Transplant Tourism

# Transplant Tourism

*An International and National Law Model to Prohibit Travelling Abroad for Illegal Organ Transplants*

*By*

Terry O. Adido




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# List of Abbreviations

| | |
|---|---|
| AA | Appropriate Authority |
| AAAQ | Availability, Accessibility, Acceptability and Quality |
| AC | Authorization Committee |
| AMA | American Medical Association |
| ANZDATA | Australia and New Zealand Dialysis and Transplant Registry |
| ASEAN | Association of Southeast Asian Nations |
| ATPA | *Anti-Trafficking of Persons Act* of the Philippines |
| AU | African Union |
| BHFS | Bureau of Health Facilities and Services |
| BMA | British Medical Association |
| CA | Court of Appeal |
| CAT | *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* |
| CEDAW | *Convention on the Elimination of all forms of Discrimination against Women* |
| CESCR | Committee on Economic, Social and Cultural Rights |
| CIL | Customary International Law |
| COE | Council of Europe |
| CRC | *Convention on the Rights of the Child* |
| CSN | Canadian Society of Nephrology |
| CST | Canadian Society of Transplantation |
| CST | Child Sex Tourism |
| DAFOH | Doctors Against Forced Organ Harvesting |
| ECPAT | End Child Prostitution, Child Pornography and Trafficking of Children for Sexual Purposes |
| ESRD | End-Stage Renal Disease |
| GA | General Assembly |
| HIV | *Human Immunodeficiency Virus* |
| HRC | Human Rights Committee |
| HTA | *Human Tissue Act* of Victoria |
| HTGA | *Human Tissue Gift Act* |
| HTODA | *Human Tissue and Organ Donation Act* of Alberta |
| ICCPR | *International Covenant on Civil and Political Rights* |
| ICESCR | *International Covenant on Economic, Social and Cultural Rights* |
| ICJ | International Court of Justice |
| ICTY | International Criminal Tribunal for the Former Yugoslavia |
| ISN | International Society of Nephrology |

| | |
|---|---|
| LNRDS | Living Non-Related Donors |
| LRDS | Living Related Donors |
| MESOT | Middle East Society for Organ Transplantation |
| MLATS | Mutual Legal Assistance Treaties |
| MOU | Memoranda of Understanding |
| MPC | *Model Penal Code* |
| NCB | Nuffield Council on Bioethics |
| NCTOTD | National Clinical Taskforce on Organ and Tissue Donation |
| NGO | Non-Governmental Organization |
| OAS | Organization of American States |
| ODA | *Organ Donation Act* of the Philippines |
| OP1-ICCPR | *First Optional Protocol to the ICCPR* |
| OP2-CRC | *Second Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography* |
| OP3-CRC | *Third Optional Protocol to the Convention on the Rights of a Child on a Communications Procedure* |
| OP-ICESCR | *Optional Protocol to the International Covenant on Economic, Social and Cultural Rights* |
| OPCAT | *Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment* |
| OPDT | Organ Procurement and Donation Taskforce |
| OTST | Organ Trafficking and Sale Taskforce |
| OTDTAA | *Organ and Tissue Donation and Transplantation Authority Act* of Australia |
| PCIJ | Permanent Court of International Justice |
| PRDR | Philippines Renal Disease Registry |
| REDCOP | Philippine Renal Disease Control Program |
| SC | Special Constables |
| TANS | Transnational Advocacy Networks |
| TGLNA | *Trillium Gift of Life Network* of Ontario |
| THOA | *Transplantation of Human Organs Act* of India |
| THOAA | *Transplantation of Human Organs* (*Amendment*) *Act* of India |
| THOAR | *Transplantation of Human Organs* (*Amendment*) *Rules* of India |
| THOR | *Transplantation of Human Organs Rules* of India |
| THOTR | *Transplantation of Human Organs and Tissues Rules* of India |
| TTA | *Transplantation and Anatomy Act* of Australia |
| TTS | The Transplantation Society |
| UAGA | *Uniform Anatomical Gift Act* |
| UDHR | *Universal Declaration of Human Rights* |
| ULCC | Uniform Law Conference of Canada |

| | |
|---|---|
| UN | United Nations |
| UNICEF | United Nations Children's Fund |
| UPR | Universal Periodic Review |
| WHA | World Health Assembly |
| WHO | World Health Organization |
| WMA | World Medical Association |

CHAPTER 1

# Introduction

## A Background

Transplant tourism is a species of medical tourism.[1] In the general sense, it refers to the practice of travelling abroad for organ transplants. The most common trend involves tourists from developed States travelling abroad to get organs transplanted in foreign, often developing, States. Travelling abroad for organ transplants is not by itself illegal if the organs are acquired in accordance with the transplant laws of the States where the organ are acquired and/or transplanted. Traveling abroad for organ transplants becomes illegal when the organs are acquired and transplanted in ways which contravene organ transplant laws of transplant States. Though condemned by a majority of the world's governments, the United Nations (UN), intergovernmental organizations such as the World Health Organization (WHO),[2] international and national NGOs, medical associations and societies such as the World Medical Association (WMA),[3] the Nuffield Council on Bioethics

1 In the broad sense, medical tourism refers to travel "with the express purpose of obtaining health services abroad." See Annette Ramirez de Arellano, "Patients without Borders: The Emergence of Medical Tourism" (2007) 37:1 Int'l J Health Serv 193; Valorie Crooks *et al*, "What is Known about the Patient's Experience of Medical Tourism? A Scooping Review" (2010) 10:1 BMC Health Serv Research 266.

2 In *Resolution WHA57.18*, the World Health Organization admonished member states "to take measures to protect the poorest and vulnerable groups from 'transplant tourism' and the sale of tissues and organs, including attention to the wider problem of international trafficking in human tissues and organs.": Article 1(5), World Health Assembly, *Human Organ and Tissue Transplantation* (Geneva: World Health Organization, 22 May 2004), online: <http://www.who.int/transplantation/en/A57_R18-en.pdf>. The World Health Organization can be found online: <http://www.who.int/en/>

3 As far back as 1985 the World Medical Association, in consideration of the fact that a trade of considerable financial gain had developed in live kidneys from underdeveloped States for transplantation in Europe and the US, issued a statement condemning the "purchase and sale of human organs for transplantation." It also called on the governments of all States to take "effective steps to prevent the commercial use of human organs." See World Medical Association, "Statement on Live Organ Trade," adopted by the 37th World Medical Assembly of the World Medical Association, Brussels, Belgium, October 1985, online: <http://www1.umn.edu/humanrts/instree/organtrade.html>. The World Medical Association can be found online: <http://www.wma.net/en/10home/index.html>.

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(NCB),[4] The Transplantation Society (TTS),[5] the Canadian Society of Transplantation (CST),[6] the Canadian Society of Nephrology (CSN),[7] the British Medical Association (BMA),[8] and the American Medical Association (AMA),[9] among others, transplant tourism goes on to the detriment of persons, societies and systems around the world. It is estimated that transplant tourism makes up approximately 10% of all transplants globally.[10] While no type of organ is excluded from transplant tourism practices, kidneys are the most commonly traded and transplanted organs.[11] This coincides with the global escalation of the number of patients with kidney failure, the long waiting time to access kidneys in most States, the fact that individuals can survive on a single kidney and the availability of ready markets for kidneys in developing States.[12] The prevalence of transplant tourism practices, their

4 See Nuffield Council on Bioethics, *Human Tissue: Ethical and Legal Issues* (NCB: London, 1995), online: <http://www.nuffieldbioethics.org/sites/default/files/Human%20tissue.pdf>. The Nuffield Council on Bioethics can be found online: <http://www.nuffieldbioethics.org/>.

5 The Transplantation Society (TTS) is a non-governmental organization in official relations with the WHO which provides the focus for global leadership in transplantation via the development of science and clinical practice, scientific communication, continuing education and guidance on ethical practices. The TTS can be found online: <http://www.tts.org/>.

6 John Gill *et al*, "Policy Statement of Canadian Society of Transplantation and Canadian Society of Nephrology on Organ Trafficking and Transplant Tourism" (2010) 90:8 Transplantation 817.

7 *Ibid.*

8 In 2000, the British Medical Association (BMA) condemned transplant tourism in its publication: British Medical Association. Medical Ethics Committee, *Organ Donation in the 21st Century: Time for a Consolidation Approach* (London: BMA, 2000) at 20. The BMA can be found online: <http://bma.org.uk/>.

9 In its 2007 position statement on transplant tourism, the American Medical Association (AMA) expressed significant medical and ethical concerns associated with transplant tourism. The AMA has also endorsed the 2000 and 2006 update of the World Medical Association, *Statement on Human Organ Donation and Transplantation*. The AMA can be found online: <http://www.ama-assn.org/>.

10 Jennifer Babik & Peter Chin-Hong, "Transplant Tourism: Understanding the Risks" (2015) 17:4 Curr Infect Dis Rep 473; "Legal and Illegal Organ Donation" (2007) 369:9577 The Lancet 1901; Jeremy Haken, *Transnational Crime in the Developing World* (Washington: Global Financial Integrity, 2011) at 21.

11 Yosuke Shimazono, "The State of the International Organ Trade: A Provisional Picture Based on Integration of Available Information" (2007) 85:12 Bull World Health Organ 955; Jacob Akoh, "Key Issues in Transplant Tourism" (2012) 2:1 World J Transplant 10.

12 Akoh, *ibid.*

negative effects on persons and societies globally, and the inability of States to root out the practices so far are factors which have dictated the focus of this publication which is the eradication of transplant tourism using international and national laws.

## B Definition of Transplant Tourism

Transplant tourism is a compound term used to describe several interrelated concepts, some of which are overlooked. Most people erroneously equate transplant tourism to organ commercialization. While organ commercialization is an essential aspect of transplant tourism as the paramount motivation for organ sellers who engage in transplant tourism practices is the need to gain some form of financial reward or consideration, it is only one aspect of transplant tourism which involves other elements such as travel for transplantation and organ trafficking.[13] A proper definition of transplant tourism is thus central to its prohibition as some of the most effective legal instruments are those which capture every aspect of the phenomenon they aim to legislate against. Failure to do this often results in lacunae in the law. Legislators need to ensure that the laws they pass cover the entire field of the activity that they are legislating on subject, of course, to their legislative powers.[14]

An important starting point for any discussion on transplant tourism is to understand what transplant tourism is and the factors which make it a unique phenomenon worthy of special attention. The most comprehensive definition of transplant tourism is that contained in the *Declaration of Istanbul on Organ Trafficking and Transplant Tourism* (*Declaration of Istanbul*) which was developed by participants in the International Summit on Transplant

13 In a 2001 study in Chennai in Tamil Nadu India which is notorious for the sale of kidneys, 95% of the participants stated that helping a sick person with kidney disease was not a major factor in their decision to sell. All the participants sold their kidneys to pay off different forms of debts: Madhav Goyal *et al.*, "Economic and Health Consequences of Selling a Kidney in India" (2002) 288:13 JAMA 1590.

14 This might however be a difficult task as the expression of some crimes change over time and it might be impossible for legislatures to legislate over aspects of crimes which were non-existent at the time the legislation was made. Revision or amendment of laws sometimes helps to remedy these shortcomings. See generally: Frank Remington, "Codification Vs. Piecemeal Amendment" (1954) 33 Neb L Rev 396.

Tourism and Organ Trafficking convened by the TTS and the International Society of Nephrology (ISN) in Istanbul, Turkey from April 30 to May 2, 2008.[15] In attendance were 152 participants from 78 States.[16] Although the *Declaration of Istanbul* is a non-binding instrument, it has had a lot of influence on States and policy makers involved in the regulation of organ transplants. This in turn has given rise to some new laws and policies which address transplant tourism practices.[17]

In its definition of transplant tourism, the *Declaration of Istanbul* makes reference to its three core elements: organ trafficking, transplant commercialism and travel for transplantation.[18] Organ trafficking is defined as the recruitment, transport, transfer, harboring or receipt of living or deceased persons or their organs by means of threat, the use of force or other forms of coercion, abduction, fraud, deception, the abuse of power or a position of vulnerability, or the giving to, or the receipt by, a third party of payments or benefits to achieve the transfer of control over the potential donor, for the purpose of exploitation

15 The Steering Committee of the Istanbul Summit, "Organ Trafficking and Transplant Tourism and Commercialism: The Declaration of Istanbul" (2008) 372:9632 The Lancet 5; "The Declaration of Istanbul on Organ Trafficking and Transplant Tourism" (2008) 3:5 Clin J Am Soc Nephrol 1227–1231. The *Declaration of Istanbul* builds on the principles of the *Universal Declaration of Human Rights*, GA Res. 217 (III), UN GAOR, 3d Sess., Supp. No. 13, UN Doc. A/810 (1948) 71 and *Resolution WHA57.18*, *supra* note 1. The initial text of the *Declaration of Istanbul* was prepared by a multicultural Steering Committee. The Steering Committee was convened by the TTS and the ISN in Dubai in December of 2007. The committee's draft declaration was circulated and then revised after comments were received. At the summit, the revised draft was reviewed by working groups and finalized in plenary deliberations.

16 The participants were made up of scientific professionals, legal scholars, representatives of governmental and social agencies, ethicists, State liaisons of the TS, anthropologists, sociologists, stakeholders in the public policy aspect of organ transplantation, etc.: Francis Delmonico, "The Development of the Declaration of Istanbul on Organ Trafficking and transplant Tourism" (2008) 23:11 Nephrol Dial Transplant 3381.

17 The principles contained in the *Declaration of Istanbul* have been endorsed by over 100 transplant organizations and have led to new legislation or strengthened existing organ trafficking laws in key transplant tourism States such as China, Israel, Pakistan and the Philippines: Frederike Ambagtsheer & Williem Waimar, "A Criminology Perspective: Why Prohibition of Organ Trade in not Effective and How the Declaration of Istanbul can Move Forward" (2012) 12:3 Am J Transplant 571. Updates, articles and other news on the *Declaration of Istanbul* can be found online at the declaration's website: <http://www.declarationofistanbul.org/index.php>.

18 Definitions, *Declaration of Istanbul*, *supra* note 15.

by the removal of organs for transplantation.[19] Transplant commercialism is defined as "a policy or practice in which an organ is treated as a commodity, including by being bought or sold or used for material gain."[20] Finally, travel for transplantation is defined as "the movement of organs, donors, recipients or transplant professionals across jurisdictional borders for transplantation purposes."[21] Transplant tourism is then defined as travel for transplantation "if it involves organ trafficking and/or transplant commercialism or if the resources (organs, professionals and transplant centers) devoted to providing transplants to patients from outside a country undermine the transplant country's ability to provide transplant services for its own population."[22]

The above definition draws attention to four practices involved in transplant tourism, the most significant being travel for transplantation. Transplant tourism is transnational in nature meaning that it involves the movement of persons and/or organs from one State to another. Four patterns have been established which form the bulk of transplant tourism cases.[23] The first and most common pattern involves potential recipients of organs traveling from tourist States to access organs in transplant States. Although transplant tourism takes place in almost all States in varying degrees, some States have however distinguished themselves as key tourist or transplant States. Tourist States are consumer States from which people in need of organs for transplantation originate. The major tourist States are the US, Canada, Australia, Saudi Arabia, Oman, Italy, Malaysia and Japan.[24] Transplant States are States of origin of organs or where the organ transplant occurs.[25] The lucrative trade in human organs flourishes in nations such as the Philippines, India, China and Pakistan and, to some extent, Colombia, Brazil, Iran, Nigeria, Turkey, Egypt, Brazil, Peru, Bolivia and Bangladesh.[26] With the fall of the Soviet Union, new

19 *Ibid.* This definition is based on article 3a, *Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children*, supplementing the *United Nations Convention Against Transnational Organized Crime*, 40 ILM 335 (2001) / UN Doc. A/55/383 (Annex II. p. 53) / [2005] ATS 27, (*Trafficking Protocol*).

20 Definitions, *Declaration of Istanbul*, *supra* note 15.

21 *Ibid.*

22 *Ibid.*

23 Debra Budiani-Saberi & Frances Delmonico, "Organ Trafficking and Transplant Tourism: A Commentary on the Global Realities" (2008) 8:5 Am J Transplant 926.

24 Alexis Aronowitz, *Human Trafficking, Human Misery: The Global Trade in Human Beings* (Westpoint: Praeger, 2009) at 111.

25 Nancy Scheper-Hughes, "Prime Numbers: Organs Without Borders," (2005) 146 Foreign Policy 26.

26 *Ibid*; Aronowitz *supra* note 24 at 111.

supply sources were created in Eastern Europe in States such as Moldova and Romania.[27] Organs from these Eastern European States have been cynically described as "top of the range"[28] as they are deemed to come from States with more sanitary health conditions.[29] There are also States which act as both transplant and tourist States. Israel, for instance, was once classified as both a tourist and transplant State for transplant tourism and a destination State for human trafficking in general.[30]

The second major pattern of travel for transplantation happens when persons travel from transplant States to tourist States to sell their organs. This pattern might have been born out of convenience or because not all developing States (which form the bulk of transplant States) have the medical facilities to carry out organ transplants. There is some documented evidence of this pattern. In 1988, it was reported that several Turkish citizens had travelled to Britain to sell their kidneys to British citizens.[31] Again, in 2002, there were reports about organ donors from Moldova who were smuggled into the US to sell their lungs and kidneys.[32] A third pattern involves persons from both transplant and tourist States moving to a third State to carry out the operation. This pattern may be influenced by the need to carry out the operation in States with inadequate or no regulations on organ transplantation. The fourth pattern involves both an organ seller and a buyer from the same State going to a second State to carry out the transplant operation.[33] This last pattern is like the third pattern as the State where the operation is performed is different from the State of origin of both the organ seller and buyer. I expect the last two patterns to become increasingly common in the future because key transplant States now have laws banning organ transplants to foreigners who are not near

27 Aronowitz *supra* note 23 at 85.

28 Catherine Berthillier, "The Trade in Organs in Europe" in Peter Morris, ed, *Ethical Eye: Transplants* (Strasbourg: Council of Europe Publishing, 2003) at 163.

29 Vanessa Chandis, "Addressing a Dire Situation: A Multi-Faceted Approach to the Kidney Shortage" (2006) 27:1 U Pa J Int'l L 220; Berthillier, *supra* note 28 at 163.

30 Aronowitz *supra* note 24 at 97.

31 Ronald Munson, *Raising the Dead: Organ Transplants, Ethics, and Society* (Oxford: Oxford University Press, 2002) at 112.

32 Brian Kates, "Donors Smuggled into U.S. to Sell Body Parts" New York Daily News (14 March 2013), online: <http://www.nydailynews.com/archives/news/black-market-transplant-organs-donors-smuggled-u-s-sell-body-parts-article-1.507489>; Shimazono, *supra* note 11 at 957.

33 Budiani-Saberi & Delmonico, *supra* note 23 at 926.

relatives of the organ donors.[34] There are already reports of the transfer of Indian organ sellers to Sri Lanka for organ sales.[35]

The second practice involved in transplant tourism is organ trafficking which is a species of human trafficking with an aim of harvesting organs for transplantation. All forms of transplant tourism involve organ trafficking in the same way that organ trafficking always involves organ commercialization.[36] According to Alexandra and Francis, "Organ trafficking exists only in the realm of commercialism—the intent to make profit."[37] Organ trafficking also covers cases where "donors" directly offer their organs for sale as is sometimes the case where the "donor" is economically disadvantaged or is from an impoverished community seeking desperate means of earning some financial reward.[38] Anyone accepting organs from such a person is receiving organs from a person in a position of vulnerability. Most cases of organ trafficking, however, involve organized crime syndicates which sometimes have coordinated worldwide networks.[39] Individuals are often procured through force and deception

34 Charles Haviland, "Nepal's Trade of Doom," BBC News (21 September 2004) online: <http://news.bbc.co.uk/2/hi/south_asia/3674328.stm>; Shimazono, *supra* note 10 at 957.

35 Uditha Jayasinghe, "Sri Lanka Suspends Kidney Transplants for Foreigners after India Arrests" The Wall Street Journal (28 January 2016) online: <http://blogs.wsj.com/indiarealtime/2016/01/28/sri-lanka-suspends-kidney-transplants-for-foreigners-after-india-arrests/>.

36 The argument can be made about the possibility of an unsuspecting victim being tricked or abducted for the purpose of the removal of his/her organs by friends of an individual in need of such an organ, the only motive of those friends being to save the life of that individual in need. This argument is, however, purely academic.

37 Alexandra Glazier, & Francis Delmonico, "The Declaration of Istanbul Is Moving Forward by Combating Transplant Commercialism and Trafficking and by Promoting Organ Donation" (2011) 12:3 Am J Transplant 515.

38 An example of an unsolicited offer is an e-mail of a desperate person seeking buyers for one of her kidneys published by Nancy Scheper-Hughes in her article: "Commodity Fetishism in Organs Trafficking." She stated: "Please I need money to get dentures, and am a senior desparet [sic] for money. Want to sell a very good kidney. Am desperate for money for teeth. Am a senior citizen in excellent medical shape, but need $ for dentures." (Email from E.B., Oak Hills, California, to N.S-H @ Organs Watch, 26 January 2001). See Nancy Scheper-Hughes, "Commodity Fetishism in Organs Trafficking," in Nancy Scheper-Hughes, ed, *Commodifying Bodies*, (London: SAGE Publications, 2001) at 42.

39 In October 2010, 11 people were arrested who were alleged to be members of an organ trafficking syndicate between Syria and Egypt. The group is believed to have transported over 150 poor individuals from Syria to Cairo, where their kidneys were sold "to wealthy patients from Saudi Arabia and the United Arab Emirates.": "Eleven arrested for alleged Damascus-to-Cairo organ trafficking," Egypt Independent (04 October 2010) online: <http://www.egyptindependent.com/news/eleven-arrested-alleged-damascus-cairo-organ-trafficking>. See generally: Ranee Panjabi, "The Sum of a Human's Parts: Global

in order to have their organs removed.[40] In some cases, unsuspecting persons are recruited for foreign jobs which never materialize.[41]

The third and most common practice involved in transplant tourism is organ commercialization. Organs acquired via the aforementioned means are sold to individuals in need of transplant organs, often at high prices. Organs can be sold by their owners or by family members of individuals who are recently deceased.[42] No matter the form which it takes, a common denominator in transplant tourism is the transfer of money or other forms of consideration for the exchange of organs. The prices of these organs depend on a variety of factors such as the type of organ being sold, the nationality of the donor and the State where the transaction or operation takes place.[43] While it is impossible to put an exact figure on the annual retail value of organs worldwide due to the secrecy in which most of these transactions take place, average figures calculated using global estimates are quite high.[44]

Aside from the above core activities which are characteristic of transplant tourism practices, there is a forth element introduced by the *Declaration of Istanbul* that involves devoting resources to providing transplants to foreign patients in transplant States at the expense of the transplant needs of a State's own population. It is often argued that by making organs available only to the

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Trafficking in the Twenty-First Century" (2010) 28:1 Pace Envtl L Rev 21; Syed Naqvi *et al,* "A Socioeconomic Survey of Kidney Vendors in Pakistan" (2007) 20:11 Transplant Int'l 934.

40 Vienna Forum to Fight Human Trafficking, "Human Trafficking for the Removal of Organs and Body Parts" (2008) U.N. Doc. GIFT B.P.: 011 at 8.

41 *Ibid*.

42 Stephen Spurr, "The Proposed Market for Human Organs," (1993) 18:1 J Health Polit Policy Law 189.

43 While a human kidney can sell for as much as $15,000 in Cairo, Egypt, the sellers receive only about $2,500 with the rest of the money going to facilitators and transplant centers: Haken, *supra* note 10 at 1. The price of a kidney sold in the black market in India is about $1,000, $2,700 in Romania and Moldova and as high as $10,000 in Turkey: Peter Hummel, "Kidneys on Special Offer," Deutsche Welle (31 July 2012), online: <http://www.dw.de/kidneys>.

44 Kidneys are the most transplanted organs with an annual global estimate of about 68,500. Experts have also estimated that globally, 5 to 10% of kidney transplants are a result of trafficking which means that there are about 3,400 to 6,800 illegal kidney transplants yearly. With the price of each transplant being approximately $150,000, it means the retail value for kidneys is between $514 million and $1 billion per year. See generally: Haken, *supra* note 10 at 21; Jeneen Interlandi, "Not Just Urban Legend," Newsweek (09 January 2009), online: <http://www.thedailybeast.com/newsweek/2009/01/09/not-just-urban-legend.html>.

highest bidder, organ traffickers prevent the poor from accessing those organs.[45] If people can get money for their organs, they might be discouraged from donating those organs and, being that local populations in developing States might not have the means to pay for an organ at the black market value, they would indirectly be excluded from the organ access pool.[46] Richard Titmuss (in reference to blood) states that the introduction of markets "represses the expression of altruism and erodes the sense of community."[47] This reasoning is however speculative as it has not been proven that those choosing to sell their organs would otherwise donate these organs.

Of the four practices discussed above, travel for transplantation remains the *sine qua non* of transplant tourism. A combination of travel for transplantation with any of the other three practices will result in transplant tourism. Without travel for transplantation, organ commercialization and trafficking are crimes which are punishable under national laws which penalize such activities. Organ trafficking as a transnational crime is also prohibited at international law mainly by the *Protocol to Suppress and Punish Trafficking in Persons, Especially Women and Children* (*Trafficking Protocol*).[48] Transplant tourism, however, remains an activity with little national law prohibition and no direct prohibition at international law. This absence of transplant tourism prohibition has informed the major recommendation in this publication which is the prohibition of transplant tourism by a legal model which makes use of national laws, international law treaties and soft laws.

## C Transplant Tourism Parties and Aggravating Factors

The major reason behind transplant tourism is the huge shortage of organs which prevents patients from receiving the benefits of transplantation nationally. In many States, the demand for organs far exceeds the number of organs

45 Haken, supra note 10 at 24.

46 Debra Satz, *Why Some Things Should Not Be For Sale: The Moral Limits of Markets* (Oxford: Oxford University Press, 2010) at 192–195.

47 Richard Titmuss, *The Gift Relationship: From Human Blood to Social Policy* (London: LSE Books, 1997) at 314. See however authors who hold the opinion that allowing payment for organ donation does not discourage those who believe in altruism: Mark Cherry, *Kidney for Sale by Owner: Human Organs, Transplantation, and the Market*, (Washington: Georgetown University Press, 2005) at 101; Tom Wilkinson, *Ethics and the Acquisition of Organs: Issues in Biomedical Ethics* (Oxford: Oxford University Press, 2011) at 187.

48 *Trafficking Protocol, supra* note 19.

supplied through the traditional routes.[49] Several factors are responsible for this shortage; paramount among them is the organ procurement policies of various States which are usually expressed in their organ donation laws.[50] Most States depend entirely on altruistic donations which can be given only with the consent of the donor or the family in cases of post-mortem donations and without the exchange of consideration save for reimbursement for health and other expenses connected with the donation.[51] The consent of the donor can either be express or implied. Apart from a few exceptions like Belgium, Austria, France, Denmark, Greece and Switzerland which have adopted presumed consent legislation,[52] most other States insist on the express consent of donors before

49 James Taylor, *Stakes and Kidneys: Why Markets in Human Body Parts are Morally Imperative* (Aldershot: Ashgate Press, 2005) at 1; Nina Parisi & Irwin Katz, "Attitudes Towards Posthumous Organ Donation and Commitment to Donate" (1986) 5:6 Health Psycho 565.

50 James Childress, "Ethical Criteria for Procuring and Distributing Organs for Transplantation" (1989) 14:1 J Health Polit Policy Law 90.

