donation as they emphasize the

need to maintain the integrity of the body at burial. In Egypt, until 2010 legal restrictions existed to prohibit the procurement of organs from deceased donors (Budiani, 2007). In Israel, low donation rates have been caused by cultural practices and religious beliefs that favour leaving the dead intact and Orthodox Jews' objection to the concept of brain death (Efrat, 2013b). So too, Asian concepts of bodily integrity, the respect of elders and objections to brain death standards made cadaveric organ donation in countries such as Japan scarce (Lock, 2001). The countries that do perform deceased donor transplants have a lack of registered donors, which leads some to argue for the implementation of an opt-out system, where it is assumed that people want to donate their organs unless they have registered their desire not to[35] (Susan, 2012). Others see the low supply of organs as a consequence of the fact that living donation is not carried out to its full potential (Lopp, 2013). They argue for an expansion of the criteria under which such donations may be performed. While some favour the extension of 'indirect' and 'unspecified' donations[36] (Dor et al., 2011), others argue for the implementation of a regulated market for the purchase and sale of organs (Kranenburg et al., 2009; Matas et al., 2012a; Radcliff-Richards, 2004). The arguments for the latter claim will be further discussed in paragraph 2.2.3.

Secondly, regarding the organ shortage, the causes for the high demand for organs for transplantation are much less discussed. Instead, the successful development of transplant medicine and its capacity to expand its activities to an ever-growing number of patients is taken as an unquestionable point of departure for the discussion on the low supply (see Pascalev et al., 2013). However, some scholars claim that the cause for the high demand for organs is not to be found just in the notion of the life-saving and normality-restoring capacity of transplantation, but also in its role as a hope technology, fuelling the dream of the ever-reborn, regenerative body (Cohen, 2009; Lock & Nguyen, 2011; Lundin, 2012; Sanal, 2004; Waldby & Mitchell, 2007). These scholars claim that organ transplantation becomes more than a life-saving treatment; it becomes a symbol for the potential of medicine to completely eradicate disease in the not so distant future (Pascalev et al., 2013). Others critize and attempt to nuance the scarcity explanation. According to Columb (2015), there would be no demand without the life enhancing promise that transplant medicine offers patients in need of an organ transplant. Scheper-Hughes (2000; 2001; 2003b) affirmatively argues that the shortage is an artificial need, an invented scarcity, created by the global medical community by promising

[35] The alternative is a system in which consent for postmortal organ donation is obtained by explicit consent (opt-in system).
[36] Indirect and unspecified donations are aimed at anonymous recipients, for example through kidney exchange programmes in case the original intention was to donate to a specific person but this proved impossible because of incompatibility (Dor et al., 2011).

patients the life-saving capacity of organ transplantation. The result is a 'discourse on scarcity' that, with its focus on a deficient supply rather than an excessive demand, fuels the demand for organs. In line with scholars such as Budiani (2007), Mendoza (2010; 2011; 2012) and Vora (2008), Scheper-Hughes furthermore points out that the discourse on scarcity fails to account for the surplus of organs and willing donors that exist in certain parts of the world. In some countries, she writes, "the real scarcity is not of organs, but of transplant patients of sufficient means to pay for them" (2000: 191). Similarly, Budiani (2007: 126) addresses the "global economic split" between affluent countries, where there are waiting lists for potential recipients, and poor countries, where there are sometimes waiting lists for persons who are willing to sell an organ.

2.2.2 "Incentives will increase the supply of organs"

The international instruments discussed above encourage the development of legitimate transplant programs, in particular deceased donation programs, as a measure to prevent organ trafficking by increasing the donor pool. For example, the DoI states that "in countries without established deceased organ donation or transplantation, national legislation should be enacted that would initiate deceased organ donation and create transplantation infrastructure, so as to fulfill each country's deceased donor potential" (2008: 4). But as demand continues to outweigh supply in countries with established organ procurement programs, opponents of the prohibition claim that incentives are necessary in order to save lives. In the absence of incentives, it is argued, there will be insufficient motivation for organ donation and therefore insufficient supply of organs for transplantation, resulting in deaths that could have been avoided (Martin & White, 2015). In estimating the impact of incentives, it is plausible that the offer of compensation for living donors may increase the supply of at least kidneys for transplantation (Mahdavi-Mazdeh, 2012), as has been the case in Iran, where the kidney shortage has been solved[37] (Fry-Revere, 2014). However, it is important to note that the Iranian incentive program was introduced in the absence of a well-developed donation program and should not be evaluated by comparison with a 'failing' previous altruistic donation program. In countries with a well-established altruistic donation program, incentives may be less effective in recruiting donors. After all, where incentives are offered, potential living related donors may feel less urgency to donate (Ghods, Savaj & Khosravani, 2000). Compensation of living donors may also exert a negative

[37] Iran has a surplus of kidney donors. It should be noted though that there are still Iranian people dying of kidney failure, as Iran is a developing country with poor medical services outside its large metropolitan areas. A significant number of Iranians die of complications associated with kidney desease without being diagnosed and many Iranian people go without specialized medical care long enough to no longer qualify for a transplant. Furthermore, Iran has a shortage in other organs, because of a lack of a well-developed deceased donor organ program (Fry-Revere, 2014).

influence on altruistic deceased organ donation by compromising public trust in the integrity of donation programs and by undermining societal recognition of organ donation as an ethically praiseworthy act (International Transplant Nurses Society, 2014). A decrease in post mortem organ donations is problematic, as deceased donors provide numerous life-saving organs that are not possible to receive from living donors, such as hearts. In order to avoid a declining urgency for post mortem donation, Matas and Schnitzler (2003) suggest investigating the possibility of an incentive program for deceased organ donors. Opponents argue that a number of evidence-based strategies of proven efficacy in increasing living and deceased organ donation have yet to be implemented and should be prioritized (International Transplant Nurses Society, 2014).

2.2.3 "Prohibition does not prevent victimization"

Another common argument against the organ trade prohibition is that it does not prevent victimization. On the contrary, as Radcliffe-Richards et al. (1998: 150) wrote, "there is much more scope for exploitation and abuse when a supply of desperately wanted goods is made illegal." The ban on organ sales increases the value of organs and their potential profitability (Goodwin, 2006). The resilience of demand-driven crime to prohibition is emphasized by Ambagtsheer and Weimar (2012). They claim that, as is often the case with illicit trade (see Becker, Murphy & Grossman, 2006), the prohibition may drive up prices, provides illegal income, displaces crime to other regions and may go underground, resulting in higher crime and victimization rates (see also Efrat, 2013a). In the words of Fry-Revere (2014: 201): "We have not prevented exploitation, we have merely hidden it." In response to scholars who argue that a financial incentive puts pressure on deprived persons to donate an organ, which would have an adverse effect on the voluntariness of the donation (Danovitch & Delmonico, 2008; Scheper-Hughes, 2002), it is claimed that harm already caused to donors in black markets is sufficient proof that the protection argument is not valid. Concern over exploitation of the poor, it is said, should lead to regulation, not its continued prohibition (Matas, 2004; Taylor, 2006). The criminalization of selling organs renders it even more difficult to identify and help potential victims of trafficking, who buy into a system where there are no legal protections for either donors or recipients (Fry-Revere, 2014). Radcliffe-Richards et al. (1998) further argue that to justify the prohibition, it is necessary to illustrate that organ selling is against the interests of potential donors while removing their option to sell leaves them poor, and makes their range of options even smaller. In this respect, Evans (2008) believes the ban on the organ trade is 'ethnocentric', perceiving the world primarily from the perspective of Western culture. The prohibition is also said to be 'hypocritical' (Erin & Harris, 1994; Volokh, 2007); in transplant medicine, everyone, except the donor, benefits financially or physically from the organ transplantation: the medical facility, the surgeon, the medical team and the recipient. In an ethical

regulated organ market, organ donors should equally benefit and be rewarded for their gift; a gift to the recipient and to society (Friedman, 2006), as compared with the expensive option of long-term dialysis, organ transplantations are a much cheaper solution (Matas & Schnitzler, 2003).[38] Organ transplantations are, in principle, a one-time treatment and the recipient again becomes a functioning productive member of society (Efrat, 2013b). To prevent people in dire financial straits from donating a kidney for money, a financial reward could be provided in instalments without cash payments instead of offering a large payment. An example is exempting organ donors from healthcare insurance premiums for the rest of their lives, as proposed in 2007 by the Dutch Council for Public Health and Care (Raad voor de Volksgezondheid en Zorg, 2007).

2.2.4 "Individuals have ownership over their own bodies"

Another key question in the debate over the moral legitimacy of the prohibition is whether or not and under what conditions permitting the sale of organs would truly serve the autonomy of donors (Cohen, 2003; Goodwin, 2006; Hughes, 2009; Orr, 2014). In most (Western) states, individuals are considered to be the owner of their organs (Lopp, 2012) and governments only restrict autonomy if certain behaviour may harm individuals; which is why in most countries organ donation is permitted, but the sale of organs is prohibited (Ambagtsheer & Weimar, 2014). Opponents of the organ trade's prohibition, however, argue that individuals have a right to sell their own organs (Savulescu, 2003). The prohibition is said to violate individuals' right to ownership over their bodies, as people are unable "to enter freely into contract from which both sides expect to benefit, and with no obvious harm to anyone else" (Radcliffe-Richards, 1996). As will be further discussed in chapter 5, many of this study's respondents emphasize the rationality and competent judgment of organ donors, attributing considerable agency to them (see Orr, 2014). But this stands in stark contrast to the empirical studies on donors who sold an organ on the black market, in which the concept of autonomy is highly challenged: these "responsible individuals" are reduced to commodities, circulated as global bodies (Lundin, 2012) by being exploited for their organs. In the words of Kunin (2009: 270): "The arguments against selling organs include the concern that the possibility of selling an organ may undermine a poor person's status as an autonomous individual – that is, given the opportunity to sell an organ, a desperately poor person may be compelled to sell." As any real choice of indigent donors is compromised by their poverty, their

[38] Matas and Schnitzler (2003) estimated the total benefit to society of one kidney transplantation equals US$100,000 annually for the United States. De Charro, Oppe, Bos, Busschbach and Weimar (2008), using the same analysis for Western countries, calculated an amount of €80,000 each year. Therefore, if incentives for living donors were to be established, a significant payment could be made to them without increasing the overall costs to the healthcare system.

vulnerability may lead to exploitation; a situation which is recognized under the human trafficking definition of the Palermo Protocol (Yea, 2010).

In discussing the autonomy of solid organ donors, the ethical debate on incentives for sperm and oocyte donors should be addressed. In the United States, for example, in the absence of federal regulations on compensation for sperm and oocyte donors, practices of payment for the donors' discomfort, time and effort have emerged (Kenney & McGowan, 2014).[39] Consequently, scholars claim that it is not self-evident why it should be forbidden to sell solid organs, while in countries such as the United States it is allowed to sell body cells such as sperm and ova (Rothman et al., 1997). The ethical debate on payment for sperm and oocyte donors equally revolves around the question whether gametes can be conceptualized as something that has market value or whether they inhabit a sacred category of human life that cannot or should not be commodified (Holland, 2001).[40] Arguments in the latter realm even go one step further than the ethical positions on solid organ sales, as some argue that gametes are the building blocks from which human beings are created, and, as such, should not be commodified (Cohen, 1999). Others express the concern that prohibition of payment for sperm and oocyte donation would encourage the development of black markets, which could leave donors unaware of the risks entailed in the process (Jones & Nisker, 2013). In response, those active in the fertility industry emphasize that any compensation meets only the (non)financial costs of the provider and is unrelated to the number of gametes retrieved for donation, and therefore they claim that they are not purchasing gametes (Ethics Committee of the American Society for Reproductive Medicine, 2007; Swain, 2014). Confusion and conflation of the two incentives strategies – offering compensation to reimburse donors for costs incurred and offering compensation for financial gain – have hampered the debate on incentives for the donation of body parts.

2.2.5 The need of an evidence-based approach

Although the foregoing arguments shed a different light on the prohibition of the organ trade, they are more theoretical than empirical, raising the need for an evidence-based approach (Ambagtsheer et al., 2013). The struggle with the control of demand-driven crimes is not new in the field of criminology. Lessons learned from the regulation of illegal markets other than the underground organ transplant industry are twofold. First of all, evidence-based studies have shown

[39] The practices of payment for donors' discomfort, time and effort have emerged through the development of professional guidelines which have no formal regulatory power.

[40] Similarly, in the Netherlands, there is a significant dividing line between those who accept prostitution as part of society and those who feel prostitution is involuntary, without exceptions, and wrong. Whether or not regulating prostitution is seen as an effective approach depends largely on one's point of view (Spapens & Rijken, 2015).

that prohibition of the commercial trade in certain goods and services generates black markets, drives up prices, displaces crime to other regions and drives the trade underground, possibly leading to higher crime rates and victimization rates (Becker et al., 2006; Best, Stang, Beswick & Gossop, 2001). An example of an ineffective prohibition of the organ trade has been witnessed in Pakistan, where although since 2008 foreign patients are prohibited to purchase organs, in 2011 it has been reported that, despite the ban, Pakistan is being "sucked back into the vortex of kidney trade and transplant tourism" (Moazam, 2011). Meanwhile, regulation has significantly reduced the abuses of the black market. In countries such as Britain, the regulation of the supply and consumption of alcohol, gambling and prostitution reduced the social harms and the profitability of supplying them criminally (MacCoun & Reuter, 2001). Secondly, as long as there is a high public demand for certain goods and services, large profits can still be made by illegal entrepreneurs. For instance, in the Netherlands the regulation of voluntary adult prostitution in 2000 did not end trafficking in women for the purpose of sexual exploitation (Spapens & Rijken, 2015). As the high public demand of organs available for transplantation has led to a highly profitable black organ market, in debating the prohibition of the organ trade the root cause of the problem, the organ scarcity, should be equally addressed.

To date, the debate on the prohibition of organ commercialism is ongoing (Delmonico, Danovitch, Capron, Levin & Chapman 2012; Matas et al., 2012b). In the absence of an evidence-based approach, the question whether some form of regulation of the trade in organs would result in more organ donations and would combat the trade remains unanswered. However, there is no validation for the WHO's and DoI's premise that commercialism should be banned because it leads to profiteering and trafficking. On the contrary, the prohibition of the organ trade has generated an underground industry, which means criminalization is more likely to have *reinforced* trafficking (Ambagtsheer & Weimar, 2012; R5; R25). As Passas writes, "if the goods or services happen to be outlawed, illegal entreprises will emerge to meet the demand" (1998: 3). The organ trade prohibition must be seen in the context of the time it was formed: in the 1990s, when there was a relatively low shortage of organs available for transplantation compared to the current scarcity, and there were barely any reports about organ purchases and sales (Sándor et al., 2012). Given the current situation, the risks known to have arisen despite of or as a result of the prohibition should be taken seriously. Between prohibition and decriminalization, a wide range of alternatives exists that can be addressed to control the trade more effectively (Ambagtsheer & Weimar, 2012). The lessons learned from the Iranian incentive system constitute a solid basis for the exploration of an approach aimed at boosting the supply of organs by increasing living and deceased organ donation through the implementation of some form of regulation towards organ supply. As

a regulated system of incentives for donation has the potential to increase living and deceased donation while reducing or eliminating the harms of unregulated markets, such a system is worthy of a trial. As the authors of the Working Group on Incentives for Living Donation (2012) argue, under properly controlled circumstances permitting incentives would allow competent, informed adults to judge about their own best interests and would therefore be ethically justifiable.

There have been several proposals for principles and guidelines for the development of a system of incentives for deceased and living organ donations. Critical elements include protection, oversight and transparency; all elements that are absent within the underground transplant industry.[41] In addition, the donation should be anonymous and nondirected and the fixed 'incentive' should be provided by the state or a state-recognized third party. The form of these principles should be determined by individual governing bodies (Working Group on Incentives for Living Donation, 2012). Yet, to prevent individuals in dire financial straits from donating a kidney for money, a financial reward could be provided in instalments and without cash payments; for example, by exempting donors, or their family members in case of deceased donation, from healthcare insurance premiums for the rest of their lives (Raad voor de Volksgezondheid en Zorg, 2007). These principles may lower the potential risks of the Iranian incentive program; which allows donors, whose motives to sell a kidney are (partially) financial (Heidary Rouchi, Mahdavi-Mazdeh & Zamyadi, 2009), to receive money from their recipients. Many donors represent lower income groups of the Iranian society and for some the amounts agreed upon with their recipients have left them dissatisfied when they found out others have been paid more or when the amount was not enough to fulfill their basic needs (Fry-Revere, 2014).

In contrast to the debate on the *organ trade*, based upon the idea that human beings must never be objects of utility for others (Titmuss, 1970) a consensus prevails that *organ trafficking* should remain universally prohibited (Ambagtsheer et al., 2013; Sándor et al., 2012). However, the prohibition largely remains a "paper exercise" as prosecutions are scarce (Ambagtsheer & Weimar, 2014; Sándor et al., 2012) for several possible reasons. It may be due to authorities in developing countries turning 'a blind eye' to the trade, since it can yield health and economic gains for influential (political) groups in the society. It may also be a matter of involvement in organ trafficking of authorities themselves. Another cause may be that donors do not come forward because of feelings of humiliation and fear (Lundin, 2012) or because they sustain the trade themselves

[41] Most unregulated organ markets occur in countries that lack the appropriate control or willingness to enforce the prohibition. As similar lack of control of a system of incentives could limit its success, countries should develop strict policies and guidelines before incentives systems are tested (Working Group on Incentives for Living Donation, 2012).

by taking on the role of organ broker (Budiani-Saberi & Delmonico, 2008). Furthermore, international aspects of the crime complicate law enforcement efforts. "Organized crime has been more efficient than law enforcement when it comes to working in a globalized world with multiple jurisdictions" (*Organ Traders*). Yet, despite the clandestine and secretive ways in which traffickers operate, which is highlighted by international organizations as one of the key reasons why the crime is difficult to detect and investigate (OSCE, 2013; United Nations, 2006), "as with other forms of trafficking, organ trafficking is visible – provided that [law enforcement authorities] are prepared to commit intelligent thought, time, effort and resources to uncover it" (Holmes, 2009: 471). However, there is little awareness of organ trafficking amongst judicial and law enforcement authorities and the crime is not on the enforcement agenda of these authorities (Ambagtsheer & Weimar, 2014; UNODC, 2015). Legislative prohibitionist efforts are fruitless, if they are not accompanied by enforcement from local, national and international policy agencies (Sándor et al., 2012).

2.3 Implementation, violation and enforcement

The international instruments discussed above contain no consideration of how these policies should be implemented and enforced or what penalties ought to be imposed for violations (Rothman et al., 1997). The WHO, for example, states: "National legal frameworks should address each country's particular circumstances because the risks to donors and recipients vary. Each jurisdiction will determine the details and method of the prohibitions it will use" (World Health Organization, 2010: 5). In focussing upon the implementation, violation and enforcement of the prohibition of organ trade and organ trafficking in South Africa, the United States, Kosovo and Israel, many legal loopholes are disclosed.

2.3.1 South Africa

In 2001, the largest private hospital group of South Africa, Netcare, started an Israeli transplant program for so-called related transplants between recipients and donors from Israel. At the time, there was a strict ministerial policy in place – a policy which had no legal effect, so violation could not lead to criminal charges – which required all organ transplants between non-related and foreign recipients and donors to obtain prior approval from the Ministerial Advisory Committee (D2; R4; R7). Within the Israeli transplant program, however, Netcare did not follow this policy. According to a social worker, a former Netcare employee, during team meetings the transplant team members were falsely informed that the Israeli transplant program had been cleared by the Department of Health, so therefore it was not necessary to obtain ministerial

approval for every single transplant within the program. The deviation of the protocol was justified to them by Netcare's executives who said (R7):

> "Oh, you know, it's all kind of really good, because they'll come with all their support services. They will do most of the work in Israel, they will come over and have their transplants, because they don't support organ transplantation in Israel. Our surgeons will do it, they'll use our facilities. We'll make money out of it, which is good for the hospital, which is good for people's salaries, and then they'll go back to Israel."

Despite the reassurance of Netcare's executives, several transplant team members had suspicions about the legality of the program. The so-called related recipients and donors did not seem to know each other; they did not look out for each other, did not speak the same language (R4; R7) – in Durban the recipients spoke Hebrew and most of the donors spoke Portuguese (D5) – and while some recipients were circumcised, their donors were not; all circumstances which led to the question (R7): "If they are family, why are things different?" But Netcare's executives kept on reassuring them that it was all legal: "If you get queries, the legal paperwork is in place, you don't have to worry, just refer them to us" (R4), as "legal opinions had been obtained from Netcare's legal department which vouched for the legality of the Israeli transplant programme" (D5: 74).

In prosecuting the commercial organ transplants performed by Netcare's St. Augustines hospital in Durban, South Africa (the Netcare case), the "very old fashioned" (R1) Human Tissue Act 65 of 1983 has been applied. According to this Act, organs from minors shall not be used for organ donation purposes (article 19) and it is not allowed, except for authorized institutions, to receive any payment for the "import, acquisition or supply" of organs (article 28). The Human Tissue Act contains numerous loopholes; no regulations exist regarding the purchase of brokering of organs, cross-border transplants and stipulations of specific relations between recipients and donors (R4). Consequently, under the Human Tissue Act the defendants in the Netcare case could only be charged for the unlawful acquisition, use or supply of organs, and a similar charge was listed regarding minors as five donors were underaged. In addition, common law charges against them were drafted under the Prevention of Organised Crime Act 1998; fraud, forgery, uttering, assault with intent to do grievous bodily harm and acquisition, use or possession of proceeds unlawful activities (D5).

In South Africa, the *Prevention and Combating of Trafficking in Persons Act*, in which human trafficking is defined in accordance with the Palermo Protocol,[42]

[42] South Africa ratified the Palermo Protocol on 20 February 2004.

was enacted in 2013. This means that at the time of the prosecution of the Netcare case, human trafficking legislation had not yet been implemented (R1; R2). Although it was not possible to prosecute the defendants under a human trafficking provision, there were many indications of exploitation (trafficking) within the Israeli transplant program, such as coercion of the donors by indebtness (R6) and the taking of their passports upon arrival in South Africa (R4; R6), and the abuse of a position of vulnerability by recruiting economically marginalized donors who received relatively low amounts of money (R2) and for whom proper aftercare was in principle not available in their home country (R6). These and other indications are further addressed in detail in chapter 5.

2.3.2 The United States

The prohibition of the trade in organs is dealt with in Title 42 of the United States Code, which concerns public health, social welfare, and civil rights. Chapter 6A captures the *Public Health Service Act*, a federal law which was enacted in 1944, which includes the prohibition of organ brokering and purchases in Section 274e: "It shall be unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for the use in human transplantation if the transfer affects interstate commerce." The offence is punished by a maximum fine of US$50,000 or a maximum period of 5 years imprisonment. In October 2011, for the first time, an organ broker pleaded guilty and was convicted for violating 42 U.S. Code §274e (the Rosenbaum case).

The major legislative instrument on trafficking in persons in the United States is the *2000 Trafficking Victims Protection Act* (TVPA). The TVPA has adopted the Palermo Protocol's three-element approach requiring an 'act', a 'means' and a 'purpose', by defining trafficking in persons as the recruitment, harbouring, transportation, provision, or obtaining of a person through the use of force, fraud, or coercion, for the purpose of a commercial sex act, or subjection to involuntary servitude, peonage, debt bondage, or slavery (sec. 103(8) en (9)). As is clear from this definition, organ removal is *not* included as a purpose in the United States' legislation and understanding of the human trafficking offence.

Although Rosenbaum's activities were qualified as a violation of organ transplant laws, there were several indications of exploitation (trafficking). For instance, deception concerning the nature, risks and longterm consequences of the transplant procedure, and coercion by portraying the donation as a noble act that would save the patient's life and by giving no reasonable opportunity to decline the surgery even in case of serious second thoughts (D18). These and other indications of human trafficking are further addressed in chapter 5 in detail.

Unlike the medical institutions Netcare in South Africa and the Medicus clinic in Kosovo (see paragraph 2.3.3), the numerous United States' hospitals where the commercial transplants orchestrated by Izhak Rosenbaum were performed, were not found to be complicit (R8; R10). However, there have been some suspicions about the illegal nature of these organ transplants by local hospital staff (D18; R8). An FBI police officer described several "red flags" (R10) by saying:

> "The hospital staff began to notice or started to think like 'how come the recipients did not check to see how the donor is doing?' There were a lot of red flags that should have raised some eye brows back in the day. […] There did not seem to be any interaction between the donor and recipient, or the recipients' family. […] The recipient did not seem to care. Their family was surrounded by them, and then you had the donor in a room by himself with no one around him. So if you ask me what was the biggest red flag, that would be the one. The other would be the differences in language. Cultural contrast."

A separate issue is that transplant units of United States' hospitals are fairly autonomous in the way the burden of proof of a free and voluntary donation needs to be established (unlike, for example, hospitals in the United Kingdom) (Scheper-Hughes, 2016),[43] which led the United States' law enforcement officials to question the adequacy of the hospitals' screening procedures (R8; R10).

2.3.3 Kosovo

In February 2004, the Kosovo Assembly enacted the *Kosovo Health Law, No. 2004/4*. Section 46 of the law prohibits transplantation of human organs by stating that "private health activities are not allowed in the following fields: […] collection, preservation, transport and transplantation of tissues and human organs." According to section 110, "organ and tissue transplantation shall be carried out only in a Health Care Institution authorized for this purpose by the Ministry of Health" and "provisions regarding organ and/or tissue removal shall be defined in the special law." The reasons behind the absolute prohibition on organ transplants by private medical facilities in Kosovo are manifold. The medical infrastructure is not in place, the health budget of the government is small and overstretched, there is not enough medical expertise and there is no medical oversight or relevant legislation in place (D27). Therefore, the Ministry of Health is

[43] The United Network for Organs Sharing (UNOS), a non-profit organisation under contract with the United States Department of Health and Human Services, has provided guidelines which state that transplant units must demonstrate their certainty that patients have not purchased or coerced the organ procured from a living donor. Transplant units are, however, fairly autonomous in the way they apply to UNOS' request for 'confirmation' that the donation is free and voluntary; the burden of proof varies from hospital to hospital (Scheper-Hughes, 2016).

arranging for Kosovar inhabitants to have organ transplantations in neighbouring countries such as Turkey, Macedonia and Croatia through bilateral agreements (R16). To date, there is still no legal framework for organ transplantations in Kosovo (D27). According to the head of the Inspection Office at the Ministry of Health (R16): "The law on organ and tissue transplantation is still drafted. The draft was presented to the parliament but was rejected, because there are still not enough resources, material and medical expertise."

In May 2008, the Medicus clinic requested approval from the Ministry of Health to perform kidney transplants, by claiming that the Medicus clinic fulfilled all necessary conditions regarding this surgical activity and expressing the hope that Kosovar patients could be treated in Kosovo by local professionals. This would save a lot of means to them as well as the state budget (D29); after all, because of the prohibition of organ transplants in Kosovo, patients needed to travel abroad for such procedures (D27; R16). The Ministry of Health replied to the request of the Medicus clinic by writing an advisory note which said that if special authorizing legislation was enacted at some time in the future, the clinic "in principle" would be permitted to conduct kidney transplants (D29: 50-52). There was no such authority within the Ministry of Health to license a health institution as no legislation existed in this area (D27). Indeed, the Medicus clinic never understood the document to be a license; the document was never used as such and in later correspondences with the Ministry, the clinic complained about the Ministry's lack of response to their requests for authorization. Therefore, it was known to the practitioners that all transplants that were conducted at the clinic were illegal as they were done in contravention of the Kosovo Health Law (D29). The request for a license for a Turkish surgeon, Yusuf Sonmez, to conduct surgery in Kosovo as a non-Kosovar health professional was granted by the Ministry. Although one of the conditions of his license was that the Medicus clinic must become licensed, and the clinic was never licensed to conduct organ transplant surgeries, Sonmez's license was used by the criminal actors to convince foreign patients[44] that the clinic was authoritized to conduct transplants (D27). As is summarized in the statement of a Canadian recipient in court (D29: 79):

> "Prior to traveling to Kosovo, he received information from the Ministry of Health in Kosovo that the clinic was licensed to perform transplants, and Yusuf Sonmez was chosen as the surgeon in this field. At the top it has the emblem of UNMIK,[45] and there is the government of Kosovo's Ministry of Health emblem on the right hand side. He received the document from

[44] Therefore, the claim expressed by the owners of the Medicus clinic in their request to the Ministry of Health for a license, to perform organ transplants for Kosovar patients in order to spare the state budget and local patients' means, turned out to be untrue.
[45] United Nations Interim Administration Mission in Kosovo (see paragraph 1.1.2, footnote 13).

> Moshe Harel upon his questioning in regard to the quality of the clinic and if the clinic was authorised to do the surgery."