51 This rule is in line with the existing bioethical framework for obtaining organs and tissues which is based on four key values – respect for individuals, autonomy, consent and altruism: Council of Europe, *Trafficking in Organs, Tissues and Cells and Trafficking in Human Beings for the Purpose of the Removal of Organs* (Strasbourg: Council of Europe, 2009), online: <http://www.ont.es/publicaciones/Documents/OrganTrafficking_study.pdf>. Iran deserves special mention here as it is the only State in the world with a legal and regulated market for the sale of kidneys for compensation. The trade of organs is regulated by the Charity Association for the Support of Kidney Patients (CASKP) and the Charity Foundation for Special Diseases (CFSD) under the control of the Ministry of Health. The applicable law is the *Organ Transplantation and Brain Death Act* which was approved by parliament in 2000. See *Organ Transplantation and Brain Death Act*, H/24804-T/9929, 6-4-2000; Javaad Zargooshi, "Iranian Kidney Donors: Motivations and Relations with Recipients" (2001) 165:2 J Urology 386; Benjamin Hippen, "Organ Sales and Moral Travails: Lessons from the Living Kidney Vendor Program in Iran" (2008) 614 Cato Policy Anal 1.

52 Presumed consent laws refer to laws that permit the procurement of organs without explicit permission. Though the system of presumed consent has come under great criticism due to the inferior nature of the consent involved and its inability to eliminate waiting lists, it has been shown to increase the availability of organs for transplantation. E.g. in Belgium there has been a 140 percent increase in the total number of organs that became available for transplantation following its adoption of a system of presumed consent. See generally: Robert Veatch & Jonathan Pitt, "The Myth of Presumed Consent: Ethical Problems in New Organ Procurement Strategies" in Robert Veatch ed, *Transplantation Ethics* (Washington DC: Georgetown University Press, 2000); Lloyd Cohen, *Increasing the Supply of Transplant Organs*, (Austin, TX: R.G. Landes Co., 1995); Ian Kennedy *et al,* "The Case for 'Presumed Consent' in Organ Donation" (1998) 351:9116 The Lancet at 1650.

organ extraction.[53] However, a challenge with altruistic donation, especially posthumous donations, is that there is generally an enormous gap between the number of individuals who want to donate their organs and those who actually act on this desire.[54] Even when consent has been given by a deceased donor, physicians still consult with the family of the deceased and if there is a conflict between the deceased's wishes and those of the family, the family's wishes are usually respected.[55] This gives rise to a contrived shortage of organs.

Further limiting the pool of available organs are factors governing the acquisition of organs from posthumous donors. Being that organ needs cannot be satisfied only through living donors, posthumous organ donation is becoming an attractive option with various States amending their organ donation laws to reflect this trend.[56] There are, however, cultures around the world which prohibit cadaveric organ donation and thereby further limit the pool of organs available in those places.[57] But cadaveric organ donation, even when practiced, is not

53 E.g. in Canada, see *Human Tissue and Organ Donation Act of Alberta*, SA 2006, c.H-14.5, s. 5.

54 In Canada, a 2004 survey showed that though 73% of Canadians intend to donate their organs, only 34% have signed donor cards: Leger Marketing, "Organ Donation" (March 2004), online: <http://www.legermarketing.com/admin/upload/publi_pdf/040419Eng.pdf>.

55 Childress, *supra* note 49 at 92; Wilkinson, *supra* note 46 at 64; Jeffery Prottas, "Obtaining Replacements: The Organizational Framework of Organ Procurement" (1983) 8:2 J Health Polit Policy Law 238; Maeghan Toews & Timothy Caulfield, "Evaluating the 'Family Veto' of Consent for Organ Donation" (2016) 188:17–18 CMAJ E436.

56 See e.g. Egypt which prohibited deceased organ donation until it passed *Law No. 5 of 2010 on the Organization of Human Organ Transplantation.*

57 The cultural and religious beliefs of a people also affect their willingness to donate organs. In the Middle East, some religious precepts discourage cadaveric organ donation because Islam encourages the maintenance of body integrity at the time of burial. Though religious leaders have sanctioned the practice of cadaveric organ donation, most Muslims still object to the practice: George Abouna, "Organ Transplantation in the Middle East: Problems and Possible Solutions" in Mehmet Habera, ed, *Recent Advances in Nephrology and Transplantation* (Ankara: Pelin Group Pub Co, 1990) at 236. The concept of body integrity is also upheld in parts of Asia. E.g. in Japan objections to the standard of brain death makes cadaveric organ donation almost impossible: David Rothman *et al*, "The Bellagio Task Force Report on Transplantation, Bodily Integrity, and the International Traffic in Organs" (1997) 29:6 Transplant Proc 2739; Margaret Lock, "Deadly Disputes" in Alexander Capron & Margaret Lock, *Deadly Disputes: Understanding Death in Europe, Japan and North America*, Occasional Papers of Doreen B. Townsend Center for Humanities, No. 4 (California: University of California, 1995) at 12, online: <http://townsendcenter.berkeley.edu/sites/default/files/publications/OP04_Deadly_Disputes.pdf>.

without its challenges. A majority of potential cadaveric organs cannot be used for organ transplants because the criterion of brain death invariably means that dead donors will have to be diagnosed brain dead in an intensive care unit.[58] The organs of other dead donors cannot be used as they would have deteriorated by the time extraction is possible.[59] Other vitiating elements such as infection and old age might also make certain organs unsuitable for transplantation.[60] Even when organs have been successfully acquired and preserved, they have to be matched with potential recipients to ensure that they are both compatible.[61] All of the above factors make human organs needed for transplantation very scarce.

In spite of the current scarcity of organs, the demand for organs keeps increasing with each passing year.[62] Various factors have led to this increase in demand such as the current success achieved by organ transplantation worldwide, the willingness of transplant teams to accept far sicker patients than was previously the case, the aging population in industrialized nations, diet and lifestyle changes which have increased the incidence of diseases such as diabetes and coronary vessel disease that lead to organ failure, and the fact that people who have received transplants are living longer and sometimes require re-transplantation as the organs they initially received begin to fail.[63] This increase in demand has also increased the scarcity of human organs which in turn has given rise to long waiting times for organs by those in need. In some parts of Canada, people in need of kidneys can wait four to six years for a transplant.[64] By mid-2012, 4,810 Canadians were awaiting transplants, with 137 dying

58 Wilkinson, *supra* note 47 at 6; Munson, *supra* note 30 at 183; Chandis, *supra* note 29 at 205. Brain death has been defined as "complete irreversible loss of brain-stem function.": Eelco Wijidicks, "The Diagnosis of Brain Death" (2001) 344:16 N Engl J Med 1215; "Diagnosis of Brain Death: Statement Issued by the Honorary Secretary of the Conference of Medical Royal Colleges and their Faculties in the United Kingdom on 11 October 1976" (1977) 59:2 Ann R Coll Surg Engl 170; Roger Rosenberg, "Consciousness, Coma, and Brain Death" (2009) 301:11 JAMA 1172.

59 Wilkinson, *supra* note 47 at 6.

60 *Ibid.*

61 See generally, Gerhard Opelz, "HLA Compatibility and Organ Transplant Survival: Collaborative Transplant Study" (1999) 1:3 Reviews in Immunogenetics 334.

62 Parisi & Katz, *supra* note 49 at 565

63 *Ibid.*

64 Julian Sher, "Ontario, B.C. Residents Wait Longer for Kidney Transplants than any other Canadians," The Star (23 January 2012), online: <http://www.thestar.com/news/canada/article/1119432--ontario-b-c-residents-wait-longer-for-kidney-transplants-than-any-other-canadians>.

while waiting and a further 200 withdrawing from the list.[65] These figures are relatively the same for 2011.[66]

The current scarcity of organs has driven organ buyers to source organs from parts of the developing world where organs can be easily purchased with little or no legal repercussion.[67] The existence of local laws against organ commercialization in these States has not discouraged transplant tourism practices by much as high poverty and corruption rates in these States still make it easy for persons involved in transplant tourism to carry on.[68] Transplant tourism revolves around these organ buyers as it developed to satisfy their needs. As noted earlier, a huge majority of these buyers are patients from key tourist States like the US, Canada, Australia, Israel, Saudi Arabia, Oman, Italy, Malaysia and Japan. These patients are either at the bottom of the waiting list in their home State or localities or are not eligible to get on the list due to several factors such as age, capacity of the recipient to benefit from the transplant and the cost of maintaining the transplant.[69] They are usually "desperate and

65 Canadian Institute for Health Information, "E-Statistics Report on Transplant, Waiting List and Donor Statistics," Canadian Organ Replacement Register, online: <http://www.cihi.ca/CIHI-ext-portal/pdf/internet/REPORT_STATS2012_PDF_EN>.

66 By mid-2011, 4539 Canadians were awaiting transplants, with 123 dying while waiting and a further 203 withdrawing from the list: Canadian Institute for Health Information, "E-Statistics Report on Transplant, Waiting List and Donor Statistics," Canadian Organ Replacement Register, online: <http://www.cihi.ca/CIHI-ext-portal/pdf/internet/REPORT_STATSMID2011_PDF_EN>.

67 There are currently States with no organ transplant law or laws prohibiting the sale of organs and other forms of transplant tourism, e.g. Nigeria.

68 In India, for instance, transplant tourism goes on despite the several laws prohibiting the sale of organs and organ donation to foreigners. This is due partly to the ease with which law enforcement officials can be corrupted. Although India is also a signatory to the *United Nations Convention Against Corruption,* UN Doc. A/58/422 (2003)/ (2004) 43 ILM 37, and several extradition and mutual legal assistance treaties in criminal matters, corruption is still a major menace plaguing the State and frustrating the enforcement of laws. According to Raj Kumar, "Corruption is an all-pervasive phenomenon in the administrative system of India. It has reached such alarming proportions that the entire governance structure of India is affected by the social, economic and political consequences of corruption, leading to the misallocation of resources.": Raj Kumar, "Corruption and Human Rights: Promoting Transparency in Governance and the Fundamental Right to Corruption-Free Service in India" (2003) 17:1 Colum J Asian L 33.

69 In the US, the federal government only covers the cost of immunosuppressive drug therapy for people under 65 and not otherwise disabled for three years after a successful kidney transplant. Many people with low incomes do not meet the financial criteria to qualify to receive a kidney transplant because they will not be able to pay the cost of

willing to travel great distances and face considerable insecurity to obtain the organs they need."[70] Aided by globalization tools such as the internet, these buyers have access to a lot of illegal organ procurement options.[71]

The second group of persons involved in the practice of transplant tourism are the "organ donors" who should more appropriately be referred to as "organ sellers." These individuals are equally desperate and trade their organs in exchange for money. Kidneys are the most common organs traded in this way. In a 2001 study carried out in Chennai in Tamil Nadu India, all of the 305 participants stated that they sold their kidneys in order to pay off debts.[72] Most of the organs acquired via transplant tourism are from living donors due to the fact that organs transplanted from living donors do better and lead to longer survival rates.[73] In addition, the buyers do not have to wait until the organs are available, and thus they can plan in advance for their operations. Getting organs from living donors also helps in ensuring that the organs do not stay out of the body and blood supply for an extended period and there is no urgency for their transportation to the hospital and other medical centers.

Although they cannot be termed as organ sellers, executed prisoners in China provide a unique pool of organs which satisfy some of the needs of the human organ market. By 2009 it was reported that the organs of convicted prisoners made up two-thirds of all transplant organs in China.[74] It was reported in 2012 that China plans to phase out organ harvesting from condemned

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maintaining the transplant: Jennifer Smith, "Kidney Transplant: Only for the Well-to-Do?" (2008) 31:333 Campbell L Rev 335; Roger Evans *et al.,* "Cost-Related Immunosuppressive Medication Nonadherence Among Kidney Transplant Recipients" (2010) 5:12 Clin J Am Soc Nephrol 2323.

70 Vienna Forum to Fight Human Trafficking, *supra* note 40 at 7.

71 Naqvi, *supra* note 39 at 934.

72 The most common sources of these debts were food, household expenses, rent, marriage expenses and medical expenses: Goyal, *supra* note 13 at 590.

73 Marilyn McClellan, *Organ and Tissue Transplants: Medical Miracles and Challenges*, (Berkeley Heights, Enslow Publishers, 2003) at 72–73.

74 In China, it is legal to acquire organs from convicted criminals with the requisite consent and, in 2005, China admitted that the organs of executed prisoners were sold to foreigners for transplant: David Rothman, "Bodily Integrity and the Socially Disadvantaged:The traffic in Organs for Transplantation," in Bethany Spielman, ed, *Organ and Tissue Donation: Ethical, Legal and Policy Issues*, (Carbondale: Southern Illinois Uni Press, 1996) at 40; Jane Macartney, "China to 'Tidy Up' Trade in Executed Prisoners' Organs," *The Times* (3 December 2005) online: <http://www.timesonline.co.uk/tol/news/world/asia/article745119.ece.>; "China Admits

prisoners over the next few years and create a national organ donation system.[75] In 2013, the *Hangzhou Resolution* was reach by China with a 5-point plan for organ donation and transplantation.[76] The resolution was in part supposed to bring an end to the reliance on executed prisoners for organ transplants.[77] Recent reports in June of 2016, however, state that China still harvests organs from prisoners at a large scale.[78]

The third group of persons involved in transplant tourism are organ brokers and intermediaries. Except for a few isolated cases, no transaction in human organs is ever complete without the use of an intermediary. In the Chennai study, 70% of participants sold their kidneys through an intermediary, with the remaining 30% selling directly to a clinic.[79] The intermediaries usually charge a large sum of money for their services (a brokerage fee) and give only a small fraction of their profits to the actual organ sellers.[80] Thus, financially, intermediaries benefit the most from transplant tourism activities. Intermediaries come in various forms: from a highly-sophisticated network of facilitators to influential locals who are familiar with the terrain.

Because organ transplantation involves surgical expertise and a wide range of other skills, individuals from professional and organized sectors of society are also involved in transplant tourism practices. As enumerated in the report of the Vienna Forum to Fight Human Trafficking,[81] these individuals include: "[m]edical directors of transplant units, hospital and medical staff,

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Death Row Organ use," *BBC News* (26 August 2009) 13:32 GMT, online: <http://news.bbc.co.uk/2/hi/asia-pacific/8222732.stm>.

75 Laurie Burkitt, "China to Stop Harvesting Inmate Organs," The Wall Street Journal (23 March 2012), online: <http://online.wsj.com/article/SB10001424052702304724404577298661625345898.html>.

76 Vivekenand Jha, "Reforms in Organ Donation in China: Still to be Executed?" (2015) 4:2 Hepatobiliary Surg Nutr 139; Jie-Fu Huang *et al*, "China Organ Donation and Transplantation Update: The Hangzhou Resolution" (2014) 13:2 Hepatobiliary Pancreat Dis Int'l 122.

77 Jha, *ibid*.

78 James Griffiths, "China Still Harvesting Organs from Prisoners at a Massive Scale" CNN (24 June 2016), online: <http://www.cnn.com/2016/06/23/asia/china-organ-harvesting/>.

79 Goyal, *supra* note 13 at 1590.

80 Haken, *supra* note 10 at 23; Vanessa, *supra* note 29 at 205; Interlandi, *supra* note 41; Zuo Likun, "Human Organ Black Market Exploiting Poverty and Hope" The China Post (10 May 2010), online: <http://www.chinapost.com.tw/print/255889.htm>.

81 Vienna Forum to Fight Human Trafficking, *supra* note 40 at 7.

technicians in blood and tissue laboratories, dual surgical teams working in tandem, nephrologists, postoperative nurses, travel agents and tour operators to organize travel, passports and visas, medical insurance agents, kidney hunters … religious organizations and charitable trusts which sometimes call upon organ brokers, and patient advocacy organizations, which sometimes call upon organ brokers."[82] Apart from travel agents and tour operators, most of these individuals are located in the transplant States and operate despite the various transplant laws existing in these States.

## D Transplant Tourism Prior to 2008

The exact origin of transplant tourism is uncertain as transplant tourism started receiving attention after it was already established. There are, however, early reports of transplant tourism dating back to the late 20th century. One of the very first hints of a commercial market in human organs which involved players from more than one State was in September 1983 when a U.S. doctor, H. Barry Jacobs, made a proposal for the establishment of an international kidney exchange company in Virginia to broker human kidneys from living donors in developing States[83] Although the proposal never saw the light of day due to legal reforms which banned the sale of human organs in Virginia and several other states in the US barely six months after it was made, his aim was to charge between $2,000 and $5,000 as brokerage fee for persons needing a transplant.[84] Barely five years after Barry's proposal, a second report emerged from Europe involving Turkish men traveling to Britain to sell their kidneys to British citizens.[85]

From these isolated cases in the 1980s, transplant tourism has grown to become a major aspect of the larger enterprise of medical tourism.[86] Medical

82 *Ibid*., Panjabi, *supra* note 39 at 24–25.

83 Munson, *supra* note 31 at 109; Susan Denise, "Regulating the Sale of Human Organs" (1985) 71:6 Virginia L Rev 1015; Nancy Scheper-Hughes, "The Global Traffic in Human Organs" (2000) 41:2 Current Anthropology 195.

84 For the state of Virginia, see *Virginia Code No. 32.1–289.1* (1985); see also: Munson, *supra* note 31 at 109; Denise, *supra* note 83 at 1015; Christine Edwards, "Giving Virginia's Anatomical Gift Code Life: Creating Liability for a Hospital's Failure to Determine Individual Donative Intent" (1995) 47 Wash U J Urb Contemp L 185.

85 Munson, *supra* note 31 at 112.

86 This is a term initially coined by travel agencies and the mass media to describe the rapidly growing practice of traveling across international borders to obtain healthcare.

tourism to a great extent involves the movement of patients from one State to another to access medical services which may or may not be available in their States of origin. Travelling to foreign nations to access health care services is not a novel practice. For centuries, people have traveled to spas and sanitariums to treat various ailments. Records show that as far back as thousands of years ago, patients came to Greece to visit the healing god Asklepios in Epidauria.[87] Recent years have, however, witnessed an upsurge in medical tourism. This boom is fueled by a variety of factors.[88] By far, the major factor is the affordability of certain medical procedures in some parts of the world when compared to others.[89] Other factors encouraging the practice of medical tourism are that it makes it easier for people who want to undergo

87 Lamk Al-Lamki, "Medical Tourism: Beneficence or Maleficence?" (2011) 11:4 Sultal Qaboos Univ Med J 444; Nafisa Samir & Samir Karim, "An Insight: Medical Tourism, Local and International Perspective" (2011) 26:4 Oman Med J 215.

88 Some factors which have fueled the practice of medical tourism include: the current ease and affordability of international travel, improvements in technology, better access to information about various States, the availability of intermediaries and facilitators, the increased standard of heath care in developing States and the development of advanced medical facilities in certain parts of the world. Certain healthcare groups and centers around the world have established themselves as research centers and prestigious destinations for certain medical procedures. Examples of these medical centers include Parkway Health Care (Singapore), Bumrungrad Medical Center (Bangkok), American Hospital of Paris (Paris), Centro Medico ABC (Mexico), Matilda Medical Center (Hong Kong Island) and The Prince of Wales Hospital (Sydney). Also, the strict regulatory framework governing certain forms of research such as stem cell research in e.g. Canada and other western States makes States in Asia such as China and India attractive for stem cell procedures: Lori Knowles, "A Regulatory Patchwork – Human ES Cell Research Oversight" (2004) 22 Nature Biotechnology 157.

89 A 2011 survey of comparative medical costs by unit carried out in about 10 States by the International Federation of Health Plans (IFHP) showed that the average US prices for procedures were the highest when compared to other States. For example, the cost of a CT head scan can be as high as $1,545 in the US, $319 in Switzerland but just $43 in India. While a C-section costs about $2,164 in India, it costs between $10,137 and $24,339 in the US. Also, the total hospital and physician cost for a hip replacement is about $3,589 in Argentina, $4,308 in India, $11,353 in France and ranges between $23,535 and $80,374 in the US: See International Federation of Health Plans 2011 Comparative Price Report: Medical and Hospital Fees by State (2011), online: <http://www.ifhp.com/documents/2011iFHPPriceReportGraphs_version3.pdf>; Jeremy Snyder & Valorie Crooks, "Medical Tourism and Bariatric Surgery: More Moral Challenges" (2010) 10:12 Am J Bioethics 28. The International Federation of Health Plans (IFHP) is an international global network of the health plan industry which assist in the maintenance of high ethical

elective procedures not covered or partially covered by healthcare insurance or undergo procedures and recuperate in complete anonymity to do so. It is also a way of avoiding the waiting periods for certain medical procedures such as receiving organ transplants.

If properly regulated, medical tourism has the potential to be an effective and expeditious means of accessing health care and building a global medical village where best practices, procedures and data can be easily interchanged among States. However, the poor application of healthcare policies and statutory frameworks governing the practice of medical tourism in transplant States and the lack of adequate healthcare facilities and properly trained professionals has given rise to a lot of medical malpractice that contravenes established ethical and legal rules in transplant States and also impacts negatively on healthcare delivery. A classic example of medical tourism gone wrong can be found in the growing reliance on developing States by other States for organs needed for transplantation.

Transplant tourism practices are more common than they appear to be. A recent report by Global Financial Integrity ranks the trade in human organs in the top 12 of the illegal activities studied in terms of illegal profits made.[90] The report further states that profits from these illicit markets are making their way to transnational crime syndicates through vast international commercial channels.[91] Indeed, apart from major transplant and tourist States, transplant tourism activities have also been recorded in various parts of the world such as

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and professional standards throughout the health plan industry. The IFHP can be found online at <http://www.ifhp.com/>. There have also been publications which show that the cost of certain surgical procedures in India, Thailand or South Africa are estimated to be about one-tenth of the cost in the US or Western Europe. For instance, a heart-valve replacement that would cost about $200,000 or more in the US goes for about $10,000 in India, and that includes round-trip airfare: Becca Hutchinson, "Medical Tourism growing Worldwide" UDaily (25 July 2005), online: <http://www.udel.edu/ PR/UDaily/2005/mar/ tourism072505.html>.

90 See Haken, *supra* note 10. This report analyzes the scale, flow, profit distribution, and impact of 12 different types of illicit trade: drugs, humans, wildlife, counterfeit goods and currency, human organs, small arms, diamonds and colored gemstones, oil, timber, fish, art and cultural property, and gold. Generally, these operations originate primarily in developing States, thrive in the space created by poverty, inequality, and state weakness, and contribute to the prosperity of billions of people in States across the world. See page v of Report.

91 Ambagtsheer & Waimar, *supra* note 17 at 572.

Egypt,[92] South Africa,[93] Brazil,[94] and Colombia.[95] A growing number of tourist States also report on patients travelling to key transplant States for the purpose of buying organs.[96]

Transplant tourism peaked in 2007 with key Asian States being the major destinations for persons seeking organs for transplantation. For example, in Pakistan, renal transplantation started in the 1980s from living related donors.[97] However, the absence of a deceased donor programme and the

92 Although there is a history of other vulnerable groups such as Sudanese serving as major sources of commercial organs in Egypt, the vast majority of organs used are Egyptian for Egyptian patients and thus commercial transplants in Egypt are via internal organ trafficking. Until June 2011, Egypt was one of the few States that prohibited deceased organ donations and relied entirely on the living. Accordingly, commercial living donors have served as the key source of organ suppliers, with only a minority of organ donations from related living donors. Estimates suggest the Egypt performs approximately 500–1000 transplants per annum and that between 80% and 90% of living kidney donors in Egypt are unrelated/commercial donors: Debra Budiani-Saberi & Amr Mostafa, "Care for Commercial Living Donors: The Experience of an NGO's Outreach in Egypt" (2011) 24:4 Transplant Int'l 319.

93 Jean Allain, "Trafficking of Persons for the Removal of Organs and the Admission of Guilt of a South African Hospital" (2011) 19:1 Med L Rev 117. This is a commentary on the case of *The State v Netcare Kwa-Zulu (Pty) Limited*, Case No. 41/1804/2010a 2010. In this case, Netcare Kwa-Zulu (Pty) Limited pleaded guilty to 102 counts related to charges stemming from having allowed its employees and facilities to be used to conduct illegal kidney transplant operations. The charges were brought under the *South African Tissue Act* 1983 and the *Prevention of Organized Crime Act* 1998. The case involved 109 illegal kidney transplant operations which took place between June 2001 and November 2003 within a scheme whereby Israeli citizens in need of kidney transplants would be brought to South Africa for transplants performed at St Augustine's Hospital. As the scheme progressed, Romanian and Brazilian citizens were also recruited as their kidneys were obtainable at a much lower cost. The broker set a fee of between US$100,000 and $120,000 for recipients and paid the original suppliers of kidneys $20,000, though later, the Romanians and Brazilians received on average $6,000.

94 A police investigation in Brazil revealed the existence of an international organ trafficking syndicate: Abraham McLaughlin, "What is a kidney worth?," Christian Science Monitor (09 June 2004), online: <http://www.csmonitor.com/2004/0609/p01s03-wogi.html>.

95 Roger Mendoza, "Colombia's Organ Trade: Evidence from Bogota and Medellin" (2010) 18:4 J Pub Health 375–376: In 2005, the WHO listed Colombia as one of the top 5 State destinations for organ trafficking. It has ranked 3rd or 4th worldwide since 2008, when tighter restrictions on foreign organ recipients took effect in China and Pakistan.

96 Ambagtsheer & Waimar, *supra* note 17 at 572.

97 Adib Rizvi *et al.*, "Factors Influencing Graft Survival in Living-Related Donor Kidney Transplantation at a Single Center" (1998) 30:3 Transplant Proc 712.

growing shortage of organs led to living unrelated donor transplants constituting 70% of all transplants, most of which are suspected to be commercial in nature.[98] By 2005, it was estimated that of the 2000 renal transplants which were performed, up to two-thirds were performed on foreigners.[99] Also in India, in spite of the *Transplantation of Human Organs Act* of 1994 which was passed to streamline organ donation and transplantation activities, the Voluntary Health Association of India estimated in 2002 that about 2000 Indians sell a kidney every year.[100] There are currently slum colonies like Villivakkam in a Chennai suburban area in India which are so full of people who have sold their kidneys that it has become internationally known as "kidney-vakkam."[101] The Philippines is another State notorious for transplant tourism practices. Data obtained in 2003 from the Renal Disease Control

98 Unregulated commercial trade in human organs has thus surpassed ethical living-related transplants which has made Pakistan one of the largest destinations for transplant tourism: Mukhtar Shah, *et al.*, "Safety and Efficacy of Basiliximab for the Prevention of Acute Rejection in Kidney Transplant Recipients" (2003) 35:7 Transplant Proc 2737; Kirpal Chugh & Jha Vivekanand, "Commerce in Transplantation in Third World Countries" (1996) 49:5 Kidney Int'l 1181; Naqvi, *supra* note 39 at 934.

99 Adib Rizvi, "*Pakistan: Legislative Framework on Transplantation. Second Global Consultation in Human Transplantation*" (Geneva: WHO, 2007). However, non-related foreigners are no longer legally able to receive organs for transplantation from living donors in Pakistan. Section 3(1) of the *Transplantation of Human Organs and Tissues Act*, Act No. VI of 2010, makes blood relationship a condition precedent for donating and receiving organs. Section 7(1) goes on to exempt foreigners from exceptions to section 3(1). See generally ss 3 & 7 of the Act.

100 *Transplantation of Human Organ Act*, Act No. 42 of 1994; Aronowitz, *supra* note 24 at 113; Shimazono, *supra* note 10 at 957; Chris Hogg, "Why Not Allow Organ Trading?," BBC News (30 August 2002), online: <http://news.bbc.co.uk/2/hi/health/2224554.stm>.

101 There are various communities around the world, most especially in States in southern and eastern Asia, which are now "kidney colonies." In India, for instance, there are slum communities like Villivakkam in Chennai suburban area which is full of people who have sold their kidneys that it has become internationally known as "Kidney-Vakkam": Sanjay Kumar, "Curbing Trade in Human Organs in India" (1994) 44:344 *The Lancet* 48–49; Chugh & Jha, *supra* note 98 at 1184. There are reported cases of "kidney colonies" in several villages in Moldova such as Mingir. Moldova has been described by the European Parliament as the poorest State in Europe in terms of GDP and has become a breeding ground for organ trafficking: Bethany Bell, "Moldova's Desperate Organ Donors," BBC News (21 May 2003), online: <http://news.bbc.co.uk/2/hi/europe/3046217.stm>; Tarif Bakdash & Nancy Scheper-Hughes, "Is It Ethical for Patients with Renal Disease to Purchase Kidneys from the World's Poor?" (2006) 3:10 PLoS Med e349, online: <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.0030349>.

Program of the Department of Health, National Kidney Transplant Institute shows that of the 468 kidney transplants in 2003, 110 were for patients from abroad.[102]

## E Transplant Tourism after 2008

2008 was a turnaround year for transplant tourism globally. The *Declaration of Istanbul* of 2008 brought the focus of the international community to transplant tourism and influenced many States to strengthen their laws and policies against organ commercialization and, in a few cases, transplant tourism.[103] Though there is currently no binding international law instrument prohibiting transplant tourism in its entirety, recent years have witnessed the development of laws and regulations in a few States which deal with some aspects of transplant tourism. For instance, the Israeli parliament passed the *Organ Transplantation Law* in 2008 which focuses on the eradication of transplant tourism and organ commercialization and the increase in organ donations.[104] Though not a key tourist State, Spain amended its *Penal Code* in 2010 to prohibit its nationals from engaging in organ trafficking and using organs which have not been acquired legally for transplant purposes.[105] Both States have recorded some amount of success in preventing their nationals from engaging in transplant tourism activities.[106]

The same level of success has, however, not been recorded in transplant States with laws prohibiting transplant tourism. On May 29, 2008, in response

102 Shimazono, *supra* note 11 at 957. This number increased in the following years. It is estimated that transplants to foreigners in the Philippines increased more than 60% between 2002 and 2006. In 2007 alone, the social welfare department stated that 500 transplants were performed on foreigners alone: Carlos Conde, "Philippines Ban Kidney Transplants for Foreigners," The New York Times (30 April 2008), online: <http://www.nytimes.com/2008/04/30/world/asia/30phils.html?ref=asia&_r=0>; Karl Wilson, "Manila May Lift Donation Ban," The National, (08 August 2010), online: <http://www.thenational.ae/news/world/asia-pacific/manila-may-lift-donation-ban>.

103 Ambagtsheer & Waimar, *supra* note 17 at 571; Glazier & Delmonico *supra note* 37 at 515.

104 See *Organ Transplant Law 5768-2008*, Israeli Book of Laws.

105 See article 156 bis, *Penal Code of Spain* (Organic Law No. 10/1995 of November 23, 1995, as amended up to Law No. 4/2015 of April 27, 2015.

106 Benita Padilla *et al*, "Impact of Legal Measures Prevent Transplant Tourism: The Interrelated Experience of The Philippines and Israel" (2013) 16:4 Med Health Care Philos 916.

to the high volume of transplant tourism activities in the State, the Executive Committee of the Philippine Department of Health (Filipino: *Kagawaran ng Kalusugan*)[107] passed *Administrative Order No. 2008-0004-A, Amendment to Administrative Order No. 2008-0004 on Revised National Policy on Living Non-Related Organ Donation and Transplantation and its Implementing Structure*.[108] The new Administrative Order states that "foreigners are not eligible to receive organs from Filipino living non-related donors."[109] Despite this total ban on non-related foreign organ donees, there are reports of foreigners still having operations done in the Philippines and getting their transplant organs from non-relatives.[110]

Apart from the Philippines, a few other transplant States also have laws banning organ transplants to foreigners.[111] These legal regimes have, however, not

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107 The Philippine Department of Health (DOH) is the executive department of the Philippine government which holds the overall technical authority on health in the Philippines. It is a national health policy maker and regulatory institution and develops national plans, technical standards and guidelines on health. The DOH can be found online: <http://www.doh.gov.ph/index.html>.

108 *Amendment to the Administrative Order No. 2008-0004 on Revised National Policy on Living Non-Related Organ Donation and Transplantation and its Implementing Structure, Department of Health Administrative Order* No. 2008-0004-A (May 29, 2008).

109 *Ibid*. The Order states that "The Executive Committee of the Department hereby amends provision no. 7 of Section V of the Revised National Policy on Living Non-Related Organ Donation and Transplantation and its Implementing Structure, the following amendment to state: 'Foreigners are not eligible to receive organs from Filipino living non-related donors.' " See generally: See generally, Sue Pondrom, "LYFT Goes to Office of Civil Rights for Review" (2008) 8:8 Am J Transplant 1572.

110 Anne Bueno, "18 Foreigners Still Had Kidney Transplants after Ban – Redcop," ABS-CBN News (08 July 2009), online: <http://www.abs-cbnnews.com/special-report/08/07/09/18-foreigners-still-had-kidney-transplants-after-ban-%E2%80%93-redcop>.

111 In India, under section 4A(3) & (4) of the *Transplantation of Human Organs Rules* of 2008 [GSR 571 (E), dt. 31-7-2008], when the proposed donor or recipient or both are not Indian nationals/citizens, whether "near relatives" or otherwise, an Authorization Committee will have to consider a lot of factors before assenting to the donation. However, in 2011, under the *Transplantation of Human Organs* (*Amendment*) *Act*, Act No. 16 of 2011, the Authorization Committee is not to approve the removal or transplantation of human organs or tissues "if the recipient is a foreign national and the donor is an Indian national unless they are near relatives." See section 9(1) of *Amendment Act.* In Pakistan, non-related foreigners are no longer legally able to receive organs for transplantation from living donors. Section 3(1) of the *Transplantation of Human Organs and Tissues Act*, *supra* note 98, makes blood relationship a condition precedent for donating and receiving organs. Section 7(1) goes on to exempt foreigners from exceptions to section 3(1). See generally ss 3 & 7 of the Act.

been very effective in bringing an end to transplant tourism. Aside from the fact that other key transplant States do not have laws banning transplant tourism, the bans in the aforementioned States have only led to "forum shopping" by transplant tourists who travel to States with little or no organ transplant laws.[112] For so long as States cannot meet the organ needs of their nationals without resorting to external aid, people in need of organs for transplantation will always devise means of getting these organs.[113] This being the case, there is the need for States, tourist States in particular, to explore other legal avenues which will better deter their nationals from taking part in transplant tourism.

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112 Nancy Scheper-Hughes, "The New Cannibalism" (1998) 300 New Internationalist 14.

113 Instruments reflecting global standards on organ transplantation also place a direct responsibility on States to strive to meet the organ demands of their nationals from within their own population. This duty is known as a state's duty to be self-sufficient. See for instance: Principle 5, the *Declaration of Istanbul, supra* note 14*; WHO EMR Informal Regional Consultation on Developing Deceased Donor Donation, 2006* (hereinafter: *Kuwait Statement*): World Health Organization, *Second Global Consultation on Critical Issues in Human Transplantation: Towards a Common Attitude to Transplantation* (Geneva, World Health Organization, 2007) at 25, online: <http://www.who.int/transplantation/publications/ReportGlobalTxConsultation_March_2007.pdf>; The *Third Global Consultation on Organ Donation and Transplantation, 2010* (hereinafter: *Madrid Resolution*): "The Madrid Resolution on Organ Donation and Transplantation: National Responsibility in Meeting the Needs of Patients, Guided by the WHO Principles" (2011) 91:11S Transplantation S29; Chris Rudge *et al*, "International Practices of Organ Donation" (2012) 108:S1 Br J Anaesth i49; Francis Delmonico *et al.,* "A Call for Government Accountability to Achieve National Self-Sufficiency in Organ Donation and Transplantation" (2011) 378:9800 The lancet 1414.

CHAPTER 2

# Schools of Thought on Transplant Tourism and the Creation of Regulated Markets in Human Organs

## A Introduction

The practice of sourcing organs from foreign nations for transplant purposes has attracted a lot of attention from a wide range of stakeholders including State government officials, organ transplant experts, ethicists, policy makers, scholars and persons affected directly or indirectly by the organ shortage crisis. The views on transplant tourism are unbalanced. While a greater percentage of individuals view transplant tourism and various other practices related to it as condemnable, transplant tourism also has a few proponents. Individuals and groups who endorse transplant tourism include those who believe in the benefits it brings to both the organ sellers and buyers. There are also proponents of transplant tourism who believe that everything of value can be traded as articles in exchange for money or other benefits. This concept, known as "universal commodification," is a world view which sees everything that can be desired or valued as an object which can be possessed as a good.[1] A strong proponent of this theory is Richard Posner who sees everything valuable as alienable property which should be sellable.[2] Most individuals who support the sale of human organs do not, however, support transplant tourism but the creation of a regulated system in which organs can be traded. Due to the close relationship between transplant tourism and the creation of a regulated market in human organs, arguments in favor of both practices will be examined together in this Chapter. I will conclude the Chapter with arguments against transplant tourism and the sale of human organs in general and show why these practices should be discouraged and legislated against by both transplant and tourist States.

1 Margaret Radin, "Market-Inalienability" (1987) 100:8 Harvard L Rev 1861.

2 See generally Richard Posner, *Economic Analysis of Law*, 7th ed (New York: Aspen Publishers, 2007) at 29–33.

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## B Schools of Thought in Favor of Transplant Tourism and Related Practices

Though the most support for transplant tourism appears in recent scholarship, the idea of a commercial market in human organs has been in existence long before transplant tourism was first recorded in the 1980s.[3] This idea has been carried forward by modern day transplant tourism proponents who often argue that transplant tourism is the most practical way of meeting the current transplant needs of transplant patients globally. The reasoning here is that since altruistic organ donations have not increased the number of available organs, incentivized organ donations could help bridge the wide gap between the demand and supply of organs.[4] A strong advocate of transplant tourism is Gerald Dworkin who holds that transplant tourism and the sale of organs in general is the most practical way of dealing with the organ shortage problem.[5] Judging the extent of people's control over something by their ability to sell that article, Dworkin argues that since respect for a person's bodily autonomy requires that "we accept the idea that individuals have the right to dispose of their organs and other bodily parts if they so choose," persons should be allowed to engage in market transactions with their bodily organs.[6]

There are two notable flaws in Dworkin's argument. The first is that the notion of bodily autonomy does not translate into the right of individuals to dispose of their organs as and when they choose to. On the contrary, it simply means that

3 As far back as 1963, Nobel Prize winning geneticist Joshua Lederberg stated that medical advances would impose "intolerable economic pressures on transplant sources." See Russell Scott, *The Body as Property*, (New York: Viking Press, 1981) at 182. The reality of this statement has unfolded through the years with organ commercialization receiving a lot of endorsements from individuals who see no other way of satisfying the demand for human organs for transplantation. See also Gregory Boyd, "Considering a Market in Human Organs" 4:2 North Carolina J L Tech 417; Curtis Harris & Stephen Alcorn, "To Solve a Deadly Shortage: Economic Incentives for Human Organ Donation" (2001) 16:3 Issues L Med 213.

4 Michael Gill & Robert Sade, "Paying for Kidneys: The Case against Prohibition" (2002) 12:1 KIEJ 19.

5 Gerald Dworkin, "Markets and Morals: The Case for Organ Sales," in Gerald Dworkin ed, *Morality, Harm and the Law* (Boulder, CO: Westview Press, 1994) at 155–161.

6 Dworkin further argues that a market transaction in human organs is a species of the larger class of voluntary transactions in human body matter which includes the sale of reproductive garments, blood, hair and tissues: Dworkin, *supra* at 156; James Taylor, *Stakes and Kidneys: Why Markets in Human Body Parts are Morally Imperative* (Aldershot: Ashgate Press, 2005) at 29.

individuals have the decision-making power when it comes to matters dealing with their body.[7] This power does not extend to disposing of parts of the body as one would dispose of an article, for a human's body is a part of that person's being and not an extraneous substance. Making a similar case against transplant tourism, Charles Fried in his formulation of the "alienation argument" which is a restatement of Thomas Aquinas' "principle of totality"[8] states that "… when a man sells his body he does not sell what is his, he sells himself. What is disturbing, therefore, about selling human tissue is that the seller treats his body as a foreign object."[9] In response to the alienation argument, Dworkin has also argued that when an individual donates an organ, s/he is also alienating it and treating it as a foreign object.[10] While this might be so, there is a great difference between donating and selling an organ. The sale of a human organ in most cases eliminates altruism and freedom which are elements which must be present in any transfer of human organs.[11] When a human organ is sold, it transforms the organ into a mere commodity and is often done out of desperation.[12]

The second flaw in Dworkin's argument is that it ignores the current ills brought about by transplant tourism and focuses mainly on the right of individuals to dispose of their bodies at will. Contrary to some views, transplant tourism practices do not involve two individuals with equal bargaining power bargain in a free market. Transplant tourism is characterized by factors such as the coercion and exploitation of the poor and vulnerable. This is in line with the nature of transplant tourism which often involves individuals from

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7 Wim Dekkers, "Persons with Severe Dementia and the Notion of Bodily Autonomy" in Julian Hughes *et al*, eds, *Supportive Care for the Person with Dementia* (Oxford: Oxford University Press, 2010) at 256.

8 Per Thomas Aquinas, a man's body "should be entire in its members" and thus, it is morally wrong to remove a part of a human's body so long as it is healthy and retains its natural disposition: Thomas Aquinas, *Summa Theologica* (Translated by the Fathers of the English Dominican Province) (Westminister, MD: Christian Classics, 1948) at Q II-II, Q65.

9 Fried also states that it is not the sale of the body itself which is disturbing but the treatment of the body as a "separate, separable entity": Charles Fried, *Right and Wrong* (Cambridge: Harvard University Press, 1978) at 142.

10 Dworkin, *supra* note 5 at 160.

11 Roland Chia, *The Ethics of Human Organ Trading* (Singapore: Armour Pub Pte Ltd, 2009) at 63; Richard Titmuss, *The Gift Relationship: From Human Blood to Social Policy* (London: LSE Books, 1997) at 314;

12 *Contra*: Stephen Wilkinson feels that things can be regarded as commodities without money changing hands: Stephen Wilkinson, "Commodification Arguments for the Legal Prohibition of Organ Sale" (2000) 8:2 Health Care Anal 195.

richer industrialized States traveling to poorer developing States to buy organs for transplants.[13] Other negative factors present in transplant tourism are the neglect of the post-transplant health care needs of organ vendors, non-payment of agreed compensation and the lack of proper screening of vendors.[14]

Due to the shortcomings in the above noted views in favor of transplant tourism and views of a similar nature, many transplantation practitioners, ethicists and economists have pushed for the establishment of a regulated market in human organs which will increase organ donation and lead to fewer deaths for people on the organ waiting list.[15] Propositions for the creation of regulated markets in human organs are technically not arguments in favor of transplant tourism. Except for a few cases where advocates push for a regulated system involving various partnering States, devotees of a regulated system in human organs press for the creation of such a system within a State.[16] As noted earlier in Chapter 1, an important aspect of transplant tourism is travel for transplantation. Thus, proposals for the creation of a regulated system in human organs will in most cases be suggestions on how a State can become self-sufficient and meet the organ needs of their nationals from within their own population. If successfully implemented, such a system might in fact eliminate a State's waiting list as is the case with Iran which is said not to have had an organ waiting list since 1999.[17] This in turn will, indirectly, do away with the need for travel for transplantation purposes by nationals.

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13 Alexis Aronowitz, *Human Trafficking, Human Misery: The Global Trade in Human Beings* (Westpoint: Praeger, 2009) at 111; Nancy Scheper-Hughes, "Prime Numbers: Organs Without Borders," (2005) 146 Foreign Policy 26.

14 Working Group on Incentives for Living Donation, "Incentives for Organ Donation: Proposed Standards for an Internationally Acceptable System" (2012) 12:2 Am J Transplant 306.

15 Debra Satz, "Ethical Issues in the Supply and Demand of Human Kidneys" in Debra Satz, *Why Some Things Should not be for Sale: The Moral Limits of Markets* (Oxford: Oxford University Press, 2010) at 189; Arthur Matas, "Why We Should Develop a Regulated System of Kidney Sales: A Call for Action!" (2006) 1:6 Clin J Am Soc Nephrol 1129.

16 A few other recommendations have been made and, in some cases, implemented on how States can collaborate with each other to address the organ shortage problem. For e.g., a system of kidney paired donation (KPD) already exists where strangers in various States can donate kidneys to each other through a system of kidney sharing based on compatibility. See Alex Crees, "Kidney Exchange Between Strangers Span Continents," Fox News, (04 June 2012), online: <http://www.foxnews.com/health/2012/06/04/kidney-exchange-between-strangers-spans-continents.html>.

17 Saeed Dehghan, "Kidneys for Sale: Poor Iranians Compete to Sell their Organs," The Guardian (27 May 2012), online: <http://www.guardian.co.uk/world/2012/may/27/iran-legal-trade-kidney>. *Contra:* Anne Griffin, "Kidneys on Demand" (2007) 334:7592 BMJ 502; Imran

Proponents of a regulated market in organs often acknowledge the concerns existing in the current unregulated market in human organs and promote a system which will eliminate all or most of these concerns while ensuring that there is a steady supply of organs for transplantation. For this goal to be achieved, it has been suggested that such a system must have structures which ensure justice and equality, eliminate exploitation and protect vulnerable people.[18] Other requirements for such a system include the prohibition of brokering, competitive remuneration and continuous healthcare.[19] It has also been suggested that a fixed price be paid to the organ vendor by the government or an agency established for that purpose, the organs be allocated by a system similar to that used for deceased donors, access to organs be given to everyone on the waiting list and that the government ensures proper evaluation and protection of the organ vendors.[20]

By insisting that the organs be paid for by a single buyer who will be the government or an agency in charge of the program (a monopsonist), proponents of a regulated market in organs reason that this will ensure that vendors receive full and fair payments for their organs.[21] They also maintain that the elimination of direct purchasing will ensure that the rich do not prey on the poor which will in turn reduce or phase out exploitation.[22] At first consideration, these suggestions seem plausible as a major argument against transplant tourism is that it leads to the exploitation of the poor and vulnerable as most of the persons who have been the victims of transplant tourism are usually

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Sajjad *et al*, "Commercialization of Kidney Transplants: A Systematic Review of Outcomes in Recipients and Donors" (2008) 28:5 Am J Nephrol 751.

18 Charles Erin & John Harris, "An Ethically Defensible Market in Organs" (2003) 29:3 J Med Ethics 137.

19 Miran Epstein, "Sociological and Ethical Issues in Transplant Commercialism" (2009) 14:2 Curr Opin Organ Transplant 136.

20 James Taylor states that for a regulated market to be morally permissible, it must at the very minimum require vendors to give their informed consent to the sale of their organs [kidneys], that they not be forced into selling their kidneys by a third party and that they receive adequate post-operative care: Taylor, *supra* note 6 at 110. See also Arthur Matas, "The Case for Living Kidney Sales: Rationale, Objections and Concerns" (2004) 4:2 Am J Transplant 2008.

21 Matas *ibid*; Erin & Harris, *supra* note 18 at 114; John Harris, "An Ethically Defensible Market in Organs: A Single Buyer like the NHS is an Answer" (2002) 325:7356 BMJ 114.

22 Erin & Harris, *supra* note 18 at 115.

financially disadvantaged.[23] These views are, however, fallible because in Iran where a regulated market in human organs does exist, a majority of the donors are economically challenged individuals who desperately need money to fulfill certain financial obligations or pay off debts.[24] It is thus evident that a regulated system does not necessarily protect the poor from exploitation as they are still being taken advantage of in one way or the other, be it by the rich or the government.[25]

Another argument in favor of the establishment of a regulated system in organ trade is that it will lead to the reduction or complete elimination of the current illegal market in human organs and provide better protection for both vendors and recipients of organs.[26] The argument here is that the development of a regulated system in organ trade will increase donations which in turn will reduce the need for people to travel to transplant States to buy organs.[27] It is also maintained that by failing to create a regulated market in human organs, the welfare of patients who travel abroad to buy organs is being neglected and they are abandoned to the devices of an unregulated market enterprise.[28] This position endorses organized trade in human organs as a better means of regulating transplant tourism than laws banning it. Although the illegal market in human organs exists despite the existence of laws prohibiting their sale, the failures of these laws are due to many internal and external factors. Some of these factors include the weak enforcement of available laws, corruption, poverty and the complacence of medical personnel and enforcement officers to transplant organs acquired illegally. These challenges can, however, be surmounted. For instance, in the Philippines and India, there has been a reduction in transplant tourism cases after laws banning organ donation to foreigners were passed in these States.[29]

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23 Michael Bos, *Transplant Tourism and Organ Trafficking: An Overview of Practices in Europe* (Prague: European Society of Organ Transplantation, 2007) at 19; Nancy Scheper-Hughes, "Keeping an Eye on the Global Traffic in Human Organs" (2003) 361:9369 The Lancet 1645.

24 Dehghan, *supra* note 17; Sajjad, *et al., supra* note 17 at 751; Javaad Zargooshi, "Iranian Kidney Donors: Motivations and Relations with Recipients" (2001) 165:2 J Urol 386; Nima Sarvestani, "Iran's Desperate Kidney Traders," BBC News (31 October 2006), online: <http://news.bbc.co.uk/2/hi/programmes/this_world/6090468.stm>.

25 Gill & Sade, *supra* note 4 at 30.

26 Matas, *supra* note 20 at 2009.

27 Matas, *supra* note 15 at 1129.

28 Michael Friedlaender, "The Right to Sell or Buy a Kidney: Are we failing our Patients?" (2002) 359:9310 The Lancet 973.

29 Benita Padilla *et al*, "Impact of Legal Measures Prevent Transplant Tourism: The Interrelated Experience of The Philippines and Israel" (2013) 16:4 Med Health Care Philos 915.

With similar laws in other transplant States and laws in tourist States prohibiting their nationals from travelling abroad to engage in transplant tourism activities, transplant tourism can be prevented.

A more conservative approach which has been adopted by experts in the field of transplantation who support the establishment of a regulated market in human organs is the use of other forms of incentives apart from direct monetary compensation such as the reimbursement of funeral expenses, insurance coverage and tax breaks or credits to the donors or their families.[30] Apart from the belief that the creation of incentivized donation systems will encourage more people to donate their organs, support for such a system is also based on the fact that since the donors and their families are the only parties involved in the organ transplantation process who do not directly benefit financially from it, it is only right that they receive some form of compensation for their selfless deeds.[31] This reasoning is, however, not entirely accurate as individuals involved in altruistic organ donation get some level of satisfaction and fulfilment from their selfless act of providing something of value to someone in need. It has even been suggested that unrelated donors get greater satisfaction from their gift than related donors do because no sense of obligation exists, which makes their gift extraordinary.[32]

Public opinion on the implementation of incentivized organ donation systems seems to be divided. While a greater number of the public is somewhat skeptical about monetary compensation for organ donations, most are more open to other forms of compensation. Public opinion is often crucial in the implementation of a new organ donation regime for it is an issue people are passionate about due to both its life saving potentials and avenues for abuse. It is thus not surprising that different studies have been carried out through the

30 Jake Linford, "The Kidney Donor Scholarship Act: How College Scholarships Can Provide Financial Incentives for Kidney Donation While Preserving Altruistic Meaning," ExpressO (2008), online: <http://works.bepress.com/cgi/viewcontent.cgi?article=1000&context=jake_linford>; David Schwark, "Organ Conscription: How the Dead Can Save the Living" (2011) 24:2 J L Health 323.

31 Archil Chkhotua, "Incentives for Organ Donation: Pros and Cons" (2012) 44:6 Transplant Proc 1793; Mark Cherry, *Kidney for Sale by Owner: Human Organs, Transplantation, and the Market* (Washington: Georgetown University Press, 2005) at 41.

32 Victoria Butterworth *et al*, "Psychosocial Effects of Unrelated Bone Marrow Donation: Experiences of the National Marrow Donor Program" (1993) 81:7 Blood 1957; David Levine, "When a Stranger Offers a Kidney: Ethical Issues in Living Organ Donation" (1998) 32:4 Am J of Kidney Diseases 684–685; Reginald Gohh *et al.*, "Controversies in Organ Donation: The Altruistic Living Donor" (2001) 16:3 Nephrol Dial Transplant 620.

years to gauge public acceptance, or the lack thereof, of financial incentives for organ donation. These studies have, however, showed great variance in public opinion which makes it more difficult for experts to settle on a specific form of incentive which will best attract donors and ensure a steady supply of organs.[33] For instance, while there seems to be a higher acceptance for incentivized organ donation in the US and Canada, a more conservative position is taken in European and developing States.[34] In 2011, a Canadian study was carried out to "determine the acceptability of the use of expense reimbursement or financial incentives by the Canadian general public, health professionals involved with organ donation and transplantation, and those affected by kidney disease."[35] Though health professionals were the least supportive of any form of incentivized organ donation, the general feedback showed that the public views financial incentives for organ donation to be acceptable, with more people favoring other forms of incentives over financial compensation.[36]

It is worth mentioning that as important as public opinion is to the success of a new organ procurement regime, the impetus for such a regime cannot be based solely on public opinion. As noted earlier, there is often an enormous

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33 Klaus Hoeyer *et al*, "Public Attitudes to Financial Incentive Models for Organs: A Literature Review Suggests that it is Time to Shift the Focus from 'Financial Incentives' to 'Reciprocity' " (2013) 26:4 Transplant Int'l 355.

34 See generally: Cindy Bryce *et al*, "Do Incentives Matter? Providing to Benefits to Families of Organ Donors" (2005) 5:12 Am J Transplant 2999; Scott Halpern *et al*, "Regulated Payments for Living Kidney Donation: An Empirical Assessment of the Ethical Concerns" (2010) 152:6 Ann Intern Med 358; Stephen Leider & Alvin Roth, "Kidneys for Sale: Who Disapproves and Why?" (2010) 10:5 Am J Transplant 1221; Leonieke Kranenburg, *et al*, "Public Survey of Financial Incentives for Kidney Donation" (2008) 23:3 Nephrol Dial Transplant 1039; Mark Schweda & Silke Schicktanz, "The 'Spare Parts Person?' Conceptions of the Human Body and their Implications for Public Attitudes towards Organ Donation and Organ Sale" (2009) 4:4 Philos Ethics Humanit Med 1; Mark Schweda & Silke Schicktanz, "Public Ideas and Values Concerning the Commercialization of Organ Donation in Four European Countries" (2009) 68:6 Soc Sc Med 1129; Gillian Haddow, " 'Because You're Worth It?' The Taking and Selling of Transplantable Organs" (2006) 32:6 J Med Ethics 324; Karen Kennedy, "Organ Donation and Transplantation in India: An Inquiry in Kerala" (2002) 11:1 J Soc Distress Homel 41; Joseph Neuberger *et al,* "Living Liver Donation: A survey of the attitudes of the public in Great Britain" (2003) 76:8 Transplant 1260; Ebony Boulware *et al*, "Public Attitudes toward Incentives for Organ Donation: A National Study of Different Racial/Ethnic and Income Groups" (2006) 6:11 Am J Transplant 2774.

35 Lianne Barnieh *et al*, "Attitudes toward Strategies to Increase Organ Donation: Views of the General Public and Health Professionals" (2012) 7:12 Clin J Am Soc Nephrol 1.

36 *Ibid.*

gap between the expressed desires of people and the implementation of those desires. More than the lack of financial consideration, a major reason behind the low number of altruistic donations is the fear of the unknown. A lot of people have fears about the safety of developing post-operative medical complications. Though the risk of developing such complications is low, a few donors have died postoperatively.[37] There is also the fear that a close family member might need an organ in future. This fear rationalizes their decision not to donate their organs to persons who they are not related to or otherwise feel obligated to or sympathetic towards. These fears will still exist in a regulated system of organ donations and might lead to the failure of such a system.