Unlike the situation in South Africa and the United States, at the time of the illegal organ transplantations Kosovo had implemented sufficient legislation to be able to prosecute the defendants under the human trafficking provision. In article 139(1) of the Criminal Code of Kosovo (CCK) human trafficking is defined in accordance with the Palermo Protocol. The CCK punishes the offence of trafficking of adults with the maximum penalty of twelve years imprisonment. Trafficking of a child, a person under eightteen years of age, carries a maximum penalty of fiftheen years in prison (OSCE, 2011). In addition to organ trafficking, the defendants were charged with the following offences under the CCK: organised crime, unlawful exercise of medical activities, abusing official position or authority, grievous bodily harm, fraud, and falsifying (official) documents (D29).

A lack of enforcement, a weak infrastructure of organ transplantation and socio-economic reasons make some societies more vulnerable and more targeted to organ trafficking than others (Sándor et al., 2012). Numerous respondents claimed that Kosovo was chosen for all the above reasons. They especially addressed the post-war legal and political vacuum in Kosovo (R11; R12; R15; R18), as criminal networks profit from unstable transition periods and the lack of a strong central authority (R12; R15). "When there is a gap in governance, in regulatory scheme, in rule of law, that's when organized crime, corruption, moves in because it's opportunistic, it's entrepreneurial" (R11). Furthermore, as Kosovo is claiming sovereignty, it is not recognized by several states which were asked for assistance in the Medicus case; this issue seriously hampered judicial international co-operation (R11; R18). Respondents also pointed to Kosovo's weak health industry and the lack of regulation of private health institutions (R11; R12) and the high level of corruption[46] in Kosovo (R11; R15; R21; R23; R24).

2.3.4 Israel

In 2006, Israel amended its trafficking legislation to cover all forms of human trafficking. The *Prohibition of Trafficking in Persons (Legislative Amendments) Law 5766-2006* defines trafficking as "transaction in persons" and adds article 337A to the Penal law. Article 337A prohibits trafficking in persons for several purposes, amongst which removing an organ from a person's body, with a maximum penalty of sixteen years imprisonment and twenty years if the victim is a minor.

[46] As will be described in paragraph 4.1, corruption is strongly linked to organ trafficking.

Until 1 May 2008, Israel had not implemented legislation regarding the organ trade.[47] Given the absence of any legal ban on the buying, selling and brokering of organs and the long waiting period for kidney transplantations (more than four years in 2006) in Israel, transplant tourism grew steady from the early 1990s to 2008. It is estimated that since 2002 every year around 150-210 Israelis traveled abroad for commercial organ transplants, facilitated by extensive global organ trafficking networks managed by Israelis (Orr, 2014). In 2006, the peak year, at least 155 Israelis obtained a kidney abroad (Lavee, Ashkenazi, Stoler, Cohen & Beyar, 2013).[48] These practices were made affordable by the Israeli funding policy, resulting from "the pleas of desperate patients facing a local organ shortage, combined with cost-saving considerations" (Efrat, 2013b: 1). From the mid-1990s to 2008, the Israeli Ministry of Health reimbursed transplants abroad without asking questions about the circumstances.[49] According to the deputy manager of the largest public health insurance company in Israel (R28), this practice was suggested to them by one of the first Israeli organ brokers, who felt that the least the health insurance companies could do was to pay the costs they saved by the performance of transplants abroad. In response, the ministry and insurance sector decided to reimburse recipients according to the official DRG (diagnosis-related group) rate of kidney transplantation in Israel, which evolved from US$37,000 in the early 1990s until around $55,000 in 2007 (R28). For years, insurance companies in Israel facilitated commercial transplants abroad economically and accorded them legitimacy. In addition, public support was high and NGOs helped to raise funds for the out-of-state transplants (Orr, 2014).

On 1 May 2008, Israel implemented the *Organ Transplant Act* which prohibits the purchase, sale and brokering of solid organs such as kidneys, while at the same time offering an alternative by implementing measures to encourage altruistic organ donation within Israel (Efrat, 2013b). According to the *Organ Transplant Act*, brokers are liable to a penalty of three years' imprisonment or a fine. The law also regulates extraterritorial jurisdiction, so Israeli brokers can be prosecuted in Israel for criminal activities performed abroad. The law does not set a punishment for the buyers and sellers of organs, thus rendering the prohibition against these

[47] The only ban appeared in a 1997 directive to physicians. The ban prohibited physicians from performing transplant procedures if an organ was paid for; punishable by disciplinary action and criminal prosecution (Efrat, 2013b).

[48] In the majority of cases, the kidneys were from foreign paid donors. Sometimes, the paid donor was Israeli. Ministry of Health regulations only allow Israeli hospitals to transplant organs from living donors if the donation is altruistic, so if an Israeli patient found a local donor willing to sell a kidney, the transplant had to take place abroad (Efrat, 2013b).

[49] According to the deputy general manager of the largest public health insurance company in Israel (R28), patients were reimbursed without asking for official receipts, "because we knew in advance, if we ask for documentation we will get fake documents." Upon return in Israel, patients only needed to provide the insurance company with a certificate of an Israeli doctor which proved that they had successfully undergone an organ transplantation (R28; R33; R41).

acts declaratory only. The explanatory report of the law details that this is due to consideration of the distress and vulnerability of the recipient and donor which led them to the organ purchase and sale (Orr, 2014). A medical professional who was part of the team that formed the law explained that there has been a long debate about the question whether to or not to add punishment for patients and donors in the law (R32): "A thought behind it was that the patient is already in such a bad condition that the members of the parliament didn't feel the law should add also punishment to the definition of being illegal. […] They felt that the donors are already poor enough people and it didn't felt right to go after them with some punishment. […] It is sort of a double face. I know, I told them." Deliberations conducted by the parliamentary committee entrusted with resolving the issue lasted several years. Most committee members were initially supportive of legalizing payment for organs. Opponents, among them senior physicians and Ministry of Health officials, emphasized the moral censure to which they were treated in international professional forums. The international condemnation of Israel's policy towards transplant tourism and the international pressure, mainly in the medical field, had a decisive role in the implementation of the law (Efrat, 2013a; Orr, 2014; R26; R28; R38; R41), as Israeli transplant surgeons have been condemned from international conferences and their articles were not accepted for publication (R41). Israel was "blamed in different forums around the world and we felt that we were paying big price for what we were doing. […] The Israelis are so much involved in this type of transplantation that our doctors and our system and everything started to be treated differently" (R28). Although patients from other countries underwent commercial transplants abroad as well, Israel was seen as the "leader of transplant tourism". As Efrat explains, "Israel's rate of transplant tourist per capita was one of the highest among organ-importing countries. Moreover, the growing reach and sophistication of Israeli transplant tourism set an example soon followed by brokers and patients in other countries" (2013b: 8). In explaining the eagerness of Israeli citizens to invest considerable resources into procuring organ transplantations abroad, Greenberg (2013) addresses Israel's relatively low deceased donation rate and the Jewish concept of *pikuah nefesh*, according to which one is permitted to transgress laws and regulations to save a life.

After the implementation of the *Organ Transplant Act*, there has been a sharp drop in out-of-state transplants funded by Israeli public health insurance companies (Lavee et al., 2013), as these companies started to fund only those transplants of which they were convinced that the organ donation was altruistic

and from deceased donors[50] (Orr, 2014). As a result, the number of patients who traveled abroad for an illegal transplant declined and the Israeli waiting list grew, although the number of living and deceased kidney donations slightly increased (Efrat, 2013b; Lavee et al., 2013). However, Israeli patients who can buy a kidney by their own means still travel abroad for illegal transplants[51] and brokers are still involved in arranging these transactions (R28; R41). According to Orr (2014: 44), "it is still relatively easy for patients to be transplanted with a kidney purchased from a foreigner, but it is much harder to obtain financial reimbursement for the transplant." Enforcement has been scant. Greenberg (2013: 241) states that "since 2008, when 'commercial' transplants were outlawed through legislation, informal practice still tends to turn a blind eye wherever possible." During court deliberations, state prosecutors admitted that there are still brokers operating in the open who are not prosecuted in Israel (Orr, 2014), although their identities are well-known. During interviews, Israeli state attorneys and police officers have disclosed they find it difficult to prove that Israeli donors have been trafficked. They explained that they often do not have strong evidence about donors' victimization; it is said to be difficult to locate them and to indicate exploitation as they apparently donated a kidney voluntarily. Therefore, since 2008, the Israeli authorities rather tend to charge brokers under the *Organ Transplant Act* instead of the *Prohibition of Trafficking in Persons* (R34-R37; R42-R45).

The above is illustrated by the charges in the criminal cases which have been brought to court in Israel. First of all, in 2007, before the implementation of the *Organ Transplant Act*, one case led to two convictions of organ trafficking, reached through plea bargains in the beginning of the procedures. The Court noted that the case was very complicated as important witnesses and evidence were outside the borders of Israel, and at the time, there was no interpretation of the 2006 law on human trafficking for the purpose of organ removal by the courts (UNODC Case Law Database, J.A. v State of Israel). After the *Organ Transplant Act* came into existence, in 2012 another case was brought to court to request the extension of the arrest of six Israeli brokers, including Moshe Harel, charged for conducting human trafficking for the purpose of organ removal, organ brokerage, fraud, aggravated assault, conspiracy, money laundering and tax transgressions in Israel, Azerbaijan, Kosovo, Sri Lanka and/or Turkey. Some events took place four years ago and some of the suspicions referred to are still

[50] In 2008, several patients tried to convince their health insurance companies to pay for the illegal transplant they underwent abroad. As the companies refused to reimburse these transplants, some patients went to court (R28).

[51] Greenberg (2013) reports that according to the head of the nephrology department at the only public hospital in the north of Israel, around one-third of the 390 posttransplant patients currently treated in the department's transplant section underwent an operation abroad, almost all of them having purchased an organ from a living donor. In previous years, before the implementation of the law, two-thirds of those treated had gone abroad.

ongoing. The brokers' representatives claimed that the offences, if any, are not human trafficking, but should be viewed as offences pursuant to the *Organ Transplant Act* (D24). Although the judge decided there is a reasonable suspicion of human trafficking (ibid), in 2015 the Israeli authorities filed an indictment against the brokers and surgeon Zaki Shapira concerning violations of the *Organ Transplant Act* (D30). In August 2016, in the prelimerary stage of the trial, three defendants amongst which Zaki Shapira and Moshe Harel, pleaded guilty in a plea bargain (e-mail communication with the Israeli police, September 2016).

After having discussed here the establishment, implementation, violation and enforcement of international instruments which prohibit the organ trade and organ trafficking, particularly in relation to South Africa, the United States, Kosovo and Israel, the next chapter presents empirical studies published about the phenomenon's scope and mechanisms – influenced by the prohibition.

3. The organ trade

The first accounts of the organ trade date from the late 1980s by transplant physicians in the Gulf States, who were confronted with high mortality amongst patients who had purchased a kidney in India and returned home for follow-up treatment. The physicians disclosed that, between June 1984 and May 1988, 130 patients from the United Arab Emirates and Oman traveled to Bombay to buy a kidney from a living unrelated Indian donor (Salahudeen et al., 1990); a practice that was not criminalized in India until 1994. Around the same time, the anthropologist Scheper-Hughes (1990: 1) wrote about organ stealing rumours that she picked up during her ethnographic research in Brazil. "The whisperings tell of the abduction and mutilation of children and youths who, it is said, are eyed greedily as fodder for an international trade in organs for wealthy transplant patients in the first world." Although similar stories are still being used today by media to explain mysterious disappearances,[52] accusations of stolen organs of children[53] or adults have never been verified (Campion-Vincent, 2015). From the beginning of the 21th century, cases of more verifiable nature came to the surface. An increasing number of physicians published articles on the medical outcomes of transplant tourism from 'importing' countries, from which their patients originate, such as the United States, Canada, Israel, the United Kingdom and some other European countries (Alghamdi et al., 2010; Canales, Kasiske & Rosenberg, 2006; Gill et al., 2008; Ivanovski et al., 2011). These studies commonly address some patient characteristics, their destination countries and post-operative results. Furthermore, scholars and NGOs started to report on negative outcomes of the sale of kidneys from individuals of 'exporting' countries, whose impoverished citizens are the source of organs, such as India, Pakistan, Egypt and the Philippines (Budiani-Saberi, 2007; Goyal, Mehta, Schneiderman & Sehgal, 2002; Naqvi, 2007; Padilla, 2009). Empirical research from the perspective of other actors who are (in)directly involved in the crime, such as brokers and transplant professionals, is barely available.

This chapter addresses the empirical studies on organ trade and organ trafficking that have been published to date, for the greater part from the perspective of physicians who published reports on patients purchasing organs (paragraph 3.1)

[52] In June 2014, the Dutch newspaper *Algemeen Dagblad* published an online story about two young Dutch women who had disappeared in Panama, asserting that local sources had revealed that they had fallen victim to organ theft. Within days, the publication had been withdrawn by the newspaper, because they acknowledged that on closer inspection the basis of the story turned out to be insufficient (Algemeen Dagblad, 2014).

[53] The transplanting of a child's organ into an adult's body is medically possible.

and the perspective of scholars and NGOs who published reports on the experiences of donors after selling an organ (3.2). The final paragraph, paragraph 3.3, discusses to what extent and in which contexts the literature reveals information about the scope and mechanisms of the phenomenon.

3.1 Patients purchasing organs

According to Moniruzzaman, domestic organ trade "perhaps comprises the majority of organs being trafficked worldwide" (2012: 71). Illegal domestic trade in organs has been identified in countries across the world: Bangladesh (Moniruzzaman, 2012), Brazil (Scheper-Hughes, 2000), Colombia (Mendoza, 2010), Egypt (Budiani-Saberi & Mostafa, 2010), India (Budiani-Saberi, Raja, Findley, Kerketta & Anand, 2014; Muraleedharan, Jan & Ram Prasad, 2006), Pakistan (Rizvi et al., 2009) and Syria (Saeed, 2010). In their search for potential donors, patients travel abroad for organ transplants as well. Although traveling abroad for transplantation does not necessarily imply organ purchase, it is generally regarded as illegal and unethical behaviour that carries health risks for both patients and donors (Delmonico, 2009; Gill et al., 2011). Countries where patients travel from are multiple, but particularly noteworthy are wealthy countries in the Middle East, the Persian Gulf and Israel. The number of patients traveling from the United States and European countries is smaller and often represents patients returning to their countries or regions of ethnic origin (Padilla, Danovitch & Lavee, 2013). The most commonly reported destination country is China (e.g. Adamu, Ahmed, Mushtaq & Alshaebi, 2012; Kapoor, Kwan & Whelan, 2011), followed by Pakistan (e.g. Polcari et al., 2011), India (e.g. Majid, Al Khalidi, Ahmed, Opelz & Schaefer, 2010), Colombia, the Philippines and Egypt (e.g. Padilla et al., 2013). The organs procured in these countries are from deceased as well as living donors. In China and Pakistan, foreign patients can receive a transplant within two weeks (Abdeldayem et al., 2008; Geddes, Henderson, Mackenzie & Rodger, 2008). Below, the literature about patients' pre-transplant situation (3.1.1), transplantation process (3.1.2) and post-operative situation (3.1.3) is addressed.

3.1.1 Pre-transplant situation

Patients who travel abroad for transplantation are usually diagnosed with end stage organ failure. Often, they are waitlisted for a transplantation and, in case of kidney failure, undergo dialysis treatment (Allam et al., 2010; Ben Hamida, et al., 2001; Kapoor, Kwan & Whelan, 2011; Polcari et al., 2011). Desperation because of the long waiting time and a lower quality of life experienced on

dialysis (medical complications and physical discomfort)[54] are the main reasons why patients search for a potential donor abroad (Berglund & Lundin, 2012; Geddes et al., 2008; Huang, Hu, Shih, Chen & Shih, 2011; Inston, Gill, Al-Hakim & Ready, 2005; Van Balen, Ambagtsheer, Ivanovski & Weimar, 2016). In this context, it is important to note that the chances of a transplant succeeding drops significantly the longer a patient is on dialysis (Meier-Kriesche et al., 2000). An equally important and frequently given reason are patients' cultural and ethnic affinities with the destination country or region. Many recipients who travel are foreign-born and go to their home countries because of greater familiarity and trust with those countries' health systems (Berglund & Lundin, 2012; Cronin, Johnson, Birch, Lechler & Gurch, 2011) and/or have contacts established within the transplant society of these countries (Ambagtsheer et al., 2014a). Some feel alienated and discriminated against by the health system in the country of residence. "Ahmed decided to go abroad for transplantation when he was moved to the bottom of the wait list [in Sweden] as a consequence of him terminating the evaluation of his sister. The reason he terminated the evaluation process was that he felt sorry for his sister who had to stay in Sweden for months, since the doctors could not decide whether to or not to allow her to donate to her brother. No one, however, had told him that this [terminating the evaluation] would mean that he lost his place on the waiting list" (Ambagtsheer et al., 2014a: 10). Foreign-born patients point to a lack of trust in and poor communication with their doctor due to language barriers (Ambagtsheer et al., 2013; Berglund & Lundin, 2012) and to inequality in access to transplantation. Minority ethnic communities are least likely to receive organ transplants because they have a greater propensity of kidney failure, participate less often in living donation programs (Roodnat et al., 2010) and have lower chances of receiving suitable deceased donor organs (Cronin et al., 2011; Krishnan et al., 2010). On the other hand, patients have had relatives and/or friends come forward who were willing to donate, but instead preferred to go abroad to receive or buy organs from unrelated donors (Gill et al., 2011; Saeed, 2010). Others did not attempt to receive a donor kidney in the country of residence at all (Geddes et al., 2008; Krishnan et al., 2010) because of reluctance to ask family and friends for a kidney,[55] or they did not find a suitable living donor (Abdeldayem et al., 2008) because of unwillingness of family and friends to donate. Not all patients who travel abroad are waitlisted. Some patients are considered unsuitable (too old or unfit) for an organ transplant in their country of residence, but are accepted for

[54] Dialysis filters out about 10 percent of the toxins that a healthy kidney removes from blood, which means decline is inevitable: heart damage and other serious complications usually occur within a few years (Fry-Revere, 2014).

[55] A reason for patients to turn to a paid donor instead of an altruistic relative or friend may be to avoid the feeling of "indefinite indebtness" – the burden of feeling permanently indebted – as the gift of a kidney can never be repaid (Fry-Revere, 2014: 99).

an organ transplant abroad (Fan, Wang & BK, 2009; Krishnan et al., 2010). Others leave because their country of residence does not offer an organ transplant program (Ackoundou-N'Guessan et al., 2010; Maijd et al., 2010). Some leave pre-emptively, meaning before starting with dialysis treatment and before being waitlisted (Geddes et al., 2008; Gill et al., 2008). Living donor transplants currently represent the best treatment, giving superior results in terms of survival and quality of life when compared with dialysis and deceased donor organ transplants (Biancone, Cozzi, López-Fraga & Nanni-Costa, 2016).

3.1.2 Transplantation process

Patients are often reported to travel to countries that they have an affinity with; they have the nationality of the country, have friends or family living there or used to work or live there (Ambagtsheer et al., 2013; Canales et al., 2006; Cronin et al., 2011; Geddes et al., 2008; Ghods & Nasrollahzadeh, 2005; Gill et al., 2011). Some receive logistic and/or financial help from family and friends, when it comes to finding doctors or donors and the payment for the organ transplant (Ambagtsheer et al., 2013; Berglund & Lundin, 2012). Others leave upon recommendation from other patients (Ambagtsheer et al., 2014a; Kwon, Lee & Ha, 2011; Sanal, 2004). Patients who have no affinity with the country of destination often pay brokers to arrange their transplants (Huang et al., 2011; Kucuk et al, 2005; Saeed, 2010; Scheper-Hughes, 2011; Yea, 2010). The most common form of organ purchase is through websites offering 'transplant packages' (Abdeldayem et al., 2008; Erikoglu, Tavli & Tonbul, 2004; Kwon et al., 2011; Muraleedharan et al., 2006; Rizvi et al., 2009; Sanal, 2004; Scheper-Hughes, 2006), but the extent to which these transplant packages are called upon and to whom or what payments are made, is unknown. Although patients who travel abroad for transplants are usually depicted as wealthy, scholars documented cases of poor recipients as well (Budiani, 2007; Budiani-Saberi & Columb, 2013).

Patients who travel abroad for an organ transplant often leave without notifying their physicians (Gill et al., 2008). Yet others discuss their plans with their nephrologists (Fan et al., 2009) and seek advice from them (Leung & Shiu, 2007). Doctors are often the first to learn about a patient's intention to travel abroad, towards which they express ethical, legal and medical concerns (Ambagtsheer et al., 2013). These concerns relate to the likely exploitation of the unknown organ donor, the fact that organ purchase is prohibited and that obtaining an organ abroad may lead to post-transplant complications (Gill et al., 2011; Kapoor, Kwan & Whelan, 2011). Some doctors point out that patients who are planning to buy an organ or return with one put them in "a difficult position". Organ purchase creates conflicts around their duty of care, their privilege of non-disclosure and their maintenance of confidentiality (Wright, Zaltzman, Gill & Prasad, 2012). A recent survey amongst Dutch transplant professionals revealed

that the majority (65 per cent) reported a conflict of duties when suspicions arose about a patient's kidney purchase. Their most commonly reported explanation was that because of their secrecy oath, they were unable to protect the donor (a possible victim) and nothing was done to prevent the crime (Ambagtsheer, Van Balen, Duist-Heesters, Massey & Weimar, 2015). Yet other physicians are understanding or neutral about their patients' endeavors (Leung & Shiu, 2007). Some avoid discussing the topic with their patients, they point out that it is not their responsibility to know about their patients' wrongdoings (Ambagtsheer et al., 2013). A few researchers have reported that physicians have been working together with brokers or have the role of brokers in facilitating commercial organ transplants (e.g. Efrat, 2013b; Mendoza, 2010; 2011; Moazam, 2012; Scheper-Hughes, 2003a; 2011; Yea, 2010). For instance, Sanal (2004: 281) writes about a transplant surgeon in the Middle East who "operates 'underground' on wealthy patients in different countries, from Israel to Turkey to Russia." Budiani-Saberi, Karim and Zimmerman (2011: 19-20) write about Egypt and claim that "brokers provide a list of potential 'donors' to doctors in order for doctors to present their sex, age and nationality profiles to potential recipients for their selection." Scheper-Hughes goes even further by stating that she "observed and interviewed hundreds of transplant surgeons who practice or facilitate, or who simply condone illicit surgeries with purchased organs" (2003a: 1645).

Of the dozens of studies about patients who engaged in illegal domestic organ trade or transplant tourism, only a small number of studies actually identified patients who paid for the transplant procedure and/or the transplanted liver or kidney. These payments were made to donors (Berglund & Lundin, 2012; Moniruzzaman, 2012), brokers (Allain, 2011; Awaya et al., 2009; Greenberg, 2013; Kwon et al., 2011; Lundin, 2012; Mendoza, 2010; Moniruzzaman, 2012; Muraleedharan et al., 2006; Rizvi et al., 2009; Scheper-Hughes, 2006; Schiano & Rhodes, 2010), hospitals (Khalaf, Farag & El-Hussainy, 2004; Yakupoglu et al., 2010), doctors (Awaya et al., 2009; Sanal, 2004; Scheper-Hughes, 2000) and "small private companies" (Sanal, 2004). Others do not go beyond assumptions. Erikoglu et al. write that the mean costs of a living related donor transplant in Turkey are around US$11,000. Compared to the average expenses of $20,000 abroad, "we think that the difference between the costs is shared among donor, doctor, hospital, and intermediary persons" (2004: 1253). From the few studies that mention the amounts of the payments, these amounts vary extensively. For kidneys, reported prices range from US$20,000 to, in some cases, exceeding $200,000 (Efrat, 2013b; Pascalev et al., 2013). For instance, Erikoglu et al. (2004) write about six patients from Turkey who went to Iraq or India to receive a living nonrelated donor kidney for US$20,000. The average cost of a transplant procedure for over 150 Egyptian patients who were transplanted in Europe, the United States and Japan was US$130,000; this included the costs of medical care

and immunosuppressive drugs, but did not include other expenses such as travel and accommodation costs (Khalaf et al., 2004). Usually, however, the amounts and the benificiaries of the payments are unknown. For instance, Ackoundou-N'Guessan et al. (2010) reported that in the Ivory Coast, patients returned "financially exhausted" and were no longer able to afford proper follow-up care. Based upon the limited studies that mention the costs of the organ transplantation, Sanal (2004) argues that it seems like the price is influenced by the patients' wealth and the risks doctors take operating on the patients.

Only two studies indicate that patients had an active role in trafficking prospective donors. From Bangladesh, Moniruzzaman (2012) reports that patients (and brokers) extracted kidneys from donors through deception, manipulation and without consent. Schloenhardt (2012) writes about an Australian patient who was suspected to have trafficked a woman from the Philippines for the purpose of organ removal. However, the Australian Federal Police dropped the investigation after the patient passed away from kidney disease (O'Brien, 2012).

3.1.3 Post-transplant situation

An illegal transplant abroad with implanted grafts of which the origin is unknown could leave the recipient worse off. Financial incentives and absence of monitoring and regulation may result in poor screening of the recipient and donor and while some foreign transplant centres offer high-quality care, others provide suboptimal treatment (Efrat, 2013b). Consequently, commercial organ transplants may yield inferior outcomes. Patients returning from transplants abroad are often reported to suffer from various forms of post-operative complications, of which infections such as HIV and Hepatitis are the most common (Erikoglu et al., 2004; Fan et al., 2009; Ivanovski et al., 2011; Khalaf et al., 2004; Krishnan et al., 2010; Kennedy et al., 2005; Kucuk et al., 2005; OSCE, 2013; Wright et al., 2012). Besides infections, in comparison with organ transplants that meet ethical requirements, commercially transplanted patients face a higher risk of surgical complications and acute organ rejection, which may lead to a higher morbidity and mortality rate (Alghamdi et al., 2010; Allam et al., 2010; Cronin et al., 2011; Kwon et al., 2011; Sajjad, Baines, Patel, Salifu & Jindal 2008). Patients have returned to their native country with active transplant rejection and no knowledge of the medications they were given (Alghamdi et al., 2010; Budiani-Saberi & Delmonico, 2008; Ivanovski et al., 2011; Krishnan et al., 2010). Often, the medical and surgical details of the organ transplantation are unknown, causing tremendous difficulty for their home transplant centre to ensure good continuation of care (Working Group on Incentives for Living Donation, 2012). Several physicians have reported the death of their patients during the commercial organ transplant abroad or within a short time frame upon return in their home country (e.g. Anker & Feeley, 2012; Sajjad et al., 2008).

If patients bring back information at all after a transplantation abroad, their medical records commonly contain very limited information about the donor selection (e.g. Allam et al., 2010; Canales et al., 2006; Gill et al., 2008). For instance, the donors of Tunisian patients who were transplanted in Iraq, Egypt and Pakistan were reported to be "laborers from neighboring countries" (Ben Hamida et al., 2001). After organ transplants in Egypt, a group of patients from Turkey brought back documents that stated that they were all transplanted in a hospital in Cairo by the same surgical team. The patients were told that their donors came from Sudan and Pakistan and that they had "good matches" with them (Yakupoglu et al., 2010). Of those studies that do present information about the donors, most report that they are living donors (Alghamdi et al., 2010; Canales et al., 2006). Some studies highlight that donors are unrelated (Adamu et al., 2012) or, to a lesser extent, related. Related donors are reported to be parents and grandfathers (Majid et al., 2010), but more frequently they are said to be cousins or distant relatives (Berglund & Lundin, 2012; Cronin et al., 2011).

3.2 Donors selling organs

Individuals who are known to have sold an organ predominantly come from poor developing countries or countries with a large proportion of the population living below the poverty line (OSCE, 2013; Scheper-Hughes, 2000), and often are poor themselves (e.g. Caplan, Domínguez-Gil, Matesanz & Prior, 2009; Goyal et al., 2002; Shimazono, 2007). Mendoza (2010) found that around 83 to 91 per cent of the donors in his study belonged to the two lowest income strata in Colombia. Motivations reported for selling an organ are poverty, debt and the inability to provide for their family (Tong et al., 2012; Yea, 2010). In a study conducted among donors in Pakistan, Naqvi et al. (2007) reported that 93 per cent sold their kidney in order to repay debts. Besides these economic factors, donors share several socio-demographic factors (Pascalev et al., 2013). The vast majority of donors are men (Budiani-Saberi & Mostafa, 2010; Lundin, 2012), they often have a low level of education (Moniruzzaman, 2012; Moazam et al., 2009) and are of a relatively young age of 20-30 years old (Sándor et al., 2012; Yea, 2010). Below, the literature about donors' pre-operative situation (paragraph 3.2.1), donation process (3.2.2) and post-operative situation (3.2.3) is addressed.