It has also been argued that the creation of a system based on incentivized organ donation might further discourage potential altruistic donors from coming forward.[38] This argument known as the "crowding out effect" has been used by authors like Richard Titmuss in reference to blood markets.[39] This might be especially true for people who are against any form of organ commercialization or compensation for donation. However, this view remains largely unproven, and even if discovered to be true, it can be argued that since the current program governing organ donation based on altruism has not been successful in providing an adequate supply of organs, a program based on compensation would encourage more donors and thus increase the net supply of organs.[40]

In spite of its drawbacks, the creation of a system based on incentivized organ donations will be a means via which States can move towards becoming

37 Levine, *supra* note 32 at 680; John Najarian & Blanche Chavers, "20 Years or More of Follow-up of Living Kidney Donors" (1992) 340:8823 The Lancet 807; John Dunn *et al*, "Living Related Kidney Donors: A 14-Year Experience" (1986) 203:6 Ann Surg 637; Alan Bennett & John Harrison, "Experience with Living Familial Renal Donors" (1974) 139:6 Surg Gynecol Obstet 894, Margaret Bia *et al*, "Evaluation of Living Renal Donors: the Current Practice of US Transplant Centers" (1995) 60:4 Transplant 322.

38 Janet Radcliffe-Richards, "Nefarious Going On: Kidney Sales and Moral Arguments" (1996) 21:4 J Med Philos 390; George Abouna *et al*, "The Negative Impact of Paid Organ Donation," in Walter Land & John Dossetor, eds, *Organ Replacement Therapy: Ethics, Justice, Commerce* (Berlin; Springer-Verlag, 1991) at 167; James Childress, "Ethical Criteria for Procuring and Distributing Organs for Transplantation" (1989) 14:1 J Health Polit Policy Law 110.

39 Titmuss, *supra* note 11; Carl Mellstrom & Magnus Johannesson, "Crowding Out in Blood Donation: Was Titmuss Right?" (2008) 6:4 J Eur Econ Assoc 845; Bruno Frey & Reto Jegen, "Motivation Crowding Theory" (2001) 15:5 J Econ Surv 589.

40 Satz *supra* note 15 at 194; Ahad Ghods *et al*, "Adverse Effects of a Controlled Living-Unrelated Donor Renal Transplant Program on Living-Related and Cadaveric Kidney Donation" (2000) 32:3 Transplant Proc 541.

self-sufficient and meet the organ needs of their nationals from within their own territories for it is bad practice for a State to depend on other States to meet the organ needs of its nationals.[41] However, a regulated system of organ donation, whether based on monetized donation or other forms of incentivized donations, will not do away with the current criticisms of organ commercialization such as the exploitation of the poor and the commodification of human organs.[42] These problems will still exist in spite of any measures put in place to ensure that the system functions properly.[43] The above criticisms will form part of the focus of the next section of this Chapter.

## C Schools of Thought against Transplant Tourism and Related Practices

Understandably, there are several arguments against travel for transplantation if it involves organ trafficking or organ commercialization. Anti-transplant tourism scholars argue that organ trafficking and commercialization and, by extension, transplant tourism in its entirety is wrong and should not be condoned under any circumstance. Among the arguments against transplant tourism, three arguments often used are those against organ commodification, the exploitation of the poor and the challenges it has on the healthcare system of both transplant and tourist States. Aside from the above major arguments against transplant tourism, other arguments include the lack of autonomy and real consent on the part of organ vendors, the possible discouragement of altruistic donors and the encouragement of organ theft. Though these arguments have attracted a great deal of criticism from writers in favor of organ commercialization, they nonetheless reflect the

41 WHO EMR *Informal Regional Consultation on Developing Deceased Donor Donation, 2006* (hereinafter: *Kuwait Statement*): World Health Organization, *Second Global Consultation on Critical Issues in Human Transplantation: Towards a Common Attitude to Transplantation* (Geneva, World Health Organization, 2007) at 25.

42 There are also arguments that the creation of an incentivized system for organ donation will increase the cost of transplant procedures: Chkhotua *supra* note 31 at 1793; Roger Evans, "Incentives for Organ Donation" (1992) 339:8786 The Lancet 185.

43 Several guidelines have been suggested for the proper functioning of a system based on incentivized organ donations such as the protection of the poor from exploitation, proper regulation and oversight of the program and transparency and proper international observation: Working Group on Incentives for Living Donation, *supra* note 13 at 308–309.

consensus of the international community on transplant tourism and organ commercialization and trafficking. This consensus is visible in the existing bioethical framework for obtaining organs and tissues which is based on four key values—respect for individuals, autonomy, consent and altruism.[44] I will discuss these arguments below.

### 1 *The Commodification Argument*

The first major argument against transplant tourism is philosophical and condemns organ commercialization which is an important aspect of transplant tourism. The argument here is that the transfer of human organs by sale leads to the commodification of human beings.[45] Commodification is the social practice of treating things as properties that can be bought, sold or rented.[46] The reasoning behind the commodification argument as it relates to human organs is that like people themselves, human organs have special or intrinsic value and selling them shows disrespect for human organs and individuals themselves.[47] This intrinsic value is sometimes described in terms of "human dignity" and it is argued that putting a price on a body part and exchanging it for economic gain compromises the dignity of the person as it reduces the human body and its parts to the status of a mere commodity.[48] It is further argued that human organs are not spare parts and no one can put a price on an organ which is ultimately going to save someone's life.[49] Put differently, human organs do not belong in a

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44 Council of Europe, *Trafficking in Organs, Tissues and Cells and Trafficking in Human Beings for the Purpose of the Removal of Organs* (Strasbourg: Council of Europe, 2009), online: <http://www.ont.es/publicaciones/Documents/OrganTrafficking_study.pdf>.

45 Childress, *supra* note 38 at 110.

46 David Resnik, "The Commodification of Human Reproductive Materials" (1998) 24:6 J Med Ethics 390. Arguments against organ commodification are essentially arguments against the principle of universal commodification which is the notion that everything of value can be alienated: See generally, Posner, *supra* note 2. However, certain things like human organs are deemed to be inalienable and their commodification remain contestable: Radin, *supra* note 1 at 1856.

47 Kate Greasley, "A Legal Market in Organs: The Problem of Exploitation" (2014) 40:1 J Med Ethics 51.

48 *Ibid.*

49 Matas, *supra* note 15 at 1131; Paul Flaman, "Organ and Tissue Transplants: Some Ethical Issues," in Mervyn Lynch & Naomi Stinson eds, *Topics in Bioethics for Science and Religion Teachers: Reading and Study Guide*, (Edmonton: Edmonton Catholic Schools and St. Albert Catholic Schools, 1994) at 31–46; Teo Bernard, "Is the Adoption of More Efficient Strategies of Organ Procurement the Answer to Persistent Organ Shortage in Transplantation" (1992) 6:2 Bioethics 125.

market.[50] Aside from human dignity, arguments against the commodification of body parts are also anchored on the belief that it depreciates some fundamental societal values and convictions, compromises the autonomy of persons, constitutes unjust moral pressure on donors and leads to the violation of equity as the ability to pay will be the major factor governing the distribution of organs.[51] An extension of the argument against the commodification of human organs is that the sale of human organs is a modernized form of slavery.[52]

Commodification arguments centered on the violation of the dignity of human beings are hinged on the second formulation of Immanuel Kant's categorical imperatives, the formula of humanity, which states that: "So act that you always treat humanity, whether in your own person or in the person of any other, always at the same time as an end, never merely as a means."[53] Flowing from Kant's reasoning, it is argued that the sale of human organs makes us treat humanity simply as a means of acquiring something else: an act which, it is argued, compromises the personal dignity and bodily integrity of individuals and devalues their person.[54] A major challenge with this argument is that there is no consensus on what dignity connotes as the concept is sometimes vague and subject to many interpretations.[55] It is however a fundamental theory of

50 As noted by Agneta Sutton, "if we allow body parts to enter the marketplace, we depersonalize and devaluate ourselves.": Agneta Sutton, "Commodification of Body Parts" (2002) 325:7356 BMJ 114.

51 Flaman, *supra* note 49 at 31; Abouna, *supra* note 38 at 170; Simon Rippon, "Imposing Options on People in Poverty: The Harm of a Live Donor Organ Market" (2014) 40:3 J Med Ethics 145; Cynthia Cohen, "Public Policy and the Sale of Huma Organs" (2002) 12:1 Kennedy Inst Ethics J 59.

52 Taylor, *supra* note 6 at 16; Russell Scott, "The Human Body: Belonging and Control" (1990) 22:3 Transplant Proc 1002–4; Junius Rodriguez, *Slavery in the Modern World: A History of Political, Social and Economic Oppression* Vol. 2 (Santa Barbara: ABC-CLIO, 2011) at 310.

53 Immanuel Kant, "Groundwork of the Metaphysics of Morals" in Mary Gregor, ed, *Cambridge Texts in the History of Philosophy* (Cambridge: Cambridge University Press, 1998) at 38. See also: Immanuel Kant, *Ethical Philosophy: The Complete Text of Grounding for the Metaphysics of Morals, and Metaphysical Principles of Virtue, Part II of the Metaphysics of Morals* (Indianapolis: Hackett Publishing, 1983) at 36; Christine Korsgaard, "Fellow Creatures: Kantian Ethics and Our Duties to Animals" (2004) 24 Tanner Lectures on Human Values 3.

54 Fried, *supra* note 9 at 142.

55 The European Court of Human Rights noted that dignity is a "particularly vague concept, and one subject to random interpretation.": *Siliadin v France*, (App. No. 73316/01), Eur. Ct. H.R. 30 (2005); Ruth Macklin, "Dignity is a Useless Concept" (2003) 327:7429 BMJ 1419; Timothy Caulfield & Ubaka Ugbogu, "Stem Cell Research, Scientific Freedom and the

international human rights.[56] The preamble of the *Universal Declaration of Human Rights* (UDHR) for instance makes reference to "inherent dignity" as being part of the "foundation of freedom, justice and peace in the world."[57] As a working definition, the dignity of an individual can be said to be the right of that individual to pursue a decent existence free from all forms of violation whilst enjoying protection from any act that undermines her/his personhood. It is often tied to a person's self-worth and his/her right to self-determination.[58] The dignity of all individuals should be respected and any action aimed at depriving persons of their dignity should be frowned upon. Due to the nature of this concept, dignity forms the foundation of most international human rights treaties.[59]

The argument that the sale of human organs leads to the commodification of persons and the devaluation of human dignity has, however, met with some stiff opposition. The first counterargument is that the concept of dignity of persons has been stretched, wrongly, by commodification theorists to cover human organs. As Gill and Sade argued, "My kidney is not my humanity. Humanity—what gives us dignity and intrinsic value—is our ability to make rational decisions."[60] They go on to state that selling a kidney does not destroy or even seriously compromise our humanity.[61] The flaw in this argument is that the authors ignore the fact that dignity does not exist *in vacuo* but operates only due to our physical existence. As noted by the UDHR and other human rights instruments, the foundation of human rights includes respect for the inherent

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Commodification Concern: Vague Concerns about Possible Commodification Should Not Serve as Justification to Limit Freedom of Research" (2012) 13:1 EMBO Reps 12.

56 George Wright, "Dignity and Conflicts of Constitutional Values: The Case of Free Speech and Equal Protection" (2006) 43:3 San Diego L Rev 528; Tom Harkin, "Human Rights and Foreign Aid: Forging an Unbreakable Link" in Peter Brown & Douglas MacLean, eds, *Human Rights and U.S. Foreign Policy: Principles and Applications* (Lanham: Lexington Books: 1979) at 15; *Siliadin v France*, *supra*.

57 Preamble, the *Universal Declaration of Human Rights*, GA Res. 217 (III), UN GAOR, 3d Sess., Supp. No. 13, UN Doc. A/810 (1948) 71.

58 Rex Glensy, "The Right to Dignity" (2011) 43:65 Colum Hum Rts L Rev 68.

59 See for instance: Article 11(1), *American Convention on Human Rights,* OAS Treaty Series No. 36; 1144 UNTS 123; 9 ILM 99 (1969); Article 5, *African Charter on Human and Peoples' Rights,* OAU Doc. CAB/LEG/67/3 rev. 5, 1520 UNTS 217; 21 ILM 58 (1982; William May, "Religious Justifications for Donating Body Parts," (1985) 15:1 Hastings Cent Rep 39.

60 Gill & Sade, *supra* note 4 at 26; Thomas Hill, *Dignity and Practical Reason in Kant's Moral Theory* (Ithaca: Cornell University Press, 1992) at 38–41.

61 Gill & Sade, *supra* note 4 at 26.

dignity of the human person. If the inherent dignity of the human body as a whole which prevents it from being priced is accepted, we must be willing to extend this principle to its integral parts.[62] Aptly expressed by Cynthia Cohen:

> To sell human beings and those bits and pieces integral to them as embodied selves is to violate that which is essential to them … as it violates human dignity to sell whole persons, so, too, it violates that dignity to sell body parts integral to whole persons.[63]

It is further suggested that the widely accepted practice of organ donation and distribution already commodifies organs as everyone, including the doctors and health care workers, benefit financially from altruistic donations and the organ recipients benefit physically.[64] Closely related to this suggestion is the opinion that prices are already being placed on human cells such as gametes and the donors of these cells have not suffered any loss of dignity.[65] However, the "benefit" which health care workers derive from the transplantation process is not tied to the organ directly but comes in the form of remuneration for their services. It is thus fallacious to state that they benefit financially from the donated organ. A major factor which distinguishes altruistic organ donation from organ commercialization is that, in the latter situation, the organ is given for a price which turns it into a commodity.[66] In addition, it can be argued that organs like kidneys and lungs are non-regenerative and cannot be placed in the same category as cells which are generative in nature, the extraction of which is not as intrusive as that of human organs. Moreover, there are still writers who argue against the sale of gametes and other types of human cells.[67]

### 2 *The Exploitation Argument*

The second major argument against transplant tourism has its foundation in public policy and seeks to protect economically disadvantaged individuals

62 Calum Mackellar, "Human Organ Markets and Inherent Dignity" (2014) 20:1 The New Bioethics 59.

63 Cynthia Cohen, "Selling Bits and Pieces of Human to Make Babies: The Gift of the Magi Revisited" (1999) 24:3 J Med Phil 294. See also Radin, *supra* note 1 at 1880–1.

64 Cherry, *supra* note 31 at 41; Wilkinson, *supra* note 11 at 198.

65 Matas, *supra* note 15 at 1131.

66 Gill & Sade, *supra* note 4 at 23; Mario Morelli, "Commerce in Organs: A Kantian Critique" (1999) 30:2 J Soc Phil 315.

67 See generally, Bonnie Steinbock, "Payment for Egg Donation and Surrogacy" (2004) 71:4 Mt Sinai J Med 255.

from exploitation.[68] The argument here is that sanctioning the sale of human organs will lead to an outright exploitation of the poor as a majority of the people who have been shown to sell their organs are indigent or in debt.[69] For the purpose of this publication, exploitation means taking unfair advantage of someone or to "use another person's vulnerability for one's own benefit."[70] It has been shown that those who are most likely to sell their organs are those who are desperately in need of money, as persons with alternative sources of income will not choose to go through pain, discomfort, possible risk (physical and economical) and part with an organ for financial compensation.[71] Surveys on the state of organ sales and transplant tourism have classified the sellers of organs as usually poor, unemployed, hungry, socially marginalized, people in debt or peonage, illegal immigrants, refugees, ex-prisoners, ex-soldiers and the young and naïve.[72] This trend is present in every pattern of organ sales. In organ commercialization cases within States, it is usually the poor who sell their organs to richer individuals who can afford to buy them. This remains the case even where the sale is carried out in a regulated organ market.[73] Where organ sales are as a result of transplant tourism, it is usually individuals from richer States traveling to poorer States to buy organs.[74]

The above patterns in organ sales have led writers like Russell Scott and William May to argue that selling human organs for profit is exploitative, degrading and incompatible with basic human values such as the sanctity

68 Greasley, supra note 47 at 51.

69 *Ibid*; Bos, *supra* note 23 at 8; Cherry, *supra* note 31 at x; Yosuke Shimazono, "The State of the International Organ Trade: A Provisional Picture Based on Integration of Available Information" (2007) 85:12 Bull World Health Organ 955.

70 Matt Zwolinski & Alan Wertheimer, "Exploitation" in The Stanford Encyclopedia of Philosophy (Stanford: Stanford University, 2017).

71 Dworkin, *supra* note 5 at 157; In the 2001 study in Chennai discussed in Chapter 1, some of the participants complained of decline in their economic status after their nephrectomy because of a deterioration of their health. Fifty percent of the participants complained of persistent pain at the nephrectomy site and 33% complained of long-term back pain. See Madhav Goyal *et al*, "Economic and Health Consequences of Selling a Kidney in India" (2002) 288:13 JAMA at 1591. A different study in Egypt showed that 78% of a group of commercial living donors interviewed reported a deterioration in their health condition: Debra Budiani-Saberi & Frances Delmonico, "Organ Trafficking and Transplant Tourism: A Commentary on the Global Realities" (2008) 8:5 Am J Transplant 927.

72 Bos, *supra* note 23 at 8. Scheper-Hughes, *supra* note 21 at 1645.

73 See Iran for e.g. See Dehghan, *supra* note 17.

74 Aronowitz, *supra* note 13 at 26.

of life.[75] The rationale behind this argument is that poverty acts as an incapacitating factor which coerces poor individuals to sell their organs as a final resort. The argument can also be made that if organ sellers like kidney vendors were in a better economic state, they would not make the decision to part with their organs to strangers with whom they share no affinity. Even though these organ sellers sometimes seem to be making a "choice" to sell their organs, their choices have in fact been compromised by their economic desperation.

Individuals in support of organ commercialization do not support the view that organ vendors are exploited as they see the vendors as persons who make autonomous decisions to sell their organs and receive something of value in return.[76] Arthur Matas is famous for stating that since the poor are not prevented from taking up risky jobs such as mining, firefighting, and police and military service, which the rich will not accept, it is surprising that we prevent them from entering into "free contracts."[77] The agreement to sell an organ, however, cannot be termed a "free contract," because both parties do not negotiate on a level playing field as the organ donor is usually in a state of desperation at the time of entering into such an agreement. It has been shown that most organ vendors usually regret their actions after the sale.[78] In addition, while people involved in the aforementioned professions derive a sense of pride and accomplishment from their contribution to the society, organ vendors do not derive any satisfaction from the sale of their organs or the successful operations of the buyers of their organs.[79] Moreover, while police, military and firefighters are a necessity no society can do without and are better off with, the same cannot be said for the need to satisfy the demand for organs with their sale. It is also yet to be shown that only the poor take up these types of jobs. In parts of the UK, for instance, a percentage of the police force is made up of

75 Scott, *supra* note 3 at 184–186.

76 Matas, *supra* note 15 at 1131.

77 *Ibid*., Matas, *supra* note 20 at 2010; Radcliffe-Richards, *supra* note 38 at 377.

78 Goyal, *supra* note 71 at 1591.

79 In his article, " 'Living Cadavers' in Bangladesh: Bioviolence in the Human Organ Bazaar," Monir Moniruzzaman shares the experience of a Hindu organ vendor from India who had to undergo circumcision because he was going to sell his organ to a Muslim patient in Bangladesh pretending to be his brother. This went against the vendor's religious doctrine and beliefs. However, he went through with the procedure and after the sale, he felt a lot of guilt for his actions and had worries about condemnation from God in the afterlife for not returning his body intact. See Monir Moniruzzaman, " 'Living Cadavers' in Bangladesh: Bioviolence in the Human Organ Bazaar" (2012) 26:1 Med Anthropol Q 77.

Special Constables (SC) who are volunteers who work for free. The number of individuals signing up to be SCs continues to rise with each passing year.[80]

Another argument made in defense of organ commercialization is the "benefit argument" which is closely related to the "*Laissez Choisir* Argument." The argument here is that it is unjust to deny poor people the choices that they have to increase their well-being[81] It is also maintained that preventing the poor from selling their organs would leave them in a worse state than they previously were.[82] As argued by Lori Andrews, "banning payment on ethical grounds to prevent [exploitation] overlooks one important fact: to the person who needs money to feed his children or to purchase medical care for her parent, the option of not selling a body part is worse than the option of selling it."[83] Closely related to this argument is the "mutually advantageous argument" made by writers like Alan Wertheimer.[84] He argues that although exploitation might be morally wrong, it might be mutually advantageous to both parties and not warrant State intervention.[85] Mark Cherry also states that if one is concerned that:

> The poor will be induced by their poverty to sell their organs, one must also be concerned that removing what the poor may see as an attractive option, so as to assuage feelings of repugnance on the part of the affluent, itself coercively limits the liberty of the poor autonomously to assess available opportunities to better their lives, thereby engendering inequality-related harms.[86]

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80 Joe Whittle, "The Rise of the Special Constabulary: Are Forces Getting Value for Money from their Voluntary Officers? An Empirical Study in Avon and Somerset Police" (2014) 87:1 Police J 29.

81 The proponent of this argument is Gerald Dworkin in Dworkin, *supra* note 5. Simon Rippon, however, argues that it would be better if the poor did not have this option at all. He argues further that there are strong empirical and theoretical reasons for believing that the poor would be harmed by a commercial market in human organs and would thus be better off without one. See Rippon, *supra* note 51; Adrian Walsh, "Commentary on Simon Rippon, 'Imposing Options on People in Poverty: The Harm of a Live Donor Organ Market' " (2014) 40:3 J Med Ethics 153; Janet Radcliffe-Richards, "Commentary by Janet Radcliffe-Richards on Simon Rippon's 'Imposing Options on People in Poverty: The Harm of a Live Donor Organ Market' " (2014) J Med Ethics 152.

82 Radcliffe-Richards, *supra* note 38 at 377.

83 Lori Andrews, "My Body, My Property" (1986) 16:5 Hastings Cent Rep 32.

84 Alan Wertheimer, *Exploitation*, Rev ed. (Princeton: Princeton Uni Press, 1999) 20–21.

85 *Ibid.*

86 He further states that organ selling may be a means to generate resources for the poor which can be reinvested in personal and economic development, thereby decreasing the inequalities: Cherry *supra* note 31 at 84.

The problem with the benefit argument is that it looks at organ commercialization strictly from a theoretical economic benefit perspective without considering the actual impact of the sale as evidenced in the lives of living kidney vendors. Although vendors get some amount of benefit from the sale of their organs in terms of money received, these benefits do not meet their needs and leave them in a worse state than they were before selling their organs.[87] The aim for which they sold their organs, i.e. economic improvement, is never realized.[88]

### 3 *The Harm to Healthcare System and Patients Argument*

Another argument against transplant tourism is that it challenges the healthcare systems of both transplant and tourist States. In key transplant States, foreign patients receive a great deal of attention as, in most cases, they are the ones with the finances to purchase organs at high rates. The effect of this is that poor nationals are automatically prevented from having access to organs due to the high cost of these organs in the illegal market.[89] As was discussed in Chapter 1, it is bad practice for resources in a State to be devoted towards providing transplants to foreign patients at the expense of the transplant needs of that State's own population.[90] This argument is, however, weakened by the fact that the organs sold to foreign patients in transplant States are the product of organ commercialization and not organs which will be available to nationals who are unable to pay for them. Thus, the removal of foreign patients from the equation will not necessarily lead to the availability of more organs for the unpaying local population.

Though it might seem as if tourist States have as much to gain from transplant tourism as persons who demand these organs and pay for them are from tourist States, there are concerns about the medical safety of organs transplanted abroad and the wellbeing of patients who travel abroad for organ

87 Budiani-Saberi & Delmonico, *supra* note 71 at 927–928. In a socioeconomic and health survey in Pakistan involving 239 organ vendors, 85% of those vendors reported no economic improvements in their lives after the sale: Syed Naqvi *et al,* "A Socioeconomic Survey of Kidney Vendors in Pakistan" (2007) 20:11 Transplant Int'l 939.

88 *Ibid.*

89 Jeremy Haken, *Transnational Crime in the Developing World* (Washington: Global Financial Integrity, 2011) at 24.

90 See the definition of transplant tourism under the *Declaration of Istanbul*: "The Declaration of Istanbul on Organ Trafficking and Transplant Tourism" (2008) 3:5 Clin J Am Soc Nephrol 1227–1231.

transplants.[91] These revolve around graft survival rates, infection rates from diseased organs, substandard transplant practices and poor communication between transplant centers in transplant States and follow-up centers in tourist States.[92] Jennifer Babik and Peter Chin-Hong have summarized the risk of transplant tourism to organ recipients perfectly. According to the authors:

> Transplant tourism puts the organ recipient at risk for surgical complications, poor graft outcome, increased mortality, and a variety of infectious complications. Bacterial, viral, fungal, and parasitic infections have all been described, and most concerning are the high rates of blood-borne viral infections and invasive, often fatal, fungal infections.[93]

There are several studies which show these outcomes in patients who buy organs abroad.[94] In Saudi Arabia, for instance, in a report on sixteen dialysis patients who bought kidneys from living non-related donors in India, one patient contracted HIV from the process, another patient was infected with hepatitis B while another six patients tested positive for hepatitis C virus antibodies.[95] In a Canadian study carried out in order to expose the clinical outcomes of 20 patients from a single Canadian transplant center that had received kidneys

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91 Timothy Caulfield & Amy Zarzeczny, "Curbing Transplant Tourism: Canadian Physicians and the Law" (2016) 188:3 CMAJ 935.

92 Muna Canales *et al*, "Transplant Tourism: Outcomes of United States Residents Who Undergo Kidney Transplantation Overseas" (2006) 82:12 Transplant 1658.

93 Jennifer Babik and Peter Chin-Hong, "Transplant Tourism: Understanding the Risks" (2015) 17:18 Curr Infect Dis Rep 17.

94 See: Sean Kennedy *et al*, "Outcome of overseas commercial kidney transplantation: an Australian perspective" (2005) 182:5 Med J Aus 224–227; Sajjad *et al, supra* note 17 at 744–754; Anantharaman Vathsala, "Outcomes for Kidney Transplants at the National University Health System: Comparison with Overseas Transplants" (2010) Clin Transplant 149–160; Anthony Polcari *et al*, "Transplant Tourism: A Dangerous Journey?" (2011) 25:4 Clin Transplant 633–637; Jagbir Gill *et al*, "Transplant Tourism in the United States: A Single Center Experience" (2008) 3:6 Clin J Am Soc Nephrol 1820; Robert Higgins *et al*, "Kidney Transplantation in Patients Travelling from the UK to India or Pakistan" (2003) 18:4 Nephrol Dial Transplant 851; Ramesh Prasad *et al*, "Outcomes of Commercial Renal Transplantation: A Canadian Experience" (2006) 82:9 Transplant 1130.