3.2.1 Pre-operative situation

There are several ways in which donors may be recruited into selling an organ (see also Pascalev et al., 2013). Often, they are approached by a third party, usually brokers, "brokerage firms" (Scheper-Hughes, 2011: 86) or "feebased organ scouts" hired by a broker (Mendoza, 2010: 378); the latter of which had often sold a kidney themselves (Goyal et al., 2002; Khalili, 2007; Moniruzzaman, 2012; Yea,

2010). In Brazil, for example, where donors were recruited to sell a kidney in South Africa, two retired military officers functioned as the main brokers. These men soon hired former donors to assist them for a small compensation with the recruitments (Scheper-Hughes, 2011). Recruiters may come from the same ethnic group as their victims, increasing their capacity to connect to and gain the trust of victims (UNODC, 2015). On occasion, family members, relatives or neighbours function as recruiters or recommend the prospective donors to seek out a recruiter (Mendoza, 2010; 2011; Paguirigan, 2012). In Pakistan, researchers found that members of families where one or more persons had sold a kidney experienced an intrafamilial pressure to enter the organ market (Moazam et al., 2009). For several prospective donors, however, their way into selling an organ did not go via someone who encouraged them to sell, but rather through word of mouth or advertisements in newspapers or on the Internet. On some occasions, they responded to an advertisement posted by a patient or broker (Lundin, 2012; Mendoza, 2010; 2011; Moniruzzaman, 2012); on other occasions, they posted advertisements themselves, hoping to find a patient willing to buy their kidney (Lundin, 2008; 2011). There have also been instances where donors have actively sought out brokers to arrange the sale of an organ (Mendoza, 2011; Yea, 2010). From a study on commercial donors in the Philippines, it is even reported that "many potential kidney providers were disappointed, frustrated or angry if they failed to pass the required medical tests and therefore were ineligible to sell a kidney" (Yea, 2010: 359). Besides selling to organ brokers (Allain, 2011; Goyal et al., 2002; Lundin, 2012; Mendoza, 2011; 2012; Moazam et al., 2009; Scheper-Hughes, 2011; Yea, 2010), donors are reported to have sold their organ to (agents or staff of) medical facilities (Goyal et al., 2002; Moazam et al., 2009; Naqvi et al., 2007), physicians, "matching agencies" and, very rarely, directly to a patient in need of an organ transplant (Mendoza, 2011; Moniruzzaman, 2012).

In many instances, it appears as though the level of coercion from the side of the brokers is rather low at the time of recruitment, as they avoid brutal tactics and appeal to 'gentle' methods (Sándor et al., 2012). Several articles report about donors stating that they parted with one of their organs voluntarily (Mendoza, 2010; 2011; Paguirigan, 2012; Yea, 2010). However, this voluntariness must be viewed in the context of the dire straits and lack of options that prospective donors often face, which not infrequently cause them to frame their act of selling an organ as an act of last resort (Awaya et al., 2009; Caplan et al., 2009; Moazam et al., 2009; Yea, 2010). Furthermore, people who actively seek to sell their kidney may not have wanted to do so if they had been properly informed about the risks and health consequences, and an active role on the side of the prospective donor does of course not rule out the possibility of the use of illicit means on the part of the broker (UNODC, 2015). Some donors who have attempted to pull out after initially having agreed to sell their kidney have

experienced coercion (Moniruzzaman, 2012; Paguirigan, 2012; Yea, 2010). As Lundin (2012: 3) writes: "S.A. regretted her decision [to respond to an ad of 'Dr.' Muhammed] immediately but was subjected to veiled threats, such as that she 'would go to Paradise' if she did not undergo the operation, and was locked in Dr. Muhammed's home in Haifa until the transplantation." Similarly, in the context of sexual exploitation, it is argued that victims of trafficking may be relatively active subjects, who initiate their move to the West knowing that they will have to perform sexual services there. However, they are usually unaware of the degree of control, manipulation and exploitation involved (Aronowitz, 2003; see Franko Aas, 2013). Other coercive techniques used are emphasizing the desperation of the dying patient or withholding of passports to ensure that individuals do not back out (Moniruzzaman, 2012; Scheper-Hughes, 2011; Yea, 2010). During the recruitment phase, different forms of deception are also quite common. Potential donors are misled, or not informed at all, about the donation procedure, the need for follow-up care (Caplan et al., 2009; Moazam et al., 2009), its risks and long-term consequences (Lundin, 2012; Mendoza, 2012), and the psychological and lifestyle impact of the donation (Moniruzzaman, 2012; Pascalev et al., 2013; Tong et al., 2012). Brokers utilize the "information asymmetry" (Mendoza, 2010: 378) to deceive donors into believing the operation to be risk-free and into accepting a low price for their organ (Mendoza, 2010; 2011). This information asymmetry, in which donors are relatively powerless in influencing the price they can ask or attain for their kidney, allows brokers to offer less than prevailing global prices on the black market (Yea, 2010). Brokers are also known to provide misleading and inadequate information by telling potential donors the story of "the sleeping kidney",[56] presenting the donation as a win-win situation without any risks involved (Moniruzzaman, 2012). Brokers have also told prospective donors that a removed kidney can grown again (UNODC, 2015). More extreme forms of deception have occasionally been reported, as some individuals have been recruited by means of false promises of employment to work abroad, only to realize upon their arrival that the purpose of their recruitment was to buy their kidney (Beširević, Codreanu, Demény, Florea & Sándor, 2012; Lundin, 2012; Scheper-Hughes, 2003a). Another example is the recruitment of Sudanese refugees and asylum seekers in Egypt, who have been offered food and housing from brokers who subsequently demanded money for their help. If they were unable to pay, the proposition to sell a kidney was presented. These Sudanese victims have also reported cases of kidney theft, as they were not informed that a kidney would be removed and did not receive any payment or material gain (Budiani-Saberi et al., 2011: 17):

[56] The story of the sleeping kidney is widely circulated in Bangladesh: a person has two kidneys, of which one is asleep and only needed if the other kidney is infected. But if one kidney is damaged, the other one will be damaged too, because of the polluted blood. Therefore, everyone needs only one kidney and it is no problem to donate the other one (Moniruzzaman, 2012).

> "I fell very ill and went to the hospital and they told me that they had to remove my gull bladder. After I left the hospital I found the pain had increased. I had talked to an older Sudanese man who lived near to us about this issue. He gave me the money and I went to get a medical check-up. The doctor surprised me when he told me: 'No, you only have one kidney and the other was removed.'"

Finally, prospective organ donors are regularly misled into thinking that they will be paid more money than they actually receive; in many instances donors received less than promised, if anything at all (e.g. Goyal et al., 2002; Lundin, 2012; Pascalev et al., 2013; Tong et al., 2012; UNODC, 2015).

Yea (2010) argues that the presence of brokers increases the likelihood of exploitation of the donors. Brokers are generally seen as invaluable connectors between recipients and donors, key players in organ trafficking networks, and are claimed to financially benefit the most from the illegal transactions (Caplan et al., 2009; Muraleedharan et al., 2006; Scheper-Hughes, 2000). From a criminal justice perspective, it is said to be difficult to prosecute brokers who have been approached by donors even if there has been resulting exploitation (Yea, 2010).

3.2.2 Donation process

Before the donation can take place, several practical arrangements need to be performed. First, medical examinations have to be conducted to assess the donor's health. Secondly, if the donor is traveling abroad for the operation, legitimate or false visas and passports must be administered. Thirdly, a match of the recipient and donor must be accomplished. Usually, one or more brokers are involved in the execution of these tasks (Khalili, 2007; Mendoza, 2012; Scheper-Hughes, 2011). Sometimes, the recipient is involved as well (Moniruzzaman, 2012). At this point, the price is negotiated or simply communicated to the donor (Mendoza, 2012; Scheper-Hughes, 2011). All costs of travel documents, flight tickets and accommodation are paid for by the broker and these debts are eventually deducted from the donors' fee (Beširević et al., 2012; Mendoza, 2012; Moazam et al., 2009; Moniruzzaman, 2012; Padilla, 2009). Indebtness is a subtle mechanism commonly used to control the donor (Sándor et al., 2012). In situations where consent forms or documents which indicate that the donor is a relative of the patient are needed, brokers forge legal documents. Donors are generally not informed of the content of these documents and may be illiterate or unable to read the local language (OSCE, 2013). Brokers have also instructed donors not to disclose their identity and to deny that they have or will receive(d) any kind of payment (Budiani-Saberi et al., 2011; Muraleedharan et al., 2006).

Donors are either operated upon in their home country or leave their country of residence for an operation abroad. According to the literature, countries that qualify into the first category are the Philippines, India, Egypt and Colombia (Budiani-Saberi & Mostafa, 2010; Cohen, 2003; Lundin, 2008; Mendoza, 2012). Donors who have left their home country for an operation abroad have come from Bangladesh, Romania, Moldova and Brazil (Lundin, 2012; Moniruzzaman, 2012; Scheper-Hughes, 2011). Those who have left their country are reported to have been flown to their destination. They are quartered in hotel rooms, apartments together with other donors or at the hospital or clinic where the organ transplant operation takes place. They stay here for a few days before and after the surgery (Moniruzzaman, 2012; Scheper-Hughes, 2011).

3.2.3 Post-operative situation

Generally, only a few days after the operation, donors return home without receiving anything but minimal post-operative care and without the financial means to access local health institutions (Budiani-Saberi & Mostafa, 2010; Mendoza, 2012; Moniruzzaman, 2012; Tong et al., 2012). Many virtually have no access to medical help (Scheper-Hughes, 2005b) and some have died because they were in a bad condition after the operation (Lundin, 2012). Others, who had been promised post-operative and longer-term health-care, usually did not receive it or the quality of the medical check-ups was poor (Yea, 2010).

Donors are usually paid in cash. Payments are made on an incremental (rather than onetime) basis, with the balance usually paid after the transplant surgery is completed. Donors often receive less money than they were promised before the operation. This has been reported in Moldova, Pakistan, Egypt, Iran, India, Bangladesh, the Philippines and Turkey (Budiani-Saberi et al., 2011; Goyal et al., 2002; Lundin, 2012; Moazam et al., 2009; Moniruzzaman, 2012; Naqvi et al., 2007; Tong et al., 2012; Yea, 2010). About 25 to 50 per cent of the promised amount seemed to be withheld (Pascalev et al., 2013). Some did not receive any money at all. Lundin (2011) describes how a donor was told that "a wealthy businessman paid a high sum for her kidney." In the end, she received no payment for her organ. After an illegal transplant surgery, brokers "are generally in contact with the donor for only two reasons – either as part of the donor's effort to receive the full payment promised, or because the donor, through a variety of arrangements, has become himself or herself, a recruiter of organ donors" (OSCE, 2013: 29). The illegality of the agreement makes it difficult to pursue any claims for money not received. According to a donor from the Philippines, "there was nothing he could do, because 'my kidney is already gone and it is illegal to sell a kidney so I can't make a complaint to the police or anything'" (Yea, 2010: 369). The amount of money that donors receive varies extensively. Donors from India, Pakistan and Colombia have been reported to receive less than US$2,000

for a kidney (Goyal et al., 2002; Mendoza, 2012; Naqvi et al., 2007). Israeli and Turkish donors have obtained between US$10,000 and $20,000 (Scheper-Hughes, 2011). In Egypt, donors have mentioned amounts from US$5,000 to $25,000. Relatively high reported amounts paid to donors, such as the amount of US$25,000 in Egypt, suggests that the patients in question were also brokered to pay a high fee (Budiani-Saberi et al., 2011). The discrepancy between the low amounts of money that donors have received and the high amounts of money that have been paid by patients clearly indicates the profitability of the business.

Many of the donors used the money earned to pay off debts, and, often within months after the operation, spent the entire amount without enhancing the quality of their lives. As Cohen (2003: 676) explains: "Persons sell kidneys to get out of debt, but the conditions of indebtedness do not disappear." Consequently, for most donors, selling an organ does not improve their economic situation. It may even deteriorate, not least since they struggle with post-operative health problems which could lead to a reduction of income (Budiani- Saberi & Delmonico, 2008; Lundin, 2012; Moazam et al., 2009; Naqvi et al., 2007; Panguirigan, 2012; Yea, 2010). For instance, in the Philippines 93 per cent of the interviewed commercial living donors reported that the sale of their kidney did not improve their financial situation, whereas 21 per cent reported that the sale negatively affected their capacity to work (Budiani-Saberi & Mostafa, 2010). Many donors also struggle with problems of psychological nature: they experience existential as well as health anxiety, feelings of hopelessness, violated bodily integrity and depression. Upon returning home, many also experience social isolation, stigmatization and shame (Budiani-Saberi & Mostafa, 2010; Caplan et al., 2009; Lundin, 2012; Moazam et al., 2009; Scheper-Hughes, 2003a; Shimazono, 2007; Tong et al., 2012). A Sudanese donor stated: "I told my family and they were very angry. The family of the girl who I was engaged [to] found out, and said they didn't want me to marry her anymore" (Budiani-Saberi et al., 2011: 22). Even in Iran, where a regulated procurement system is in place and many donors are pleased with their decision to sell their kidney, a negative stigma exists towards donors. This is caused by the fact that many of the donors acted out of financial desperation and an inability to meet social expectations in a conventional manner. "There is a lot of stigma against kidney donation: I haven't told my family, and I don't want my community to know. The stigma makes it feel like you've done something wrong when in fact it's something very good, and society needs to recognize that" (Fry-Revere, 2014: 182).

3.3 The crime's scope and mechanisms

The clandestine and illegal nature of the organ trade, the lack of enforcement and the absence of consistent statistics and criminal reports makes it difficult to gather reliable data about its scope (e.g. UNODC, 2015). At present, the only 'official' data that is available on the scope of the organ trade comes from the World Health Organization (WHO). In 2007, at the WHO Second Global Consultation, Shimazono presented his estimation that 5 to 10 per cent (3,300 to 6,600) of the approximately 66,000 kidney transplants conducted annually around the globe at that time are the result of recipients traveling abroad to purchase a kidney[57] (Budiani-Saberi & Delmonico, 2008). This estimation is based upon data of the number of patients that traveled abroad for commercial organ transplants and of the number of transplants performed in China with organs from executed prisoners[58] – the local organ trade, i.e. patients who purchased a kidney in their home country, has not been taken into account. In the report in which he summarizes his presentation, Shimazono comes with a more cautious estimation though by stating that "the total number of recipients who underwent commercial organ transplants overseas may be conservatively estimated at around 5 per cent of all recipients in 2005" (Shimazono, 2007: 12).

WHO's estimation of 5 to 10 per cent commercial kidney transplantations has been widely cited and uncritically relied upon. Based upon this 'official' estimation and one media article which claims that the price of an illegal kidney transplant is approximately US$150,000 (see Interlandi, 2009), Global Financial Integrity[59] estimates the trade in kidneys generates illegal profits between US$514 million and 1 billion per year; ranking the crime on number ten of the twelve illegal activities studied in terms of illegal profits made (Haken, 2011). The estimations of the WHO and Global Financial Integrity have no empirical foundation though; these 'guesstimates' (see Steinfatt, 2011) are simply estimations of estimations (Columb, 2015) and there is insufficient information available to permit an accurate assessment of the global extent of the phenomenon (United Nations, 2006). However, the few empirical studies that recently indicated the scope of commercial transplants in countries such as Pakistan, the Philippines and Egypt indicate that the WHO estimation is conservative. For instance, Efrat (2013a: 771) writes that in 2007, "some 2,000

[57] Whether buying an organ abroad is an illegal activity depends on the regulations in the country of destination at the time of the purchase.
[58] The data was retrieved through a search of databases and the Internet that included media sources, transplant tourism websites, renal and transplant registries and reports from health authories (Budiani-Saberi & Delmonico, 2008; Shimazono, 2007).
[59] Global Financial Integrity is a Washington based research organisation working to curtail illicit financial flows.

commercial transplantations were being performed annually in Pakistan, the majority of which – roughly 1,500 – on foreigners." In the Philippines, it is estimated that circa 3,000 of Baseco's 100,000 residents[60] have sold a kidney (Yea, 2010), and the NGO Coalition for Organ-Failure Solution (COFS) estimated the total number of victims of organ trafficking in Egypt to be in the thousands (Budiani-Saberi et al., 2011). It remains unclear what percentage of paid kidney transplants would fit within the human trafficking definition. Although some researchers state that in practice it is difficult to identify commercial transplants where the donor has *not* been subject to exploitation, there is no accessible way for scholars and law enforcement officials to measure the voluntariness of organ sales as these illegal transactions usually tend to be concealed or disguised as, for example, altruistic organ donations between relatives (OSCE, 2013).

The foregoing paragraphs reveal that the extent to which the literature discloses information about the scope and mechanisms of organ trafficking is limited. The majority of the published articles on the medical outcomes of transplant tourism by patients do in fact not present any evidence that the organs were bought and therefore obtained illegally, let alone that they were obtained through human trafficking. It should be considered that most articles about transplant tourism are written by physicians, who, because of their duty of confidentiality, feel either not permitted or are not willing to report about their patients' (alleged) wrongdoings. Similarly, within the larger number of articles that can be found on the socio-economic consequences and experiences of donors who sold an organ, these studies often lack information about the circumstances under which the sale took place. Although the commercial organ trade is often discussed by scholars within a human trafficking framework (Columb, 2016; Yea, 2010), organ trafficking is "generally assumed, rather than rigorously established" (Yea, 2010: 360). The vast majority of the studies present no indications whether any of the means listed in the definition of human trafficking, such as coercion or deception, have been used. The few studies that do address some indications of human trafficking often present these indications without addressing (a clear definition of) trafficking. For instance, Moniruzzaman, who describes how "wealthy buyers (both recipients and brokers) tricked Bangladeshi poor into selling their kidneys; in the end, these sellers were brutally deceived and their suffering was extreme" (2012: 69), explores these acts through the concept bioviolence.[61] Scheper-Hughes, who wrote many articles about patients, donors, brokers, surgeons and other actors involved in illegal organ transplants, describes these practices in the context of modern neoliberal globalization and its global

[60] Baseco is part of Tondo district, which is the most economically marginal district of Manila (the capital of the Philippines) and one of the most densely populated areas in the world (Yea, 2010).
[61] Moniruzzaman considers bioviolence "a blend of physical, structural, and symbolic violence, all of which are carried out to extract organs from the oppressed bodies of the poor" (2012: 72).

economy, through which, she argues, the bodies of the poor increasingly have been turned into commodities (e.g. Scheper-Hughes, 2000; 2011). "The poor have become a spare-parts bank for the well-to-do" (Scheper-Hughes in Smith, 2011). Likewise, Lundin (2012), who aims to go behind the normative discussions that usually surround organ trafficking, describes the illegal practices through conceptual structures such as the dream of the regenerative body and the view of the body as an object of utility and value. Overall, only a few studies can be found which clearly address human trafficking within the context of the organ trade. In a report of the NGO COFS, the experiences of Sudanese refugees and asylum seekers in Egypt are explored within the definition of human trafficking (Budiani-Saberi et al., 2011), and in a study on commercial organ donors in Manila, the Philippines, Yea (2010) evaluates the relevance and applicability of human trafficking regarding the phenomenon. In her article, Yea concludes that it is difficult to unequivocally define the local kidney market in Manila as an expression of human trafficking, as the donors only present elements of human trafficking; "they do not present as 'total' victims, meaning that their experiences are often viewed by anti-trafficking actors as diluted forms of trafficking as they do not readily conform to the dramatic stereotypes of some other victims" (2010: 360). In response, it should be emphasized that the information provided by recipients and donors is a partial account of the phenomenon, as they are not aware of the overall extent of the criminal network, its structure and financial profitability. Usually they have only been in contact with the broker, surgeon and/or hospital staff; many did not meet the recipient or donor of their kidney, and the ones who did could not always interact with the other because of a language barrier. Moreover, recipients and donors are often restrained in revealing information about the illegal transaction to others, because they could be held criminally liable and/or are threatened to silence by the criminal network (see chapter 5). Therefore, the literature on patients' transplant tourism and donors' experiences after selling an organ discloses limited information about the mechanisms and organizational model of organ trafficking as well as the main perpetrators and the purpose with which they initiate or become involved in the illegal activities; the purpose being a key element of the human trafficking definition.[62] As has been dicussed, empirical research from the perspective of other actors who are (in)directly involved in the crime, such as brokers and transplant professionals, is barely available. More qualitative research involving in-depth methodologies is required to give a more comprehensive account (see also Pascalev et al., 2013). I chose to do this through the analysis of three criminal cases, because the information available with law enforcement authorities sheds a light on the entire trafficking process, from recruitment to exploitation.

[62] The lack of empirical research into motivations of traffickers is acknowledged for human trafficking in general (Rijken, Muraszkiewicz & Van de Ven, 2015; OSCE, 2010).

4. Theoretical perspectives

Up until now, criminological studies of the organ trade and organ trafficking are scarce. A plausible explanation for the relative absence of attention from criminologists is that, traditionally, criminology focuses on crime and law-breaking behaviour; an important limitation of the discipline (Walklate, 2007), as crime is a so-called *social construct* that depends on the time and place in the context of changing norms and morals (Becker, 1963). In other words, certain behaviour can be perfectly legitimate in one country or time frame, while being illegal in another; as is the case with the purchase and sale of organs (organ trade) as well as human trafficking for the purpose of organ removal (organ trafficking).

The importance of criminological research into this field should no longer be ignored. This chapter focuses on relevant theoretical concepts in order to establish a framework through which the phenomenon could be approached. It shows in paragraph 4.1 that the mechanisms and organizational model of organ trafficking cannot be understood without the context of globalization. As a result of globalization, new inequalities have been manifested between developed and developing countries. Due to global inequalities, patients who are affected by the shortage of organs available for transplantation in their home country can travel to a foreign country and purchase an organ from an impoverished donor, willing to sell an organ out of desperation and strain. Given the almost worldwide prohibition of the commercial trade in organs, these 'goods' are exchanged within a highly profitable global underground industry (black market) facilitated by transnational organized crime; a concept that is addressed in paragraph 4.2. These criminal organizations operate with a certain similarity to and intertwinement with actors and institutions that constitute the legal transplant industry, such as transplant surgeons, medical facilities and medical insurers. In addressing the analogies and differences of the organizational model of legal and illegal entreprises (paragraph 4.3) and in discussing the variety of manifestations in which legal actors participate in illicit market activities (4.4), a theoretical framework is provided for the organizational model of organ trafficking networks; a model which will be further discussed in chapter 5. In explaining criminal behaviour of legal actors, an important theoretical approach draws on the justifications and excuses by which they neutralize their moral commitment to conventional norms and values, which is the focus of the final paragraph (4.5). The strain experienced by patients in need of an organ and impoverished donors offers the actors involved in the crime many possibilities for neutralization techniques, which again, will be further addressed in chapter 5.

4.1 Globalization, criminogenic asymmetries and strain

The technological revolution has led to information, money and people now crossing the planet within a short time frame (e.g. Ruggiero, 1997). Consequently, globalization scholars (e.g. Franko Aas, 2007) argue that the world, including the connection between people and goods, has become smaller. Amongst the various attempts to define the concept, for Beck and Camiller globalization refers to "the processes through which sovereign national states are criss-crossed and undermined by transnational actors with varying prospects of power, orientations, identities and networks" (2000: 11). Within the global capitalist economy, states have become increasingly dependent on the global market, as economic gains are realized through the trade of products. Prices are determined by supply and demand; the neoliberal paradigm, the ideology that endorses power of a competition-driven market model, is dominant (Farmer, 2005). As globalization has served well the need of legal capital, it has also created new transnational opportunities for criminal entreprises (Passas, 2002; Ruggiero, 2003) that are difficult to stop by territorially-bound law enforcement authorities (Bauman, 1998; Nelken, 1997; Ruggiero, 2000). According to Scheper-Hughes (2000: 193), "the flow of organs follows the modern route of capital", as the same global structures that allow legal companies to capitalize on third-world natural assets and cheap labour facilitate the trade in organs. Under the growing influence of globalization, the organ shortage has driven citizens of industrialized countries to developing countries in search of organs available for transplantation (Farmer & Gastineau-Campos, 2004; Scheper-Hughes, 2005a).

As a result of globalization, new international inequalities have manifested themselves between developed and developing countries. These "structural disjunctions, mismatches and inequalities in the spheres of politics, culture, the economy and the law" – Passas' definition of *criminogenic asymmetries* – provide opportunities for crime. "Asymmetries are criminogenic in that they generate or strengthen the demand for illegal goods and services; they generate incentives for particular actors to participate in illegal transactions; and they reduce the ability of authorities to control illegal activities" (Passas, 2002: 26). On a global level, criminogenic asymmetries lead to *global anomie*s. A core assumption in the anomie or strain tradition[63] is that disjunctions between culturally induced goals and accessible legitimate means to attain these goals weaken commitment to dominant norms and lead to deviance (Passas, 2010).

[63] The concept of anomie, a state of mind characterized by the absence of values, was introduced by Durkheim. Later, Merton linked anomie with deviance by arguing that the strain towards anomie between culturally induced goals and accessible legitimate means to achieve these goals leads to various possible adjustments: conformity, innovation, ritualism, withdrawal and rebellion (Macionis, Peper & Van der Leun, 2010).

Crime may be used to reduce or escape from strain. For example, individuals experiencing chronic unemployment may engage in theft or drug selling to obtain money. Inequality and poverty influence the level of strain that individuals experience and the likelihood that they will cope through crime (Agnew, 1999). Applied to organ trafficking, criminogenic asymmetries between industrialized and developing countries provide opportunities for criminal networks to exploit both relatively wealthy patients – whom need to deal with a disjunction between culturally induced goals and accessible legitimate means, i.e. the organ shortage – and impoverished donors – as poverty, unemployment and poor social conditions in developing countries appear to be important incentives for its inhabitants to be willing to sell an organ out of frustration and strain. Due to global inequalities, desperate patients do not need to rely on the overburdened health system of their home country but they can purchase an organ in a foreign country, where many people are willing to sell an organ (Scheper-Hughes, 2005).

As the development of the organ trade into a globalized industry is related to local conditions and contexts, attending to global processes does not suffice in explaining the opportunities for the crime (Cohen, 2011; Kierans, 2011; Yea, 2010). As Columb wrote: "The conditions that facilitate various aspects of the organ trade, are grounded in the particular circumstances and environments of a given context" (2015: 38). Three criminogenic asymmetries within certain local or regional settings are repeatedly mentioned in the literature on the organ trade and organ trafficking (Pascalev et al., 2013). First is the absence of either the legislative or the non-legislative means to effectively prohibit and prosecute the crime (Caplan et al., 2009; Mendoza, 2010; Moazam et al., 2009; Shimazono, 2007). Countries that have been deeply involved in the organ trade, for example Pakistan, Egypt and the Philippines, have only recently implemented relevant laws (Efrat 2013a; 2013b; Padilla et al., 2013). Although the prohibition in these countries did lead to a certain visible reduction in the trade's scope – an immediate effect being a diminishing inflow of foreign patients which could regain due to inadequate enforcement – the prohibition has led to the development of underground economies as well, possibly resulting in higher crime and victimization rates (Columb, 2016; Efrat, 2013a; 2013b; Greenberg, 2013; Padilla et al., 2013; Rizvi et al., 2009). The second criminogenic asymmetry is the relative mundaneness and routineness that has come to characterize the act of selling an organ in some local settings. The regions or parts of major cities where a significant proportion of the population has sold a kidney are not infrequently referred to in terms of 'kidney-villes', 'villages of half men', 'kidney towns/villages' or 'no-kidney islets'. In these local settings selling a kidney has become an established way of attempting to make ends meet (Cohen, 2003; Mendoza, 2011; Moazam et al., 2009; Yea, 2010;). Finally, the third criminogenic asymmetry connected to organ trafficking is corruption, which refers to the

efforts of both criminals and legal actors to maximize their profits (Ruggiero, 1997). As many donors sell an organ abroad, criminal groups are often suspected to have excellent connections with official authorities in order to facilitate the movement of people across borders (Bilgel, 2011; Caplan et al., 2009; Padilla, 2009; Scheper-Hughes, 2000; 2011; Vermot-Mangold, 2003; United Nations, 2006). Scheper-Hughes (2003a) claims that strong links with officials are established through bribes in return for not reporting the violation of the forgery of travel documents or to 'secure' border crossing. According to Mendoza (2010), the existence of organ trafficking in Colombia can to a large extent be assigned to corrupt local authorities turning a blind eye to the illegal activities of brokers and hospitals. In the Philippines, politicians and police have received contributions from hospitals, doctors and other agencies in exchange for advising how to handle various aspects of the illegal organ transplants (Mendoza, 2011). Shimazono (2007) reports about allegations towards embassy officials of certain Middle Eastern countries who are said to have facilitated commercial transplants in the Philippines and Pakistan. Efrat (2013a) further states that poor enforcement of Pakistan's organ trade results from the ties between law enforcement officials and the physicians and hospital owners involved in illegal transplants. "The organ mafia is hand in glove with the administration and the police. People have been caught red-handed but have been let off because high-ups are beneficiaries of the huge amounts that the trade generates. It speaks volumes for the 'integrity' of a government which cannot even nab a handful of individuals who have been so clearly identified" (Mustafa 2012, in Efrat 2013a: 775).

In short, globalization has created new opportunities for criminal entreprises. Under influence of criminogenic assymetries which are manifested within and between industrialized and developing countries, the organ trade has developed into a globalized industry; a profitable underground market where organs can be obtained illegally in parallel existence to the legal transplant industry (e.g. Ambagtsheer et al., 2013; Columb, 2015; United Nations, 2006; UNODC, 2015). Due to the complex nature of organizing these illegal organ transplants on a global level, the involvement of *transnational criminal organizations* is generally unchallenged amongst scholars from different disciplines (e.g. Scheper-Hughes, 2011; Vermot-Mangold, 2003; Yea, 2010). The concept 'transnational organized crime' is addressed in the following paragraph.

4.2 Transnational organized crime

The term 'transnational crime' was developed by the United Nations to guide discussions at the Fifth United Nations Congress on Crime Prevention in 1975 (Mueller, 2001; Reuter & Petrie, 1999) and "simply" consisted of a list of five

activities (Mueller, 1998). During the 1980s, however, transnational crime came to describe a broader array of criminal activities (MacNamara & Stead, 1982; Smith, 1989) and in 1990, Bossard introduced a more precise definition, by claiming that transnational crime is an activity that is considered a criminal offence by at least two countries. Twenty years after introducing the term transnational crime, the United Nations expanded the list of offenses to include activities such as trafficking in persons and the trade in human body parts, and added a conceptual definition: "offenses whose inception, prevention and/or direct or indirect effects involve more than one country" (see Mueller, 2001: 14).

The concept 'transnational crime' now belongs to the everyday lexicon of criminologists, policymakers, law enforcement officials and the public. Yet, it is not a legal concept; it lacks a precise judicial meaning (Felsen & Kalaitzidis, 2005). It remains a criminological term (Mueller, 2001) that is both sociological, because of its concern with understanding criminal groups, and political, because transnational criminal actors operate within a global environment (Serrano, 2002) by taking "advantage of all forms of progress, especially in international transport, […] telecommunication and computers" (Bossard, 1990: 141). As has been described in the foregoing paragraph, the technological revolution has transformed the global market. The increase in transnational flows of goods and people is considered the underlying condition for the growth of organized crime (Ruggiero, 1997). In the words of Galeotti (2001: 203): "Organized crime is in many respects the shadowy underside of modernity. Transnational organized crime, similarly, is the underside of globalization."

The concept 'organized crime' has drawn widespread criticism though. It was introduced by anticorruption reformers in the United States during the nineteenth century in referring to political corruption (Felsen & Kalaitizidis, 2005), after which the concept evolved into one that referred to associations of gangsters (Woodiwiss, 2003) which have traditionally been portrayed as pyramidal structured organizations with a strict hierarchy and clear divisions of tasks (Block & Chambliss, 1981). Mafia groups such as the Italian Cosa Nostra and the Japanese Yakuza have been presented as the archetype of organized crime (Paoli, 2002). In the words of Reuter (1983: 175), "organized crime consists of organizations that have durability, hierarchy and involvement in a multiplicity of criminal activities. […] The Mafia provides the most enduring and significant form of organized crime." Today, while many scholars apply the concept organized crime to features such as hierarchical structure, division of labor, continuity in operations, corruption and violence (e.g. Lee, 1999), others have shown that criminal organizations could be loosely structured, flexible and dynamic in anticipating opportunities for illegal markets (e.g. Fijnaut & Paoli, 2004; Morselli, 2009).

Consequently, organized crime remains "an ambiguous, conflated concept, produced by a stratification of different meanings which have been attributed to the term 'organized crime' over the years" (Paoli, 2002: 52). The lack of clarity surrounding the topic has also hampered the negotiations of the preparations of the *United Nations Convention against Transnational Organized Crime*, which prohibits organ trafficking as a form of organized crime (paragraph 2.1.2). It took more than two years before a loose definition was adopted (United Nations, 2000a) and included in article 2 of the Convention (United Nations, 2000c):

> (a) 'Organized criminal group' shall mean a structured group of three or more persons, existing for a period of time, acting in concert with the aim of committing one or more serious crimes or offences established in accordance with this Convention, in order to obtain, directly or indirectly, a financial or other material benefit;
> (b) 'Serious crime' shall mean conduct constituting an offence punishable by a maximum deprivation of liberty of at least four years or a more serious penalty;
> (c) 'Structured group' shall mean a group that is not randomly formed for the immediate commission of an offence and that does not need to have formally defined roles for its members, continuity of its membership or a developed structure.

The separate interpretative notes show the all-encompassing nature of the term 'structured group' by stating that the term "is to be used in a broad sense so as to include both groups with hierarchical or other elaborate structure and non-hierarchical groups where the roles of the members of the group need not be formally defined." As the degree of organization of criminal activities can vary widely, critics argue that the term 'organized crime' merely simplifies and mystifies its complexity (Reuter, 1985; Reuter & Petrie, 1999). This criticism extends to *transnational* organized crime (Passas, 1999), equally seen as ranging "from highly structured organizations to more fluid and dynamic networks" (United Nations, 1994: 11). At the same time, however, a growing number of scholars and practitioners make use of the term 'transnational organized crime' (e.g. Felsen & Kalaitizidis, 2005; Galeotti, 2001), because they claim that some degree of organization is required for criminal activities that cross national boundaries (Beare, 2003; Berdal & Serrano, 2002). Although illegal market activities which are usually associated with organized crime – such as trafficking in human beings and body parts and smuggling of drugs, weapons and information (e.g. Castells, 1998; Levi, 2002; Spapens, 2010; Paoli, 2002; Van Duyne, 1995) – are often taken to be the work of local criminal groups, the activities of which they are a part are global; other countries function as source, transit and/or destination routes for the illegal commodities to sell (Hobbs, 1998; Karstedt, 2000).

As 'organized crime' is not a common noun which describes a well-understood set of arrangements to commit crime, but rather a diverse subject matter of people and activities, Levi (2002) suggests a more meaningful way to think about organized crime: the organization of crime, by which he means the way in which criminals organise themselves and the manner in which criminal markets work. Levi argues that the organization of crime is a *dynamic* process, which results from "the interaction of crime opportunities, offender and prospective offender skills and networks, and formal control efforts (whether through the criminal law, administrative law, or disruption)" (2002: 903). The following paragraph addresses the scientific approaches regarding the organization of crime; the organizational model of the supply of illegal goods and services by criminal entreprises.

4.3 Organizational model of the provision of illegal commodities

The scientific approaches concerning the operational model of illicit market activities by criminal groups differ (Paoli, 2002). While some scholars emphasize the analogies between legal and illegal businesses, others claim that the illegal status of the products offered tends to prevent the consolidation of large-scale, durable criminal entreprises. Both perspectives are presented in this paragraph.

On the one hand, scholars emphasize the similarities between legal and illegal entreprises. They point to the market rationality of illegal businesses and presume that criminal organizations which provide illegal commodities react to the same incentives and restraints of legal firms and follow the same organizational models to gain profit (Sieber, 1997; Williams & Florez, 1994). According to Passas (1998: 3):

> "If the goods or services happen to be outlawed, then illegal entreprises will emerge to meet the demand. In this respect, there is no difference between conventional and criminal entreprises. Very often, all that changes when the business is illegal are some adjustments in modus operandi, technology and the social network that will be involved. In some cases, we have a mere re-description of practices to make them appear outside legal prohibitive provisions."

On the other hand, researchers have argued that illegal market activities by criminal groups largely take place in a disorganized way. The illegal status of the products is said to affect the way in which their production and distribution are carried out and tends to prevent the consolidation of large-scale, durable criminal entreprises (Naylor, 1996; Reuter, 1983). Paoli (2002) further explains that although illegal markets have a lot in common with their legal counterparts, the analogy can not be pushed too far, as the illegality of the products obligates

criminal entrepreneurs to operate both without and against the state. Since the provided goods and services are prohibited, criminals operate *without* the state as they cannot resort to state institutions to enforce contracts, have violations sanctioned or appeal for redress of injury (Reuter, 1983). Due to the lack of a public power, illegal marketplaces have no "systematic trust" (Luhmann, 1979: 68-69). Consequently, the exchange of goods and services is bound to occur on the fragile basis of trust. Therefore, social ties are crucial to, and embedded in criminal groups (e.g. Bruinsma & Bernasco, 2004; Kleemans & Van de Bunt, 2003; Van de Bunt, Siegel and Zaitch, 2014). Long-term criminal partnerships have proven to be easier to establish and to maintain among people that are bound by family ties or by a common ethnic or religious background (Paoli, 2002). Illegal market actors also operate *against* the state. They are bound to function under the constant threat of being arrested and having their assets intercepted by the authorities. In reality, for some illegal entrepreneurs the effective risk of arrest is strongly reduced because they are successful in bribing representatives of state institutions and/or the latter are weak and inefficient. In minimizing the detection risk, illegal entrepreneurs will reduce the amount of information available to their customers. Other constraints of product illegality which Paoli (2002) puts forward are the local scope of illegal entreprises which follows from the difficulty of monitoring distant activities and the higher risks associated with transportation and communication to distant locations (see also Reuter, 1985), the shorter time planning horizon, and the exclusion from the possibility to market the products by advertising, as this would attract law enforcement attention. For all the above reasons, Paoli (2002) argues that it is rather unlikely that large, hierarchically organized criminal entreprises will arise in the illegal marketplace.

In line with the theoretical disorganised crime hypothesis, empirical evidence has demonstrated that illegal markets are populated by numerous relatively small and often transient 'networks' (Paoli, 2002); a concept which is frequently used to describe the distribution system of legal as well as illegal commodities. A network is likely to have a core group of people who are closely connected and a more dispersed set of participants, who usually have more specialized functions and will collaborate only in response to initiatives by the core group (Reuter & Petrie, 1999). Empirical studies show that the strength and cohesion of most criminal networks should not be overestimated. Even though long-term relations may develop among network members, the majority are arms-length buyer-seller relationships. Within most networks, exclusivity is not required; members usually belong to more than one network at the same time since they have many customers to whom their commodities can be sold. Consequently, although some members occasionally enjoy a monopolistic power over a local market, most actors are unable to determine the commodity's price independently; they are "price-takers" rather than "price-givers". Within criminal

networks, positions and tasks are interchangeable. New partners are included and others disappear as a result of law enforcement actions. Many network members only know their immediate suppliers and buyers and are not aware of the network's overall extent and structure (Paoli, 2002). In this respect, Hobbs (1997) and Coles (2001) stress the importance of brokerage roles in putting people and skills together. It is these connectors rather than the most highest-ranking figures who may be the most crucial actors within criminal networks (Jackson, Herbrinck & Jansen, 1996). As Coles argues, "the identification of any varying usage of brokers in this way might provide an indication of the sophistication or degree of 'organization' of a criminal network" (2001: 586).

In adressing the organizational model of illicit market activities, it is important to note that many transnational criminal activities require the co-operation of legitimate organizations and actors (Paoli, 2002; Reuter & Petrie, 1999). This is particularly appropriate for organ trafficking; a crime which may involve 'professional criminals' who act as brokers, but the majority of those involved are legitimate actors: recipients, donors, surgeons and medical teams that perform the organ transplantation, hospital administration, laboratories that conduct prior tests and evaluations, and medical insurers. All of these legal actors directly or indirectly contribute to the practice of organ trafficking (Efrat, 2013b). As the organizational model of criminal activities cannot be understood without explaining the interaction between the 'upperworld' and 'underworld', the following paragraph discusses its manifestions. Based upon this theoretical framework, chapter 5 will discuss the organizational model of organ trafficking.

4.4 Involvement of the 'upperworld' in black market activities

In trying to enfold the variety of manifestations of the interaction between the 'upperworld' and 'underworld', Passas (2002) designed a typology of the symbiotic relationships[64] between legal and illegal actors. In his typology, he distinguished eight types of symbiotic relationships: outsourcing, collaboration, co-optation, reciprocity, (systemic) synergy, funding, legal interactions and legal actors committing organized crime. *Outsourcing* refers to a division of labour between legal and illegal actors, where one party offers specialized services to the other party. It is possible that only one of the parties is aware of the quasi-contractual relationship. *Collaboration* means that the links become stronger and more direct as legal and illegal actors work together for the commission of the same offence. Under this category, various types of professionals such as lawyers, politicians, bankers or medical professionals knowingly offer their services

[64] Symbiosis refers to a relationship that is sustainable and mutually profitable for two parties.

to criminal organizations. By *co-optation*, Passas points to uneven power relations between the parties through which mutual benefits are accomplished. An example could be the agreement between a company which allows a government agency to collect inside information about their clients in exchange for the company to operate unimpeded. *Reciprocity*, or 'even exchanges', refers to conscious mutual benefits between legal and illegal actors, including government officials who receive commissions in exchange for favours to criminal organizations (corruption). *(Systemic) synergy* means that legal and illegal actors benefit each other while they independently do business. The effects are similar with those of outsourcing, but there is no conspiracy or client-provider relationship. The legal actors reap benefits from others' criminal activities but there may be no knowledge, intent or reasonable suspicion of illegal activities – in some cases, however, suspicions may be 'cured' by efforts to avoid any knowledge. The opposite occurs as well, where criminals benefit from the practices of legal actors. *Funding* relationships refers to the situation in which legitimate businesses, knowingly or not, provide essential support for the operation of criminal groups. By *legal interactions* Passas points to the fact that all criminal actors have legal faces. Diversification is required, for instance, for money laundering purposes, the reduction of risk or to strive for wider respectability. Inevitably, criminal actors interact with conventional actors, whose knowledge of their counterparts' background could range from complete ignorance to benign neglect. The final relationship distinguished by Passas (2002) is *legal actors committing organized crime*, which refers to legal actors who engage in organized crime without interaction with illegal actors from outside their entreprise, as some official industries are able to set up their own illicit services to boost their economic performance (see also Ruggiero, 1997).

As is explained, the illegal actors involved in organ trafficking coexist with the legal institutions that constitute the transplant industry. "There would be no organ trade without the necessary medical infrastructure or trained medical staff to remove/harvest the organ(s)" (Columb, 2015: 39). The interaction between both worlds could either entail *collaboration*, in which case medical professionals knowingly work together with brokers for the commission of illegal transplants, or *outsouring* or *funding* relationships, in which case the medical staff is unaware of the illegal nature of the transplants. Both types of symbiotic relationships provide mutual benefits, either independently and possibly unconsciously (*systemic synergy*) or through the exchange of commissions (*reciprocity*). The organ trade is generating more transplants worldwide, from which medical institutes and medical professionals knowingly or unknowingly benefit in terms of financial earnings and surgical experience (R10 (see quote on the following page)).

> "I am not defending the hospital, but, again, they didn't know what was going on. The hospital was very interested in building their program. They wanted to become known as.. and built expertise so that within the medical world people would say 'this is a good hospital to go to if you need an organ, a kidney or a liver.' The more popular or well-known a hospital becomes, they get more grand, funding, they will have fellowships and attract better doctors. […] They become like an authority on the topic and it is just better all-around for the hospital."

Illegal actors benefit from the general practices of the medical industry as well, especially with regards to the duty of medical confidentiality by which physicians feel restrained in interfering in patients' (suspected) activities regarding organ purchases (see also paragraph 3.1.2) and, in case they knowingly facilitate or perform illegal organ transplants, are able to prevent the crime's detection.

Crimes committed by legitimate business entities or by its employees in the context of regular business activities are respectively defined as corporate crime and white-collar crime (Braithwaite, 1984; Hoefnagels, 1981). The concept of *white-collar crime* was introduced by Sutherland as "a crime committed by a person of respectability and high social status in the course of his occupation" (1949: 9). Friedrichs (2009) referred to such individuals as "trusted criminals". More than any other type of crime, white-collar offences are attacked for undermining the basis of trust which holds society together, as those in authority or positions of privilege are supposed to be models of respectability (Nelken, 2002), instead of abusing the opportunities which their position of power provides (Geis, 1992). Crimes committed by medical institutions and specialists are clear examples of undermining society's basis of trust; the medical profession is highly respected and comes with the responsibility to obey professional ethics (Imber, 2008).

Several scholars have focused on white-collar crime characteristics which facilitate the illegal activities. According to Clarke (1990), unlike ordinary crimes where a crucial clue is presence at the scene, offenders of white-collar crime have every justification to be present at the crime scene – an operating theatre in the case of organ trafficking – and the problem is to discover whether there has been an offence rather than to identify the offender. Their location in the midst of daily business activities facilitates their achievement and helps to prevent their detection by colleagues, superiors and local authorities. In this respect, Simmel spoke of "secret societies" (Simmel & Wolff, 1950: 345), in which secrecy is achieved by selectively providing information. This implies that part of the internal and the external environment are not informed about the true nature of the group's activities. Corporate illegal activities can remain undetected for many years because of failing supervision, successful concealment of illegal

activities and the silence maintained by victims, bystanders and relevant control agencies – ignoring the "red flags" that give rise to suspicion and critical questions (Van de Bunt, 2010). It is not complete isolation of offenders that increases the changes of maintaining secrecy, but rather their social embeddedness in the society. According to Van de Bunt (2010: 441): "It is precisely when perpetrators participate as 'normal' people in their social environment that they are less likely to be regarded with distrust. When their general demeanor inspires trust, they can rise above all suspicion." As will be described in chapter 5, the case studies constitute clear examples of Simmel's secret societies. Clarke (1990) further notes that on the surface the behaviour which constitutes white-collar crime is often indistinguishable from normal legal behaviour. The involvement of victims is apparently voluntary, though sometimes the result of the lure of easy money. Furthermore, the criminal aspects of business activities are often collateral features of an undertaking pursued for legitimate purposes. Criminal consequences, such as damage to victims' health, are not inherent to the activity as such. As it is difficult to prove the intentionality of an encountered criminal activity (Nelken, 2002), the actors involved easily redefine the misconduct as not having been deliberate (Mann, 1985); neutralization techniques, which is the focus of the following final paragraph of this chapter.

4.5 Neutralizing criminal acts

The large possible variety of "techniques of neutralization" is a typical theoretical approach in dealing with white-collar crime (Nelken, 2002); several scholars found that neutralization is most applicable to explaining behaviour of socially attached individuals (Copes, 2003; Topalli, 2006), such as 'upperworld' criminals. The central idea behind Matza and Sykes's neutralization theory (1957) – a theory which extend the rationalizations that accompany behaviour in Sutherland's learning theory – is that crime can become a behavorial option when people's commitment to conventional values and norms is neutralized by justifications and excuses that render them morally free (Lanier & Henry, 2010). In analysing these justifications and excuses, Matza and Sykes (1957) divided them into five "techniques of neutralization":

1. *Denial of responsibility*: offenders claim their behaviour was not in their control
2. *Denial of injury*: offenders minimize or negate the extent of the harm caused
3. *Denial of victim*: offenders argue although people got hurt, they deserved it
4. *Condemnation of the condemners*: others' rights to pass judgment is negated
5. *Appeal to higher loyalties*: offenders argue that their loyalties lie with others

Since Matza and Sykes's original studies on delinquency, their neutralization theory has been applied to a wide variety of other crimes, from sex offenders to corporate offenders to domestic violence survivors (Maruna & Copes, 2004). As a consequence of this extended research, additional types of neutralization have been identified, such as *claim of normality*, which argues that the law is not reflecting the popular will and that everyone engages in the crime (Lanier & Henry, 2010). Cohen's psychoanalytic theory 'states of denial' (2001) further extends Matza and Sykes's original formulation by adding two new techniques: moral indifference and denial of knowledge. *Moral indifference* refers to the absence of appeals to conventional morality, and *denial of knowledge* points to the technique through which offenders profess not to know what they and others around them did. The attitude of aloofness (looking away) is characteristic of people who find themselves confronted by uncomfortable situations they simply do not want to face. They do not want to know and they make sure they have a story ready to explain their ignorance in case the malpractices are disclosed by pointing out that they could not have known (Van de Bunt, 2010).

In research on techniques of neutralization it is difficult to establish when the neutralization occurs – before or after the criminal act. As Maruna and Copes summarize it: "There is little empirical evidence that individuals ascribe to neutralizations in advance of behaving criminally, and it is difficult to imagine how evidence of this could be reliably collected, [but] neutralization techniques may play an important role in maintaining persistence in crime" (2004: 7). Their viewpoint is confirmed by longitudinal research, which is the only way "to determine whether neutralizations precede criminal behaviour or are merely after-the-fact rationalizations" (ibid.: 45). In one of the few well-designed longitudinal studies of neutralization, Agnew found that in relations to violence acts, most of the respondents disapproved of violence and "accept one or more neutralizations for violence" (1994: 573), which means neutralization may be an important cause of subsequent violence (see Lanier & Henry, 2010).

As will be further discussed in the following chapter, the neutralization theory is found to be applicable to organ trafficking, with the majority of those involved in the crime being legitimate socially attached actors, such as medical professionals. In explaining behaviour of individuals who violate the law despite a commitment to the usages of conformity, global and local conditions and contexts should be taken into account. As Sykes and Matza (2003: 233) explained: "Values or norms appear as *qualified* guides for action, limited in their applicability in terms of time, place, persons, and social circumstances." The normative system of a society is featured by what Williams (1951: 28) has termed *flexibility*; it does not consist of a set of rules held to be binding under all conditions (Sykes & Matza, 2003). For instance, private property is held inviolable,

but in times of acute social need the taking and distributing of scarce goods is felt by many people to be right. Likewise, given the growing organ shortage, the purchase and sale of human organs is increasingly seen as an ethically justifiable solution. The desperation experienced by both patients in need of an organ transplant and impoverished individuals willing to sell an organ offers a variety of possibilities for neutralization techniques – arguments that are consistent with viewpoints in the ethical debate surrounding the organ trade discussed before.

5. Organ trafficking mechanisms and business model

Within a holistic approach that considers the legal, ethical, theoretical and cultural conditions and contexts of organ trafficking discussed in the foregoing chapters, this chapter addresses the methods of global organ trafficking networks and the way participants justify the nature of their activities and neutralize their behaviour, by combining existing empirical studies with the analysis of three criminal cases: the Netcare, Medicus and Rosenbaum case. Following the human trafficking definition,[65] the illicit acts recruitment (paragraph 5.1), transportation, transfer and harbouring (5.2) are addressed, followed by the illicit means coercion, fraud, deception, abuse of power and abuse of a position of vulnerability (5.3) for the purpose of exploitation, i.e. organ removal (5.4). The final paragraph (5.5) defines the organizational model of organ trafficking.

5.1 Recruitment

In the foregoing chapters, it is described that under the growing influence of globalization, the organ shortage has driven citizens of industrialized countries to other countries in search of organs available for transplantation. Patients who travel abroad for commercial transplants usually receive logistic and/or financial help from family and friends or they pay brokers to arrange these transplants. They find brokers through websites offering 'transplant packages' or upon recommendation from other transplant patients. Donors are either directly approached by brokers, openly recruited through advertisements in newspapers or on the Internet or they actively seek for brokers themselves to sell an organ.

As recipients and donors often voluntarily engage in illegal organ transplants, it is not uncommon for law enforcement officials to treat them as offenders, rather than victims in need of protection (Aronowitz, 2003; Franko Aas, 2013). As some of Yea's respondents told her, "police would often come to Baseco and tell the men not to sell kidneys because it was illegal, but none of the men could recall the police telling them that they could receive protection as victims of trafficking or file for compensation as such. […] No police officer ever questioned them in a way that might help identify how their conditions of selling a kidney might fit within a trafficking framework" (Yea, 2010: 366, 370). Patients' and donors' voluntariness to purchase or sell an organ must however be viewed in the

[65] The human trafficking definition includes three key elements; an act (what is done), a means (how it is done) and a purpose (why it is done) being exploitation.

context of the lack of options they face. They often frame their decision as an act of last resort; they felt that they had no choice other than to purchase or sell an organ, out of despair and strain – a context which is taken into account in the broad United Nations' definition of human trafficking (Aronowitz, 2003).

5.1.1 Recipients and donors: agents, offenders or victims?

In explaining their choice to purchase or sell an organ, recipients and donors emphasize that they are victims of circumstances given the lack of options they face. In other words, due to the strain they experience they neutralize their commitment to conventional norms by *denial of responsibility* (Matza & Sykes, 1957); a technique of justification that renders them morally free. As is described, donors usually come from poor developing countries. Motivations often reported for selling an organ are poverty, debt and the inability to provide for their family (e.g. Tong et al., 2012; Yea, 2010). The case studies show that all donors identified sold their kidney because they were under financial distress. Most of them are Israeli, many originated from the former Soviet Union.[66] They have been recruited via Russian language advertisements in newspapers and on the Internet,[67] and it is evident that the recruiters specifically targeted these vulnerable immigrants who were desperate for money (D27; D29; D30; R8; R10). As an e-mail (which had been read aloud during Rosenaum's sentencing hearing) written by a former employee of a religious charitable organization, discloses (D18: 192, 195):

> "The way it works, in short, is that potential donors are offered the amount of $25,000 for their kidney. […] These are Russian immigrants that arrived in Israel after the Russian government allowed Russian Jews to leave and go back to Israel. Most of them are new immigrants that have been in Israel just a few months […]. On extreme situations, they are picked up at the airport [in Israel]. […] They always been approached by Russian-speaking individuals who are well-spoken and have the powers to convince and promise a good start in Israel for merely giving up one small kidney. […] All are promised a new future."

In the Netcare case, donors were initially recruited from Israel, while later brokers became aware that they could acquire kidneys at a lower cost from

[66] In the 1990s, there had been an influx of Jews who migrated to Israel from the former Soviet Union, caused by the dismantling of the Soviet Union, leading to an increase of the Israeli population by roughly 20 per cent (Efrat, 2013b). Greenberg (2013) writes that Soviet immigrants, as well as Israeli Arabs and Arabs living in the Palestinian territories, constitute an "organ pool" for affluent Israelis who bring their donors along for a transplant abroad.

[67] The documentary *Tales from the Organ Trade* showed one of the advertisements published by recruiters involved in the Medicus case in a Russian newspaper: "Kidney donor wanted. Urgently. Looking for a kidney donor, any blood type. Compensation guaranteed. Will pay for visa, transportation and hospital costs. Please call this number: 022 544 6173."

impoverished individuals in Romania and Brazil, recruited through word of mouth (D4; R2; R6). In Brazil, the individuals who were not allowed to donate, for instance because the blood test revealed that they suffered from yellow fever, were given the opportunity to earn some money by recruiting others instead (R6). The illicit means used become even more evident as some Medicus case donors did not even know the transaction was illegal. Upon asking their broker whether selling an organ is permitted in Kosovo, these donors were told the procedure was entirely legal, "but that they did not need to draw attention" (D29: 65).[68]

When it comes to the recipients, the case studies reveal that many of them were identified at one of the top hospitals in Israel, where transplant surgeon Zaki Shapira wrote letters of recommendation for commercial transplants abroad (R11). The recipients chose to buy an organ because they experienced strain; desperation because of the long waiting time for a deceased organ donor and/or a lower quality of life expected or experienced on dialysis. Without the prospect of a donor organ, many recipients felt that they had "no choice" but to save their life through a commercial organ transplant (R32; R38; R40; R41); a procedure which is superior to dialysis in terms of longevity and morbidity (R33). Some respondents go even further by claiming that anyone would engage in organ commercialism when suffering from critical organ failure without an available solution. According to an Israeli recipients' defense lawyer (R40), "even the most cleanest person in the world, mother Theresa, would buy a kidney if that person were in the situation of a kidney patient." In the documentary *Tales from the Organ Trade*, the Israeli transplant surgeon Zaki Shapira states: "I am sure that if the same people who are against this or who condemn me, if they needed a transplant wouldn't they do anything to save their life or the life of a loved one? They would." The expression of this technique of neutralization, *claim of normality* (Lanier & Henri, 2010), corresponds with the ethical argument of scholars who argue that the cause of the organ shortage can be found in the notion of the life-saving and normality-restoring capacity of organ transplantation and its role as a hope technology, fuelling the dream of the ever-reborn body (Cohen, 2009; Lock & Nguyen, 2011; Waldby & Mitchell, 2007).

It should be noted, however, that an illegal transplant abroad with a living foreign donor may not necessarily save a recipient's life. As the main purpose of the criminal organization is financial profit, the kidney may be of poor quality because of insufficient donor screening and the surgery may be performed in suboptimal conditions, in which case the recipient may need hospitalization and possibly a retransplant (Efrat, 2013b). Therefore, an illegal transplant could leave recipients worse off. In various documentaries, (relatives of) patients explain that

[68] These, and other means for the purpose of exploitation, are addressed in paragraph 5.3.

they know people who have come back with severe infections and some of them died. For instance, the son of an American transplant patient with kidney failure, who went to China to obtain a kidney transplantation for the amount of US$100,000, said in *What in the World* about his father:

> "He came back in a wheelchair and lived for one year and three months. Unfortunately, the kidney didn't even function there [in China], so obviously he came back on dialysis. The place was not sterile: there was infection. It wasn't right to do it. Afterwards, the condition of the donor was very very severe and they transferred her to another hospital. I think she died in that hospital in the end."