95 These patients were not infected prior to their operation. Both the persons with HIV and hepatitis B tested negative before their operation and the infections were detected after post-transplant testing. It was however discovered that the patient and graft survival rates were like those of patients who obtained their organs from altruistic donors in Saudi Arabia: James Onwubalili *et al*, "Outcome of Bought Living Non-Related Donor Kidneys

from commercial non-related donors abroad from 1998 to 2005, it was discovered that the patient and graft survival rates were significantly worse than those of persons who had received organs from biological or emotionally related donors.[96] In addition, eleven (52%) of the patients had serious post-transplant opportunistic infections, with two of the patients dying from fungal infection-related sepsis.[97] It has also been noted that transplant patients usually bring back infections that are endemic to the area where the transplant was done and resistant to many of the drugs in the tourist States.[98] Transplant professionals in tourist States often have to deal with all these issues which could be fatal.[99] It has been advised that transplant professionals and infectious disease physicians "should have a high degree of suspicion" for complications in patients who have acquired their organs through transplant tourism abroad.[100]

### 4 *Other Arguments against Transplant Tourism*

Aside from the three major arguments against transplant tourism discussed above, other arguments against it include the lack of autonomy and real consent on the part of organ vendors, the possible discouragement of altruistic donors, its effect on the attainment of organ self-sufficiency goals of States

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Followed up at a Single Center" (1994) 7:1 Transplant Int'l 27 & 29. See also, Mohamed Al-Sulaiman, *et al*, "Impact of HIV Infection on Dialysis and Renal Transplantation" (1989) 21:1 Transplant Proc 1970; Ninoslav Ivanovski *et al*, "Renal Transplantation from Paid, Unrelated Donors in India: It is not only Unethical, it is also Medically Unsafe" (1997) 12:9 Nephrol Dial Transplant 2028. Similar results were arrived at in a larger study involving 540 patients who bought organs and were transplanted in India. In the survey leading to this report, data was collected from 22 centers on 540 patients who received kidneys commercially in India. There was a high incidence of HIV infection (4.6%) and hepatitis B infection (8.1%) among these patients: Wajeh Quinibi, "Commercially Motivated Renal Transplantation: Results in 540 Patients Transplanted in India" (1997) 11:6 Clin Transplant 536.

96 Prasad *et al*, *supra* note 84 at 1130.

97 *Ibid* at 1131.

98 "The Perils of Transplant Tourism," *Globe and Mail*, (6 January 2009), online: <http://www.theglobeandmail.com/life/article964133.ece>.

99 For instance, a case was reported involving George Archer, a 78-year-old Canadian who travelled to Lahore, Pakistan in May 2006 for a kidney transplant. A few weeks after his return from Pakistan his transplant incision, which had been leaking slightly, split open. While treating him, doctors in Montreal discovered other health problems: respiratory distress, heart beat irregularities and atherosclerosis. He died two days later: "The Perils of Transplant Tourism," *supra* note 98.

100 Babik & Chin-Hong, *supra* note 93 at 17.

and the theft of organs. Based on the importance of autonomy to the existing framework governing the acquisition of organs in most nations, it is often argued that the organ vendors involved in transplant tourism practices are coerced into selling their organs by external circumstances such as poverty which compromises their autonomy.[101] Autonomy has been defined as encompassing "self-rule that is free from both controlling interference by others and limitations that prevent meaningful choice, such as inadequate understanding."[102] Thus, for individuals to be seen as acting autonomously, they must be able to act intentionally and with understanding which can only be achieved via full disclosure. They must also be free from external controlling influences.[103] As was noted in Chapter 1, a unique practice which challenges the rules of consent and autonomy in organ donation takes place in China where organs of executed prisoners are sold to foreigners for transplant purposes.[104] In 2005, China admitted that the organs of executed prisoners were sold to foreigners for transplant purposes and in 2009, it was reported that executed prisoners provide two-thirds of all transplant organs in China.[105]

As has been shown in Chapter 1, some organ vendors seek out clinics and directly sell their organs to those clinics.[106] Although this group of organ vendors cannot be said to have been physically coerced into selling their organs, as with other organ vendors in general, they have been found to be undereducated and financially disadvantaged. It can therefore be argued that they are incompetent to make informed choices regarding the sale of their organs as they do not fully comprehend the nature of the risks involved in the procedure nor the aftereffects of their decisions.[107] This argument has some merits as the primary concern of intermediaries, clinics and transplant centers that

101 Radcliffe-Richards, *supra* note 38 at 381; John Dossetor & Valavandan Manickavel, "Commercialization: The Buying and Selling of Kidneys" in Carl Kjellstrand & John Dossetor, eds, *Ethical Problems in Dialysis and Transplantation* (Dordrecht; Kluwer Academic Publishers, 1992) at 61.

102 Tom Beauchamp & James Childress, *Principles of Biomedical Ethics*, 7th ed (New York; Oxford University Press, 2013) at 101.

103 *Ibid* at 104.

104 See Chapter 1, footnote 74.

105 "China Admits Death Row Organ use," *BBC News* (26 August 2009), online: <http://news.bbc.co.uk/2/hi/asia-pacific/8222732.stm>.

106 Goyal, *supra* note 71 at 1590.

107 Radcliffe-Richards, *supra* note 38 at 379; Matas, *supra* note 20 at 2012; Robert Sells, "Resolving the Conflict in Traditional Ethics Which Arises from our Demand for Organs" (1993) 25:6 Transplant Proc 2983.

purchase organs is to get the organs, as the agreement takes the form of a regular commercial transaction in which a buyer makes purchases at the lowest price possible.[108] This being the case, little or no time is devoted to educating the vendors about the transplant process and ensuring that they comprehend the risks fully. This view has been subject to much scrutiny as it is seen as being paternalistic.[109] It is further contended that people should be allowed to make the decision whether to sell their organs based on their own values and without constraints.[110] Another counter argument to the autonomy argument is that the market system in which individuals sell their organs relies on the voluntary exchange between a willing buyer and a willing seller and is devoid of agents of coercion and control.[111] This being the case, individuals should be allowed to engage in organ trade which usually makes both parties better off.[112] However, as noted earlier, organ vendors are actually worse off after the sale of their organs.[113] Even in a regulated market, the transaction in organs cannot be seen as voluntary as the desperate financial situation of the vendor can be deemed to be a form of economic coercion which pushes them into selling their organs. As George Abouna puts it, "a truly voluntary and non-coerced consent" is doubtful in the organ market.[114]

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108 Dworkin, *supra* note 5 at 157.

109 *Ibid*; Per Friedlaender, "… we are paternalistic when we judge the motivation and values of other peoples and cultures. A paternalistic attitude to donors implies that they are poor, ignorant, and endangering their health." See Friedlaender, *supra* note 28 at 927. See also, Julian Savulescu, "Is the Sale of Body Parts Wrong?" (2003) 29:3 J Med Ethics 138.

110 Matas, *supra* note 20 at 2009.

111 James Taylor argues that for a person's autonomy to be impaired through coercion the coercer must intend to exercise control over them and since the condition of intention to control is not present in cases dealing with organ sale, the person's autonomy is unimpaired. He goes on to state that even if vendors wish not to be motivated by their desire to sell a kidney because they want to be in a different economic situation from the one they are actually in, they are still directing their own actions within the situation. As such, vendors would not necessarily suffer an impairment in autonomy when selling a kidney, even if they do so out of desperation: Taylor, *supra* note 6 at 110. See also Andrew Barnett *et al*, "Improving Organ Donation: Compensation versus Markets" in Arthur Caplan & Daniel Coelho, eds, *The Ethics of Organ Transplants: The Current Debate*, (Amherst NY: Prometheus Books, 1998).

112 Barnett *et al*, *ibid.*

113 Rippon, *supra* note 51.

114 Abouna, *supra* note 38 at 166.

It is important to point out here that not every organ obtained as a result of transplant tourism is the product of a "voluntary" exchange between seller and buyer. Transplant tourism also encourages organ theft and removal of organs without the consent of the owners. Though urban legends abound of persons going out for a drink and later waking up in a hotel room with severe pain in the lower back and a missing kidney, there are actual reported cases of organs being taken forcefully from unsuspecting victims. For example, in Bombay, there have been alleged cases of kidnapping where the victims regain consciousness to find out that one of their kidneys was removed while they were drugged.[115] In Argentina, there have been investigations in a mental hospital regarding allegations that patients were intentionally preyed upon and killed for their organs by employees of the hospital.[116] A similar allegation was made after the Kosovo war ended in 1999. It was alleged that 40 people mysteriously disappeared from a mental hospital in the southern Kosovo town of Stimlje and their disappearance was linked to an organ trafficking ring in Albania.[117] The theft of organs resulting in the death of individuals is obviously a deprivation of the right to life of the affected individuals and a strong argument against transplant tourism.

Transplant tourism also has negative effects on the attainment of organ self-sufficiency goals of States. Tourist States in general ought to be concerned about the overall impact transplant tourism is having on the progress being made in the achievement of national self-sufficiency in organs. For instance, transplant tourism has been blamed for the current wearing away of the development of local deceased donor systems.[118] It is my belief that if patients in tourist States had no other external alternatives to sourcing organs, a lot more focus would be placed on the sustainable acquisition of organs locally. This focus could come in the form of local enlightenment and follow up programs, education on transplant issues and/or frantic lobbying of governments and

115 Dianne Rinehart, "Sold for Organs, Risk to Kids Grows," The Edmonton Journal (22 June 1993) B14; David Rothman, "Bodily Integrity and the Socially Disadvantaged: The Traffic in Organs for Transplantation," in Bethany Spielman, ed, *Organ and Tissue Donation: Ethical, Legal and Policy Issues*, (Carbondale: Southern Illinois University Press, 1996) at 40.

116 Mark Hanson, "A Pig in a Poke" (1992) 22:6 Hastings Cent Rep 2.

117 Cameron Ainsworth-Vincze, "Where Kosovo Patients Slain for Organs?: Forty Inmates Disappeared from the Stimlje Mental Asylum in 2001," Maclean's (24 November 2008), online: <http://www2.macleans.ca/2008/11/24/were-kosovo-patients-slain-for-organs/>.

118 Babik & Chin-Hong, *supra* note 93 at 17; Sajjad *et al, supra* note 17 at 751.

policy makers to implement new organ acquisition models. The existence of an international market in human organs is a distraction from the exploration of these other avenues.

## Conclusion

In this Chapter, I focused on the various schools of thought in favor of and against transplant tourism. The key arguments against transplant tourism are: non-commodification of the human body, the protection of vulnerable members of society from exploitation, and the negative effects it has on healthcare systems and the health of organ sellers and buyers. Individuals who support transplant tourism cite its benefits to both the organ sellers and buyers, its use in addressing the organ shortage crises and the rights of individuals to control their bodies and freely deal with its parts in ways they deem fit. Examinations of these views, however, expose their shortcomings. Transplant tourism has not brought an end to the organ shortage crises. On the contrary, the long waiting times for organs continue to increase in key tourist States. Transplant tourism also has negative effects on both the organ buyers and sellers with no real benefits accruing to the sellers in the long run. While I agree that humans should have control over their bodies, I have supported the arguments against universal commodification because human organs do not belong in commercial markets. Arguments in support of the creation of a regulated market in human organs are not without loopholes. The poor will always bear the brunt of the establishment of such a system.

It is for the above reasons that a few States have taken legal steps to ensure that their nationals do not engage in transplant tourism either as organ sellers or buyers. Beginning with the next Chapter, I will start to explore ways in which transplant tourism can be prevented through national and international law. To achieve this goal, the current national and international laws prohibiting aspects of transplant tourism will be examined. In Chapter 3, the legal response of some key transplant and tourist States to transplant tourism and their impact will be discussed. As will be seen, there are currently very few national laws which prohibit transplant tourism in whole or in part. The absence of these laws makes transplant tourism legal in most States.

CHAPTER 3

# Current National Laws on Transplant Tourism

## A Introduction

In the last Chapter, I focused on the different schools of thought on transplant tourism. Although there are a few individuals who support it for reasons related to increased access to organs needed for transplantation, the presumed benefit transplant tourism brings to both the organ sellers and buyers, and respect for the bodily autonomy of individuals who choose to sell their organs, most people see transplant tourism as condemnable and push for its eradication. It is for this reason that a few States have passed laws which prohibit transplant tourism. Laws against transplant tourism differ depending on whether the State concerned is a key transplant or tourist State. In transplant States, laws with anti-transplant provisions have been passed in three States to protect nationals of those States from being victimized by organ brokers and foreign organ buyers.[1] In Israel, a tourist State, a law with anti-transplant tourism provisions was passed to discourage nationals from traveling abroad to buy organs for transplantation.[2] No matter the nature of the law adopted, they all have the common goal of prohibiting and eradicating transplant tourism and all have had various levels of successes in achieving this goal.

A major portion of this Chapter will be devoted to the examination of the transplant tourism laws of a few key transplant and tourist States and will show the approach they have adopted in eradicating transplant tourism practices. For transplant States, the organ transplant laws of the Philippines and India will be examined as they are two of the three transplant States which currently have laws which prohibit transplant tourism by preventing organ donations to foreigners who are not near relatives of the donees. The third transplant State with such a law is Pakistan.[3] For tourist States, the transplant laws of Israel, Canada and

1 The Philippines, India and Pakistan.

2 Israel is the only tourist State with such a law. Spain, though not a tourist State, also prohibits its nationals from engaging in transplant tourism under its *Penal Code*.

3 In March2010, the President of Pakistan assented to the *Transplantation of Human Organs and Tissues Act*, Act No. VI of 2010. Section 3(1) of the Act lays down the general rule that living organ donations are to be made by adults to individuals who are close blood relatives. Section 7(1) goes on to exempt individuals who are not Pakistani citizens from receiving organs from donors who are not close blood relatives.

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Australia will be looked at.[4] As will be seen, Israel is currently the only tourist State with a law against transplant tourism.[5] The organ transplant laws of other States focus on various other aspects of organ transplantation such as organ acquisition and the prohibition of organ commercialization. The first section of this Chapter will thus focus on the nature of organ transplant laws in general and will show aspects of organ transplantation which most States legislate on. Throughout the various sections of this Chapter, a case will be made for the adoption of more comprehensive national legislation against transplant tourism as partial legislation by a few key States have not succeeded in bringing it to an end.

## B An Overview of National Organ Transplant Laws

An ophthalmologist, Eduard Zirm, performed the world's first human organ transplant in 1905 after he and several others had made countless unsuccessful attempts.[6] Since then, organ transplantation has grown to become a standard medical procedure for treating various ailments in most parts of the world. In the US alone, close to 30,000 organ transplants are performed yearly.[7] The regulation of organ transplantation did not however begin until a few decades after the first procedure was carried out. One of the earliest statutes on organ procurement and transplantation was the *Corneal Grafting Act* which was passed in the UK in 1952.[8] The Act allowed medical practitioners to harvest the eyes of recently diseased persons for use in grafting.[9] In North America, one of the first efforts at setting a national organ and tissue donation policy through

4 These three States were selected based on their importance to transplant tourism, their geographical location and the differences in approach they have chosen in their regulation of organ transplantation within their territories.

5 See *Organ Transplant Law 5768-2008*, Israeli Book of Laws (OTL)

6 Eduard Zirm, "A successful total keratoplasty" (1906) 64:3 Graefe's Arch Clin Exper Ophthal 580; John Armitage, *et al*, "The First Successful Full-Thickness Corneal Transplant: A Commentary on Eduard Zirm's Landmark Paper of 1906" (2006) 90:10 Br J Ophthal 1222.

7 The National Organ Procurement and Transplantation Network, Number of U.S. Transplants per Year, available online: <http://www.infoplease.com/sciencehealth/us-transplants-year-1988–2007.html>.

8 Benjamin Rycroft, "The Corneal Grafting Act, 1952" (1953) 37 Brit J Ophthal 349; David Price, "Legal Framework Governing Deceased Organ Donation in the UK" (2012) 108:1 Br J Anaesth i68; Tom Woodcock & Robert Wheeler, "Law and Medical Ethics in Organ Transplantation Surgery" (2010) 92:4 Ann R Coll Surg Engl 282.

9 See section 1(1) *Corneal Grafting Act*, 1952: 15 & 16 Geo. VI & 1 Eliz. II, c.28; David Hamilton, *A History of Organ Transplantation* (Pittsburg: University of Pittsburgh Press, 2012) at 248.

legislation came in 1968 when the *Uniform Anatomical Gift Act* (UAGA) was enacted in the US.[10] By 1972, the UAGA had been passed in some form by all of the 50 US states.[11] Due to recent advancements in transplant surgery and the widespread nature of the practice, most States in the world now have laws regulating organ donation and transplantation. Though organ transplant policies and laws differ from State to State, most of them share certain similarities. In general, they have three focal areas in common: the acquisition of organs, the penalization of organ commercialization and the administration of the practice of organ transplant. Also, very few national organ transplant laws cover the regulation of transplant tourism.

The focal point of most national organ transplant laws is the acquisition of organs for transplantation. Due to the shortage of organs globally, most developments in national organ transplant laws focus on ways of increasing the supply. One way in which this has been achieved is the revision of organ transplant legislation to accommodate organ donation from minors. Despite the legal and ethical concerns surrounding the rights of children and the need to protect them from exploitation, most States now permit organ donation from minors.[12] In Canada, for instance, organ donation from minors was not allowed under the former *Human Tissue Gift Act* of the province of Alberta.[13] This changed in 2006 when the *Human Tissue and Organ Donation Act*[14] which aimed at broadening the scope of the former law was passed.[15] Among other

10 There were two subsequent revisions of this Act, in 1987 and 2006. See *Revised Uniform Anatomical Gift Act* (2006) 8A ULA 52 (Supp. 2009). For more on the Act including its history and events leading to its enactment, see Alfred Sadler *et al*, "The Uniform Anatomical Gift Act: A Model for Reform" (1968) 206:11 JAMA 2501; Arthur Dalley *et al*, "The Uniform Anatomical Gift Act: What Every Clinical Anatomist Should Know" (1993) 6:4 Clin Ana 247.

11 Arthur Caplan *et al*, "Increasing Organ and Tissue Donation: What are the Obstacles? What are our Options?" (1992) (Paper presented at Surgeon General's Workshop on Organ Donation, Washington, D.C.) at 204, available online: <http://profiles.nlm.nih.gov/ps/access/NNBCZL.pdf>.

12 See generally: Mary Olbrisch *et al,* "Children as Living Organ Donors: Current Views and Practice in the United States." (2010) 15:2 Curr Opin Organ Transplant 241; Howard Kaufman, *ed, Pediatric Brain Death and Organ/Tissue Retrieval: Medical, Ethical and Legal Aspects* (New York: Plenum Medical Book Company, 1989); Joe Carcillo *et al*, "A Call for Full Public Disclosure and Moratorium on Donation after Cardiac Death in Children" (2010) 11:5 Pediatr Crit Care Med 641.

13 *Human Tissue Gift Act*, RSA 2000, c.H-15

14 *Human Tissue and Organ Donation Act* of Alberta, SA 2006, c.H-14.5, s. 5.

15 Erin Nelson, "Alberta's New Organ and Tissue Donation Law: The Human Tissue and Organ Donation Act" (2010) 18:2 Health L Rev 5.

changes made by the latter Act, it allows for organ donation from minors in certain circumstances and with the approval of an independent assessment committee.[16]

A different approach increasingly used by States to increase the availability of transplant organs is to focus on cadaveric organ donation. This shift in focus is significant especially in Asian States where the prevalent cultural belief is that the removal of an organ violates the sanctity of the deceased.[17] In Japan for instance, cadaveric organ donation is greatly hindered by emotional attachment of family members to the body of the deceased.[18] This, however, did not stop the government from legalizing cadaveric organ donation through the 1997 *Law Concerning Human Transplant*[19] after a thirty-year ban on the practice.[20] In a bid to increase the rate of cadaveric organ donation, about twenty-four European States including Spain, Austria, Belgium and France went a step further and passed presumed consent legislation at different points in time. These statutes allow organs from the dead to be used for transplant purposes unless the individuals objected to such use during their lifetime.[21] This trend of using presumed consent laws is beginning to spread to other regions. In August 2016, Colombia, a transplant State, passed a new law on presumed

16 See section 5(2–7), HTODA, *supra* note 14.

17 Kevin Woo, "Social and Cultural Aspects of Organ Donation in Asia" (1992) 21:3 Ann Acad Med Sing 421; Christina Chung *et al*, "Attitudes, Knowledge, and Actions with Regard to Organ Donation among Hong Kong Medical Students" (2008) 14:4 Hong Kong Med J 282.

18 Dana Alden & Alan Cheung, "Organ Donation and Culture: A Comparison of Asian American and European American Beliefs, Attitudes and Behaviors" (2000) 30:2 J App Soc Psyc 296; Kazuo Ota, "Present Status of Kidney Donation in Japan" (1991) 23:5 Transplant Proc 2512.

19 The *Law Concerning Human Transplant*, Law No. 104 of 1997.

20 Kazuya Kondo, "The Organ Transplant Law of Japan: The Past, the Present and the Future" (2005) 16:1–2 J Int'l Bioethique 91; Rihito Kimura, "Organ Transplantation and Brain-Death in Japan: Cultural, Legal and Bioethical Background" (1998) 3:3 Ann Transplant Med 55; Masami Ishii & Mieko Hamamoto, "Bioethics and Organ Transplantation in Japan" (2009) 52:5 JMAJ 289.

21 Examples of state laws on presumed consent include: Law No. 30, dated October 27, 1979, *On the Removal and Transplantation of Organs* (Spain); Law No. 97, *On the Removal and Transplantation of Biological Materials of Human Organs*, 1987 (Cyprus); Act 285/2002, *On Donation, Removal, and Transplantation of Organs and Tissues, and mending Certain Acts* (*The Transplantation Act*) (Czech Republic); *The Transplantation of Organs and Tissues Act*, 2002 (Estonia); Law No. 355, *On the Removal of Human Organs and Tissues for Medical Purposes*, 1985 (Finland); Law No. 76–1181, dated December 22, 1976, *On the Removal of Organs* (France); *Removal and Transplantation of Biological Substances from Humans*, Act 2737 of 1999 (Greece); Law no 91 of April 1, 1999, *On the Removal and Transplantation of*

organ donation.[22] Although States with such "opt-out" legislation have been greatly criticized due to the inferior nature of that form of consent, they have reported higher donation rates.[23]

Aside from the acquisition of organs, a second major similarity between most national organ transplant laws and the regulations made under them is that they focus on the administration of organ donation and transplantation. This is achieved by different means. Very common in transplant or developing States are provisions which regulate transplant procedures in hospitals and transplant centers by ensuring that organ transplants take place only in duly certified centers and in accordance with the applicable national organ transplant laws.[24] Regulation is also aimed at curbing the activities of unscrupulous medical practitioners and ensuring that organ donation and transplantation standards are continually improved and complied with.[25] Another form of administration is the establishment of assessment committees or individuals who make decisions on organ transplants.[26] An example is the creation of the Authorization Committee (AC) under the *Transplantation of Human Organs* (*Amendment*) *Rules*, 2008 in India.[27] As we shall see later, a major duty of the

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*Organs and Tissues* (Italy); Law of October 26, 1995, *On the Removal and Transplantation of Cells, Tissues, and Organs* (Poland); Law No. 2238, dated May 29, 1979, *On the Removal, Storage, Transfer, and Grafting of Organs and Tissues* (Turkey), etc.

22 See *Law 1805, Amending Law 73 of 1988 and Law 919 of 2004 in Matters Related to Donation of Anatomic Components and Other Norms* (August 4, 2016).

23 Alberto Abadie & Sebastien Gay, "The Impact of Presumed Consent Legislation on Cadaveric Organ Donation: A Cross-Country Study" (2006) 25:6 J Health Eco 599; Veronica English, "Head to Head: Is Presumed Consent the Answer to Organ Shortages? Yes" (2007) 334:7603 BMJ 1088; Amber Rithalia *et al*, "Impact of Presumed Consent for Organ Donation on Donation Rates: A Systematic Review" (2009) 338:a3162 BMJ 284.

24 See section 10, *Transplantation of Human Organ Act*, Act No. 42 of 1994 (India); section 7, *Human Organ Transplant Act*, Chapter 131A (Singapore); ss V–XI, *Revised Rules and Regulations Governing Accreditation of Hospitals Engaged in Kidney Transplantation* (*Administrative Order No. 2008-0034*) (The Philippines).

25 In the US, the Task Force on Organ Transplantation was created by section 101 of the *National Organ Transplant Act* 1984, Pub. L. 98–507, to examine issues presented by human organ procurement and transplantation. In India, section 13(1) of the *THOA* provides for the establishment of Appropriate Authorities which grant and renew certificates of registrations to hospitals to carry out transplantations. The Authorities also have the power to revoke such certificates.

26 See for instance the duty of the "designated officer" under section 5, HOTA *supra* note 24.

27 The *Transplantation of Human Organs Rules* [GSR 571(E), dt.31-7-2008].

Committee is to investigate and approve organ donations involving individuals who are not near relatives.[28]

A third common focus of most organ transplant laws is the penalization of organ commercialization.[29] Each law is unique and they range from simple provisions penalizing the sale and supply of human organs to more elaborate provisions covering various aspects of negotiations, sales and advertisements involving human organs.[30] Most legislation does not go beyond the prohibition of organ commercialization and, as noted in Chapter 1, organ commercialization is only one part of transplant tourism. There are, however, a few revolutionary transplant laws which go further than the penalization of organ commercialization and address broader issues of transplant tourism.[31] Most of these progressive laws were passed after the *Declaration of Istanbul* in 2008 and are the product of a long history of legislative amendments. Below, I shall look at a few organ transplant laws starting with organ transplant laws in key transplant States.

## C Organ Transplant Laws in Key Transplant States

Though practiced on several continents, transplant tourism has become notorious in Asia as most patients looking for organs around the world travel there to purchase organs either directly from organ vendors or with the help of highly specialized facilitators and intermediaries.[32] As noted in Chapter 1,

28 See also section 5(5–7), HTODA *supra* note 14, which empowers an Independent Assessment Committee to make decisions concerning organ donations by minors.

29 For a list of States with laws restricting organ commercialization, see Mark Cherry, *Kidney for Sale by Owner: Human Organs, Transplantation, and the Market*, (Washington: Georgetown University Press, 2005) at 163–168. Cherry has a list of 52 States with legislation restricting the sale of human organs for transplantation.

30 For a simple provision prohibiting organ commercialization, see ss 3(2) & 13(3), HTODA, *supra* note 14, which makes it an offence for a person to offer, give or receive any reward or benefit for any tissue, organ or body for use in transplantation, medical education or scientific research. For a more elaborate provision, see section 19, *THOA* of India *supra* note 24.

31 See for instance section 22 of the *Organ Transplant Law*, *supra* note 5, which prohibits reimbursement of medical expenses of patients who travel abroad to receive organs: Alan Jotkowitz, "Notes on the New Israeli Organ Donation Law-2008" (2008) 40:10 Transplant Proc 3297; Gabriel Danovitch & Mustafa Al-Mousawi, "The Declaration of Istanbul – Early Impact and Future Potential" (2012) 8:6 Nature Rev Nephrol 360.

32 Alizera Bagheri, "Asia in the Spotlight on the International Organ Trade: Time to Take Action" (2007) 2:1 Asian J WTO & Int'l Health L & Pol 11. Apart from States in Asia,

Asian States such as the Philippines, India, China, Pakistan, Bangladesh, China and Turkey have distinguished themselves as hot spots for transplant tourism.[33] There are so many factors responsible for the concentration of transplant tourism activities in Asia. These include the existence of advanced and world-class transplant centers which carry out complex transplant procedures and the creation of legalized systems for organ procurement as is the case in China where convicted prisoners remain a legal source of organs for transplantation.[34] Other factors fueling the trend are the current ease of global travel, corruption and the laxity in law enforcement, and the high rate of poverty.[35] The product of all of these factors are urban slums around the world where the trade in human organs flourishes. Examples of such slums are those found in Sargodha[36] and Lahore[37] in the Punjab Province of

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a large concentration of transplant tourism activities can also be found in States in Eastern Europe and South and Central America such as Moldova, Romania, Italy, Turkey, Peru, Colombia, Bolivia and Brazil: Catherine Berthillier, "The Trade in Organs in Europe" in Peter Morris, ed, *Ethical Eye: Transplants* (Strasbourg: Council of Europe Publishing, 2003) at 163. In Africa, the major destination for patients seeking to buy organs for transplantation are South Africa and Egypt. Transplant tourism is not common in most parts of Africa due to the fact that most African States do not have the facilities to carry out major organ transplants. This does not however keep Africans away from transplant tourism as organ vendors are flown from African States to other States such as South Africa and Malaysia where the operations are carried out: John Connell, *Medical Tourism* (Wallingford: CABI, 2011) at 139; Nancy Scheper-Hughes, "Keeping an Eye on the Global Traffic in Human Organs" (2003) 361:9369 The Lancet 1646; David Bass, "Kidneys for Cash and Egg Safaris: Can We Allow 'Transplant Tourism' to Flourish in South Africa?" (2005) 95:1 SAMJ 42; Jean Allain, "Trafficking of Persons for the Removal of Organs and the Admission of Guilt of a South African Hospital" (2011) 19:1 Med L R 117.