Insufficient donor screening and suboptimal surgical conditions puts the donors at risk as well (D29; D30). The documentary *Tales from the Organ Trade* discloses for example that a Filipino donor who sold his kidney on the black market should never have been accepted as a donor because he most likely had renal failure at that time himself, as he now suffers from a detoriating remaining kidney which is failing quickly and probably so is the kidney that he donated to a foreigner.

In addition to the justifications "I have no choice" and "everyone does it", many actors involved in the organ trade prefer to ignore or deny the possibility of exploitation of the donor, in order to appease their conscience and reduce their criminal liability. On the one hand, they explained that they were not interested in knowing the actual circumstances of the organ transplant. The Court of Pristina summarized the statement of an Israeli recipient who received a transplant in Kosovo by writing that "he never met the person or persons who donated their organs. He did not ask the surgeon or anyone else who the donor was. He was not interested" (D29: 74). Similarly, an Israeli transplant surgeon (R32) spoke about a patient who was told by his health insurance company to go to China to receive a heart transplant on a specific date within two weeks time, from which it was obvious the organ would come from a prisoner who was about to be executed on the given date,[69] and stated that "all the patient said was: 'I did not ask any questions. I am fed-up, I cannot wait any longer.'" According to the Medicus case prosecutor, the desperation of the recipients was such that "the

[69] With respect to organ transplants performed in China, according to Efrat (2013b) Israeli patients and insurance companies reasoned that the prisoners on death row would die anyway; transplanting their organs at least could save the lives of other people. Indeed, although the manager of Israel's largest public health insurance company confessed to having had some scruples by saying that he did not feel very comfortable about the reimbursements which enabled patients to buy organs from poor individuals or Chinese executed prisoners, he explained that these practices will take place anyway. "The prisoners would be killed even without my money", as without the reimbursement provided by health insurance companies patients will find other ways to finance the organ transplants abroad (R28).

question of legality of the operations was far from the forefront of their thoughts" (D27: 106). This 'state of denial' (Cohen, 2001), which could indicate *moral indifference* as well as *denial of knowledge*, is also characteristic for the medical staff working at the Medicus clinic and Netcare hospital. Although the nurses employed by the Medicus clinic, who were directly responsible for taking care of the recipients and donors, had to know exactly what operations were being performed they all stated that "they were not told, and did not ask, what the surgeries were. They were not interested in knowing. […] They were concerned they may faced criminal prosecution for co-perpetration in these criminal acts" (D29: 107-108) and had concerns over losing their job, given the high unemployment rate in Kosovo of 40 per cent (R21; D27). Similarly, a transplant coordinator employed by Netcare explained that "if she had caused a scene and lost her employment she would have struggled to find another job in the same field as it was a closed circle" (D5: 53). According to Van de Bunt (2010), an aloof attitude is characteristic of people who find themselves confronted by uncomfortable situations they simply do not want to face, and in case any malpractices are disclosed, they explain their ignorance by pointing out that they could not know. On the other hand, participants in the organ trade often choose to believe, usually without asking questions, that the donor financially profits from the transaction and is not exploited (R13; R26; R32; R38; R40). According to one of the South African transplant surgeons who has been one of the accused in the Netcare case (D6: 75):

> "With the exception of the last donor who, virtually, jumped up and ran away, none of the donors examined by me, showed any reluctance for the procedure. Apart from the usual anxiety with which anyone might approach a procedure, they appeared relaxed and demonstrated their full consent to the procedure."

A Canadian recipient who received an illegal transplant at the Medicus clinic equally claims in *Tales from the Organ Trade* that the donors were not exploited:

> "There is a propaganda machine in as far as looking at it from only one viewpoint. That organs are stolen against people's wishes, but I can see that from my experience that the donor seemed quite willing to do the surgery. […] They [the donors] seemed to be smiling, they didn't appear to be nervous."

Matza and Sykes (1957) have referred to the technique of neutralization through which people convince themselves that their actions do not cause any harm or damage, attributing considerable agency to donors, as *denial of injury*. This reasoning corresponds with the ethical argument that individuals are considered

to be the owner over their own bodies (Lopp, 2012) and have a right to sell their organs (Savulescu, 2003); not taking into account the possibility that any real choice of the donor is compromised by their poverty (Yea, 2010).

Neutralization techniques referred to above are further stimulated by the methods of criminal networks to reveal as little as possible about the donors. An Israeli recipient who received a transplant in Durban explained about the broker that "he didn't told me anything about the donor and he recommended me not to be in touch with her because it is not healthy, that's what he said" (R41). Upon asking their brokers, recipients have been lied to as the brokers have been giving them the impression that the donor was fairly remunerated (D15) or that it concerned an altruistic donor (D29). As an Israeli recipient who received an illegal kidney transplant at the Medicus clinic in Kosovo explained, he "thought it was difficult to believe that they [the donors] did not get money, although he was told by the brokers they were not getting money. […] In his situation, it was easy and convenient to believe what he wanted to believe" (D29: 83).

Recipients and donors who have been involved in commercial transplants are criminally liable, unless they are considered victims of organ trafficking (Columb, 2015). As is explained, it is not uncommon for law enforcement officials to treat recipients and donors as offenders because of their relatively 'active attitude', rather than victims in need of protection. Yet, in general, they have not been the target of criminal prosecution, because their desperation and/or poor health is generally acknowledged; they are treated as witnesses instead (R2; R6; R11; see also OSCE, 2013). As the Rosenbaum case prosecutor explained (R8):

> "We were not seeking to charge the recipients or the donors because both of them.. Obviously the recipients were under the distress of being in bad health and needing a kidney transplant. The donors, our view was that by and large, if they were desperate enough to sell their kidney for 25.000 dollars, there was a certain level of economic distress that they were under to do this. […] As long as they were willing to cooperate with us, it was not our intention to prosecute them."

From the cases studies, however, two exceptions have arisen. In the Netcare case, a recipient was charged with fraud and violations of South Africa's Human Tissues Act and he pleaded guilty (R2). In 2010, an investigative proceeding was started into the criminal liability of a German recipient who bought a kidney in Kosovo; the investigation was closed without an indictment (e-mail exchange

with the German police, April 2013).[70] In the case studies, none of the recipients have been labelled as victims of trafficking by law enforcement officials, and in South Africa and the United States neither have the donors, because of inadequate existing legal frameworks (see chapter 2) and, as will be argued later, lack of experience. As they could be criminally liable, recipients and donors are reluctant to come forward to report illegal transactions to law enforcement officials, even when there are clear indications of trafficking. For instance, Budiani-Saberi et al. (2011) stated about twelve Sudanese refugees and asylum seekers who had been exploited for their organs that these victims feared being arrested. They were reluctant to talk with anyone that had a position of authority relevant to their status in Egypt. Another reason for the reluctance of recipients and donors to come forward is out of protection to the brokers and medical professionals involved. An Israeli recipient explained that "I lied to the police and did not tell them about X [a broker], because I wanted to protect the people that had given me my life back" (D29: 70). The Israeli police confirmed that it was difficult to convince recipients who received an illegal organ transplant in Kosovo to make statements against their brokers. The police managed to convince some of the recipients by explaining that there were many victims (donors) as a result of the brokers' activities (R34-R37). Recipients who were not doing well after their transplant were more cooperative than those who were doing well (R42-R45). Donors also seldom come forward (Lundin, 2012). The case studies reveal that some were threatened not to complain to the police, or else they would be arrested since they had been complicit in the offence (see also J.A. v State of Israel) or they would not be safe from the brokers' repercussions (R15; D29). "He [the broker] said that I should not go to the police and if I was contacted by anyone not to tell anything. He also said that he has 'long arms' and can reach me everywhere. I did perceive this as a threat to my life and health. In the last conversation he said to me that 'if you go the police you can disappear'" (D29: 67). In the Medicus case, several donors, recipients and their relatives were protected witnesses (D27; D29). Due to severe threats, one foreign donor and his family were resettled in another country by the government of Kosovo (R15).

[70] In several other countries, patients and donors have been charged and/or prosecuted as well. For example, in 2003 in Austria, a man who offered to sell his kidney in an online advertisement for at least €80,000 was prosecuted and convicted (De Jong, 2015). In 2005, a man in Romania was convicted for selling his kidney to an Austrian man of Serbian origin for US$18,000. The transplant had been carried out as a 'living related donation' in a hospital in Vienna (Ionescu, 2005). In 2007 in Ukraine, a mother was prosecuted for trying to sell one of her child's kidneys on the Internet. She was found guilty and sentenced to five years imprisonment (Holmes, 2009). In 2008, a patient from Singapore and two donors from Indonesia were convicted of charges under the Human Organ Transplant Act. In determining their sentences, the judge took into account the fact that the donors had been approached and exploited by a syndicate to sell their organs (see UNODC Case Law Database, Wang Chin Sing v Public Prosecutor).

5.1.2 Tactical crime displacement

As recipients and donors are reluctant to come forward for reasons stated above, brokers are seldom prosecuted and many operate relatively open. The recruitment of recipients and donors is openly initiated through advertisements in newspapers and on the Internet (R11; R34-R37). After having heard of successful commercial transplants, patients also know how to find brokers through word of mouth (R34-R37).[71] Israeli patients explained that everyone knew about the possibility to go abroad (D29; R41). "It went ear to mouth between the sick people. Everyone knew someone who have done that and they got the telephone numbers and I spoke to patients, I got recommendations, and I have met two persons organizing this and I chose the cheaper one" (R41). In meetings with potential clients, brokers propose that they should speak to others for whom they successfully facilitated a transplant in the past. "Defendant Rosenbaum also listed another recipient by name who had received a kidney transplant approximately four years earlier, and defendant Rosenbaum offered to contact other recipients to assure the UC[72] and her uncle about the process" (D15: 4). The tactic of persuasion by former clients is used in recruiting donors as well (D27). A donor victim in the Medicus case said about the recruitment process: "He [the recruiter] called back later and asked if I had made a decision. He introduced me to someone who had the same operation and who said that his condition was fine. After the meeting, the young man called me again and said he would order tickets, and I decided to go" (D29: 56). The recruiter's pitch is particularly effective when the recruiter himself has sold his kidney in the past (D18; R1; R11; R34-R37; R42-R45). In addition to these recruitment methods, legitimate actors in direct contact with patients, such as transplant professionals and health insurance companies, have been actively approached by brokers and have been requested to refer patients to them in exchange for money (R30; R31; R33). "I did get some phone calls, because they [brokers] used to contact nephrologists, especially transplant nephrologists, in order to ask them to either send patients who are in need for them or do the evaluation [of patients' health] for them" (R33). Some nephrologists went along with these proposals and have earned "big money" by recommending patients to go abroad (R31). A recipient's defense lawyer explained that patients were much calmer, going abroad to a doctor that was recommended by doctors here in Israel (R27). Public health insurance companies were involved as well. They "had a list of brokers and said: 'If you go to these brokers, it's okay and when you come back,

[71] Brokers who have been approached by recipients and donors, instead of actively recruiting them, may profit from the fact that it is more difficult to lay charges upon them, even if there has been resulting exploitation (R34-R37; R42-R45; see also Yea, 2010). Moreover, as Israeli police officers explained, when directly approached by a recipient, a broker does not need to pay commission to recruiters or brokers higher in rank within the criminal network (R34-R37).

[72] UC means 'undercover Special Agent with the FBI' (D15).

we pay'" (R31). A recipient who went to South Africa for an illegal transplant explained that her broker was in direct contact with her health insurance company, without her involvement. The broker knew exactly how much the insurer would reimburse for the transplant abroad, deducted this amount from his commission and asked the recipient to pay him the remaining money. After the transplant, the broker received the reimbursement directly from the insurance company (R41). Staff of health insurance companies have also been acting as brokers (R26; R34-R37; R42). For instance, one of the brokers who facilitated illegal kidney transplants in Kosovo worked as an insurance man, which is how he encountered patients in need of a kidney transplant (R26; R34-R37).

The fact that enforcement is practically non-existent, notwithstanding the universal prohibition of the trade apart from Iran (Columb, 2015), enhances the relatively open methods of recruitment of brokers. In several countries where the prohibition has been enforced, illegal activities have (temporarily) become more hidden (Shimazono, 2007; Van Dijk et al., 2011). The case studies confirm the relocation of crime, including the tactical displacement of recruitment methods, as a result of the prohibition in Israel where the majority of the recipients and donors in the cases have come from. After the implementation of the Organ Transplant Act, Israeli brokers continued their criminal activities, albeit with greater discretion (Greenberg, 2013), because the demand of transplantable organs did not diminish. A transplant surgeon who was part of the team that formed Israel's Organ Transplant Act stated in an interview (R32):

> "One of the major things that happened since our law has been accepted, is that the mediators who used to publish themselves on the internet and newspapers openly, from that day on they're.. I don't know if they are gone, but obviously we don't hear from them. They have no websites and nothing is out there."

Israeli transplant professionals further explain that since the implementation of the Act brokers do not approach physicians anymore (R30; R31; R33), although Israeli brokers are still involved in facilitating commercial transplants abroad (R28; R41; see also Orr, 2014). A change identified after the implementation of the transplant law in Israel and in destination countries such as Egypt and the Philippines, is that, instead of bringing foreign donors from countries such as Brazil and Moldova, Israeli patients generally purchase organs from fellow Israelis – many of them Israeli Arabs, Arabs living in the Palestinian territories and immigrants from the former Soviet Union – who travel with them abroad (Greenberg, 2013; Orr, 2014).

5.2 Transportation, transfer and harbouring

Similar to the use of the Internet as a way of communication in recruiting recipients and donors in a globalized world, technological progress has allowed criminal networks to transfer people from one side of the globe to the other with an ease and rapidity that was unthinkable before (Paoli, 2002). Consequently, it became possible for recipients and donors to travel halfway around the world for a commercial organ transplant. Patients have often been reported to travel to countries which they have an affinity with. Given the international context, brokers may help recipients to locate transplant centres and accommodations abroad and arrange travel documents, transfer and accommodation for donors (Lundin, 2012; Mendoza, 2011; Moniruzzaman, 2012; Scheper-Hughes, 2011; Turner, 2009). As is outlined in chapter 3, only a few studies describe aspects of the transportation and harbouring of recipients and donors involved in illegal transplants. These studies show that recipients and donors who leave their country for an illegal transplant abroad are usually flown to their destination. For the donors, who predominantly come from poor developing countries, it could be necessary to arrange legitimate or false visas and passports. Recipients and donors are housed in hotel rooms, apartments or at the hospital or clinic where the operation will take place. All costs of travel documents, flight tickets and accommodation are paid for by the brokers and eventually deducted from the donors' fee. Below, the case studies' findings of the acts listed in the human trafficking definition (transportation, transfer and harbouring) are addressed.

5.2.1 Procedural logistics

The case studies reveal that the procedure of recruitment and transfer of recipients and donors into an operating theatre in another country is performed as quickly as possible; the speed with which the whole procedure is executed – characterized by the Medicus case prosecutor as "the McDonalds of kidney transplants" (D27: 130, 131) – entails a clear indication of the organised structure of the organ trafficking networks and their purpose of exploitation for profits.

> "The prosecutor submits that […] there are many desperate patients seeking kidneys and so the organised crime groups involved in this industry are feasting on easy pickings. It is key to get victims across borders and to the place of the transplant as soon as possible so as to make money and not allow victims time to change their mind or gossip and therefore cause unnecessary risk" (D27: 130, 131).

Prospective donors are usually required to undergo medical tests in their home country. The results are sent (abroad) to a broker, a transplant surgeon or service provider such as a blood bank and matched with the prospective recipients.

Once a matching recipient has been found, the donor is transported as soon as possible to the country where the transplant centre is located (D16; R2; R4; R11). The tests could include a complete medical check-up or could be limited to a blood and tissue test, after which a more thorough medical exam is done upon arrival in the transplant centre where the commercial organ donation would take place. Consequently, in some instances, prospective donors were sent back home because they could not donate (D30; R2; R6), for instance, because a donor had only one kidney to begin with, which was the case with a potential Brazilian donor in the Netcare case (R6; R7). To perform many kidney transplants within a short time frame, criminal networks 'collect' a pool of willing donors (R2; R7). A Canadian recipient explained in *Tales from the Organ Trade*:

> "Moshe Harel informed me right from the outset that as soon as we complete the required medical tests, they have so many donors that they can do the operation within one week or two weeks. And he said to me: 'We are ready, we are waiting for you.' And I said: 'What is this guys, I mean, do you have a football team of donors?' And he said: 'Well, pretty close to it.'"

Due to the donor pool, when a prospective recipient presented himself or herself, a match could be established within a few weeks (D27; D30). In the Netcare case this practice resulted in unusual blood test patterns: whereas usually a finite pool of donors would be cross-matched for a specific recipient (family or person with a particular relationship), in this scheme numerous potential donors and recipients were cross-matched against each other by the South African National Blood Bank until a match was found (D4; D5; R2; R4). Therefore, in the Netcare case, "the State alleges that there was random cross matching between donors and recipients, the implication being that those involved knew that the donors and the recipients were not related" (D5: 80). Criminal networks can fall back on their donor pool when someone is not available or suitable right before the organ transplantation is scheduled. Situations have been reported in which prospective donors were replaced by others within a short time frame (D27; R2).

Recipients and donors who are compatible for transplantation have been put together on the same flight to the country where the illegal transplant takes place, so both parties arrive at the same time and can be operated upon within a short time frame[73] (D30; R10; R11; R41). In the Medicus case, many of the recipient-donor-matches did not originated from the same country, but they all flew to Istanbul and from there were put on the same flight to Pristina. Recipients

[73] A removed kidney needs to be transplanted within 48 hours. Therefore, the operation on the donor and the recipient must be performed in proximity to one another within a short time frame.

and donors did not know each other beforehand, and only saw each other right before entering the plane or during the transplant preparations after arrival in the country of destination; these were situations in which they were often not able to communicate because they did not share a common language (D29; D30). An Israeli recipient who traveled to South Africa for a commercial kidney transplant stated about herself and her donor: "We were on the same flight to South Africa, but we haven't known each other. […] I've met the donor the day before [the operation]" (R41). Some recipients did not meet their donor at all (D18). If necessary, passports and visas were generally arranged and paid for by brokers, as well as flight tickets (D15; D16; D29; D30; R2; R4; R6; R34-R37). Some recipients claimed that they bought their own ticket (D18; D29) and paid for the donor's accommodation (D18). During the flight, they have been (sometimes unnoticed) accompanied, usually by a broker (D27; D30; R2). In the Medicus case, Yusuf Sonmez, the Turkish surgeon who would perform the transplant in Kosovo, accompanied several recipients and donors from Istanbul to Pristina (D29). Recipients and donors have also traveled (part of their journey) without supervision (D29; R2; R4). Finally, while donors were not allowed to bring a companion, recipients brought a husband or wife, family member or friend (D29, D30; R6). An Israeli recipient (R41) said: "We were allowed to bring one companion within the same price. If you would like to bring more, it costs more."

In the Netcare and Medicus case, some recipients and donors have been instructed about what to say to the border police upon arrival. Their instructions ranged from visiting relatives to touristic purposes (D30; see also UNODC, 2015). Many received an invitation letter from the Medicus clinic, which they could show to the border police upon arrival in Pristina to facilitate their entry into Kosovo (D29). "It said they were flying for medical check-ups at a certain clinic" (D29: 57). In the Medicus and Netcare case, some donors stated that upon arrival their passports were taken to make sure they would go through with the operation (D27; D29; R4; R6; see also Moniruzzaman, 2012; Scheper-Hughes, 2011; Yea, 2010). In every case, on arrival in the destination country, recipients and donors have been picked up from the airport (D29; D30; R2; R4; R6). In South Africa and the United States, recipients and donors were transferred to separate residences, where they (the donors in particular) were housed under supervision (D4; D16; R2; R6; R10; R41). In Kosovo, upon arrival in Pristina – after a stopover in Istanbul, where blood tests were done and they stayed one night in a hotel – recipients and donors were brought directly to the clinic (D29).

Within the Netcare and Medicus case, which involved complicit medical facilities, it was revealed that although some recipients and donors were reluctant to go through with the procedure (see paragraph 5.3.1 on coercion), the transplant was performed as quickly as possible. "They literally went from the

airport to the clinic into the surgery" (R11). In Kosovo, as many operations as possible took place on the same day, often late in the evening or even at night. "The three operations were all performed on the same night" (D29: 80). In South Africa, "they used to come in groups so they would bring about eight patients at a time, transplants got done and then they are off again. And a few months later, they bring another eight patients" (R7). The Israeli transplant surgeon Zaki Shapira confirmed in the documentary *Tales from the Organ Trade* that as many surgeries as possible where performed during their visits in foreign countries:

> "Many times, we did more than one operation. We didn't travel to these places just to perform the one. We would perform six or seven operations at a time. […] I think that the surgeon performed in 24 or 48 hours six transplants, that means twelve operations, and after that went for a beer and a swim in a pool."

After the surgeries in South Africa and Kosovo, recipients and donors were discharged as soon as possible. In the Medicus case, recipients were discharged in four to seven days (D29). Donors were often discharged a few days earlier. For some of them return tickets were pre-booked (D29; see also Scheper-Hughes, 2011). In the Netcare case, donors were discharged in a few days as well, several days earlier than the recipients[74] (R4 (see quote below); R6; R7).

> "They tried to get them in like a Chinese laundry, in at nine and out by five. The shortest possible time. These people were put on an aircraft with the hospitals knowledge. They were leaving the hospital without any medical file to take back to their medical practitioners, whether they even were worried that they had one. There was just no concern about that, they just tried to clear them out of the hospital just as quick as possible, so that they can do the next one."

Many recipients and donors were not feeling well upon leaving (D27; D30). Some recipients died within hours or days after their discharge (R1; R2; R4). "There was one case where the operation didn't go too well and they didn't want the woman to die in South Africa, so although she was very sick, they put her on a plane and she died halfway between Israel and South Africa" (R1). A short recuperation period is medically and morally irresponsible, even more because

[74] It is important to note here that in many Western countries, where the removal of a kidney is performed laparascopically (which leaves only a small scar), it is normal medical practice to discharge the donor within two to four days. In South Africa and Kosovo, however, the donor kidneys were removed through an 'open flank incision' (which leaves a very large scar; in the documentary *Medical Greed!*, a Brazilian donor shows his scar of around 40 cm), after which the kidney donors should have been hospitalized for at least a week.

the organ donors were sent home with an uncertain post-operative care scenario. This irresponsible practice is also evident from the fact that the donor stopped at Pristina airport five days after having 'donated' his kidney at the Medicus clinic (see the introduction) was in poor medical condition, not capable of traveling to Istanbul and immediately taken to a hospital for urgent medical treatment, where he had to stay for two weeks. His recipient was provided with medical treatment in Kosovo for two more weeks as well (D27). According to the Medicus case prosecutor, the short recuperation period was mainly based on the desire of the criminal actors to lower medical costs and thereby increase their profits (D27). While recipients usually received medication, instructions and/or documents upon leaving the medical facility to present to their physician in their home country, donors did not receive any medical documents at all nor the necessary medical follow up checks (D27; D30; R2; see also Yea, 2010).

5.2.2 Spatial crime displacement

Organ trafficking networks generate an ongoing search for operating theatres all over the world where illegal organ transplants can be performed. As law enforcement officials who prosecuted the Netcare case disclosed (R1; R2):

> "Ilan Perry was trying all over the world, places to agree to do the operations. So one of the hurdles he had to get past is to get either a hospital or a doctor who's prepared to do the operation. […] In a lot of countries, they just came back and said 'No we can't do it', so he went through a process of getting people to buy in."

The Netcare case revealed that initially the plan was to recruit donors in Turkey, "but there weren't enough to satisfy the demand" (R4). Also, Brazil was targeted as a destination country for Israeli recipients, but this didn't work out and Brazilian donors were flown to South Africa instead (R2). Besides operating theatres, organ trafficking networks also generate an ongoing search for cheaper markets for commercial living organ donors (see also OSCE, 2013). In the Netcare case, Israeli donors who received around US$20,000 were 'replaced' by organ donors from Brazil and Romania, who got paid between $2,000 and $6,000 (R2; D4).

Like the adjustment of recruitment methods, enforcement has led criminal actors to relocate the venue of the illegal organ transplantations (spatial crime displacement) (R6). The countries that have served as destination countries for these transplants have changed over the years. From the early 1990s on, many Israeli patients traveled to Turkey for a kidney transplant. In the early 2000s, South Africa opened as a destination country. Shortly after, the operating theatre in Turkey was invaded by the police who arrested the people involved. With Turkey no longer being a destination country, the number of patients from Israel who

went to South Africa started to climb, until the South African police found out about the illegal transplants (R28). In the following years, Israeli organ brokers kept on searching for other destination countries, such as the Philippines, China and Ukraine in the peak years until 2007, and then to Kosovo, Sri Lanka, Azerbaijan, Cyprus, Panama, Ecuador, Costa Rica and Egypt in the last few years (Orr, 2014; R28; R34-R38; R42-R45). Whenever local authorities intervened, often because of media exposure of the illegal practices, and closed their doors to transplant tourism, brokers 'simply' changed their venue and brought recipients to other countries (Efrat, 2013a; 2013b; R28; R34-R38; R42-R45), sometimes incurring higher costs. An Israeli recipient stated before the Court of Pristina that he initially "had paid the broker US$100,000. He later had to pay a further $8,000 as the location of the operation changed from the Philippines to Kosovo" (D27: 106). A recipient from Canada explained in *Tales from the Organ Trade* that his transplant operation moved to Kosovo because a Turkish clinic had been closed.

5.3 Illicit means

In the literature on the organ trade, most studies either lack information whether any of the means of the human trafficking definition have been used or present indications of human trafficking without addressing (a clear definition of) trafficking (see paragraph 3.3). Therefore, Yea (2010: 360) argues that organ trafficking is "generally assumed, rather than rigorously established." This paragraph addresses the illicit means encountered in the case studies, namely coercion (paragraph 5.3.1), fraud (5.3.2), deception (5.3.3), abuse of power (5.3.4) and abuse of a position of vulnerability (5.3.5) with the purpose of exploitation, i.e. organ removal (paragraph 5.4), and the various kinds of exemptions claimed by criminal actors in their belief that they are not bound by law under the mitigating circumstances of the human organ shortage.

5.3.1 Coercion

Prospective recipients and donors have been persuaded to purchase or sell an organ through various coercive techniques. To prospective donors, the donation has been portrayed as a noble act that would save a patient's life, would not harm the donor and would be performed by world-renewed specialists (see Moniruzzaman, 2012; Yea, 2010). To urge donors to proceed with their original decision to sell, donors have been told the recipient's health has declined (see Yea, 2010) and that the recipient will die, if the donor backs out; a scheme which

constitutes coercion according to the Palermo Protocol.[75] As a donor victim stated in the Rosenbaum case (D18: 129):

> "Q: Now turning to the morning of the surgery itself, can you describe your emotions that morning after you woke up? A: Um, everything was a bit heightened. You know, up until now, it was pretty much talk really. Everything just kind of hit. I was pretty emotional about the whole ordeal. […] Q: Was X [a broker] saying anything to assure you as you were crying and dealing with the emotions of going through this? A: He just assured me that I was doing a really great thing, I was helping save someone's life, you know, told me that a few people had – one other person had tried, other people were tested, and nobody was a match, and that, you know, if I wanted to turn around, I could, but he told me something about the recipient, only had three weeks to live, so that, you know, it was my decision to turn around, but if I did.. ."

Another coercive technique is reported by Brazilian donor victims who sold their kidney in South Africa. After they agreed to the sale of their kidney and received their first money, there was no turning back due to indebtness (R6; see also Sándor et al., 2012). As anthropologist Nancy Scheper-Hughes explains about the Brazilian donors in the Netcare case in the documentary *Medical Greed!*: "You can't go out. Once you're in, you're in. And they [the donors] didn't learn that it was illegal until they came back [in Brazil]." Donors' passports have also been seized upon arrival in the country of destination to ensure that they cannot return home before their kidney is 'donated' which has been reported in Kosovo as well as in South Africa (D27; D29; R4; R6; see also Moniruzzaman, 2012).

Furthermore, in preparation for the surgery, recipients and donors have been coerced to sign consent and altruistic donation documents (in a language) that they did not properly understand or they were not given the time to thoroughly read the documents (see also Lundin, 2012). An Israeli recipient who traveled to South Africa for a commercial kidney transplant explained (R41):

> "I'd met the donor the day before, we went to some office to sign and we signed that we are friends or something, I don't know. […] I haven't read it. He told me 'sign', I haven't read it. Maybe related or friends, I'm not sure. But we had to sign this."