33 Alexis Aronowitz, Human Trafficking, Human Misery: The Global Trade in Human Beings (USA: Praeger, 2009) at 111; Nancy Scheper-Hughes, "Prime Numbers: Organs without Borders" Foreign Policy (2005) at 26.

34 Jiefu Huang *et al*, "A Pilot Programme of Organ Donation after Cardiac Death in China" (2012) 379:9818 The Lancet 862; Allison Owen, "Death Row Inmates or Organ Donors: China's Source of Body Organs for Medical Transplantation" (1995) 5:2 Ind Int'l & Comp L Rev 495.

35 Bagheri, *supra* note 32 at 11; Zaki Zaher, "Transplantation in Asia: Meeting the Challenges" (2004) 36:7 Transplant Proc 1861.

36 Farhat Moazam *et al*, "Conversations with Kidney Vendors in Pakistan: An Ethnographic Study" (2012) 39:3 Hastings Cent Rep 29; Syed Naqvi *et al,* "A Socioeconomic Survey of Kidney Vendors in Pakistan" (2007) 20:11 Transplant Int'l 934.

37 Aamir Jafarey *et al*, "Asia's Organ Farms" (2007) 4:2 Indian J Med Ethics 52.

Pakistan, Dhaka in Bangladesh[38] and Kavre in the Bagmati Zone of Central Nepal.[39]

Among the various key transplant States, the Philippines and India were identified by the WHO as hot spots for transplant tourism and organ trafficking in 2005.[40] These two States were notorious as locations for transplant tourism prior to 2008 when legal reforms aimed at controlling transplant tourism and ensuring that only nationals could have access to organs donated by living non-related organ donors started coming into force. These reforms were influenced, in part, by the global focus on transplant tourism in 2008 which led to the *Declaration of Istanbul*.[41] Though the incidence of transplant tourism has dropped in these two States in recent years, it has not been entirely eradicated. This is due partly to poor enforcement of the new laws and the lack of corresponding laws in tourist States prohibiting their nationals from traveling to these States to buy organs.

### 1 *The Philippines*

The first successful organ transplant in the Philippines was performed in 1969.[42] This success was followed by a long history of transplant tourism and the enactment of several pieces of legislation to curb it. A common factor fueling transplant tourism practices in the Philippines is the high rate of poverty in various communities. In a study carried out on the economic and social consequences of compensated non-related kidney donation in the Philippines, a majority of the organ vendors (67.5%) interviewed stated that

38 Monir Moniruzzaman, " 'Living Cadavers' in Bangladesh: Bioviolence in the Human Organ Bazaar" (2012) 26:1 Med Anthropol Q 69.

39 Kalpana Dulal & Sher Karki, "Nepalese Kidney Transplant Recipient in a Follow Up Clinic: Related and Unrelated Living Donor" (2008) 47:171 J Nepal Med Ass 98; Sunil Nuepane, "The Village of Kidneys," Nepali Times, (03 June 2011), online: <http://nepalitimes.com/news.php?id=18256>.

40 Angelo Nicolaides & Athena Smith, "The Problem of Medical Tourism and Organ Trafficking" (2012) 26:2 Med Tech SA 34.

41 Frederike Ambagtsheer & Williem Waimar, "A Criminology Perspective: Why Prohibition of Organ Trade in not Effective and How the Declaration of Istanbul can Move Forward" (2012) 12:3 Am J Transplant 571.

42 Cecilia Tuazon, "Kidneyconomics: The Black Market, Scarcity, and the need to Realign the System of Incentives and Disincentives in the Laws Governing Kidney Donations" (2010) 84:2 Philippine L J 510.

poverty was the motivating factor behind their actions.[43] Despite being the 40th largest economy in the world, more than a quarter (26.5%) of Filipinos continue to live in poverty.[44] It has been estimated that about 84.5% to 92.5% of kidney vendors in the Philippines are extremely poor, homeless or jobless.[45] This high poverty rate, coupled with low all-inclusive transplant packages offered by transplant agents in the Philippines, made the State an attractive destination for organ traffickers and tourists seeking organs for transplantation in the mid-1990s.[46]

In an effort to set rules governing the acquisition of human organs for transplantation and to increase the number of organs available for organ transplantation, the *Organ Donation Act* (ODA or Act) was passed in 1991.[47] This Act however only regulates posthumous organ donation. It does not have provisions on living organ donation which is the major route used for transplant tourism. Section 3 of the Act allows individuals of at least 18 years to give, by way of a bequest, all or parts of their organs for the purpose of medical research, education or transplantation.[48] Even where the deceased individual has given no such authorization and there is no opposition from his/her immediate family members, the donation of all or parts of his/her organs can be made by a spouse, adult son or daughter, parent, adult siblings or guardian, in that order.[49] However, the ODA has not recorded much success as cadaveric

43 The findings of this study were published in Tsuyoshi Awaya *et al*, "Failure of Informed Consent in Compensated Non-Related Kidney Donation in the Philippines" (2009) 1:2 Asian Bio Rev 138.

44 Romulo Virola, *2009 Official Poverty Statistics: Towards Better Targeted and Focused Poverty Reduction Programs* (National Statistical Coordination Board, 08 February 2011), online: <http://maps.napc.gov.ph/drupal/sites/default/files/documents/2009%20Poverty%20Stats-%20DSWD%20mar172011%20A_latest.pdf>.

45 Roger Mendoza, "Kidney Black Markets and Legal Transplants: Are They Opposite Sides of the same Coin?" (2010) 94:3 Health Pol 255 & 258.

46 Mendoza, *supra* note 45 at 256.

47 *Organ Donation Act* of 1991, *Republic Act No. 7170* of 1992. This Act is an update of *Republic Act No. 349* of 1949 which was "An Act to Legalize Permissions to Use Human Organs or any Portion or Portions of the Human Body for Medical, Surgical, or Scientific Purposes, Under Certain Conditions." The *Organ Donation Act* of 1991 has since been amended in 1995 by the *Amendment to Republic Act No. 7170*: Amelia Ancog, "Philippines Law on Donations of Human Organs" (1992) 3:3 J Int'l Bio 169.

48 ODA, ss 3 & 6, ibid.

49 Ibid, section 4; In the absence of the above enumerated individuals, the physician in charge of the patient, the head of the hospital or a designated officer of the hospital with custody of the body can authorize the removal of an organ for the purpose of transplantation

organ donations in the Philippines remain low with an average donation of 1 per million people per year.[50]

Due to the lack of legislation on living organ donation, transplant tourism bloomed in the Philippines and by the beginning of the 21st century about 25% of the transplants performed in the Philippines were on patients from abroad.[51] This trend led to many media reports on organ commercialization and the abuse suffered by organ vendors in the hands of brokers.[52] In response to these reports, in 2002, the Department of Health (DOH) adopted *Administrative Order No. 124-02* which was the *National Policy on Kidney Transplantation for Living Non-Related Donors* (*LNRDs*).[53] *Administrative Order No. 124-02* focuses entirely on living organ donation and divides living donors into two major groups: Living Related Donors (LRDs) and LNRDs.[54] The definition of LRDs is very broad and

provided reasonable efforts are made within 48 hours to locate the nearest relatives of the deceased. In the case of cornea extraction, the 1995 Amendment Act reduced this time frame to 12 hours because corneas must be retrieved within 12 hours of death if they are to be used for transplantation purposes: Margaret Tooke *et al,* "Corneal Transplantation" (1986) 86:6 Am J Nur 687.

50 Tuazon, *supra* note 42 at 512; The low rate of cadaveric organ donation led the Department of Health to pass *Administrative Order No. 2010-0019* in June of 2010 on the Establishment of a National Program for Sharing Organs from Deceased Donors. The aim of this Order is to increase deceased organ donation and remove obstacles and disincentives to deceased organ donation.

51 Yosuke Shimazono, "The State of the International Organ Trade: A Provisional Picture Based on Integration of Available Information" (2007) 85:12 Bull World Health Organ 901. By 2005, there was a high influx of wealthy patients into the Philippines who purchased organs from poor locals for prices ranging from $30,000-$60,000. Most of these monies however went to medical practitioners and intermediaries and the organ vendors who were usually young men in their 20s who belonged to low income groups received only about $3,000 or less: Nicolaides & Smith, *supra* note 40 at 34; Scheper-Hughes, *supra* note 33 at 26

52 Preamble, *National Policy on Kidney Transplantation for Living Non-Related Donors* (*Administrative Order No. 124-02*).

53 *Ibid*. The Department of Health (Filipino: *Kagawaran ng Kalusugan*) is the principal health agency in the Philippines. It is the technical authority on health and is responsible for ensuring access to basic public health services to Filipinos. As with other government departments, the Department of Health has the power to make Administrative Orders which are primary sources of laws and rank in the same level with other legislative statutes: Milagros Santos-Ong, *Philippine Legal Research* (Manila: Central Book Supply, 2007). The Department of Health can be found online: <http://www.doh.gov.ph/index.html>.

54 *Administrative Order No. 124-02*, section III, *supra* note 52.

includes parents, children, siblings, cousins, nephews, nieces, and other blood relatives.[55] LNRDs are further subdivided into 2 groups: Voluntary Donors and Kidney Vendors.[56] Voluntary Donors include spouses, friends and strangers who donate out of benevolence or altruism.[57] *Administrative Order No. 124-02* allows living organ donation from LRDs and LNRDs who are Voluntary Donors and expressly prohibits the sale and purchase of kidneys by Kidney Vendors.[58] *Administrative Order No. 124-02* also created the Organ Donation Program (ODP) which is the body in charge of organ distribution and exchange in the Philippines.[59] Specific guidelines on the operation of the ODP were later provided in 2003 under *Administrative Order No. 41-03*.[60]

Although a notable step in prohibiting transplant tourism activities in the Philippines, *Administrative Order No. 124-02* did not control transplant tourism. On the contrary, it provided an avenue for kidney donees to purchase organs from LNRDs who claimed they were motivated by compassion to donate their organs. Also, the coverage of *Administrative Order No. 124-02* was very narrow and focused only on kidney donations. By so doing, it failed to legislate on other forms of living organ donation such as liver donation. Another shortcoming of *Administrative Order No. 124-02* is that like most national instruments on organ transplantation, it focused entirely on the supply side of the organs market without trying to control the demand for organs. Foreigners were thus able to come into the Philippines and buy organs from poor and vulnerable vendors.

*Administrative Order No. 124-02* also failed to penalize the activities of brokers and intermediaries who are a significant driving force behind the indiscriminate trade in human organs. This penalization however came 11 months after *Administrative Order No. 124-02* came into force when the *Anti-Trafficking of Persons Act* (ATPA) was passed in May 2003.[61] The ATPA adopted the definition of "Trafficking in Persons" used by the *Protocol to Prevent, Suppress*

55 *Ibid.*

56 *Ibid.*

57 *Ibid.*

58 *Ibid,* section IV(1). The Order defines Kidney vendors as "commercial donors for the reason that they offer their kidneys for a valuable consideration." It goes on to state that "Payment or a promise of payment is a precondition and pre-requisite to the organ donation." See Section III(2)(b), *Ibid.*

59 *Ibid*, section V.

60 *Administrative Order No. 41-03* also prohibits the sale and purchase of kidneys by kidney vendors. See Section III (1).

61 *Anti-Trafficking of Persons Act, Republic Act No. 9208* of 2003.

*and Punish Trafficking in Persons, Especially Women and Children* (*Trafficking Protocol*) which makes the removal or sale of organs a form of human trafficking.[62] Section 4(g) of the ATPA makes it unlawful for anyone to "recruit, hire, adopt, transport or abduct a person, by means of threat or use of force, fraud, deceit, violence, coercion or intimidation for the purpose of removal or sale of organs of [the] said person."[63] Individuals who contravene the provisions of the Act are liable to fines between 2 to 5 million pesos and imprisonment terms ranging from 20 years to life imprisonment.[64] ATPA, however, failed to have its desired effect as no case was ever filed in court against intermediaries or organ brokers under the Act.[65] Organ trafficking continued to grow with intermediaries and brokers dealing in human organs targeting residents of outlying rural areas and the urban slums and shantytowns in the peripheries of Manila and other cities as potential vendors.[66] Intermediaries usually visited these poor settlements and scouted for organ vendors who were promised more money than they eventually got out of the trade.[67]

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62 See article 3a, *Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children*, supplementing the *United Nations Convention Against Transnational Organized Crime*, 40 ILM 335 (2001) / UN Doc. A/55/383 (Annex II. P. 53) / [2005] ATS 27.

63 Section 4(g), ATPA, *supra* note 61.

64 *Ibid,* Section 10; 1 million pesos is about $27,500 CND.

65 Tuazon, *supra* note 42 at 519.

66 Nancy Scheper-Hughes, "Rotten Trade: Millennial Capitalism, Human Values and Global Justice in Organs Trafficking" (2003) 2:2 J Hum Rts 199; Leigh Turner, "Commercial Organ Transplantation in the Philippines" (2009) 18:2 Cam Q Healthcare Ethics 192.

67 One such settlement notorious for transplant tourism and organ commercialization is Bagong Lupa which is located in Manila, the capital of the Philippines. It is made up predominantly of shanties and makeshift houses with most of its residents living below the national poverty rate: Nancy Scheper-Hughes, "From the Field" (2003) 15:1 Pub Culture 209; Francis Aguilar & Lalaine Siruno, "A Community without Kidney: A Tragedy? Analysis of the Moral and Ethical Aspects of Kidney Organ Donation" (2004) at 2, being a paper presented at the 5th Asian Bioethics Conference (ABC5) and Ninth Tsukuba International Bioethics Roundtable (TRT9) at the University of Tsukuba, Tsukuba Science City, Japan on Feb. 12–16, 2004. There are several other urban slums scattered around Asia which intermediaries target to recruit organ vendors. Some of these slums include Sargodha and Lahore in the Punjab Province of Pakistan, Dhaka in Bangladesh and Kavre in the Bagmati Zone of Central Nepal. See generally: Farhat Moazam *et al*, "Conversations with Kidney Vendors in Pakistan: An Ethnographic Study" (2012) 39:3 Hastings Cent Rep 29; Syed Naqvi, *et al,* "A Socioeconomic Survey of Kidney Vendors in Pakistan" (2007) 20:11 Eur Soc Organ Transplant 934; Aamir Jafarey *et al*, "Asia's Organ Farms" (2007) 4:2 Indian J Med Ethics 52; Moniruzzaman, *supra* note 38 at 69; Dulal & Karki, *supra* note 39 at 98; Nuepane, *supra* note 39.

By 2005, the Philippines had become a hotspot for transplant tourism and was recognized by the United Nations as one of the top 5 destinations for transplant tourism and organ trafficking.[68] Yet this recognition did not lead to any policy change on organ transplantation in the Philippines and commercial organs continued to be available to foreign patients.[69] With the establishment of more stringent restrictions on transplants for foreigners in some key transplant countries such as China, the Philippines rose from being merely a major destination for transplant tourism in 2005 to become one of the top 3 hotspots in 2007.[70] In that year, the Philippines Renal Registry listed a total of 1,046 kidney transplants conducted in the Philippines. More than 50% of the recipients were foreigners and more than 80% of the organs were from LNRDs.[71]

It consequently became apparent to the government that the regulation of LNRDs was a major step towards the prevention of organ commercialization in the Philippines. Nevertheless, the government was unwilling to completely do away with this category of donors as a majority of Filipinos agreed that LNRDs were an acceptable source of organs.[72] Thus, in March 2008, the DOH revised the national policy on LNRDs as contained in *Administrative Order No. 124-02* by passing the *Revised National Policy on Living Non-Related Organ Donation and Transplantation and its Implementing Structures* (*Administrative Order No. 2008-0004* or Order).[73] Under the new Order, Filipino recipients were

68 Nicolaides & Smith, *supra* note 40 at 34; Scheper-Hughes, *supra* note 33 at 26.

69 Transplants to foreigners in the Philippines increase by more than 60% between 2002 and 2006: Carlos Conde, "Philippines Ban Kidney Transplants for Foreigners," The New York Times (30 April 2008), online: <http://www.nytimes.com/2008/04/30/world/asia/30phils.html?ref=asia&_r=0>; Karl Wilson, "Manila May Lift Donation Ban," The National (08 August 2010), online: <http://www.thenational.ae/news/world/asia-pacific/manila-may-lift-donation-ban>.

70 Mendoza, *supra* note 45 at 256.

71 Leonardo Castro, "The Declaration of Istanbul in the Philippines: Success with Foreigners but a Continuing Challenge for Local Transplant Tourism" (2013) 16:4 Med Health Care Philos 930.

72 The government arrived at this conclusion after national surveys conducted by the Philippine Information Agency – Public Opinion Research Division and the University of Philippines Institute of Clinical Epidemiology on people's knowledge and opinions about organ donation in 2001 and 2005. 44% (2001) and 53% (2005) of the respondents agreed that LNRDs are acceptable sources of organs: see Preamble, *Revised National Policy on Living Non-Related Organ Donation and Transplantation and its Implementing Structures, Department of Health Administrative Order* No. 2008-0004 (March 3, 2008).

73 *Ibid.*

to be given priority in donor allocation as a majority of organs that were sold at that time were to foreigners to the detriment of Filipinos who needed organs for transplantation.[74] Like *Administrative Order No. 124-02*, *Administrative Order No. 2008-0004* also prohibited the sale and purchase of kidneys and laid down principles which should guide organ donation and distribution.[75] For the first time, the national policy had provisions dealing directly with transplant tourism. The Order tried to exclude kidney transplantation from medical tourism and forbade the exportation or transportation of kidneys abroad.[76] These provisions sought to discourage foreigners from viewing the Philippines as an attractive destination in their quest for human organs. The revision of the national policy on LNRDs again failed to yield many results. Filipinos were still not given priority in the distribution of organs. Transplant centers in the Philippines continued to exceed the quota of foreign kidney recipients which was placed at 10 % by the implementing rules and administration of *Administrative Order No. 124-02*.[77] This was due majorly to the fact that the regulatory agencies such as the Bureau of Health Facilities and Services (BHFS)[78] were unable to effectively regulate transplant facilities to make sure that they complied with the guidelines.[79]

The government of Philippines responded to the above problem in two ways. A month after passing the revised policy on LNRDs in *Administrative Order No. 2008-0004*, the health secretary, Francisco Duque, announced a total ban on organ transplants to foreigners in a move to curb transplant tourism within the Philippines.[80] This ban became the sole focus of *Administrative*

74 *Administrative Order* No. 2008-0004, section V (1), *ibid.*

75 *Ibid*, section IV & V(3), *supra* note 72. According to Section IV, the principles guiding organ donation and transplantation should be equity, justice, benevolence, non-maleficence, solidarity, altruism and volunteerism. The Order further states in Section V(1) that the "ability to pay should not be a deterrent" for the prioritization of Filipinos in organ allocation.

76 *Administrative Order* No. 2008-0004, section V(4 & 10), *supra* note 72.

77 Sue Pondrom, "LYFT Goes to Office of Civil Rights for Review" (2008) 8:8 Am J Transplant 1572.

78 The Bureau of Health Facilities and Services (BHFS) was created Section V(B) of *Administrative Order No. 124-02* as a regulatory body of health and health-related facilities involved in kidney transplantation. The BHFS is primarily responsible for the issuance and revocation of licenses of facilities engaged in kidney transplantation.

79 Benita Padilla, "Regulated Compensation for Kidney Donors in the Philippines" (2009) 14:2 Curr Opin Organ Transplant 122.

80 Pondrom, *supra* note 77 at 1572.

*Order No. 2008-0004-A*[81] which states that "foreigners are not eligible to receive organs from Filipino living non-related donors."[82] This ban was repeated in the 2010 revised policy on LNRDs contained in the *Revised National Policy on Living Non-Related Organ Donation and Transplantation and its Implementing Structures Amending Administrative Order No. 2008-0004-A* (*Administrative Order No. 2010-0018*).[83] In November 2008, a third administrative order containing revised rules and regulations governing the accreditation of hospitals engaged in kidney transplantation, *Administrative Order No. 2008-0034,* was passed by the DOH.[84] The objective of *Administrative Order No. 2008-0034* was to address the low compliance of transplant facilities with the federal policy on LNRDs and to "strengthen the regulation of hospitals engaged in kidney transplantation."[85] This Order laid down guidelines for the accreditation of transplant facilities and rules for monitoring these facilities.[86] *Administrative Order No. 2008-0034* also enumerated the functions of several agencies and mechanisms involved in the regulation of organ transplants in the Philippines.[87]

Because of the above laws and policy changes in the Philippines, the number of reported transplant tourism cases in the State has been greatly reduced. Transplant tourism, however, continues. Data obtained from the Philippine

81 *Amendment to the Administrative Order No. 2008-0004 on Revised National Policy on Living Non-Related Organ Donation and Transplantation and its Implementing Structure, Department of Health Administrative Order* No. 2008-0004-A (May 29, 2008).

82 *Ibid*, Jennifer Smith, " 'Dirty Pretty Things' and the Law: Curing the Organ Shortage & Health Care Crises in America" (2009) 12:2 Chap L Rev 374; Eli Friedman & Amy Friedman, "Reassessing Marketing of Kidneys from the 2008 Perspective" (2009) 27:1 Blood Purif 54; Mendoza, *supra* note 45 at 262.

83 *Revised National Policy on Living Non-Related Organ Donation and Transplantation and its Implementing Structures Amending Administrative Order* No. 2008-0004-A (June 23, 2010).

84 *Revised Rules and Regulations Governing Accreditation of Hospitals Engaged in Kidney Transplantation, supra* note 24. Section V(5) states that "Foreigners are not eligible to receive organs from Filipino living non-related donors."

85 *Ibid*, section II.

86 *Ibid*, ss V–XI.

87 The various agencies involved in the regulation of organ transplantation in the Philippines include the Bureau of Health Facilities (BHFS), the Department of Justice (DOJ), the National Transplant Ethics Committee (NTEC), the Philippine Board for Organ Donation and Transplantation (PBODT), the Philippine Health Insurance Corporation (PhilHealth), the Philippine Network for Organ Donation and Transplantation (PhilNETDAT) and other partner agencies. See section XIII, *Administrative Order* No. 2008-0034, *supra* note 24.

Renal Disease Control Program (REDCOP) on the number of kidney transplants in the Philippines in 2008 showed that 178 foreigners had transplants in the State for the entire year, 18 of which were carried out after the ban.[88] Of the 18 foreigners, 10 received kidneys from LNRDs.[89] There continues to be a dramatic decrease in the number of foreigners receiving organs from Filipino LNRDs.[90] Figures released by the Philippines Renal Disease Registry (PRDR) continue to indicate a decline in the number of LNRDs.[91] A local foundation called Life to Life which used to recruit LNRDs for beneficiaries who were majorly foreigners has since ceased operations due to the decline in the number of LNRDs selling their kidneys.[92] While the new laws have not totally stopped transplant tourism practices in the Philippines, their effects have been remarkable.

### 2 *India*

India is another State notorious for the pivotal role it plays in the global trade in human organs. As the second most populous State in the world, India is estimated to have one-third of the world's poor with more than 32% of its population living on less than $1.25 US per day.[93] This high rate of poverty has forced a lot of Indians to get involved in transplant tourism both as organ vendors and intermediaries/agents who link the organ vendors with the transplant patients and healthcare centers. As with all other transplant States, the traded organs in India come from the poor, most of whom live in slums and rural areas.[94] An example of a slum where many kidney vendors live is Villivakkam in the Chennai suburban area.[95] Other factors which have led to the high prevalence of transplant tourism in India include the availability of highly skilled organ

88 Anna Bueno, "18 Foreigners Still Had Kidney Transplants after Ban – Redcop," ABS-CBN News, (08 July 2009), online <http://www.abs-cbnnews.com/special-report/08/07/09/18-foreigners-still-had-kidney-transplants-after-ban-%E2%80%93-redcop>.

89 *Ibid.*

90 Benita Padilla *et al*, "Impact of Legal Measures Prevent Transplant Tourism: The Interrelated Experience of the Philippines and Israel" (2013) 16:4 Med Health Care & Philos 915.

91 Castro, *supra* note 71 at 930.

92 *Ibid.*

93 World Bank, "India – New Global Poverty Estimates," (2010), online: <http://povertydata.worldbank.org/poverty>.

94 Kurien Tharien, "Ethical Issues in Organ Transplantation in India" (1996) 6 Eubios J Asian & Intl Bio 168; Scaria Kanniyakonil, *Living Organ Donation and Transplantation: A Medical, Legal and Moral Theological Appraisal* (India: Scaria Kanniyakonil, 2005) at 29.

95 Sanjay Kumar, "Curbing Trade in Human Organs in India" (1994) 44:344 *The Lancet* 48–49.

transplant practitioners, the absence of adequate laws regulating organ transplantation and the weak enforcement of existing laws.[96]

Renal transplant in India began in May of 1965 at the King Edward Memorial Hospital in Bombay (now Mumbai) using a cadaveric organ, and in 1971, the first successful living donor renal transplant was performed in India.[97] The beginning of renal transplantation in India also marked the beginning of solid organ transplantation in the State. Currently, India has grown to be a major destination for living donor renal transplantation with about 200 centers currently performing renal transplants.[98] A major boost to the practice of renal transplantation emerged in the mid-1970s when, in a bid to increase the number of organs available for transplants, unrelated living donors were allowed to donate organs to transplant patents.[99] Though this form of organ donation was allowed only when a suitable donor was unavailable, it soon became a major route for organ commercialization as the scarcity of organs around the world pushed desperate individuals to pay vendors for their organs. By the mid- and late 1980s, India had grown to become a global center for organ commercialization with an annual kidney sale of about 500.[100]

With the development of organ transplantation in India, there came the need to pass laws and guidelines to regulate the practice. This need was initially satisfied only at the state level. In Maharashtra, for instance, the *Maharashtra Kidney Transplantation Act* of 1982 was passed to make provisions for the use of kidneys of deceased persons for transplantation and for the donation of kidneys in the State.[101] The various laws on organ transplantation however only

96 Vivekanand Jha, "Paid Transplants in India: The Grim Reality (2004) 19:3 Nephrol Dial Transplant 541.

97 Vidya Acharya, "Status of Renal Transplant in India" (1994) 40:3 J Postgrad Med 158; Sunil Shroff, "Indian Transplant Registry" (2007) 23:3 Indian J Urol 273.

98 Sanjay Agarwal & Rajesh Srivastava, "Chronic Kidney Disease in India: Challenges and Solution" (2009) 111:3 Nephron Clin Pract c-197; Sanjay Agarwal *et al*, "Evolution of the Transplantation of Human Organ Act and Law in India" (2012) 94:2 Transplant 110.

99 Kumar Mani *et al,* "Renal Transplantation at Jaslok Hospital" (1978) 2 Bull. Jaslok Hosp Res Center 124.

100 Raj Chengappa, "The Organs Bazaar," India Today (18 December 2006), online: <http://indiatoday.intoday.in/story/india-has-largest-number-of-kidney-transplants/1/180170.html>.