[75] One of the definitions of coercion provided by the UN Model Law against Trafficking in Persons, developed to assist States in implementing the Palermo Protocol, is "any scheme, plan or pattern intended to cause a person to believe that failure to perform an act would result in serious harm to or physical restraint against any person" (UNODC, 2009: 13).

In Kosovo, recipients and donors were also given no time to read the documents and to make a final conscious and voluntary decision about the surgery. Almost immediately after they reached the Medicus clinic they were required to sign documents which were not explained to them and soon after they signed them, they were operated upon (D27; D29).

> "X tried to explain to him in broken Russian and with some Serbian or Albanian that it was all legal and he was to give his kidney to his cousin who was an Arab. This discussion took place about 45 minutes after he arrived in the clinic and 10 to 15 minutes before he went into surgery. He did not have time to read the documents as X flicked through page after page and just got him to sign them. X in fact only spent two minutes with him talking to him about this crucial document" (D27: 127).

As the prosecutor of the Medicus case points out, "if these operations were in fact legitimate ones surely such important documents would have been given earlier, with more warning and with a full and complete explanation of what they were", instead of having these documents signed when both parties were at their most vulnerable (D27: 110-111). Some recipients stated that they do not remember signing any documents before the surgery. Their memory might have failed them or someone else signed the documents in their name without them knowing (see paragraph 5.3.2 on fraud), but either way "it shows what scant regard was paid to this hugely important part of the procedure" (ibid: 117).

Several recipients and donors have strongly felt that they could not get out of the operation, even though some of them had serious second thoughts (D18; D29; D30; R10). A donor victim stated during the Medicus case trial that "from what he understood, the document said that he was having an operation with his consent, and that no one was forcing him to have the operation. They saw, however, that he was extremely anxious, and did not stop" (D29: 56). Another donor victim stated she had been injected with a tranquilizer to calm her down before surgery because she was very fearful, but that "she was afraid that even if she said 'no' to the surgery, the operation would take place even against her will as the only aim was to make money" (D29: 57). After arrival in the country of destination, donors were alone, isolated, did not speak the local language and had no one to consult as to their best interest (D29). Some recipients have been coerced as well. An Israeli recipient who upon arrival in the Medicus clinic was very uncomfortable with the fact that there was no dialysis machine, as he had had no dialysis treatment in four days and no return ticket to Israel, was coerced to undergo the operation by being told this was the only option available to him and whether he would proceed with the transplant or not, he would not get his money back (D27; D29; D30). Having returned home, coercive techniques have

been laid upon donors to recruit others, by withholding part of the payment earned and/or promising more money for every donor they would bring forward (D29). In this respect, the Medicus case prosecutor (R11) explained the resemblance of the crime with other, more common, forms of human trafficking:

> "Typically what we would see is, someone would get recruited, become a victim of organ trafficking and then be sent out to find other victims in his own town. […] And that's typically the modus operandi of trafficking in.. sex slaves, for labor, for body parts. These people are finally released from the obligation and are told 'now, get others'. And some of them might move into the organized crime group and become agents, criminal agents, themselves."

5.3.2 Fraud

As is explained in the foregoing paragraph, recipients and donors have been coerced into signing documents which incorporated important legal statements, claiming that the transplant was conducted with their consent, between relatives and/or for altruistic reasons. In the Medicus case, the 'consent' of both parties was obtained after they allegedly appeared in front of a so-called ethical committee. However, none of the recipients and donors who testified ever actually appeared before such a committee, although they had been required to complete a Kidney Transplant Clearance Form which stated otherwise. An Israeli recipient stated before the Court of Pristina that "he did not at any time appear before an Ethical Committee at the hospital. X told him that he was not supposed to appear in front of the Ethical Committee" (D29: 83). The signature of two committee members could not be verified by an expert witness on graphology (D29), and both of them testified they had never served on an ethics committee at the clinic (D27). Similarly, some recipients and donors have stated that the signatures on the documents are not theirs. The Court of Pristina summarized the statement of the son of a recipient by writing that (D27: 109):

> "When he was shown a document entitled 'Kidney Transplant Clearance Form' he testified that the writing on it does not look like his father's handwriting. He was shown a Deed of Donation, which also had not been signed by his father. Indeed, his father's name is spelled incorrectly on it. These documents again point out what was going on at Medicus: fraud, the falsification of documents and the pursuit of profit at all costs."

The fraudulent nature of the Deed of Donation, which purpose was to show that the donors were allegedly donating their kidney for altruistic reasons or to a relative, was further revealed by the fact that the document contained a stamp of a notary which was not valid (D29). Similarly, the documents which were used

in South Africa to claim that the transplant was conducted between relatives and for altruistic reasons contained a false stamp and signature from an attorney in Israel, while a handwriting expert linked the handwriting on the documents to one of the defendants in South Africa. This means the document had to be completed after the transplantation, probably because it was not always clear beforehand from the pool of available donors who would be a specific recipients' donor (R2). These documents were fabricated to create an appearance of legitimacy to the transplants and designed in an attempt to shield the perpetrators from criminal liability (D5; D29; R2; R4).

> "Netcare realised that the only way they could justify the transplants from living donors was to make it appear that the donors were, in fact, related to the recipients. Otherwise they would need to comply with the 'Policy Guideline on Organ transplantation' that was issued by the Department of Health in 1996. […] In no operation was written ministerial notification done despite the fact that non-South African citizens were involved in the operations performed" (D5: 7,9).

Furthermore, recipients and donors were falsely informed that the Medicus clinic was licensed and authorized to conduct organ transplants (D29), while in Kosovo there is an absolute prohibition on organ transplants, as there is no medical infrastructure, medical expertise and relevant legislation in place (D27). A witness has reported some deficiencies of the clinic in terms of organisational and medical malpractice; old equipment, outdated rooms, a defective sewage system (D27; D29) and during the police investigation "it was found that usually only two [instead of the needed four] surgeons were performing the kidney extraction and implementation, which is contrary to good practice" (D27).

Another frequently used fraudulent technique is brokers' instruction of recipients and donors to state to a donation or ethical committee that they are relatives and to deny the giving or receiving of any kind of payment, in order to receive approval for the organ donation. Recipients and donors are familiarized with the questions that will be asked and the donor may be advised not to disclose his true identity (D15; D16; R2; R4; see also Budiani-Saberi & Columb, 2013; Moniruzzaman, 2012; Muraleedharan et al., 2006). Criminal actors in the Netcare and Rosenbaum case circumvented the law by coaching donors to state that they are not being coerced and are motivated by altruism, not financial gain, and have an (emotional) relationship with the recipient (D15; D16; R2; R4). A recorded conversation between the organ broker Izhak Rosenbaum and an FBI undercover police officer revealed the following modus operandi (D15: 2):

> "Defendant Rosenbaum explained that the hospital would screen any potential donor carefully for various ailments and diseases before authorizing a transplant. Defendant Rosenbaum noted that 'I'm doing this for a long time'. Defendant Rosenbaum then warned the CW and the UC[76] in the following terms: 'Let me explain to you one thing. It's illegal to buy or sell organs, so you can not buy it. What you do is, you're giving a compensation for the time… whatever – he [the donor] is not working.' […] Defendant Rosenbaum then explained that it would be necessary to fabricate some sort of relationship between the donor and recipient. Defendant Rosenbaum stated that 'we put together something – the relationship. The hospital is asking what's the relationship between' the donor and the recipient. Defendant Rosenbaum continued, 'so we put in a relationship, friends, or neighbor, or business relations, any relations.' When the CW suggested claiming that the recipient and donor were 'cousins, third cousins', defendant Rosenbaum rejected this idea because '[you] wouldn't go to cousins, because it's, the recipient isn't going to be investigated but the donor is investigated. So if you start with family, it's real easy to find out if he's not. It's not the family, because the names and the ages and who is who, it doesn't work good.'"

5.3.3 Deception

Within the underground transplant industry, recipients and donors are often misled or not informed at all about the procedure of transplantation and its risks and long-term consequences, such as the psychological and lifestyle impact of the donation and the need for follow-up care after the donation (see also Caplan et al., 2009; Moazam et al., 2009; Moniruzzaman, 2012; Tong et al., 2012). The three case studies disclose that as the operation's nature, the length and future implications have been misrepresented or not explained at all, many did not fully understand the donation procedure (D18; D24; D29; R6; R10; R44). The possible gravity of the misrepresentations is especially obvious from the following statement from a donor victim in the Rosenbaum case (D18: 107-108):

> "Q: You make a call to the Israeli number you saw in the ad. What does the person on the other end tell you? A: They said thanks for calling, they asked for a few details, my height, my weight, told me it was a good thing that I was calling, it was a wonderful thing to do, tried to tell me a little bit about the process of donating a kidney, something about the surgery, that it would take about 10 to 15 minutes for the whole procedure because it was one of the most successful processes – one of the most surgeries done here in the U.S. Q: And jumping ahead, how long

[76] CW means 'cooperating witness' and UC 'undercover Special Agent with the FBI' (D15).

did the surgery actually take, if you know? A: I was told about four or five hours or so."

The complex surgical intervention of kidney removal is presented to prospective donors as a routine medical procedure, without risk, after which they could resume a healthy life without any restrictions (D29; D30; R6). "He was concerned about the operation, and this person explained that the operation would leave only a small scar, and that he would be able to do everything as usual, including physical labor" (D29: 54). No one properly informed the donors about possible risks, which could be serious. Indeed, some donors suffered medical complications following the removal of their kidney (D29; D30). "As a result of removing the kidney from his body, B.B. suffered from an infection in the incision of the surgery. […] In addition, the remaining kidney in his body developed renal failure and he required medical surveillance and examinations, including x-rays, every several months" (D30: 10). While some donors ended up regretting the donation because of unexpected long-term consequences, given the critical health situation which led them to choose for an illegal organ transplant in the first place, recipients usually were not concerned with the risks of a commercial transplant abroad (D29). An Israeli recipient has stated before the Court of Pristina that: "No one explained anything about the risks of getting a transplant outside of Israel. It does not matter at all, if it was not for the transplant he would be dead now. In Israel at the age of 72 years old, he would never get a kidney transplant" (D29: 74). Yet, as is explained, commercial transplants may yield inferior outcomes, and as a former employee of Netcare pondered (R7):

> "Obviously, the tissue typing, you think afterwards, was that true or was that falsified? And you wonder, some of the recipients.. who paid for the kidneys, did they really get value for their money? Did they really get value for their money? Did they get the best possible match?"

Some recipients returned to their home countries with serious complications in need of post-operative care (D27; D29). "X testified that he had major difficulties after the operation and had to be re-operated on twice more as […] Dr. Sonmez had damaged the kidney during the operation" (D27: 119). Upon arrival in Israel, some recipients were picked up by ambulances that brought them to a hospital where they received immediate aftercare (Greenberg, 2013). An Israeli physician stated (R31): "One of my patients, he bled in Kosovo and they brought, it bled in the taxi. He almost died. He told me, 'I almost died.'"

Furthermore, donors have not been remunerated fairly or to the agreed amount. They received relatively low amounts of money. Many have been misled into thinking that they would be paid substantially more than they received; they

were often given less than the promised amount, if anything at all (see also e.g. Goyal et al., 2002; Lundin, 2012; Mendoza, 2010; Moniruzzaman, 2012; Padilla, 2009; Yea, 2010). The case studies confirm that although donors were promised to receive financial compensation for their kidney, some of them were either partially compensated, not at all or they had to chase the broker, for instance Izhak Rosenbaum, down for their final payment (D18; D29; R8; R11; R34-R37).

In the Medicus case, the kidney transplant had been falsely presented as a legal transaction. This was an important aspect to several of the recipients and donors in order for them to proceed, as they did not want to commit any criminal offence (D29). A recipient explained that "before he decided to make the operation he asked X if there was a problem with the law in Kosovo and if there was a chance he could be arrested. They led him to understand that it is ok" (D29: 83). Similarly, a donor who was concerned about the legality of the situation was reassured that there was no reason to be concerned (D29: 61). "Several times during conversations with X, he told the donor that this surgical intervention was entirely legal. This was an important consideration for him."

5.3.4 Abuse of power

Physicians have a highly regarded and respected position. By caring for people's health, they are perceived by many as selfless professionals dedicated to the general welfare, and by their commitment to professional ethics, they are viewed as moral authorities (Imber, 2008). This position comes with the obligation to present a high level of moral integrity. As several medical professionals in the Medicus and Netcare case have consciously performed commercial transplant operations of which they illegally acquired financial income (D5; D29; R11), they have been abusing the opportunities which their position of power provides and exposed their patients, in particular donors, to unprecedented danger (D29). The fact that some physicians have profited from illegal transplants has led many of their colleagues and the general public to question the authority of medical practitioners and facilities (Scheper-Hughes, 2016). The involvement of a first world medical facility like Netcare indicates that not only economically struggling medical facilities are susceptible to the temptations of organ trafficking.

There may be just enough ethical ambiguity in the medical profession to leave openings for organ trafficking to operate and to lead medical professionals to claim a "plausible deniability" defense to their involvement in illegal organ transplants (OSCE, 2013: 41). Medical professionals who have been accused of consciously performing illegal transplants[77] insist to have been deceived and

[77] In addition, as has been described, physicians have been reported to work together with brokers in recruiting recipients by recommending them to travel abroad for a commercial organ

unaware of the circumstances that brought the recipient and donor together. They claim to be the mechanics performing the transplants and leaving the decision whether a donation is free and voluntarily to the ethical committee. After the ethical committee's approval, it is not their job to start another investigation into the legality of the organ transplant (*denial of responsibility*) (D4; D11; R5; R32). For instance, in the Netcare case, the South African surgeons denied guilt by arguing that "if the donors and recipients were not related and payment was made for the kidneys, we did not know this. We were not involved in setting up, implementing or administering the transplant programme, had nothing to do with the preparatory administrative and paper work and were, quite simply, engaged to render surgical services" (D6: 5). In *Tales from the Organ Trade*, the Turkish transplant surgeon Yusuf Sonmez, arrested many times in Turkey – which earned him the nicknames "Doctor Vulture" and "Doctor Frankenstein", given by the Turkish media – but escaping conviction many times by having produced 'consent forms' from his kidney donors, explained:

> "Anyone who has some brain and some reading, the capacity, I guess can read and understand the law. According to this law, the doctor obligation is just to check that the donation is for altruistic reason. Q: If a donor comes from Moldova, or Ukraine.. A: Is it my problem? It is the ethical committee's problem. It is not my problem. I am doing my surgery, that's it. Q: And you had no idea that the donors were getting paid? A: No, please, they were signing that there is no money matter, there is no selling, there is no buying, only for altruistic reasons. So my job was over, to see those papers, that's all. I was not getting the consent of the people. I need to see the papers."

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transplant and facilitating the necessary blood and tissue matching tests (D29; D30; R11; R30; R31; R34-R37; R42-R45), thereby earning "big money" (R31). For instance, an Israeli recipient stated that he "spoke to Dr. Shapira, who advised him that an operation in Kosovo would be a good option to pursue and that the clinic was a good one" (D27: 118). The retired Israeli transplant surgeon Zaki Shapira, former head of an Israeli transplant centre, authorized the execution of the illegal transplants with respect to the medical condition and suitability of prospective recipients and donors, reviewed the quality of the hospital and the doctors, and on some occasions accompanied the recipients abroad (D30; R42; Efrat, 2013b) or performed illegal transplants abroad himself. He had been arranging illegal transplants in Eastern Europe, Kosovo, Sri Lanka, Turkey and South Africa (D30; R1; R2; R30; Greenberg, 2013; OSCE, 2013). Upon asking, he stated to have performed over 3600 kidney transplants, "and the ones called illegal, I do not call them illegal, about 850" (*Tales from the Organ Trade*). He is considered to be a key player by law enforcement officials, near the level of the surgeon Yusuf Sonmez (R11; R34-R37), with whom he had explained to work together for 10 to 20 years (D29). Earlier, in 2007, Shapira and Sonmez were arrested in a Turkish clinic, where the police found an Israeli and South African recipient who had each paid more than US$200,000 and two Arab-Israeli donors who had been paid about $10,000 to undergo the surgery, facilitated by Moshe Harel. One of the donors was a young girl forced by her husband to sell her kidney so he could pay off his debts (*Organ Traders*). After three months in prison Shapira and Sonmez were released, as the charges were dropped.

Several respondents believe, however, that it is the surgeon's responsibility to make sure that recipients and donors, who can potentially be vulnerable, are not exploited in the organ transplant process (e.g. R4; R7). In this respect, the World Medical Association (WMA) provided an ethics guidance which expressly urges transplant surgeons to be proactive in determining the validity of a transplant by stating: "Transplant surgeons should attempt to ensure that the organs they transplant have been obtained in accordance with the provisions of this policy and shall refrain from transplanting organs that they know or suspect have not been procured in a legal and ethical manner" (World Medical Association, 2006). The Court of Pristina goes even further by stating that in determining criminal liability the mere existence of indications of human trafficking could lead to accountability of medical professionals (D29: 12):

> "The lead anestheiologist at the Medicus clinic personally interacted with most if not all of the donors and recipients involved in the 24 transplant operations in preparation for surgery, and therefore knew they were all foreign nationals. This striking fact should have aroused his suspicion that the Clinic was engaged in trafficking. […] He also participated in each of the surgeries, and should have known that kidney transplant operations were illegal in Kosovo, and that the Clinic had no license or authorization to conduct these operations. […] Despite his lack of knowledge that the prohibited consequence of trafficking could occur from his actions, he ought to have been aware and could have been aware of such a possibility under the circumstances and according to his personal characteristics. Therefore, he committed the offence of trafficking by negligent facilitation as a result of unconscious negligence."

As the code of protectionism and secrecy is strong within the medical profession (Scheper-Hughes, 2016), it could be difficult for law enforcement officials to determine whether a medical facility or medical professional was aware of the illegality of an organ transplantation. Derived from Passas' typology of symbiotic relations (2002), the situation could either entail *collaboration*, in case surgeons knowingly worked together with brokers, or *outsourcing* or *funding* relationships, in case they were unaware of the illegal nature of the transplants. In this respect Clarke (1990) explains that, unlike ordinary crimes where a crucial clue is presence at the scene, offenders of white-collar crime have every justification to be present at the crime scene. This facilitates their achievement and helps to prevent their detection by colleagues, superiors and local authorities, and the problem is to discover whether there has been an offence rather than to identify the offender (see paragraph 4.4). The medical profession amplifies this situation, as medicine has its own principles for confidentiality. The lead investigating police officer of the Netcare case explained the difficulty by saying (R2):

> "The big question mark from the beginning was: who was willing fully knowing, who was wrongly involved in this? […] If you just say, the surgeons are involved, how are they involved? They do the operation. That is common knowledge. The challenge is: do they do the operation knowing that these people aren't related and that they get payment? There is a difference between the two."

Some transplant surgeons have admitted that they orchestrated the illegal transplants themselves or that they were not that naïve and knew what was going on, but that they are skilled technicians who were responding to a higher authority beyond the laws and regulations of their profession (*appeal to higher loyalties*); they were "saving lives" (R30; R31; R40). Similarly, brokers state that their offences are for the greater good (D18; R8; R34-R37). Brokers who were only connected to recipients have made a distinction between their 'positive and helpful activities' in saving patients' lives, and the activities of other brokers who work with donors and used violence, threats and coercion in controlling them (D24; R2; R34-R37). According to the lead investigating police officer of the Netcare case (R2), criminal actors with an Israeli background believed they had done something good "in a religious fashion", which relates to the Jewish concept of *pikuah nefesh*, according to which one is permitted to transgress laws and regulations to save a life (see Greenberg, 2013). Furthermore, they claim that the prohibition of the organ trade is to blame for the rising demand of organs and that they are serving the needs of unfortunate ill people who would most probably die if they did not have an organ transplant (R5; R9; R25). As Israeli transplant surgeon Zaki Shapira explained in *Tales from the Organ Trade*:

> "I save people's lives. I am a doctor, that is my profession. There is no doubt that the donor issue is a very serious one. If it was regulated, then obviously the donor would not have been harmed. If it wasn't the black market, if the donor went to a serious hospital to be examined A to Z, there be no reason that he be harmed. If not, then of course there will be risks. There is a chance the donor won't be paid what they were promised. There are many possibilities. I totally agree with people who are against this on that point. […] When I know I can save a man's life, should I tell him I can't because it is illegal? How can I? I can do it, I have the connection, I can send them to the right places. Because it is illegal you should die? What is this? It is impossible."

Transplant surgeons and brokers who consciously engage in illegal organ transplants seem particularly eager to publicly present themselves as life savers to uphold their reputation. Although they might have started the illegal activities from a desire to help recipients, with time they seem no longer genuinely

concerned about their faith (*moral indifference*) (R8; R10; R30). In preparing and performing the surgery, the physical well-being of recipients and donors only concerns them because it could harm their business if someone would die under their care, which would be disastrous for their reputation. The moment recipients and donors are discharged from the medical facility, their well-being does not reflect upon their reputation any more and they no longer care (see also OSCE, 2013). This is illustrated, for instance, by a donor in the Rosenbaum case, who "certainly made it clear that once they had his kidney, they didn't care. Not that they wanted him to suffer but they just didn't care. They had gotten what they wanted and you know, thank you" (R8). Criminal transplant surgeons are proud of the number of transplants they have facilitated or performed, which manifests their surgical experience and benefits their reputation. According to Scheper-Hughes (2016), the Turkish surgeon Yusuf Sonmez told her that he had put transplants on the map in Turkey and pushed out all of his more ethical competitors by violating established norms and laws. At an international congress of transplant professionals in Ukraine in 2008, he proudly presented his "2200+ illegal and hit-or-miss (i.e. poorly matched) transplants." Following his presentation, a nephrologist from Moldova raised the objection that some of the trafficked donors returned to Moldova mortally ill and a few of them died of infections and kidney failure after their nephrectomies. The Turkish surgeon replied that "the well-being of contract kidney workers was not his responsibility" (Scheper-Hughes, 2016: 256-257). Due to this high amount of transplantations, Yusuf Sonmez "is very experienced. You know, the number.. no other surgeon has the opportunity to perform so many, so you gain experience" (R28).

Medical malpractices and exploitation of vulnerable individuals remain largely unaccounted for, as complicit physicians are rarely sanctioned for participating in illegal transplants (Orr, 2014; Scheper-Hughes, 2016). Experts argue that impunity prevails amongst physicians and that it seems to present an obstacle for law enforcement authorities to initiate investigations against members of the highly regarded medical profession (UNODC, 2015). Scheper-Hughes (2016: 255) claims "it is, I argue, a protected crime – protected by the transplant profession, hospital administrators, police, ministries of health, government officials, and in some nations also protected by the military." This may be due to authorities turning 'a blind eye', since the trade can yield economic gains for influential groups in the society (Lundin, 2012). In this respect, Reuter & Petrie (1999) stated that transnational crime produces benefits for some people, giving governments and legitimate organizations an incentive to develop relationships with criminal groups, or at least tolerate their activities. Some respondents explained that the huge number of illegal transplants performed benefitted many (R4) and ending these practices would lead to more recipients dying from kidney failure (R7):

> "If they really stopped everyone who was involved with that [Israeli transplant] program, the whole private transplant program in South Africa would collapse. And more patients would suffer through that, because there are lots of people who really need it. So, was that part of the thinking, you know, that doctors got away with it? […] They have so much power, because it's only them, they have a monopoly."

5.3.5 Abuse of a position of vulnerability

Concerning the means through which individuals can be exploited, 'abuse of a position of vulnerability' is particularly applicable to victims of organ trafficking. Vulnerability is especially easy to establish on the part of the economically marginalized donors. All donors in the Medicus case were considered victims of abuse of their vulnerable position due to their financial distress[78] (D29). The prosecutor stated that "these people were on the margins of society. They were marginalized, they were poor, they were indigent" (R11). The case further revealed that considerations about the means 'coercion' and 'fraud' could also be relevant in proving the existence of vulnerability and its abuse (D29: 87):

> "Almost immediately after they reached the clinic they were required to sign documents which they hardly understood, including the so-called 'Deed of Donation' stating they were donating their kidney for altruistic reasons or to a relative, which in all cases was patently false. After these documents were signed, the victims were wheeled into the operating theatre, sedated and operated upon, even though some of them had serious second thoughts. This scenario demonstrates another way in which the perpetrators abused the victims' position of vulnerability."

As recipients' feelings of desperation and their desire to do anything to stay alive evidently derives from the data, abuse of a vulnerable position could be applicable on their part as well. As a patient said in *Tales from the Organ Trade*: "I have to decide whether I am willing to take up my soul, the ethical burden of purchasing a kidney from somebody, or choose to die. And that is really the choice I am facing." Applying abuse of a vulnerable position on recipients is in line with the legal instruments in place; one of the possible definitions of this open-ended term in the UN Model Law against Trafficking in Persons is "reduced capacity to form judgements by virtue of illness" (UNODC, 2009: 9).

[78] As has been explained in paragraph 2.2.2, one of the possible definitions of the open-ended term 'abuse of a position of vulnerability' mentioned in the UN Model Law against Trafficking in Persons is "being in a precarious situation from the standpoint of social survival" (UNODC, 2009: 9). The Commentary further explains that elements such as abuse of the economic situation of the victim is included within the range of possible defintions as well.

The desperation on both sides leads to an almost unlimited demand and supply of human organs for transplants, which criminal networks take advantage of by turning the despair of patients and donors into a business opportunity (D24; R10). Within the underground transplant industry, abuse of the position of vulnerability of recipients and donors is further manifested by the amounts of money they are obliged to pay and promised to receive. Donors receive relatively low amounts of money (R2; R6; R11), while some are only partially compensated, or not at all; in which case their vulnerable position is further evidenced by the complete absence of any lawful enforcement mechanism to obtain the payment promised (D29). Recipients are charged significantly higher amounts of money than donors receive. "They were vulnerable, you are vulnerable if you're going to die, isn't it? That's why they could ask such a lot of money for it" (R7). The findings of this study indicate that prices charged for illegal transplant procedures abroad are influenced by the wealth of the recipients (see also Sanal, 2004) and the occurrence of complications during or after the transplant. In several instances, a (written) contract was established between the broker and a recipient which contained the price and conditions of their agreement, revealing that in case complications arose, the payment would increase (R2; R41).

> "He will have a contract with the recipient, where there is a fixed amount paid when it's a plain and simple operation, they call it an operation without complications. There's a price which will say, if there are no complications during the operation then everything is taken care of. If there are complications, it is more" (R2).

Other factors that influence the price are competition from other brokers (as the black organ market is a competition-driven market model) and the travel distance to the destination country. For instance, as is described, in the early 2000s it was possible for Israeli patients to travel to both Turkey and South Africa for an illegal organ transplant. The mutual competition of brokers and significant longer travel distance to South Africa was reflected in the price. According to the manager of Israel's largest public health insurance company (R28): "In order to attract patients to come to South Africa, which is a long trip, Turkey is close, I mean for us it's an hour and a half flight, South Africa is a ten hours flight, it's the end of the world. So he fixed a rate of US$108,000, about half of the going rate in Turkey at that time." Throughout the years, the costs of the illegal transplant procedure have risen (R28; R38). Israeli recipients paid US$40,000 for the first transplants in Turkey in the early 1990s, and a decade later, the amounts paid had risen to $220,000 per transplant (see Efrat 2013b). Whenever brokers compete with one another by facilitating illegal transplants in the same country, as has been the case in South Africa and China where multiple brokers were active, the prices stayed more or less the same throughout the years (R28).

Like the donors' situation, the vulnerable position of recipients is further evidenced by the complete absence of any lawful enforcement mechanism to retrieve their payment if the transplant fails. A physician explained that even though recipients pay high amounts of money, "if the kidney doesn't function, nobody is responsible" (R30). An Israeli recipient (R41) said that some patients have been deceived by not receiving a transplant after their payment: "I have met some recipients with coordinators that deceived them. Yes. I heard about it afterwards, after the law. Because it couldn't be done, because places were closed and things like that. I've heard. Yes, there are some bad guys, of course, just want to exploit the problems of other people." The vulnerability of recipients and donors is further manifested by the fact that they are discharged within a short time frame after the surgery, and are in such a weak physical state that they are not able to choose for themselves whether to travel home or not. At last, upon returning home the clear majority of the donors are not able to claim proper aftercare, which again points to their vulnerable position (D13; D29).[79]

5.4 Exploitation

In view of the above findings, it is clear that recipients and donors have been exploited using illicit acts and means with the purpose of organ removal. Notwithstanding the justifications that the criminal actors have raised, exploitative conditions such as the actors' disregard for the medical conditions and safeguards necessary for safe transplants and the speed of the entire procedure are indicative of the purpose for exploitation (D27; D29; D30; R2; R7; R11). Recipients and donors have been objectified; they have merely been seen as products or commodities – "kidney factories" (D27: 99) – abusing their distress without concern for their future wellbeing (D24; D27; D29; R2; R7; R8; R30; see also Scheper-Hughes, 2016). As the Medicus case prosecutor argued (D27: 29):

> "Those involved in organ smuggling are driven by one primary and all-encompassing concern, profit. The characters involved in the trade are often unsavoury and without doubt lack much, if any, concern for the victims. Once these people have what they want, the continuing needs of any victim are irrelevant as far as they are concerned."