101 *Maharashtra Kidney Transplantation Act*, Act No. 12 of 1983. At that time, the state of Maharashtra also had the *Bombay Corneal Grafting Act*, Act No. 33 of 1957. The Union Territory of Delhi also had laws dealing with the transplantation of cornea and ear drum and bones. These laws were: *Eyes* (*Authority for use for Therapeutic Purposes*) *Act*, Act No. 29 of 1982, and the *Ear Drums and Ear Bones* (*Authority for use for Therapeutic Purposes*) *Act*, Act No. 28 of 1982. See Agarwal, *supra* note 98 at 110

laid down rules for the acquisition and use of human organs and did not have provisions prohibiting organ commercialization. The sale of human organs thus remained unregulated and by the early 1990s, organ commercialization in India had quadrupled. In 1991 alone, it is estimated that more than 2,000 kidneys were traded commercially in India, and by 1994, this number had grown to over 3,500 kidneys.[102] This situation led to a lot of global and local pressure on the Indian government to pass a national law against the practice.[103] This resulted in the enactment of the *Transplantation of Human Organs Act* (THOA or Act) in 1994 which made it illegal for organs to be traded commercially in India.[104]

The THOA was passed to regulate the removal, storage and transplantation of human organs for therapeutic purposes and to prevent commercial dealings in human organs.[105] Section 19 of the THOA makes it a punishable offence for persons to deal commercially in human organs.[106] Section 9 of the Act also laid down the general rule that no body part removed from a living donor shall be transplanted into a recipient unless the donor is a near relative of the recipient. Near relatives are defined by the Act to mean "spouse, son, daughter, father, mother, brother or sister."[107] Section 9 also gives an exception to the above rule where the recipient is not a near relative but the donation is made for reasons

102 Kirpal Chugh & Vivekanand Jha, "Commerce in Transplantation in Third World Countries" (1996) 49:5 Kidney Int'l 1183; Peter Kandela, "India: Kidney Bazaar" (1991) 337:8756 The Lancet 1534; Ninoslav Ivanovski *et al,* "Living-Unrelated (Paid) Renal Transplantation – Ten Years Later" 37:2 Transplant Proc 563.

103 Sunil Shroff, "Legal and Ethical Aspects of Organ Donation and Transplantation" (2009) 25:3 Indian J Urol 349.

104 THOA, *supra* note 24; Tirath Dogra, *et al,* "Organ Retrieval in Medicolegal Cases" (2004) 16:2 J Aca Hos Admin 7.

105 Preamble, THOA, *supra* note 24.

106 *Ibid*, section 19 provides: "Whoever – (a) makes or received any payment for the supply of, or for an offer to supply, any human organ; (b) seeks to find person willing to supply for payment any human organ; (c) offers to supply any human organ for payment; (d) initiates or negotiates any arrangement involving the making of any payment for the supply of, or for an offer to supply, any human organ; (e) takes part in the management or control of a body of persons, whether a society, firm or company, whose activities consist of or include the initiation or negotiation of any arrangement referred to in clause (d); or (f) publishes or distributes or causes to be published or distributed any advertisement … shall be punishable with imprisonment for a term which shall not be less than two years but which may extend to seven years and shall be liable to fine which shall not be less than ten thousand rupees but may extend to twenty thousand rupees …"

107 *Ibid*, section 2(1).

of affection, attachment or other special reasons.[108] Where this is the case, such transplant can only take place with the prior approval of an AC which must satisfy itself that the parties have complied with all the requirements of the Act and the Rules made thereunder.[109] These Rules came into force in 1995 when the *Transplantation of Human Organs Rules* (THOR or Rules) was passed.[110] Section 4 of the THOR makes it the duty of a registered medical practitioner performing an organ transplant to certify that the donor is a near relative of the recipient. The Rules also list several tests which the medical practitioner is to carry out in order to establish the relationship between both parties.[111] In addition, the Rules made it compulsory for hospitals conducting transplantation to get registered and obtain a certificate which is to be renewed every five years.[112]

The THOA and its Rules were mostly unsuccessful in bringing an end to transplant tourism in India due largely to a clause in section 9(3) of the Act which allowed donations for reasons of affection, attachment and "any other special reasons."[113] According to Dr. Sanjay Nagral, a gastrointestinal surgeon at the Jaslok Hospital, Mumbai, the clause "produced a loophole for unrelated transplants with state sanction."[114] Organ donees were able to use the clause to forge affection with strangers who were willing to sell their organs.[115] The wording of the clause was also very ambiguous and allowed medical practitioners moved by either compassion or greed to recommend phony cases to the AC.[116] In addition, the members of the AC were not thorough when screening applications from LNRDs.[117] It has been estimated that between 1995 and 2002,

108 *Ibid*, section 9(3); Muthu Mani, "Letters from Chennai: None so Blind as those who will not See" (2002) 15:5 Natl Med J India 295.

109 *Ibid*, section 9(3–6). The purpose of the AC is to regulate the removal, storage and transplantation of human organs: Shroff, *supra* note 103 at 350.

110 The *Transplantation of Human Organs Rules*, 1995 (GSR No. 51 (E), dr. 4-2-1995). These Rules were made by virtue of the powers conferred on the central government by section 24(1) of the THOA.

111 *Ibid*, section 4 (c).

112 *Ibid*, ss 7 & 8.

113 *Ibid*, section 9(3).

114 Ganapati Mudur, "Kidney Trade Arrest Exposes Loopholes in India's Transplant Laws" (2004) 228:7434 BMJ at 246.

115 Sunil Shroff, "Organ Donation and Transplantation in India: Legal Aspects & Solutions to Help with Shortage of Organs" (2009) 2:1 J Nephrol Renal Transplant 30.

116 To a majority of the medical practitioners, the plight of the organ recipients overruled any objections to the practice: Shroff, *supra* at 29.

117 Agarwal, *supra* note 98 at 111.

about 5,000 cases were interviewed by the AC in Tamil Nadu with a rejection rate of less than 5%.[118] Most of these cases were fraudulent and were approved as long as there was no complaint or gross oversight.[119] The situation in India was summed up in 1997 by Dr. M. K. Mani, a nephrologist based in Chennai. He stated:

> The stalwarts of the unrelated live donor programme continue to do as many transplants as they did before the Legislative Assembly of Tamil Nadu adopted the Act. What is more, they do them with the seal of approval from the Authorization Committee, and are therefore a very satisfied lot. The law, which was meant to prohibit commercial dealings in human organs, now provides protection for those very commercial dealings.[120]

As a result of the loophole created in the THOA, transplant tourism in India continued at higher rates in the 21st century. According to a 2002 report by the Voluntary Health Association of India, about 2000 Indians sold their kidneys annually.[121] Also in 2002, a study was carried out in Chennai by a team of researchers on the economic and health consequences of selling a kidney in India.[122] The study revealed that about 96% of the organ vendors interviewed sold their kidneys to pay off various forms of debts ranging from household needs to marriage and medical expenses.[123] Due to the fact that the amount of money received by the vendors was just enough to take care of these debts, very few individuals could afford to save or invest.[124] The participants did not show any improvement in their financial situation and a number of participants living below the poverty line increased with an average family income

118 Shroff, *supra* note 115 at 29.

119 *Ibid.*

120 Muthu Mani, "Making an Ass of the Law" (1997) 10:5 Natl Med J India 242.

121 Aronowitz, *supra* note 33 at 113; Shimazono, *supra* note 51 at 957; Chris Hogg, "Why Not Allow Organ Trading?," BBC News (30 August 2002), online: <http://news.bbc.co.uk/2/hi/health/2224554.stm>.

122 Madhav Goyal *et al.*, "Economic and Health Consequences of Selling a Kidney in India" (2002) 288:13 JAMA at 1591; Glenn Cohen, "Transplant Tourism: The Ethics and Regulation of International Markets for Organs" (2013) 41:1 J Law Med Ethics 269.

123 About 74% of interviewed participants still had debts at the time of the survey: Goyal, *supra* at 1590 & 1591.

124 The average amount received by the vendors was about $1,070 with some individuals receiving as low as $450 for their kidneys. *Ibid* at 1591.

decline of about 33%.[125] This decline in income was due partly to the fact that most of the participants complained of a decline in their health after the operation which affected their productive abilities.[126]

With such adverse results as those reported in the 2002 survey, the Indian government had to find ways of preventing organ commercialization in India and making the national organ transplant law and rules more effective. It did this by amending the THOR and the THOAS. The THOR of 1995 went through two amendments, one in 2008 and the other in 2014. In July of 2008, the THOR was amended by the *Transplantation of Human Organs* (*Amendment*) *Rules* (THOAR).[127] Among the various amendments made to the former Rules were those relating to the duties of the AC and medical practitioners performing transplant operations.[128] In 2014, the THOR and THOAR were merged into a single document with the passing of the *Transplantation of Human Organs and Tissues Rules* (THOTR or Rules).[129] Under the new Rules, before removing any human organ or tissue from a living donor, medical practitioners performing transplant operations are to ensure that the donor is a near relative of the recipient, the donation has been approved by the competent authority and the medical tests to determine the factum of the relationship have been carried out.[130] In the new Rules, the AC is mandated to consider all requests where either the donor or recipient or both are not Indian citizens or nationals, with the caveat that transplantation shall not take place where the proposed recipient of the organ is a foreign national who is not a near relative.[131] Where the proposed donor and recipient are not near relatives, the AC has to examine evidence of the link between the two parties and ensure that there was no commercial transaction between them and that no intermediary was involved in the arrangement.[132]

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125 *Ibid.* See also Lawrence Cohen, "Where it Hurts: Indian Material for an Ethics of Organ Transplantation" (1999) 128:4 Daedalus 135.

126 *Ibid.*

127 The *Transplantation of Human Organs* (*Amendment*) *Rules*, 1995 (GSR 571 (E), dt. 31-7-2008).

128 *Ibid*, ss 4(1)(c), 4A(3) & 4A(4).

129 The *Transplantation of Human Organs and Tissues Rules*, The Gazette of India: Extraordinary [PART II-SEC. 3(I)]; March 27, 2014.

130 *Ibid*, section 5(3).

131 *Ibid*, section 7(2). This provision is in line with the new section 7(a)(1A) of the *Transplantation of Human Organs* (*Amendment*) *Act*, Act No. 16 of 2011.

132 Section 7(3), THOTR, *supra* note 129; Reeta Dar & Sunil Dar, "Legal Framework, Issues and Challenges of Living Organ Donation in India" (2015) 14:8 IOSR J Den Med Sci 60.

After the 2008 Amendment Rules were passed, it became more difficult for vendors to sell their organs to strangers. It did not however bring an end to transplant tourism in India as foreigners were still able to buy organs from vendors. This was done with the help of intermediaries and corrupt medical officers and committee members. It soon became evident to the Indian government that the only way of bringing an end to transplant tourism practices in India was to impose a ban on organ transplants to foreigners as was done in the Philippines in 2008 and Pakistan in 2010. This led to the enactment of the *Transplantation of Human Organs* (*Amendment*) *Act* (THOAA or Act) in September of 2011.[133] Section 7 of the THOAA amends the former section 9 of the THOA, 1994. It states that the AC shall not approve a donation where either the recipient or donor is a foreign national and they are not near relatives.[134] The new Act also extends the definition of organs to include tissues, thus enlarging the scope of the Act to cover other forms of transplants such as cornea, skin and pancreas.[135] The THOTR of 2014 reflects the amendments made by the THOAA.

Though the 2011 law has had some impact on transplant tourism practices in India and reduced the number of foreigners traveling to India to buy organs from willing vendors, it has not eliminated transplant tourism entirely. In October of 2012, the Times of India published a report of three attempted kidney sales which came before the AC in Madurai, Tamil Nadu. One of such transactions involved a foreign patient whose application was rejected for "lack of clarity on relationship between donor and recipient" and "contradictory statements regarding address."[136] Recently, in June of 2016, an inter-state kidney racket was arrested for facilitating paid organ donations and transplantations at the Apollo Hospital in Delhi.[137] This is in spite of the fact that the Apollo hospital has its own independent AC as mandated by the THOAR.[138]

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133 *Transplantation of Human Organs* (*Amendment*) *Act*, *supra* note 131.

134 *Ibid*, section 7(a)(1A).

135 *Ibid,* section 4.

136 "Screening Exposes Attempted Kidney Sale in Madurai," The Times of India (23 October, 2012), online: <http://articles.timesofindia.indiatimes.com/2012-10-23/chennai/34679590_1_organ-trade-organ-transplants-kidney-sale>.

137 Abantika Ghosh, "Apollo Transplant Scandal: Explaining the Kidney Market Rules," The Indian Express (07 June 2016), online: <http://indianexpress.com/article/explained/delhi-kidney-racket-illegal-organ-trade-apollo-hospital-2838263/>; Pritha Chatterjee, "Delhi Kidney Trade Racket: How the Gang Managed to Get Around Organ Transplant Rules," The Indian Express (04 June 2016), online: <http://indianexpress.com/article/cities/delhi/delhi-kidney-trade-racket-how-the-gang-managed-to-get-around-organ-transplant-rules-2833502/>.

138 See section 6A(2)(II), THOAR, *supra* note 129.

Although there has been a decrease in the number of transplant tourism cases occurring in India, transplant tourism has not yet been totally eradicated. Also troubling are reports of Indians been taken to neighboring States like Sri Lanka to sell their kidneys.[139] Cases like these give more weight to the argument that all transplant States need to have laws against transplant tourism as States without such laws leave their nationals without any form of protection. The continuation of transplant tourism in States with laws against it also show the need for tourist States to get more involved in transplant tourism regulation by taking measures to prevent their nationals from traveling abroad to buy organs. Unfortunately, transplant laws in most tourist States only regulate organ commercialization and not transplant tourism. I shall below examine the transplant laws of three major tourist States: Israel, Canada and Australia.

## D Organ Transplant Laws in Key Tourist States

### 1 *Israel*

Israel has had a long history of organ transplants dating back to 1964 when the first kidney transplant was performed using a kidney from a living related donor.[140] As the practice grew and living related doors became scarce, people started acquiring organs from non-related donors who were willing to sell their organs. With favorable conditions for both the sale and purchase of organs, Israel soon rose to become both a key tourist and transplant State for transplant tourism.[141] It was also became a destination State for human trafficking.[142] However, with the coming into force of the *Organ Transplant Law* in

139 Uditha Jayasinghe, "Sri Lanka Suspends Kidney Transplants for Foreigners after India Arrests," The Wall Street Journal (28 January 2016), online: <http://blogs.wsj.com/indiarealtime/2016/01/28/sri-lanka-suspends-kidney-transplants-for-foreigners-after-india-arrests/>.

140 Jacob Lavee & Avraham Stoler, "Reciprocal Altruism: The Impact of Resurrecting an Old Moral Imperative on the National Organ Donation Rate in Israel" (2014) 77:3 Law Contemp Pro 323.

141 Alexis Aronowitz, *Human Trafficking, Human Misery: The Global Trade in Human Beings* (USA: Praeger, 2009) at 97; Erica Roberts, "When the Storehouse is Empty: Unconscionable Contracts Abound: Why Transplant Tourism should not be Ignored." (2009) 52:3 Howard L J 769; Lillana Kalogjera, "New Means of Increasing the Transplant Organ Supply: Ethical and Legal Issues" (2007) 34:4 Human Rts 20; Nancy Scheper-Hughes & Donald Bostrom, "The Body of the Enemy" (2013) 19:2 Brown J World Aff 245.

142 *Ibid.*

2008, Israel began to record a significant decrease in transplant tourism activities.[143] Israel remains one of two States with transplant tourism-specific laws aimed at preventing nationals from traveling abroad to engage in transplant tourism activities. The other State with a Similar Law is Spain which amended its *Penal Code* in 2010 to make it unlawful for its nationals to travel abroad to engage in transplant tourism or to use organs acquired through illegal sources for transplant purposes.[144] Although not a major tourist or transplant State, Spain has always been proactive in ensuring that organ commercialization and transplant tourism practices are abolished not only within its territory but globally.[145] Both the Israeli and Spanish laws discouraging their nationals from engaging in transplant tourism activities could serve as a model for other tourist States. This is especially so as the laws have had some amount of success in preventing transplant tourism in Israel and Spain. Due to the significant role Israel played in transplant tourism practices before the new law was adopted and the amount of success the new law has recorded, the prohibition of transplant tourism in Israel will be examined in greater detail below.

Before March 2008 when the *Organ Transplant Law* was passed in Israel, Israel did not have any law prohibiting organ commercialization. Like most other States, Israel had an organ shortage problem with an average waiting time for kidney transplants being 5 years.[146] The shortage in organs was further compounded by an organ donation rate which was much lower than in most Western States.[147] The long wait time for kidneys forced nationals to seek kidneys in other States where they could be readily available.[148] Israeli patients in need of kidneys were known to travel to various destinations including South

143 See *Organ Transplant Law, supra* note 5. That same year, the Israeli parliament passed another law, the *Brain-Respiratory Death Law 5768-2008,* Israeli Book of Laws, which defined the circumstances and standards for determining brain death. See Jacob Lavee *et al*, "Preliminary Marked Increase in the National Organ Donation Rate in Israel Following Implementation of a New Organ Transplantation Law" (2010) 13:3 Am J Transplant 780.

144 See article 156 bis, *Penal Code of Spain* (Organic Law No. 10/1995 of November 23, 1995, as amended up to Law No. 4/2015 of April 27, 2015.

145 Spain is one of the 17 States which have signed the *Council of Europe Convention against Trafficking in Human Organs,* CETS No. 216.

146 Kidneys were also only available to patients on dialysis. See Jotkowitz, *supra* note 31 at 3297.

147 Jacob Lavee *et al,* "A New Law for Allocation of Donor Organs in Israel" (2010) 375:9720 The Lancet 1131; Lavee *et al*, *supra* note 143 at 780.

148 Tamar Ashkenazi *et al,* "Effect of Legal Initiative on Deceased – and Living – Donor Kidney Transplantation in Israel" (2013) 45:4 Transplant Proc 1301.

Africa to buy organs from sellers who were sourced from transplant States like Brazil and States in Eastern Europe.[149] Not only did this negatively affect organ sellers who sold their kidneys, Israeli organ buyers were also able to get funding for their activities from national health organizations and insurance companies.[150] Insurance companies on their part capitalized on the lack of laws regulating travel for transplant purposes and fully reimbursed organ transplant operations carried out abroad.[151] Israeli nationals were also known to travel to other States to sell their kidneys.[152] These factors made Israel a key tourist and transplant State for transplant tourism practices.

The *Organ Transplant Law* of 2008 reformed the way organ transplants were performed in Israel and introduced provisions which discouraged transplant tourism. The law was created to bring an end to transplant tourism and increase organ donation rates from both living and deceased donors.[153] Under the new law, there is now a total ban on the sale of organs. Organ donors cannot be rewarded for donating their organs to patients in need of organs.[154] Through new provisions, organ donors can, however, be compensated for financial losses incurred as a direct result of their donations.[155] The provision permitting compensation to be paid to organ donors for donations is a reform which the Israeli parliament had been debating for so many years with no success.[156] With its inclusion in the new law, there has been an increase in the number of local organ donors in Israel.[157]

Other reforms brought about by the law include the prohibition of organ brokering where the broker is going to be rewarded for his/her services.[158] A Transplant Center was established to oversee the removal and transplant of organs.[159] A donor wishing to donate an organ to any person would have

149 Roberts, *supra* note 141 at 768.

150 Jacob Lavee, "Organ Transplantation Using Organs taken from Executed Prisoners in China: A Case for Cessation of Israeli Participation in the Process" (2006) 145:10 Harefuah 749.

151 Lavee & Stoler, *supra* note 140 at 324; Scheper-Hughes & Bostrom, *supra* note 141 at 245; Padilla *et al, supra* note 90 at 916.

152 Lavee & Stoler, *supra* note 140 at 324.

153 Lavee *et al, supra* note 143 at 780–781.

154 Section 3, *Organ Transplant Law, supra* note 5.

155 *Ibid*, ss 3 & 22; Jotkowitz, *supra* note 31 at 3297.

156 Judy Siegel-Itzkovich, "Israel Considers Paying People for Donating a Kidney" (2003) 326:7381 BMJ 126.

157 Ashkenazi *et al, supra* note 148 at 1302.

158 Section 4, *Organ Transplant Law, supra* note 5.

159 *Ibid*, ss 7 & 8.

to submit an application to local or central evaluation boards for approval.[160] Of particular importance to transplant tourism is that the law bans reimbursement for organ transplantation carried out abroad if the procurement of the organ and its transplantation have been performed contrary to the law of that foreign State and if the provisions of the Israeli law have been contravened.[161] This new provision makes the funding of transplant tourism activities not only illegal but unattractive to insurance and other funding companies. It has had the direct effect of reducing the number of Israeli patients traveling abroad for transplant purposes as they will not do so if they are not reimbursed.[162]

The Israeli transplant law has had a positive effect on reducing the participation of Israeli nationals in transplant tourism activities. In a study on the immediate effects of the law on kidney transplants performed inside and outside Israel published in 2013, it was concluded that there was a significant drop in the number of transplants performed outside Israel when 2009–2011 figures were compared with 2006–2008 figures.[163] While about 143 Israelis went abroad yearly for kidney transplants between 2009 and 2011, this number dropped to less than 45 transplants annually between 2009 and 2011.[164] There was also an increase in the number of kidney transplants performed in Israel between 2009 and 2011.[165] While some of these figures could be traced to general global initiatives to bring an end to transplant tourism, a lot of this change was brought about by the new Israeli law.[166] The success of the Israeli law can be traced to the fact that it targeted the prevention of transplant tourism in two ways. First, it created a framework for increased organ donation and secondly, it made it unfavorable for Israelis to travel abroad to buy organs.

160 The Local Evaluation Board receives applications for organ donations to relatives while the Central Evaluation Board receives applications for organ donations to persons who are not relatives or where the donor is not a resident of Israel. See ss 13 & 14, *Organ Transplant Law, supra* note 5.

161 Section 5, *Organ Transplant Law;* Lavee & Stoler, *supra* note 140 at 326; Padilla *et al, supra* note 90 at 916.

162 Lavee *et al*, *supra* note 143 at 784.

163 The results of this study were published in Ashkenazi *et al, supra* note 148 at 1302.

164 *Ibid;* Lavee & Stoler, *supra* note 140 at 331.

165 *Ibid;* Lavee *et al*, *supra* note 143 at 782.

166 *Ibid*.

## 2 *Canada*

The first kidney transplant in Canada happened in 1958 and was carried out between identical twins in Montreal, Quebec.[167] As with other parts of the world, there are not enough organs available for organ transplants in Canada. Not only that, but Canada's organ donation rate remains one of the lowest in the industrialized world.[168] Thus, people in need of organs such as kidneys sometimes must wait for long periods of time for a transplant. This wait can be as long as six years in some parts of Canada.[169] Unfortunately, the situation is not getting any better as the waiting list for organs continues to grow. In 2014, for instance, there were about 2,429 Canadians on the waiting list for organ transplants in Canada.[170] Patients sometimes withdraw from organ waiting for many reasons including the need to access organs through alternative means such as traveling to transplant States to buy organs.[171] Canada is ranked among the key tourist States along with other States like the US, Australia, Israel and Japan whose nationals seek organs in black markets around the world.[172] Though there is no official record of how many Canadians travel abroad annually for transplant tourism purposes, it has also been estimated that about 215 Canadians have traveled outside the State for transplant purposes from 1995

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167 Anne-Maree Farrell *et al, Organ Shortage: Ethics, Law and Pragmatism* (Cambridge: Cambridge University Press, 2011) at 186.

168 It is estimated that only 13 out of every million Canadians become organ donors: Nicole Baer, "Canada's Organ Shortage is Severe and Getting Worse" (1997) 157:2 Can Med Assoc J 179; Angela Mulholland, "Should all Canadians be Automatically Considered Organ Donors?," CTV News (May 25, 2012), online: <http://www.ctvnews.ca/should-all-canadians-be-automatically-considered-organ-donors-1.831544>. *Contra*: Mark Ammann, "Would Presuming Consent to Organ Donation Gain Us Anything but Trouble?" (2010) 18:2 Health L Rev 15.

169 Linda Wright *et al,* "Kidney Transplant Tourism: Cases from Canada" (2013) 16:4 Med Health Care Philos 921; Julian Sher, "Ontario, B.C. Residents Wait Longer for Kidney Transplants than any other Canadians," The Star (23 January 2012), online: <http://www.thestar.com/news/canada/article/1119432--ontario-b-c-residents-wait-longer-for-kidney-transplants-than-any-other-canadians>.

170 Canadian Institute for Health Information, "E-Statistics Report on Transplant, Waiting List and Donor Statistics," Canadian Organ Replacement Register, online: <https://www.cihi.ca/sites/default/files/document/2014_estats_innewtemplate_en-web.pdf>.

171 Leigh Turner, "Medical Tourism: Family Medicine and International Health-Related Travel." (2007) 53:10 Can Fam Physic 1640; Wright *et al, supra* note 169.

172 Aronowitz, *supra* note 33 at 111; Shimazono, *supra* note 51 at 901; Scheper-Hughes, *supra* note 33 at 26; Debra Budiani-Saberi & Frances Delmonico, "Organ Trafficking and Transplant Tourism: A Commentary on the Global Realities" (2008) 8:5 Am J Transplant 927.

to 2004.[173] Most of those involved in transplant tourism in Canada often come from large urban towns with multiethnic populations such as Vancouver, Montréal and Toronto.[174] Canadian patients who were born outside the State or who have ties with other States are also more likely to obtain kidney transplants abroad.[175]

Unlike the case with Israel, organ donation and transplant in Canada is regulated at the provincial level. This is because Canada runs a federal system of government with powers divided between the federal and provincial/territorial governments by the Canadian *Constitution Act* (*Constitution*).[176] The first laws in Canada with provisions on organ transplant and commercialization were the *Anatomy Acts* which existed in the various provinces. Though the provisions of each of these Acts were different, a few of them attempted to regulate organ commodification. In Manitoba, for instance, the *Anatomy Act* of 1954 prohibited the sale and traffic in the bodies of dead persons.[177] The *Anatomy Acts* later gave way to more specific statutes on organ transplantation such as the *Corneal Grafting Acts* which governed post-mortem eye donation.[178] In 1965, the Uniform Law Conference of Canada (ULCC) created the *Uniform Human Tissue Gift Act* which led to the adoption of *Human Tissue Acts* by the

173 "Canada: Transplant Tourism Carries Risk for Canadians," International Medical Travel Journal News (September 02, 2010), online: <http://www.imtj.com/news/?EntryId82=247135>. More recent statistics could not be found.

174 Wright *et al, supra* note 169.

175 Jagbir Gill *et al*, "Transplant Tourism in the United States: A Single-Center Experience" (2008) 3:6 Clin J Am Soc Nephrol 1825; Ramesh Prasad *et al*, "Outcomes of Commercial Renal Transplantation: A Canadian Experience" (2006) 82:9 Transplant 1131; Jagbil Gill *et al*, "Opportunities to Deter Transplant Exist before Referral for Transplantation and During the Workup and Management of Transplant Candidates" (2011) 79:9 Kidney Int'l 1029.

176 *The Constitution Act* (1867) 30 & 31 Vict., c 3; See ss 91 & 92 of the *Canadian Constitution Act* on the division of powers between the federal and provincial governments. Note that the federal government of Canada has exclusive jurisdiction over criminal matters.

177 See section 15(1), *Anatomy Act*, RSM 1954, c. 5 as amended by SM 1959.

178 The *Corneal Acts* were an adaptation of the *Model Cornea Transplant Act* of 1959 which was approved by the Conference of Commissioners on Uniformity of Legislation in Canada and modeled after the English *Corneal Gifting Act*, 1952. This Uniform Act was adopted by all the provinces and territories except New Brunswick which already had its own *Corneal Grafting Act:* Jean-Gabriel Castel, "Legal Aspects of Human Organ Transplantation in Canada Part II" (1968) 99 Can Med Ass J 609–610.

various provinces modeled after the *Uniform Act*.[179] The *Human Tissue Acts* had more specific provisions on organ transplantation and were made superior to all other Acts regulating human organ transplant.[180] Currently, every province and territory in Canada has an organ donation and transplantation Act.[181] Though these Acts were passed at different times, they are all similar with slight variations. All the current Acts address issues relating to organ commercialization in the various provinces with no specific provisions on Canadian nationals engaging in organ commercialization in other States. Below, I will briefly examine the relevant laws dealing with aspects of transplant tourism in three provinces: Ontario, Alberta and British Columbia.