What is remarkable, however, is that the case studies only identified *donors* as victims of human trafficking. Upon asking, some of the law enforcement

[79] The Brazilian government provided aftercare for the Brazilian donors who traveled to South Africa to 'donate' their kidney, as the police investigation revealed that many of them suffered from serious complications after the surgery in South Africa (R6; *Medical Greed!*).

respondents did argue that recipients could be victims (e.g. R11; R12), but from a criminal justice perspective none of them have been treated as such. The academic literature and media articles often hint at the status of recipients of commercial organ transplants as potential human trafficking victims (OSCE, 2013) and the legal instruments in place tolerate the application of human trafficking elements on recipients, as they suffer from "reduced capacity to form judgement by virtue of illness" (UNODC, 2009: 9) – one of the possible definitions of 'abuse of a position of vulnerability' according to the UN Model Law against Trafficking in Persons (see paragraph 5.3.5). Furthermore, given recipients' fundamental health interests, their situation is not comperable to the interests of the 'customer' in other forms of human trafficking such as sexual or labor exploitation (OSCE, 2013). This finding calls for the enlargement of the pool of potential victims of organ trafficking to include the recipients of commercial organ transplants.

In line with Yea (2010), who argues that the presence of brokers increases the likelihood of exploitation, numerous respondents believe that the involvement of brokers increases the chance of victimization (e.g. R11; R12; R26; R28). As is clearly explained by the manager of an Israeli health insurance company (R28), organ brokers do not have the best interest of either donors or recipients at heart:

> "I know the dealers almost 20 years. I saw how these things go, and it comes to things that are not accepted. I mean, to take the donor, not to pay later on, to do a surgery to someone who is.. there is medically contradiction for transplantation because the kidney will not survive with him, but.. only because there is money involved here. And you know how many times I saw such things, that patients who are totally not allowed to undergo..? We had cases in which patients died. These patients will not be offered a transplant in a normal medical system, but they were offered because the dealer involves the money."

From a criminal justice perspective, however, law enforcement officials revealed to find it difficult to prove exploitation by brokers, as donors in many instances apparently voluntarily engage in the illegal transplant procedure and receive a payment for the removal of their organ (R34-R37; R42-R45). For instance, a donor who traveled to Kosovo to sell his kidney stated before court that "no one forced him to do anything against his will. He did so because of his personal circumstances, namely financial collapse, which he now deeply regrets. At that moment in 2008, it was necessary for him to do so in order to improve the situation of his family" (D29: 59). Similarly, a vast majority of the recipients do not feel victimized. "He would be dead if he had not had a transplant. He does not consider himself an injured party. He would not prosecute the defendants; he would give them a medal" (D29: 71). In this respect, it is important to note that

denial of victimization is common in situations of trafficking in persons for any exploitative purpose, for a number of reasons including shame, fear to be held criminally liable, lack of information and lack of confidence in the legal system. As is written down in the Palermo Protocol, however, the consent of a victim of human trafficking to the intended exploitation is *irrelevant* where any of the listed means have been used (United Nations, 2000c). The criminal actors in the Netcare, Rosenbaum and Medicus cases have obtained the consent of recipients and donors through coercion, fraud, deception, abuse of power and/or abuse of a vulnerable position, which means their consent is inapplicable. Therefore, the difficulty to prove exploitation experienced by law enforcement officials is more likely a consequence of a lack of knowledge and experience regarding the offense – in addition to inadequate existing legal frameworks – than of the absence of human trafficking elements. This gap is obvious from a statement made by an investigative officer of the Netcare case (R4):

> "People that came out here as donors and even the recipients, none of them came here under duress. In other words, they weren't forced to come here for the operation. It's one thing to kidnap somebody, bring them over the border, take their kidney out and then take them back across the border. That would clearly be.. […] I don't think human trafficking would have covered anything that would have solved this particular case, because the people came of their own free will."

Similar to the Israeli authorities, who rather tend to charge brokers under the Organ Transplant Act than under the Prohibition of Trafficking in Persons (see paragraph 2.3.4), the Rosenbaum case prosecutor (R8) stated that human trafficking charges are more difficult to prove than violations of organ transplant laws, as the donors did not meet the classic indications of trafficking:

> "It would have been very hard to prove trafficking, because one of the elements of trafficking under United States' law is coercion and the coercion that you could point to in X's case was not so over the top that it would have been readily provable. It was more a subtle, psychological sort of coercion. […] We didn't have any of the sort of classic indicia of trafficking in this case. I don't think even had we had them at the time, we would be bringing charges. I don't think we would have been able to prevail on a trafficking type of charge."

Yea (2010) confirms that anti-trafficking actors often view the experiences of organ donors as diluted forms of trafficking that do not readily conform to the dramatic stereotypes of victims of other forms of trafficking. But this argument should not be decisive in the attempt to define illegal organ transplants within a

human trafficking framework before court. Although it requires special efforts to establish the relevant facts, to hold someone liable under the human trafficking provision it is only necessary to prove that one of the listed acts (i.e. transfer) was committed with one of the means (i.e. abuse of a position of vulnerability) with the purpose of exploitation. Given the involvement of various criminal actors who are specialized in different segments of the procedure, an act such as 'transfer' should be relatively easy to prove. The same goes for an illicit mean such as 'abuse of a position of vulnerability' which is in particular seen as applicable to impoverished donors, but could be assigned to mortally ill recipients as well. And where any of the listed means have been used, consent to the intended exploitation is irrelevant. This finding calls for a more complete interpretation of the human trafficking elements from a criminal justice perspective.

5.5 The crime's organizational model

Criminal networks involved in organ trafficking operate with a certain similarity to the legal transplant industry in order to make the illicit activities appear outside prohibitive provisions. An example is the use of forged consent forms to falsely indicate that the organ donation is between relatives and/or for altruistic reasons, through which these transplants on the surface could be indistinguishable from legal ones; the Israeli transplant program in South Africa constitutes a sophisticated model of such a practice. Similar to legal entreprises, the underground transplant industry is competition-driven and prices charged are further influenced by factors such as the travel distance to the location of an operating theatre and the occurrence of complications related to the transplant surgery. But as the illegality of black market products obligates criminal actors to operate both without and against the state, it is argued that similarities between practices of legal and illegal entreprises can not be pushed too far (Paoli, 2002); illegal market activities by criminal networks are claimed to largely take place in a disorganized way (Naylor, 1996; Reuter, 1983). The available literature on organ trafficking does not support the theoretical disorganised crime hypothesis. Due to the complex nature of transplant activities, which require compatible recipients and donors, transplant surgeons, medical staff and an operating theatre, organ trafficking is said to require globally active and well-organized criminal networks (Scheper-Hughes, 2011; UN.GIFT, 2008; Vermot-Mangold, 2003; Yea, 2010).

A close examination of three organ trafficking cases reveals loose, flexible combinations of numerous criminal networks and actors that joined forces to facilitate illegal transplants on a global level (R1; R2; R4; R11). Within the Netcare case, for example, Israeli recipients have been transplanted with donors from Israel, Romania and Brazil through the collaboration of local recruiters and

brokers in all four countries, a private hospital group in South Africa, medical professionals and translators from Israel and South Africa, and the facilitation of service providers; a blood bank in South Africa and health insurance companies in Israel. The flexibility of the networks is reflected in the interchangeable roles between network members; which is comparable to characteristics of criminal networks associated with other forms of human trafficking (e.g. European Commission, 2016) and other common types of organized crime (e.g. Paoli, 2002). A transplant surgeon, for example, could also operate as a broker or may directly take part in accompanying recipients and/or donors to and from the location of the transplant surgery. The flexibility of the networks is also reflected in the possibility to transfer from one role to another, most notably former donor victims who become recruiters, and is further manifested by the networks' capacity to shift operations to another country within a short time frame. Although most of the relations between network members are arms-length buyer-seller relationships, the case studies reveal that some long-term criminal partnerships have been established which have maintained a certain degree of stability because law enforcement authorities did, and in some instances still do, not (effectively) intervene in their activities. An example is the long-lasting collaboration between the transplant surgeons Zaki Shapira and Yusuf Sonmez.

These loose, flexible criminal networks and actors, joining forces to facilitate illegal transplants on a global level, operate on an extremely well-organized basis (D4; D24; D29; D30; R2; R4; R11; R12). After all, the preparation and performance of organ transplantations is a complex undertaking which requires careful coordination of numerous logistics; blood and tissue matching, travel-related documents, transportation, accommodation, translation, fraudulent consent documents and financial transactions (OSCE, 2013). The high degree of organization is, for instance, evidenced by the speed with which the procedure of recruitment and transfer of multiple recipient-donor-matches from different counties into an operating theatre in a third country is executed. Another example is the short time frame by which the venue of an operating theatre is relocated to another country when interrupted by law enforcement efforts. For instance, the Turkish surgeon Yusuf Sonmez and Israeli broker Moshe Harel used existing networks of recruiters and clinics in several countries (R11):

> "There were three groups. There was Moshe and Sonmez, which was an extremely sophisticated international organ trafficking ring. […] They tapped into a network of criminal agents in Moldova, Ukraine, Russian Federation, people who knew how to recruit victims of trafficking for all purposes. […] They moved up to a higher level of medical practitioners who formed the other organized criminal group at the clinic. […] What we tapped into in Medicus was a constellation of clinics that had been

> running for a very long time. And Medicus was just one. There were clinics in Azerbaijan, in Istanbul, in Israel, we believe. There are clinics around the world that both Sonmez and Harel have been involved in."

The involvement of brokers, seen as key players in organ trafficking networks who financially benefit the most from the illegal transactions (see Caplan et al., 2009; Muraleedharan et al., 2006; Scheper-Hughes, 2000), in itself also indicates the sophistication and high degree of organization of organ trafficking (see Coles, 2001; Hobbs, 1997; Jackson, Herbrinck & Jansen, 1996). International brokers either enjoy a monopolistic position (Turkey) or facilitate organ transplants in the same country as other brokers (South Africa, Kosovo) in which case they are unable to determine the price of the illegal transplants independently; they are "price-takers" rather than "price-givers" (see Paoli, 2002). International brokers may work through local recruiters in attracting recipients and donors; recruiters are generally paid per successful recruit (OSCE, 2013). The Israeli broker Izhak Rosenbaum explained to an undercover FBI police officer about the process of finding a donor in Israel for recipients in the United States that "there are people over there hunting. One of the reasons it's so expensive is because you have to shmear (meaning pay various individuals for their assistance) all the time" (D15: 3). Recruiters, who themselves may be former donor victims, generally work in one country of which they are nationals, but there have been some exceptions, particularly across borders with shared or similar languages (OSCE, 2013). When multiple recruiters are involved, there may be a form of hierarchy amongst them, which influences the price of their services and their financial profits as they need to pay commission to recruiters higher in rank (D24; D30; R34-R37).

In contrast to the theoretical disorganised crime hypothesis, the constraints of product illegality referred to by Paoli (2002) appear to be 'easily' coped with by the organ trafficking networks studied. First of all, the lack of systematic trust experienced in illegal marketplaces is replaced by a mutual trust between network members based upon common ethnic or religious backgrounds, through which criminal partnerships have proven to be easier to establish and to maintain (see e.g. Bruinsma & Bernasco, 2004; Kleemans & Van de Bunt, 2003; Van de Bunt, Siegel and Zaitch, 2014). For instance, most of the brokers, physicians and translators in South Africa involved in Netcare's Israeli transplant program have an Israeli background (R2; R41), and so do Netcare hospital group's executives (R7). The Israeli broker Harel is born in Turkey, has the Turkish nationality and speaks the Turkish language, which, according to the Israeli police, explains his connection to the Turkish surgeon Sonmez (D30; R34-R37). Anthropologist Nancy Scheper-Hughes explained about Izhak Rosenbaum in *What in the World*: "He knew that the Hasidic community was the most closed community and they would never blow the whistle on him. So he began serving

them, and it's a very large population." As Reuter and Petrie (1999) explained, the strength of ethnic and kinship bonds within communities facilitates the development of trust. The intertwinement of organ trafficking networks with the legal transplant industry, a profession which is regarded with trust and maintains a strong code of secrecy and protectionism, is another factor in coping with the lack of systematic trust. The case studies constitute clear examples of Simmel's "secret societies", as part of the internal and the external environment was not informed about the true nature of the organ transplants (Simmel & Wolf, 1950: 345), through which the illegal activities remained undetected and/or unreported for many years. For instance, in the Netcare case, although many employees had suspicions about the illegality of the Israeli transplant program (R7 (see quote)), it took more than two years before the façade was exposed:

> "Afterwards we thought: 'why didn't we go to the police earlier? But also, that's the other thing, we didn't know how to report it, you don't know as employee. […] You tell your managers [your suspicions] and they say 'we have got it in hand' and [they] say 'let's look at it a little more and you don't have proof.'"

Secondly, the effective risk of arrest is strongly reduced by the successful concealment of the nature of illegal organ transplants (for instance through forged consent forms and fraudulent statements in front of ethical committees), the silence maintained by recipients and donors (to whom the amount of incriminating information is also reduced to lower the risks of arrest), the lack of awareness and enforcement of the crime by the society and state authorities, and the involvement and/or bribing of transplant professionals and law enforcement officials. The importance of bribing law enforcement officials is emphasized by the Israeli surgeon Zaki Shapira in *Tales from the Organ Trade*:

> "Naturally, the first thing the head surgeon did was to go to the [local] police to ask who is in charge and pay him money so that if something happens the police would inform him. The police called to say that somehow the news leaked out and someone was coming to inspect. Because this was an orthopaedic hospital, we put our patients in plastic casts. They came to check but saw only orthopaedic patients."

The absence of the threat of arrest is manifested by the open recruitment of patients and donors, through advertisements in newspapers and on the Internet. Another example which clearly indicates the absence of fear, is the fact that a local broker in South Africa resorted to the police to try to enforce a commercial organ donation contract, after the donor escaped from the hospital before the 'donation' of his kidney with his US$18,000 reward (D7; R1; R4). Even more

noteworthy is the civil case that the Israeli broker Ilan Perry initiated against Netcare over an outstanding payment of over five million South African Rand; an indication of their confidence in the appearance of legality of the commercial transplant program, as the civil case revealed the precise amounts that Netcare has received from Ilan Perry within the Israeli transplant program (R1; R4).

Thirdly, a tendens towards a local scope of the criminal activities, another constraint of product illegality mentioned by Paoli, does not apply to the organ trafficking cases studied. On the contrary, all cases reveal the international scope of the crime, with recipients and donors traveling from different home countries to a third country where the transplant centre is located. In fact, the international scope of the crime brings along considerable *advantages* for the networks: foreign recipients and donors have no knowledge of local legislation and policies and could easily be deceived about the illegality of the transaction, they are usually not able to communicate with local medical staff or each other and are alone, isolated and dependent on their traffickers (R7; R11), and finally, it is difficult for local law enforcement officials to track foreign recipients and donors down (R2; R8; R11). Therefore, the international scope of the activities is rather an important constraint for the detection and prosecution of the crime, of which organ trafficking networks take advantage:

> "Why not get people that you can literally bring in, use and then dispose of by putting them on a flight? They put these people on a flight and they disappeared in the ether. They went away, that's fantastic. They didn't have the resources to call you, or get back on a flight and come back, they were just gone. It is perfect" (R11).

For reasons stated above, organ trafficking networks appear to operate on illegal markets in a more organized way than the average criminal networks, including networks who deal with other forms of human trafficking. This could be explained by the fact that organ trafficking differs from other forms of human trafficking in several key respects (Yea, 2010). First of all, the scenery of the crime is an operating theatre, usually a hospital or clinic (R11; R12). The role of medical facilities and professionals is well recognized as an aspect of organ trafficking that sets it apart from other forms of human trafficking (OSCE, 2013; UNODC, 2015). The medical aspect of organ trafficking brings along a complexity which requires careful organization, for instance in terms of medical tests and the concealment of the illegal nature of the transactions. Secondly, the period of exploitation is merely confined to the period of the organ transplant procedure – although the effects of losing a kidney are equally, if not more, long term than other forms of trafficking (Yea, 2010). Organ trafficking is discrete in time; it is not an offence that occurs over and over again with the same victim, it can never

be as fluid as other forms of human trafficking (R11). The mere fact that central participants may be present only for a brief time in the jurisdiction where an illegal transplant is carried out may also forestall or hamper investigations; without the recipient and donor it can be difficult to establish that the sale of an organ occurred or that the recipient and donor were not related (OSCE, 2013).

In concluding this chapter, it should be emphasized that it is unlikely that the three criminal cases studied represent the underground transplant industry as a whole. While local networks can and do interact with larger transnational organ trafficking networks in case other countries function as source, transit and/or destination routes (see Hobbs, 1998; Karstedt, 2000), this does not rule out the exploitation of a small number of victims on a local level through limited organization. The organization of organ trafficking is a dynamic process, resulting from the interaction of illegal market dynamics, legal control efforts and offenders' skills and networks (see Levi, 2002) and the organ trade operates alongside a continuum of which the activities can vary in scale and severity (Columb, 2015). Human traffickers can act alone, with a partner or in different types of groups and networks. The more complex and more transnational trafficking operations are, the more likely they require concerted actions of several actors through some degree of organization (UNODC, 2014).

Conclusion

Since the 1980s, organ transplantation has become a victim of its own success; the demand for organs far outpacing the supply. At the moment, the activity of transplantation is less than 10 per cent of the global need, with kidney transplant waiting lists growing most prominently. Although the buying and selling of organs (i.e. *organ trade*) is prohibited worldwide with the exception of Iran, journalists and scientists have indicated that the trade occurs worldwide. Under influence of globalization, the organ shortage has driven patients from industrialized countries in need of a transplant to developing countries where poor individuals are willing to 'donate' an organ in exchange for money, both out of desperation and strain. Patients' global search for donors has generated a highly profitable underground economy (black market) for criminal networks, where illicit acts and means are applied for the purpose of exploitation (human trafficking for the purpose of organ removal; i.e. *organ trafficking*). Given the clandestine and illegal nature of the trade, there is no reliable data about its scope. The only 'official' data, which has been widely cited and uncritically relied upon but has no empirical foundation, comes from the World Health Organization (WHO). In 2007, the WHO estimated that 5 to 10 per cent of the 66,000 kidney transplants conducted annually around the globe at that time were the result of patients with kidney failure traveling abroad to purchase a kidney. It remains unclear what percentage of this estimation concerns organ trafficking, although some researchers state that in practice it is difficult to identify commercial organ transplantations where the organ donor has not been subject to exploitation.

In the literature, little information is revealed about the mechanisms and business model of organ trafficking. The majority of the empirical studies is either *medical*, as physicians wrote about the outcomes of commercial organ transplants conducted by their patients abroad (transplant tourism), or *anthropological* by nature, as scholars and NGOs described the experiences and socio-economic consequences of organ selling from donors' perspectives. Most articles on transplant tourism do not present any evidence that the organs were bought and therefore obtained illegally, let alone that they were obtained through organ trafficking. Similarly, within the larger number of articles that are written about donors who sold a kidney, most studies present no indications of trafficking or present some indications without addressing (a clear definition of) trafficking. Although the commercial organ trade is often discussed by scholars within a human trafficking framework, organ trafficking is "generally assumed, rather than rigorously established" (Yea, 2010: 360). Empirical research from the perspective of other actors who are (in)directly involved in the crime, such as brokers and

transplant professionals, is barely available. Despite the absence of evidence-based research, organ trafficking is said to involve globally active and well-organized criminal networks because of the complex nature of the activities and the involvement of many different type of individuals and agencies, most of them legitimate actors; recipients, donors, brokers, medical facilities, medical professionals and service providers such as medical insurers and laboratories that conduct prior medical tests. This study's objective is to address this knowledge gap by a close examination of organ trafficking cases, which are limited in number worldwide but shed a light on the entire human trafficking process.

Criminological studies of organ trafficking are scarce. Therefore, this study aimed to contribute to criminological research by providing an answer for the following central research question: *How does the interaction between the prohibition and the demand and supply of human organs for transplantation shape the mechanisms and organizational model of organ trafficking?* In this context, the following sub questions were defined: Why is the trade in human organs criminalized? What are the effects of the criminalization? What are the global and local causes for the phenomenon to occur? What is the modus operandi of the actors involved in organ trafficking? How do they consider the nature of their activities and clarify their behaviour? How can the crime's organizational model be defined? In order to answer these research questions, three criminal cases (the Netcare, Rosenbaum and Medicus case) have been analysed by studying court documents and interviewing mainly law enforcement officials and defense lawyers in South Africa, the United States, Kosovo and Israel. As a secondary data source, four documentaries which disclose valuable information about the cases are included, as well as the recordings of an United Nations expert meeting and the Writers Conference of the HOTT project – an international research project into organ trafficking of which I was an associated partner. The triangulation of this many different data sources contributes to the validity and reliability of this study. Its reliability is further enhanced by conducting and discussing a large part of the interviews with researchers from other disciplines within the HOTT project.

The trade in human organs is prohibited almost worldwide with the purpose to prevent victimization of impoverished individuals who are willing to sell an organ. While a consensus prevails about the exploitative nature of *organ trafficking*, some scholars argue that the universal prohibition of the *organ trade* is not justifiable under all circumstances. The ethical debate on the organ trade prohibition revolves around the questions whether the use of incentives would increase the supply of organs and whether a legal incentive system, in which the harms associated with illegal markets could be avoided, would be ethically justifiable. Others claim that the organ shortage is an invented scarcity, created by the global community by promising patients the life-saving capacity of organ

transplantation. Related to this view, this study has shown that recipients and donors neutralize their illegal actions by emphasizing that everyone in their situation would engage in the trade (*claim of normality*), because they are victims of circumstances given their lack of options (*denial of responsibility*). Such justifications can be explained by Matza and Sykes' (1957) neutralization theory, which is particularly applicable when explaining behaviour of legitimate socially attached actors. Another point of view in the debate on the moral legitimacy of the prohibition is that all individuals have a right to sell their organs. In accord with this perspective, many recipients prefer to ignore or deny the possibility of exploitation of the donor (*moral indifference*) to appease their conscience (*denial of injury*) and reduce their criminal liability (*denial of knowledge*).

As they could be criminally liable, recipients and donors are often reluctant to come forward to report illegal transactions to authorities, even when there are clear indications of trafficking. Moreover, many of them do not feel victimized. Consequently, it is not uncommon for law enforcement officials to treat recipients and donors as offenders or witnesses because of their 'active' role, rather than as victims of trafficking in need of protection. Denial of victimization is common in situations of trafficking in persons for any exploitative purpose, for a number of reasons besides fear to be held criminally liable, including shame, lack of information and lack of confidence in the legal system. However, consent to the intended exploitation is *irrelevant* where any of the means listed in the human trafficking definition, such as coercion, have been used. But anti-trafficking actors often view the experiences of donors as diluted forms of trafficking that do not readily conform to the dramatic stereotypes of other trafficking victims, and worldwide recipients have never been identified and treated as potential victims of human trafficking. To hold someone liable under the human trafficking provision, it is only necessary to prove that one of the listed illicit acts was committed with one of the listed means with the purpose of exploitation. Given the involvement of various actors specialized in different segments of the procedure, an illicit act such as 'transfer' is relatively easy to establish. The same goes for the mean 'abuse of a position of vulnerability', which is especially applicable to impoverished donors but could also be assigned to mortally ill recipients. The difficulty to prove exploitation experienced by law enforcement officials is more likely a consequence of a lack of knowledge and experience regarding the offense, in addition to local inadequate existing legal frameworks, than of the absence of human trafficking elements. Therefore, I advocate a more complete interpretation of the human trafficking elements from a criminal justice perspective and the enlargement of the pool of potential victims of organ trafficking to include not only donors but recipients as well – a possibility which is taken into account in the broad United Nations' human trafficking definition.

This study clearly shows that recipients and donor victims have been exploited using illicit acts and means with the purpose of organ removal. They have been *recruited* in foreign countries and *transported* to the country where the transplant centre is located and/or *transferred* to an accommodation or directly to a medical facility, where they have been *received* and/or *harboured* until the organ transplant surgery has been realized. The criminal actors could accomplish these activities by *abusing their position of vulnerability*, as recipients and donor victims were either driven by life threatening illness or inescapable poverty in their 'choice' to purchase or sell an organ. Their vulnerable position is further evidenced by the respectively high and low amounts of money they have been obliged to pay and promised to receive and the complete absence of any lawful enforcement mechanism to obtain their payment in case (part of) it is withheld or to retrieve their money if the transplant failed. Furthermore, many of them have been discharged shortly after the surgery in a weak physical state, after which some of them suffered from post-operative complications and a (further) deterioration of their health and most of the donor victims did not have access to proper aftercare. Criminal actors also employed other means; *coercion* by portraying the donation as a noble act that would save a patient's life, seizing donors' passports, not providing proper information about the nature and risks of the surgery, requiring that consent forms were signed without having been given the time to understand its content, and then giving no reasonable opportunity to decline the surgery even in case of serious second thoughts; *fraud* by falsification of documents and signatures and instructing donor victims to falsely state before ethical committees that the donation was for altruistic reasons and/or to a relative; *deception* by misleading and not informing both parties about the procedure, its risks and long-term consequences, falsely presenting the transplantation as a legal transaction, and withholding (part of) the promised payment; and *abuse of power* by abusing the opportunities that medical professionals' highly respected positions provide.

Notwithstanding their exploitative methods, actors such as brokers and transplant professionals justify their behaviour through similar neutralization techniques (Matza & Sykes, 1957). Brokers generally *appeal to higher loyalties* by portraying themselves as life savers. The same applies to a few notorious transplant surgeons – "trusted crimininals" (Friedrich, 2009) – who publicly present themselves as life savers to uphold and manifest their reputation. But most medical professionals who have been accused of deliberate participation in illegal transplants claim to have been unaware of the circumstances that brought the recipient and donor together. They *deny responsibility* by arguing that it is the ethical committee's job to investigate the legality of the transplant. Both types of 'symbiotic relationships' (Passas, 2002) – *collaboration* and *funding* – provide mutual benefits for the legal and illegal facilitators; the organ trade is generating more transplants worldwide

from which the medical profession benefits in terms of financial earnings and surgical experience. As the code of secrecy is strong within the medical profession and medical staff have every justification to be present at the crime scene, an operating theatre, it is difficult for both the individuals who are directly involved in the procedure and the local authorities to detect the offences.

Scientific approaches concerning the operational model of illicit market activities by criminal groups differ. Some scholars emphasize the analogies between legal and illegal entreprises. Others claim that the illegal status of the products obligates criminal actors to operate without and against the state and therefore prevents the consolidation of large-scale, durable criminal organizations. A close examination of organ trafficking cases reveals loose, flexible combinations of numerous organized criminal networks and actors that have joined forces to facilitate illegal transplants on a global level in an extremely well-organized manner. The flexibility of the networks is reflected in the interchangeable roles between members, a transplant surgeon for instance might also operate as an organ broker, and in the possibility to transfer from one role to another within the network, most notably former donor victims who become recruiters. The high degree of organization is evidenced by the involvement of brokers, the speed with which the recruitment and transfer of multiple recipient-donor-matches from different countries into a medical facility in another country is executed, and the short time frame by which the location of an operating theatre is relocated when interrupted by law enforcement efforts. Organ trafficking networks appear to operate on illegal markets in a more organized way than the average criminal networks, because they appear to 'easily' cope with Paoli's constraints of product illegality (2002). In many instances, there is a mutual trust between network members based upon common ethnic or religious backgrounds. The effective risk of arrest, another constraint of product illegality, is strongly reduced by the successful concealment of the illegal nature of the transplants, the silence maintained by recipients and donors, the lack of awareness and enforcement of the crime by society and state authorities, and the involvement or bribing of transplant professionals and/or law enforcement officials. Finally, the international scope of the crime brings along considerable advantages for criminal networks and important constraints for the detection and prosecution of the crime, as foreign recipients and donors have no knowledge of local legislation and policies and could easily be deceived about the illegality of the transaction, are not able to communicate with local medical staff, depend on their traffickers, and are difficult for local law enforcement officials to track down outside their jurisdiction.

The organization of organ trafficking is a dynamic process, resulting from the interaction of illegal market dynamics, the skills and networks of the offenders and legal control efforts. The trade in particular flourishes where the institutions of

governance are weak, inefficient or corrupt. In addition, a weak infrastructure of organ transplantation and socio-economic circumstances make some societies more vulnerable than others. The trade operates alongside a continuum of which the activities can vary in scale and severity, and it is unlikely that the three criminal cases studied do represent the trade as a whole. While local networks can and do interact with transnational organized networks, this does not rule out the exploitation of a small number of victims on a local level through more limited organization or voluntarily 'even exchanges' between recipients and donors. Given the latter, it is important to emphasize that although organ trade and organ trafficking are presented as being equally problematic crimes by the WHO and the Declaration of Istanbul on Organ Trafficking and Transplant Tourism (DoI), both acts warrant a different policy approach. There is no validation for the WHO's and DoI's premise that the organ trade should be banned because it leads to profiteering and trafficking. On the contrary, the trade's prohibition and the rising demand for organs since has generated a highly profitable underground organ market, possibly leading to higher crime and victimization rates. Therefore, criminalization is more likely to have *reinforced* trafficking. Lessons learned from the Iranian model constitute a solid basis for the exploration of an approach aimed at boosting the supply of organs by increasing donation through the implementation of some form of regulation towards organ supply.

Samenvatting

Sinds de jaren tachtig is orgaantransplantatie een slachtoffer geworden van haar eigen succes; de vraag naar organen overstijgt het aanbod in hoge mate. De huidige transplantatieactiviteiten vervullen minder dan 10 procent van de wereldwijde behoefte, waarbij wachtlijsten voor niertransplantaties het meest prominent groeien. Hoewel het kopen en verkopen van organen (d.w.z. *orgaanhandel*) in ieder land verboden is met uitzondering van Iran hebben journalisten en wetenschappers ondervonden dat de handel zich wereldwijd voordoet. Onder invloed van de globalisering heeft het orgaantekort patiënten uit geïndustrialiseerde landen naar ontwikkelingslanden gedreven, waar arme individuen bereid zijn een orgaan te 'doneren' in ruil voor geld; beiden uit wanhoop en *strain*. De wereldwijde zoektocht van patiënten naar donoren heeft geleid tot een zeer winstgevende ondergrondse economie (zwarte markt) voor criminele netwerken, waar ongeoorloofde handelingen en middelen worden toegepast met het doel van uitbuiting (d.w.z. *mensenhandel met het oogmerk van orgaanverwijdering*). Gezien de heimelijke en illegale aard van de transacties zijn er geen betrouwbare gegevens over de omvang van de handel. De enige 'officiële' gegevens, die op grote schaal worden geciteerd en waar zonder kritische beschouwing op wordt vertrouwd hoewel er geen sprake is van een empirische onderbouwing, komen van de Wereldgezondheidsorganisatie (WHO). In 2007 heeft de WHO geschat dat 5 à 10 procent van de 66.000 niertransplantaties die op dat moment jaarlijks wereldwijd werden uitgevoerd zijn toe te schrijven aan personen met nierfalen die naar het buitenland reizen om een nier te kopen. Het blijft onduidelijk welk percentage van deze schatting betrekking heeft op mensenhandel, hoewel sommige wetenschappers erop wijzen dat het in de praktijk moeilijk is om commerciële orgaantransplantaties te identificeren waarbij de orgaandonor niet aan uitbuiting is onderworpen.

De literatuur geeft weinig informatie prijs over de mechanismen en het organisatiemodel van mensenhandel met het oogmerk van orgaanverwijdering. Het grootste deel van de empirische studies is dan wel *medisch*, gepubliceerd door artsen die hebben geschreven over de uitkomsten van commerciële orgaantransplantaties die door hun patiënten in het buitenland zijn ondergaan (transplantatietoerisme), dan wel *antropologisch* van aard, gepubliceerd door wetenschappers en NGO's die hebben geschreven over de ervaringen en sociaal-economische gevolgen van orgaanverkoop vanuit het perspectief van donoren. De meeste wetenschappelijke artikelen over transplantatietoerisme bevatten geen bewijs dat de organen zijn gekocht en daarom illegaal zijn verkregen, laat staan dat ze zijn verkregen door middel van uitbuiting. Evenzo,

binnen de grotere hoeveelheid artikelen die zijn geschreven over donoren die een nier verkocht hebben, bevatten de meeste artikelen geen aanwijzingen voor mensenhandel of presenteren zij enkele aanwijzingen zonder te verwijzen naar (een duidelijke definitie van) mensenhandel. Hoewel de commerciële handel in organen door wetenschappers vaak wordt besproken in het kader van mensenhandel wordt de handel in personen algemeen verondersteld in plaats van grondig vastgelegd (Yea, 2010). Empirisch onderzoek vanuit het perspectief van andere actoren die (in)direct bij het misdrijf betrokken zijn, zoals makelaars en transplantatiespecialisten, is nauwelijks beschikbaar. Ondanks het gebrek aan empirisch bewijs wordt gesteld dat bij orgaanhandel wereldwijd actieve en goed georganiseerde criminele netwerken zijn betrokken, gezien de complexe aard van de activiteiten en de participatie van het grote aantal verschillende soorten individuen en organisaties, veelal legale actoren; ontvangers, donoren, makelaars, medische voorzieningen, medisch specialisten en medische dienstverleners zoals verzekeraars en laboratoria die medische testen uitvoeren. De doelstelling van deze studie was om de kennisklоof te verkleinen door het nauwkeurig bestuderen van strafrechtelijke onderzoeken naar mensenhandel met het oogmerk van orgaanverwijdering; dergelijke strafzaken zijn wereldwijd beperkt in aantal, maar werpen een licht op het gehele mensenhandelproces.

Criminologische studies naar mensenhandel met het oogmerk van orgaanverwijdering zijn schaars. Daarom is met deze studie gestreefd naar het leveren van een bijdrage aan criminologisch onderzoek door een antwoord te geven op de volgende centrale onderzoeksvraag: *Hoe vormt de interactie tussen het orgaanhandelverbod en de vraag en het aanbod van menselijke organen voor transplantatie de mechanismen en het organisatiemodel van mensenhandel met het oogmerk van orgaanverwijdering?* In deze context zijn de volgende subvragen geformuleerd: Waarom is de handel in menselijke organen strafbaar gesteld? Wat zijn de gevolgen van dit verbod? Wat zijn de globale en lokale oorzaken van het fenomeen? Wat is de modus operandi van de actoren die betrokken zijn bij deze vorm van mensenhandel? Hoe beschouwen zij de aard van hun activiteiten en hoe verklaren zij hun gedrag? Hoe ziet het organisatiemodel van dit misdrijf eruit? Om deze onderzoeksvragen te beantwoorden zijn drie strafzaken (de Netcare, Rosenbaum en Medicus zaak) geanalyseerd door rechtszaakdocumenten te bestuderen en hoofdzakelijk politie, justitie en advocatuur in Zuid-Afrika, de Verenigde Staten, Kosovo en Israël te interviewen. Als secundaire bron zijn vier documentaires opgenomen die waardevolle informatie bevatten over de zaken, evenals de opnames van een expertbijeenkomst van de Verenigde Naties en de *Writers Conference* van het HOTT-project – een internationaal onderzoeksproject naar mensenhandel met het oogmerk van orgaanverwijdering waar ik als criminoloog bij betrokken was. De triangulatie van deze verschillende bronnen draagt bij aan de validiteit en

betrouwbaarheid van deze studie. De betrouwbaarheid is verder versterkt door een groot deel van de interviews samen met wetenschappers vanuit andere disciplines binnen het HOTT-project uit te voeren en te bespreken.

De handel in menselijke organen is bijna wereldwijd verboden, met als doel het voorkomen van slachtofferschap van noodlijdende personen die bereid zijn een orgaan te verkopen. Hoewel er consensus bestaat over de uitbuitende aard van *mensenhandel met het oogmerk van orgaanverwijdering*, beweren sommige wetenschappers dat het universele verbod op *orgaanhandel* niet onder alle omstandigheden gerechtvaardigd is. Het ethische debat over het verbod op orgaanhandel draait om de vraag of bepaalde prikkels het aanbod van organen zouden verhogen en of een juridisch stimuleringssysteem, waarin de schade die met illegale markten wordt geassocieerd zou kunnen worden vermeden, ethisch verantwoordbaar zou zijn. Anderen beweren dat het orgaantekort een door de medische wereld gecreëerde schaarste is door patiënten de levensreddende capaciteit van orgaantransplantatie te beloven. Gerelateerd aan dit standpunt heeft deze studie uitgewezen dat patiënten en donoren hun gedrag neutraliseren door te benadrukken dat iedereen in hun situatie in organen zou handelen (*claim of normality*), omdat zij slachtoffer zijn van hun omstandigheden door het gebrek aan mogelijkheden (*denial of responsibility*). Dergelijke rechtvaardigingen kunnen worden verklaard door Matza en Sykes' neutralisatietheorie (1957), een theorie die in het bijzonder van toepassing is op het verklaren van gedrag van legale sociaal verbonden actoren. Een ander standpunt in het debat over de morele legitimiteit van het orgaanhandelverbod is dat alle individuen het recht hebben om hun eigen organen te verkopen. In overeenstemming met deze invalshoek kiezen veel patiënten ervoor om de mogelijkheid dat de donor wordt uitgebuit te negeren of te ontkennen (*moral indifference*) om hun geweten te sussen (*denial of injury*) en hun strafrechtelijke aansprakelijkheid te verkleinen (*denial of knowledge*).

Omdat ze zelf strafrechtelijk aansprakelijk kunnen zijn, zijn ontvangers en donoren vaak niet bereid om illegale transacties aan de autoriteiten te melden, zelfs niet als er duidelijke aanwijzingen van mensenhandel zijn. Bovendien voelen velen van hen zich geen slachtoffer. Het is daarom niet ongewoon voor politie en justitie om ontvangers en donoren vanwege hun 'actieve' rol te behandelen als verdachten of getuigen, in plaats van als slachtoffers van mensenhandel die bescherming behoeven. Ontkenning van slachtofferschap is gebruikelijk in situaties waarin personen worden verhandeld voor enige vorm van uitbuiting, om een aantal redenen naast de angst om strafrechtelijk aansprakelijk te worden gesteld, zoals schaamte, gebrek aan informatie en gebrek aan vertrouwen in het rechtssysteem. Het verlenen van toestemming voor de beoogde uitbuiting is echter *irrelevant* wanneer een in de definitie van mensenhandel opgenomen

middel, zoals dwang, is toegepast. Toch zien politie en justitie de ervaringen van donoren vaak als milde vormen van misbruik die niet overeenkomen met de dramatische stereotypen van slachtoffers van andere vormen van mensenhandel, en wereldwijd zijn ontvangers nog nooit geïdentificeerd en behandeld als potentiële mensenhandelslachtoffers. Om iemand aansprakelijk te stellen in het kader van de mensenhandelbepaling is het enkel noodzakelijk te bewijzen dat één van de ongeoorloofde handelingen met één van de middelen is toegepast met het doel van uitbuiting. Gezien de betrokkenheid van uiteenlopende actoren die gespecialiseerd zijn in verschillende aspecten van de procedure is een handeling als 'overdracht' relatief makkelijk vast te stellen, en dat geldt ook voor het middel 'misbruik van een kwetsbare positie' dat vooral van toepassing wordt verklaard op donoren maar ook kan worden toegekend aan dodelijk zieke patiënten. De belemmering om uitbuiting te bewijzen zoals door politie en justitie wordt ervaren is veeleer een gevolg van een gebrek aan kennis en ervaring van het misdrijf, in aanvulling op lokaal ontoereikende juridische kaders, dan van het ontbreken van elementen van mensenhandel. Daarom pleit ik voor een meer volledige interpretatie van de mensenhandel-bepaling vanuit een strafrechtelijk perspectief en de uitbreiding van de poel van potentiële slachtoffers van mensenhandel met het oogmerk van orgaan-verwijdering tot ontvangers – een mogelijkheid waar rekening mee is gehouden in de ruim opgezette definitie van mensenhandel van de Verenigde Naties.

Deze studie toont duidelijk aan dat ontvangers en donoren zijn uitgebuit door de toepassing van ongeoorloofde handelingen en middelen met het doel van orgaanverwijdering. Ze zijn in het buitenland *gerekruteerd* en *vervoerd* naar het land waar het transplantatiecentrum is gevestigd en/of *overgebracht* naar een accommodatie of direct naar een medische voorziening waar ze zijn *ontvangen* en/of *geherbergd* tot de uitvoering van de transplantatie. De criminele actoren zijn in staat geweest om deze activiteiten te verwezenlijken door *misbruik te maken van hun kwetsbare positie*, aangezien ontvangers en donoren worden gedreven door levensbedreigende ziekten of onafwendbare armoede in hun 'keuze' om een orgaan te kopen of te verkopen. Hun kwetsbare positie wordt verder gedemonstreerd door de respectievelijk hoge en lage bedragen die zij hebben moeten betalen en zijn beloofd te ontvangen, en de volledige afwezigheid van een wettelijk mechanisme om hun betaling te verkrijgen indien het (gedeeltelijk) is achtergehouden of hun geld terug te krijgen als de transplantatie is mislukt. Bovendien zijn velen van hen kort na de operatie in een zwakke lichamelijke toestand ontslagen, waarna sommigen postoperatieve complicaties en een (verdere) verslechtering van hun gezondheid hebben geleden en de meerderheid van de donoren geen toegang had tot gepaste nazorg. Criminele actoren hebben ook andere middelen toegepast; *dwang* door de donatie af te schilderen als een nobele daad die het leven van een

patiënt zou redden, het innemen van paspoorten van donoren, geen gepaste informatie verstrekken over de aard en risico's van de operatie, vereisen dat toestemmingsformulieren worden ondertekend zonder de tijd te geven om de inhoud te begrijpen, en vervolgens geen redelijke mogelijkheid te bieden om de operatie te weigeren, zelfs in het geval van ernstige twijfels; *fraude* door het vervalsen van documenten en handtekeningen, en het instrueren van donoren om voor een ethische commissie de valse verklaring af te leggen dat de donatie om altruïstische redenen en/of ten behoeve van een familielid plaatsvindt; *misleiding* door bedrog en beide partijen niet te informeren over de procedure, de risico's en de gevolgen op lange termijn, het onjuist voorstellen van de commerciële transplantatie als een legale transactie, en het onthouden van (een deel van) de beloofde betaling; en *machtsmisbruik* door de mogelijkheden die de hoogwaardige posities van medisch specialisten bieden, te misbruiken.

Ondanks dergelijke onrechtmatige methoden rechtvaardigen ook actoren als makelaars en transplantatiespecialisten hun gedrag door middel van neutralisatietechnieken (Matza & Sykes, 1957). Makelaars beroepen zich vaak op het algemeen belang (*appeal to higher loyalties*) door zichzelf af te schilderen als levensredder. Hetzelfde geldt voor enkele beruchte transplantatiechirurgen – "trusted criminals" (Friedrich, 2009) – die zich publiekelijk als redder in nood presenteren om hun reputatie te manifesteren en te handhaven. Maar de meeste medisch specialisten die zijn beschuldigd van opzettelijke deelname aan illegale transplantaties beweren dat ze zich niet bewust zijn geweest van de omstandigheden die de ontvanger en donor samen hebben gebracht. Zij ontkennen hun verantwoordelijkheid (*denial of responsibility*) door te betogen dat het de taak van de ethische commissie is om de rechtmatigheid van de transplantatie te onderzoeken. Beide typen 'symbiotische relaties' (Passas, 2002) – *collaboration* en *funding* – bieden wederzijdse voordelen voor de legale en illegale faciliteerders; orgaanhandel zorgt voor meer transplantaties wereldwijd, waar de medische wereld van profiteert op het gebied van financiële winst en chirurgische ervaring. Omdat de regels met betrekking tot geheimhouding binnen het medisch beroep sterk zijn en medisch personeel alle reden heeft om aanwezig te zijn op de plaats delict, een operatiezaal, is het moeilijk voor zowel de direct betrokkenen als de lokale autoriteiten om de misdrijven te detecteren.

Wetenschappelijke benaderingen met betrekking tot het organisatiemodel van illegale marktactiviteiten door criminele groepen verschillen. Sommige wetenschappers benadrukken de overeenkomsten tussen legale en illegale ondernemingen. Anderen stellen dat de illegale status van de producten vereist dat criminele actoren zonder en tegen de staat opereren en derhalve de bestendiging van grootschalige duurzame criminele organisaties verhindert. Een diepgaande analyse van strafrechtelijke onderzoeken naar mensenhandel met

het oogmerk van orgaanverwijdering heeft aangetoond dat op internationaal niveau losse, flexibele combinaties van tal van georganiseerde criminele netwerken en actoren hun krachten bundelen om op zeer goed georganiseerde wijze illegale transplantaties te faciliteren. De flexibiliteit van de netwerken wordt weerspiegeld in de uitwisselbare rollen tussen leden, een transplantatiechirurg kan bijvoorbeeld ook fungeren als makelaar, en in de mogelijkheid om binnen een network over te schakelen van de ene rol naar de andere rol, met name donoren die vervolgens andere potentiële donoren rekruteren. De hoge mate van organisatie blijkt uit de betrokkenheid van makelaars, de snelheid waarmee de werving en overdracht van meerdere ontvanger-donor-koppels uit verschillende landen naar een medische voorziening in een derde land wordt uitgevoerd en het korte tijdsbestek waarmee de locatie van de transplantatie wordt verplaatst bij tussenkomst van wetshandhavingsinspanningen. Orgaanhandelnetwerken lijken op een meer georganiseerde manier op illegale markten te opereren dan de gemiddelde criminele netwerken, omdat ze 'gemakkelijk' omspringen met de beperkingen die Paoli heeft benoemd in relatie tot de illegale status van producten (Paoli, 2002). In veel gevallen bestaat er wederzijds vertrouwen tussen netwerkleden op basis van gemeenschappelijke etnische of religieuze achtergronden. Het effectieve risico op arrestatie, een andere beperking van de illegale status van producten, wordt sterk verminderd door het succesvol verhullen van de illegale aard van de transplantaties, de onmededeelzaamheid van de ontvangers en de donoren, het gebrek aan bewustwording en handhaving van het misdrijf door de maatschappij en door overheden, en de betrokkenheid of omkoping van transplantatiespecialisten en/of politie en justitie. Ten slotte brengt de internationale reikwijdte van het misdrijf aanzienlijke voordelen voor criminele netwerken en belangrijke beperkingen voor de opsporing en vervolging van het misdrijf met zich mee. De buitenlandse ontvangers en donoren hebben immers geen kennis over lokale wetgeving en beleid en kunnen relatief gemakkelijk worden bedrogen over de illegale aard van de transactie, zij kunnen niet communiceren met lokaal medisch personeel, zij zijn afhankelijk van de mensenhandelaars, en het is moeilijk voor lokale politieagenten om hen buiten hun jurisdictie op te sporen.

De organisatie van mensenhandel met het oogmerk van orgaanverwijdering is een dynamisch proces dat voortvloeit uit de interactie tussen illegale marktdynamieken, de vaardigheden en netwerken van de daders en strafrechtelijke inspanningen. De handel floreert met name daar waar de overheidsinstellingen zwak, inefficiënt of corrupt zijn. Daarnaast maken sociaal-economische omstandigheden en een zwakke infrastructuur van orgaantransplantatie een aantal samenlevingen kwetsbaarder dan andere. De handel opereert volgens een continuüm waarvan de activiteiten in omvang en omvang kunnen variëren, en het is onwaarschijnlijk dat de drie onderzochte

strafzaken de handel als geheel vertegenwoordigen. Hoewel lokale netwerken aantoonbaar samenwerken met transnationaal georganiseerde netwerken, sluit dit niet uit dat een klein aantal slachtoffers op lokaal niveau wordt uitgebuit door een kleinschaligere organisatie of dat er vrijwillige 'gelijke uitwisseling' plaatsvindt tussen ontvangers en donoren. Gezien dit laatste is het belangrijk om te benadrukken dat hoewel orgaanhandel en mensenhandel met het oogmerk van orgaanverwijdering door de WHO en de *Declaration of Istanbul on Organ Trafficking and Transplant Tourism* (DoI) als gelijke problematische misdrijven worden weergegeven, beide handelingen een andere beleidsaanpak vereisen. Het uitgangspunt van de WHO en de DoI dat orgaanhandel moet worden verboden omdat het tot profiteren en mensenhandel leidt, is niet gevalideerd. Integendeel, het verbod op de handel en de toenemende vraag naar organen sindsdien heeft geleid tot een zeer winstgevende ondergrondse markt voor organen, wat mogelijk tot meer criminaliteit en slachtoffers leidt. Het is dan ook waarschijnlijker dat het orgaanhandelverbod de kans op mensenhandel heeft *versterkt*. Ervaringen vanuit het Iraanse model vormen een solide basis voor het verkennen van een aanpak die gericht is op het stimuleren van het aanbod van organen door het aantal donaties te verhogen aan de hand van de implementatie van een vorm van regulering ten aanzien van orgaandonatie.

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Appendix 1. Respondents

RX	Function	Location	Date	Comment
R1	state prosecutor and professor of law	Durban, SA	23-11-2012	with R2
R2	head of police commercial crime branch	Durban, SA	23-11-2012	with R1
R2	head of police commercial crime branch	Durban, SA	25-11-2012	
R2	head of police commercial crime branch	Durban, SA	26-11-2012	with R3
R3	state prosecutor	Durban, SA	26-11-2012	with R2
R4	forensic investigating officer Ministry of Health	Durban, SA	26-11-2012	
R5	surgeons' defense lawyer	Durban, SA	27-11-2012	
R6	police officer	Durban, SA	29-11-2012	
R2	head of police commercial crime branch	Durban, SA	29-11-2012	
R4	forensic investigating officer Ministry of Health	Durban, SA	30-11-2012	
R7	social worker	London, UK[80]	20-02-2013	
R8	assistant U.S. attorney Dpt. of Justice	Newark, USA	18-03-2013	
R9	defense lawyer	New York, USA	22-03-2013	
R10	FBI police officer	New Jersey, USA	22-03-2013	
R11	EU prosecutor	Pristina, Kosovo	16-09-2013	
R12	police officer	Pristina, Kosovo	16-09-2013	with interpreter
R11	EU prosecutor	Pristina, Kosovo	17-09-2013	

[80] I traveled to the United Kingdom with regard to the two victims of human trafficking for organ removal that had been identified there (see paragraph 1.1.2, footnote 20). While being in the United Kingdom, I spoke for hours with a social worker who had been working at a Netcare hospital in South Africa during the period the illegal transplants took place.

R13	surgeons' defense lawyer	Pristina, Kosovo	17-09-2013	
R14	manager Rule of Law team European Union Office	Pristina, Kosovo	17-09-2013	
R15	senior protection officer UNHCR Office	Pristina, Kosovo	19-09-2013	
R16	head of inspection office Ministry of Health	Pristina, Kosovo	19-09-2013	with R17 and interpreter
R17	legal officer Ministry of Health	Pristina, Kosovo	19-09-2013	with R16 and interpreter
R18	head of the UN Mission Rule of Law	Pristina, Kosovo	19-09-2013	with R19 and R20
R19	senior police advisor UN Mission Rule of Law	Pristina, Kosovo	19-09-2013	with R18 and R20
R20	Interpol liaison officer	Pristina, Kosovo	19-09-2013	with R18 and R19
R21	chief of mission IOM Kosovo	Pristina, Kosovo	20-09-2013	with R22
R22	program manager IOM Kosovo	Pristina, Kosovo	20-09-2013	with R21
R23	deputy minister Ministry of Internal Affairs and national coordinator THB	Pristina, Kosovo	20-09-2013	with R23
R24	deputy minister's assistant	Pristina, Kosovo	20-09-2013	with R24
R25	head of private law firm and patients' defense lawyer	Tel Aviv, Israel	07-10-2013	with R26 and R27
R26	patients' defense lawyer	Tel Aviv, Israel	07-10-2013	with R25 and R27
R27	patients' defense lawyer	Tel Aviv, Israel	07-10-2013	with R25 and R26

R28	deputy general manager health insurance company	Tel Aviv, Israel	07-10-2013	
R29	rabbi, Samaritan donation non-profit organization	Tel Aviv, Israel	08-10-2013	
R30	director department of organ transplantation	Petah Tikva, Israel	08-10-2013	with R31
R31	chief transplant nephrologist	Petah Tikva, Israel	08-10-2013	with R30
R32	director heart transplant unit and cardiac surgeon	Tel Aviv, Israel	09-10-2013	
R33	head of nephrology department and nephrologist	Jerusalem, Israel	09-10-2013	
R34	Interpol liaison officer	Lod, Israel	10-10-2013	with R35, R36 and R37
R35	chief police officer	Lod, Israel	10-10-2013	with R34, R36 and R37
R36	police officer	Lod, Israel	10-10-2013	with R34, R35 and R37
R37	police officer	Lod, Israel	10-10-2013	with R34, R35 and R36
R38	chair transplant and dialysis organization, transplant patient	Tel Aviv, Israel	10-10-2013	with interpreter
R39	director transplant centre and national transplant coordinator	Tel Aviv, Israel	10-10-2013	
R40	general defense lawyer	Tel Aviv, Israel	10-10-2013	
R41	transplant patient (Durban, SA)	Modiin, Israel	10-10-2013	
R42	State attorney, deputy director Dpt. of International Affairs	Jerusalem, Israel	13-10-2013	with R43, R44 and R45
R43	state attorney Dpt. of International Affairs	Jerusalem, Israel	13-10-2013	with R42, R44 and R45

R44	state attorney, prosecutor	Jerusalem, Israel	13-10-2013	with R42, R43 and R45
R45	state attorney, prosecutor	Jerusalem, Israel	13-10-2013	with R42, R43 and R44

Appendix 2. Court documents

DX	Type of document	Date	Content
D1	Indictment	15-09-2010	NPASA[81] v Netcare
D2	Plea sentence agreement	08-11-2010	NPASA v Netcare
D3	Plea sentence agreement	23-11-2010	NPASA v S.Z.
D4	Indictment	27-05-2011	NPASA v J.R., A.H., N.C., M.N., L.D. and M.A.
D5	Founding affidavit accused	28-11-2011	NPASA v L.D. and M.A.
D6	Founding affidavit accused	01-12-2011	NPASA v J.R., A.H., N.C. and M.N.
D7	Prosecutors answering affidavit	05-03-2012	NPASA v J.R., A.H., N.C. and M.N.
D8	Prosecutors answering affidavit	05-03-2012	NPASA v L.D. and M.A.
D9	Replying affidavit accused	04-04-2012	NPASA v J.R., A.H., N.C. and M.N.
D10	Replying affidavit ccused	14-05-2012	NPASA v L.D. and M.A.
D11	Closing statement accused	02-11-2012	NPASA v J.R., A.H., N.C. and M.N.
D12	Closing statement accused	07-11-2012	NPASA v L.D. and M.A.
D13	Prosecutors closing statement	20-11-2012	NPASA v J.R., A.H., N.C., M.N., L.D. and M.A.
D14	Judgment	14-12-2012	NPASA v J.R., A.H., N.C., M.N., L.D. and M.A.
D15	Criminal complaint	07-2009	United States of America v I.R.
D16	Indictment	2011	United States of America v I.R.
D17	Defense's pre-sentence memorandum	04-05-2012	United States of America v I.R.
D18	Transcript sentence hearing	11-07-2012	United States of America v I.R.

[81] National Prosecution Authority of South Africa

D19	Indictment	15-10-2010	SPRK[82] v L.D., A.D., D.J., R.H. and N.R.
D20	Indictment	20-10-2010	SPRK v I.B. and S.D.
D21	Judgment	02-03-2011	SPRK v L.D., A.D., D.J., R.H., N.R., I.B. and S.D.
D22	Judgment of appeal	27-04-2011	SPRK v L.D., A.D., D.J., R.H., N.R., I.B. and S.D.
D23	Indictment	06-05-2011	SPRK v Y.S. and M.H.
D24	Translated summary Israeli court session	23-05-2012	State of Israel v A.S., B.V., M.H., M.G., A.M., and N.A.
D25	Open letter defense lawyer	23-07-2012	directed to the (vice-) presidents of ECHR[83] and the (deputy) head of EULEX[84]
D26	Amended indictment	22-03-2013	SPRK v L.D., A.D., D.J., R.H., N.R., I.B. and S.D.
D27	Prosecutors closing statement	16-04-2013	SPRK v L.D., A.D., D.J., R.H., N.R., I.B. and S.D.
D28	Closing statement accused	23-04-2013	SPRK v D.J.
D29	Judgment	29-04-2013	SPRK v L.D., A.D., D.J., R.H., N.R., I.B. and S.D.
D30	Indictment	10-05-2015	State of Israel v A.S., B.V., M.H., M.G., A.M., Z.S. and R.S.
D31	Appeal	06-11-2015	SPRK v L.D., A.D., D.J., R.H., N.R., I.B. and S.D.

[82] Special Prosecution Office of the Republic of Kosovo
[83] European Court of Human Rights
[84] European Union Rule of Law Mission in Kosovo