In Ontario, the law regulating organ transplant and donation is the *Trillium Gift of Life Network Act* of 1990 (TGLNA).[182] As with other organ transplant laws in Canada, there are very few provisions in the TGLNA dealing with organ commercialization. By section 3(1) of the TGLNA, adults can consent to their organs being removed from their bodies and transplanted into the bodies of others.[183] Unlike organ transplant laws in transplant States, transplant laws in Canada do not try to restrict organ donation to individuals who are related to the donee as the need to increase the supply of human organs far outweighs the need to control possible illegal agreements for the sale of organs. Also, organ sales in tourist States are rare and not considered to be a social problem. There are nonetheless specific laws against organ commercialization in Ontario and

179 In Ontario, the *Human Tissue Act*, SO 1962–63, c. 59, was passed in 1963. Several other provinces passed their own *Human Tissue Acts* in subsequent years which were modeled after the Ontario Act: Castel, *ibid.*

180 In Manitoba for instance, section 26 of the *Anatomy Act*, RSM 1987 Supp. c.1 made the *Anatomy Act* subject to the *Human Tissue Gift Act*.

181 The various laws governing organ transplantation in Canada are: *Human Tissue and Organ Donation Act*, *supra* note 14 (Alberta); *Human Tissue Gift Act*, RSBC 1996, c. 211 (British Columbia); *Human Tissue Gift Act*, CCSM 2005, c. H180 (Manitoba); *Human Tissue Act*, RSNWT 1988, c. H-6 (Northwestern Territories); *Human Tissue Gift Act*, SNB 2004, c. H-12.5 (New Brunswick); *Human Tissue Act*, RSNL 1990, c. H-15 (Newfoundland and Labrador); *Human Tissue Gift Act*, RSNS 1989, c. 215 (Nova Scotia); *Human Tissue Gift Act*, RSN 1990, c. H-15 (Nunavut); *Trillium Gift of Life Network Act*, RSO 1990, c. H.20 (Ontario); *Human Tissue Donation Act*, RSPEI 1988, c. H-12.1 (Prince Edwards Island); *An Act to Facilitate Organ and Tissue Donation*, SQ 2010, c. 38 (Quebec); *Human Tissue Gift Act*, RSS 1978, c. H-15 (Saskatchewan); & *Human Tissue Gift Act*, RSY 2002, c. 117 (Yukon).

182 *Trillium Gift of Life Network Act*, *ibid.*

183 The age of consent under section 3(1) of the TGLNA, *ibid*, is 16 years. Section 3(2) allows donations from younger individuals where there is no reason to believe that that person was mentally incompetent or unable to make free and informed decisions.

other transplant laws in Canada. The most specific provision of the TGLNA which addresses organ commercialization is section 10 which bars individuals from buying, selling or otherwise dealing with human body parts for valuable consideration.[184] Any such sale of human organs is deemed to be contrary to public policy.[185] This prohibition however does not affect the sale of blood or its constituents which remains legal.[186] Individuals who contravene the provisions of the TGLNA are subject to a maximum fine of $1,000 or a maximum term of imprisonment of 6 months, or both.[187] Similar penalty provisions like those found in the TGLNA are present in other organ transplant laws in Canada such as those in Nova Scotia,[188] Saskatchewan[189] and Yukon.[190]

The organ transplant law in British Columbia (BC) is very similar to that of Ontario. The current Act governing organ transplants in BC is the *Human Tissue Gift Act* of 1996 (HTGA or Act).[191] In March of 2013, section 5 of the HTGA was amended to accommodate consent by a spouse and other individuals to the use of cadaveric organs from a deceased person who dies without consenting to donating his/her organs.[192] Section 3(1) of the HTGA makes living organ donation by adults legal and section 10 prohibits commercial dealings in human body parts.[193] The penalty for engaging in organ commercialization in BC is also a fine of not more than $1,000 or a term of imprisonment of not more than 6 months, or both.[194] When compared to the magnitude of

184 *Ibid,* section 10, TGLNA, states that "No person shall buy, sell or otherwise deal in, directly or indirectly, for a valuable consideration, any tissue for a transplant, or any body or part or parts thereof other than blood or a blood constituent, for therapeutic purposes, medical education or scientific research, and any such dealing is invalid as being contrary to public policy"

185 *Ibid.*

186 *Ibid.*

187 *Ibid,* section 12.

188 *Ibid,* section 14.

189 *Ibid,* section 14.

190 *Ibid,* section 12.

191 HTGA, *supra* note 181.

192 See section 5(1)(c & d), *Ibid,* for amendments.

193 The provisions of section 3 and other parts of the Act regulating living organ donation must be complied with always. By section 2 of the HTGA, *ibid*, all contrary rules on living organ donation are not valid. Section 10 states that "A person must not buy, sell or otherwise deal in, directly or indirectly, for a valuable consideration, any tissue for a transplant, or any body or parts other than blood or a blood constituent, for therapeutic purposes, medical education or scientific research."

194 *Ibid,* section 14.

the offence the Act aims at preventing, the penalty provision of the HTGA and other legislation with similar provisions are not significant enough to deter people from engaging in organ commercialization as individuals in need of life saving organs might deem the benefits to be derived from buying one as outweighing the penalty of doing so if caught. A few other provinces such as Manitoba and Prince Edward Island have increased their penalty provisions on organ commercialization to a maximum of $10,000 or a term of imprisonment of not more than 1 year, or both.[195] Though better than that of the penalties in the BC and Ontario legislation, this penalty is still insufficient.

An organ transplant law in Canada with stiffer penalties for organ commercialization activities is that of Alberta. The Albertan *Human Tissue and Organ Donation Act*[196] of 2006 (HTODA) came into force on August 1, 2009 replacing the *Human Tissue Gift Act*[197] of 2000. Though a majority of the changes made by the HTODA are minor, some have great impact on human tissue and organ donation in Alberta. One such provision is section 5(1) of the Act which reinforces the right of adults to donate not only their organs and tissues but also by-products from their bodies for the purpose of transplantation, thus expanding the list of human body parts that can be legally donated in the province.[198] However, these donations can only be made by consenting adults or duly authorized agents where an adult lacks the capacity to give consent.[199] More relevant to transplant tourism and organ commercialization in particular is section 3(2) of the HTODA which bars individuals from receiving rewards or benefits for tissue, organ or body donations used for transplantation and other legal purposes. This prohibition of organ sale does not, however, bar compensation for expenses or losses which flow directly from the transplantation procedure.[200] Another relevant provision in the HTODA dealing with aspects of

195 See section 15(3) of both the HTGA of Manitoba, *ibid,* and the HTGA of Prince Edwards Island, *supra* note 14.

196 HTODA, *supra* note 14.

197 HTGA, *supra* note 13.

198 By-products is defined by the Act as "tissue or an organ that is a waste product of a medical procedure." See section 1(b), HTODA, *supra* note 14.

199 *Ibid,* Section 5(1)(b). The duly authorized agents mentioned by the Act are agents designated in a personal directive or a court appointed guardian: Nelson, *supra* note 15 at 5. Organ donation by minors is also allowed with the approval of an independent assessment committee: *Ibid*, section 5 (2–7).

200 Though organ donors cannot be paid for their donation, they however qualify to be reimbursed for their expenses relating to the donation such as travel, accommodations, parking, meals and loss of income. In Alberta, this reimbursement program is handled by the Living Organ Donor Expense Reimbursement Program (LODERP). See The Kidney

transplant tourism is section 13 which governs penalties for the contravention of its provisions. In particular, section 13(3) makes a person who buys or sells an organ, tissue or by-products of the body guilty of an offence and liable to a fine of not more than $100,000 or to imprisonment for a term of not more than 6 months, or both. Under the former *Human Tissue Gift Act*, the maximum penalty for all breaches of the statute was a fine of $10,000 or 6 months imprisonment. This increase in penalty was introduced to deter Albertans from buying or selling organs.[201] The penalty provision in Alberta is a great improvement from what is obtainable in other parts of Canada and is more likely to deter/prevent organ sales.

The limitation of the Canadian laws regulating organ transplantation is that they have no provisions aimed at preventing transplant tourism. The various organ transplant laws are province-specific and would apply only in cases where organs are traded inside the various provinces. Since Canada is not a transplant or destination State for transplant tourism, its transplant laws have no direct effect on deterring individuals from engaging in transplant tourism within Canada. Unlike the Israeli and Spanish laws which prohibit nationals of each States from engaging in transplant tourism abroad, the Canadian law is silent on the issue. The effect of this is that Canadians who travel abroad to engage in transplant tourism are protected once they return to Canada. Such individuals can only be prosecuted for their actions in suits brought against them in the transplant States where the transactions took place, subject to the existence of an extradition agreement between Canada and that other State. Since organ commercialization is also an offence under Canadian law, Canada might agree to assist those other States as it would not be prevented from doing so by the principle of double criminality.[202]

Currently, most of Canada's commitment to fighting transplant tourism comes through statements issued by professional medical associations such

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Foundation of Canada, Northern Alberta website, online: <http://www.kidney.ca/page.aspx?pid=493>.

201 Nelson, *supra* note 15 at 11. It should however be noted that these penalties are the maximum and individuals caught engaging in organ commercialization might lesser penalties or sentences. It should also be noted that the prison term imposed by section 13(3) is not commensurate with the fine. A guilty individual can receive only a prison term of 6 months or less.

202 Canada adopts the principle of double criminality which prevents it from offering legal assistance to States on activities which are not offences in Canada. See Robert Goldstein & Nancy Dennison, "Mutual Legal Assistance in Canadian Criminal Courts" (2001) 44:1&2 Crim L Q 136.

as the Canadian Society of Transplantation (CST) and the Canadian Society of Nephrology (CSN). Both societies share one policy document on organ trafficking and transplant tourism.[203] A statement issued by both societies in the policy document states that they "condemn the practices of transplant tourism, organ trafficking and commercialization of organs …"[204] The document goes on to encourage healthcare providers to provide pre-transplant counselling to patients on the dangers of transplant tourism.[205] Like other policy documents, the policy document of the CST and CSN is a soft law instrument which is not legally binding. It is merely an official expression of expected behaviors.[206] The focus of the document is education and not the penalization of transplant tourism activities. It is doubtful that Canadians who travel abroad to buy organs are unaware of the risks involved in their actions as there are various studies and reports on the risks of having organ transplants abroad.[207] To most people who opt to travel abroad for organ transplants, the possible benefits to be derived from buying lifesaving organs from illegal foreign markets far outweigh the potential risks involved.

### 3 *Australia*

The year 1965 marked the beginning of renal transplantation in Australia after doctors successfully transplanted a kidney from a living donor in South Australia.[208] Through the years, there has been a disproportionate increase between the number of kidneys and other transplants in Australia and the number of organ donations. As is the case with most States, there are not enough human organs to satisfy the transplant needs of Australians. This problem was further compounded in Australia due to a plunge in living donor transplants.[209] According to the 2012 annual report of the Australia and New Zealand Dialysis and Transplant Registry (ANZDATA), there were 825 renal

203 John Gill *et al.*, "Policy Statement of Canadian Society of Transplantation and Canadian Society of Nephrology on Organ Trafficking and Transplant Tourism" (2010) 90:8 Transplant 817.

204 *Ibid* at 818.

205 *Ibid.*

206 See generally on the legal status of policy documents: Angela Campbell & Kathleen Glass, "The Legal Status of Clinical and Ethics Policies, Codes, and Guidelines in Medical Practice and Research" (2001) 46:2 McGill L J 473.

207 See for instance, Prasad *et al*, *supra* note 175 at 1130.

208 Timothy Mathew, "The Australian Experience in Organ Donation" (2004) 9:1 Ann Transplant 28.

209 *Ibid*; Sean Kennedy *et al*, "Outcomes of Overseas Commercial Kidney Transplantation: An Australian Perspective" (2005) 182:5 Med J Aus 224.

transplants performed in Australia in 2011 as opposed to 846 in 2010.[210] With an increase in the use of organs from deceased donors, there have been more organ transplants in Australia in recent years.[211] This increase has however not brought Australia out of the organ shortage crisis as the number of donated organs remains far below the current demand. Kidneys remain the most sought after organs with an estimate of 1.7 million Australians over the age of 25 suffering from chronic kidney disease with a large number of patients having end-stage renal disease (ESRD).[212] Due to the low organ donation rate, less than half of the patients with ESRD are able to benefit from kidney transplants and those who are lucky to do so often have to wait for long periods of time to access these organs.[213] Kidney Health Australia reports that people in need of organs sometimes have to wait up to 4 years for a transplant.[214] This shortage has pushed patients in need of organs to source these organs through alternative means such as engaging in transplant tourism activities in transplant States.[215] Although there is no official figure on how many Australian

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210 Australia and New Zealand Dialysis and Transplant Registry, "The 35th Annual ANZDATA Report 2012 – Data to 31st December 2011," Chapter 8 at 8-2, online: <http://www.anzdata.org.au/anzdata/AnzdataReport/35thReport/2012c08_transplants_v1.5.pdf>.

211 According to the 38th Annual ANZDATA Report (2015), 914 transplants were performed in Australia in 2014. This represents the highest number of transplants ever performed in Australia. See Australia and New Zealand Dialysis and Transplant Registry, "The 38th Annual Report 2015 – Data to 31st December 2014," Chapter 8 at 8-2, online: <http://www.anzdata.org.au/anzdata/AnzdataReport/38thReport/c08_anzdata_transplantation_v2.0_20160128_web.pdf>.

212 It is estimated that 1 in 9 Australian adults over the age of 25 has some form of chronic kidney disease: Claire Sparke *et al*, "Estimating the Total Incidence of Kidney Failure in Australia Including Individuals Who Are Not Treated by Dialysis or Transplantation" (2013) 61:3 Am J Kidney Dis 413; Steven Chadban *et al*, "Prevalence of Kidney Damage in Australian Adults: The AusDab Kidney Study" (2003) 14:Supp. 2 J Am Soc Nephrol S131. See generally: Wia Lim *et al*, "Outcomes of Kidney Transplantation from Older Living Donors" (2013) 95:1 Transplant 106; Stephen McDonald & Graeme Russ, "Survival of recipients of cadaveric kidney transplants compared with those receiving dialysis treatment in Australia and New Zealand" (2002) 17:12 Nephrol Dial Transplant 2212.

213 Lim *et al, ibid* at 106.

214 Formally known as the Australian Kidney Foundation, Kidney Health Australia is a non-profit organization which focuses on the promotion of kidney health through education, advocacy and research. See Kidney Health Australia, *Transplantation*, online: <http://www.kidney.org.au/ForPatients/Treatmentoptions/Transplantation/tabid/815/Default.aspx>.

215 Kennedy, *supra* note 207 at 224; Simon Lauder, "Australian Organ Tourists Drive Sinister Trade," ABC News (01 September, 2010), online: <http://www.abc.net.au/news/2010-09-01/australian-organ-tourists-drive-sinister-trade/966408>.

transplant patients buy organs abroad, there are several reports which identify Australia as a top tourist State.[216]

In spite of the infamous role Australia plays in transplant tourism activities through its nationals, there are no laws in Australia to discourage Australians from participating in transplant tourism practices. Like Canada, Australia has a federal system of government with powers divided between the central government and the states/territories by the *Commonwealth of Australia Constitution Act* (*Australian Constitution*).[217] As with most federal systems, these powers sometimes overlap. Organ donation and transplantation is a residual matter which is usually not regulated by the federal government.[218] Each state and territory in Australia has its own organ transplant law.[219] These laws were enacted following the 1977 Report of the Australian Law Reform Commission on Human Tissue Transplants.[220] In addition to the various state and territorial laws on organ transplant, Australia also has a federal organ transplant Act called the *Organ and Tissue Donation and Transplantation Authority Act* (OTDTAA or Act) which was passed in 2008.[221] The Act was created to build an

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216 Kennedy, *supra* note 209 at 224; Scheper-Hughes, *supra* note 33 at 26; Aronowitz, *supra* note 33 at 111; Budiani-Saberi & Delmonico, *supra* note 172 at 927; Shimazono, *supra* note 51 at 957; Kalogjera, *supra* note 141 at 20; Katrina Bramstedt & Jun Xu, "Checklist: Passport, Plane Ticket, Organ Transplant" (2007) 7:7 Am J Transplant 1698; Paul Garwood, "Dilemma Over Live-Donor Transplantation" (Jan 2007) 85:1 Bull World Health Organ 5; Syed Kazim, "Organ Donation Law in Pakistan: An Overview of the Current Situation" (2008) 58:2 J Pak Med Ass 99.

217 *Commonwealth of Australia Constitution Act*, 63 & 64 Victoria Chap. 12, An Act to Constitute the Commonwealth of Australia (9 July 1900).

218 Section 51 of the *Australian Constitution*, *ibid*, grants exclusive legislative powers to the Parliament. Generally, any power not included in that section is a residual power and remains the domain of the states. Health and criminal matters are residual matters governed mostly by states.

219 The current organ transplant laws in Australia are: *Transplantation and Anatomy Act*, Act No. 44 of 1978 (Australian Capital Territory); *Human Tissue Act*, Act No. 164 of 1983 (New South Wales); *Transplantation and Anatomy* Act, Act No. 121 of 1979 (Northern Territory); *Transplantation and Anatomy Act*, Act No. 74 of 1979 (Queensland); *Transplantation and Anatomy Ac*t, 1983 (South Australia); *Human Tissue Act*, 1985, Act No. 118 of 1985 (Tasmania); *Human Tissue Act*, 1982, Act No. 9860 of 1982 (Victoria) & *Human Tissue and Transplant Act*, 1982, Act No. 116 of 1982 (Western Australia).

220 Helen Mckelvie, "Reforming the Human Tissue Acts" (2006) 14:2 J Law Med 167.

221 *Organ and Tissue Donation and Transplantation Authority Act*, Act No. 122 of 2008. The OTDTAA is not superior to the various state and territorial Acts but is designed to operate concurrently with these Acts. See section 59, OTDTAA.

efficient organ and tissue donation and transplantation system in Australia and was a direct response to recommendations made by the National Clinical Taskforce on Organ and Tissue Donation (NCTOTD) in January of 2008.[222] In order to achieve its goals, the OTDTAA created the Australian Organ and Tissue Donation and Transplantation Authority (Authority) and the office of the Chief Executive Officer (CEO) to head the Authority.[223] The functions of the CEO are enumerated in section 11 of the Act and include the formulation of policies and codes of practice relating to organ and tissue donation and transplantation. In achieving these functions, the CEO is to have regards to certain objectives such as minimizing the waiting time for organs, improving the identification of potential donors and improving the public knowledge about organ and tissue donation matters.[224] While matters under the OTDTAA do not directly deal with transplant tourism, their execution can potentially increase the availability of organs and tissues needed for transplantation which in turn might eliminate the need for Australians to travel abroad for transplant purposes.

Rules relating to various aspects of transplant tourism are contained in the state and territorial laws on organ donation and transplantation. The applicable laws in each state and territory are similar in terms of their wording and the activities they regulate. For the purpose of this section, I will examine two such Acts briefly. These Acts are the *Transplantation and Anatomy Act*[225] of the Australian Capital Territory (ACT) and the *Human Tissue Act*[226] of Victoria.

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222 The National Clinical Taskforce on Organ and Tissue Donation was established in 2006 by the government of Australia to provide "evidence-based advice to government on how the system might be changed so as to improve the rate of safe, effective and ethical donation for transplantation in Australia." The Taskforce submitted its final report in January of 2008 which led to the creation of the Organ and Tissue Donation and Transplantation Authority under the 2008 Act. See Australian Policy *Online, The Future of Organ Donation in Australia: Moving Beyond the "Gift of Life"* (Swinburne Institute for Social Research, October 2008) online: <http://apo.org.au/research/future-organ-donation-australia-moving-beyond-gift-life>. The complete final report of the NCTOTD can be found on the Australian Government Department of Health and Ageing website: <http://www.health.gov.au/internet/main/publishing.nsf/content/734953F7721631D3CA257458000F330E/$File/Volume%201.pdf>.

223 Ss 8 & 10, OTDTAA, *supra* note 221.

224 For a complete list of objectives, see section 12, *ibid.*

225 TAA, *supra* note 219.

226 HTA, *supra* note 219.

The *Transplantation and Anatomy Act* (TAA or Act) which was formally a Commonwealth Ordinance, is the oldest of all the Acts on organ donation and transplantation in Australia.[227] It regulates a wide range of subject matters ranging from organ donation to blood transfusions and donation for anatomical purposes.[228] Pursuant to the Act, organs are to be donated free and with the consent of the donor. Sections 8 and 9 give adults the right to consent to living organ donations of both their regenerative and non-regenerative organs.[229] This consent must be in writing and is vitiated if the consenting party revokes it or if the doctor in charge of the operation has reasonable grounds to believe that the written consent contains false statements.[230] Section 44 of the TAA bars individuals from entering into contracts or arrangements for the sale or supply of body tissues and makes all such contracts or arrangements void.[231] The bar on receiving compensation for organ donations does not, however, affect arrangements for the reimbursement of expenses necessarily incurred by donors in relation to the removal of a tissue in accordance with the TAA.[232] In special circumstances, the Minister of Health can also approve contracts or arrangements for the sale of organs.[233] The Act however fails to explain what those special circumstances are. All other contracts and arrangements for the sale of organs are subject to the maximum penalty under the TAA which is 50 penalty units.[234] According to the Act, the value of a penalty unit is $110 AUD for an individual, which adds up to only $5,500 AUD for buying or selling a human organ.[235]

Similar penalty provisions exist under the *Human Tissue Act* of Victoria (HTA or Act). But unlike the TAA, the HTA makes a distinction between agreements

227 See section 34, *Australian Capital Territory* (*Self-Government*) *Act* of 1988.

228 See ss 20–23, TAA, *supra* note 220, for blood transfusions and ss 36–41, TAA for donations for anatomical purposes.

229 *Ibid,* ss 13 & 14 also allows children to donate their organs in accordance with rules set out in those sections.

230 *Ibid,* section 19; section 24(2–5), *ibid,* lays down the rules on how consent can be revoked by a donor and the procedures for making such revocation official.

231 *Ibid,* section 44(1) & (5). The Dictionary section of the Act defines tissue to include organs or parts of a human body.

232 *Ibid,* section 44(3).

233 *Ibid,* section 44(4).

234 *Ibid,* section 44(1).

235 The penalty for buying and selling organs under the HTTA of Western Australia, *supra* note 219, is one of the smallest. According to section 29 (2) of the Act, any person who enters into a contract to buy or sell human tissues is subject to a fine of $1,000 AUD if caught. Territories which impose larger penalties include the Northern Territory. Under the TAT of the Northern Territory, *supra* note 219, the penalty under section 22(E) is

to sell organs and agreements to buy organs. While persons who sell or agree to sell organs are liable to pay a fine of 50 penalty units, persons who buy or agree to buy organs are subject to a stiffer penalty of 100 penalty units or imprisonment of 6 months, or both.[236] The current amount of a penalty unit as calculated using the *Monetary Units Act* of Victoria is $140.84 AUD.[237] By making the penalty distinction between organ vendors and buyers, the HTC seems to recognize the fact that organ vendors are, more often than not, victims of organ commercialization practices. The Act also recognizes the importance of buyers to the practice of organ commercialization as the market in human organs will not exist without them. The HTA of Victoria provides for two exceptions to the rules against buying and selling organs. The first exception governs written permits by the Minister of Health given to persons to buy human organs.[238] The second exception relates to compensation for reasonable expenses for the supply of human reproductive gametes as provided for under section 17 of the *Prohibition of Human Cloning for Reproduction Act 2008*.[239] As is the case in Canada, the various organ transplant laws of Australia only prohibit organ commercialization. It is therefore legal to engage in transplant tourism in Australia.

## Conclusion

Organ transplantation as a means of treating certain ailments has since grown from a few breakthroughs in medical science to widespread practices in various States. Unfortunately, most States do not have access to sufficient human organs to match the transplant needs of their nationals. This global shortage in human organs has given rise to transplant tourism. Absent from most national laws regulating organ transplants are provisions against transplant tourism. Most States only prohibit national organ sales. Save for a few States, this trend of not legislating against transplant tourism is also common in the transplant laws of key tourist and transplant States. This focus on organ

400 penalty units or 2 years imprisonment. Per the Penalty Units Regulations of the Northern Territory made under the *Penalty Units Act*, the monetary value of a penalty unit is $ 144 AUD which adds up to $57,600 AUD.

236 Ss 38 & 39, HTA, *supra* note 219.

237 See *Monetary Units Act*, Act No. 10 of 2004.

238 Section 3 (2), HTA, *supra* note 219.

239 *Ibid,* ss 38(3) & 39(1A). See also section 17, *Prohibition of Human Cloning for Reproduction Act*, Act No. 72 of 2008.

commercialization alone has not had any effect on preventing transplant tourism. Transplant States with national organ transplant laws prohibiting the sale of organs have not backed these laws with effective enforcement mechanisms and have remained favorable destinations for persons seeking to buy organs. On their part, most tourist States have done nothing to legally prevent their nationals from traveling to transplant State to buy organs. The result of this is that transplant tourism remains legal in most tourist States.

With heightened global awareness on the dangers of transplant tourism and the development of the *Declaration of Istanbul* in 2008, India, the Philippines, Pakistan, Israel and Spain passed laws which directly prohibit transplant tourism. These States have prohibited transplant tourism in two major ways. Transplant States (the Philippines, India and Pakistan) currently have laws which prohibit foreigners from receiving organs for transplants in these States. The only exception is where the foreigner is a near relative of the donor and has obtained the correct approvals from relevant regulating bodies. Israel is the only tourist State which legally prohibits its nationals from traveling abroad to engage in transplant tourism or using organs which have been acquired illegally for transplantation. Although not a tourist State, Spain also prohibits transplant tourism under its *Penal Code*. The different States with laws against transplant tourism have recorded varying degrees of success. Israel and Spain have been able to prevent most of their nationals from traveling abroad to buy organs. Transplant tourism continues to occur in Philippines, India and Pakistan, although to a lesser degree than was previously the case. However, the existence of laws against transplant tourism in these States have made Neighbouring States like Sri Lanka targets for transplant tourism practitioners. Overall, transplant tourism is still a global problem. Based on the above findings, it can be concluded that for transplant tourism to be prevented, all States need to play a role in its prevention. The transnational nature of transplant tourism makes it conduct which also needs to be prohibited by international law.

Staring from the next Chapter and working my way through Chapters 5 and 6, I will discuss the prohibition of transplant tourism at international law. In Chapter 4, I will examine the various branches of international law which currently prohibit some aspects of transplant tourism, namely international health law, international human rights law and international criminal law. As will be seen, similar to domestic law, transplant tourism is not prohibited in its entirety under international law. It is therefore not surprising that transplant tourism continues to the detriment of persons and societies around the world.

CHAPTER 4

# International Law and Transplant Tourism

## A Introduction

In the last Chapter, I focused on national organ transplant laws of five prominent transplant and tourist States: India, the Philippines, Israel, Canada and Australia. In my examination of India and the Philippines, I looked at the legal developments in both States within the past few years and the impact these developments have had in preventing nationals from tourist States from buying organs from vulnerable persons within these States. Although there has been a reduction in the occurrence of transplant tourism in these States, transplant tourism has not been completely eradicated. As the only tourist State with a law against transplant tourism, Israel has been able to stop most of its nationals from traveling abroad to buy organs. A major tool used by Israel is to ensure that insurance companies do not reimburse nationals for transplants carried out with illegally obtained organs. The last Chapter was concluded with a note on the need to also prohibit transplant tourism at international law because of the international element present in all transplant tourism cases and the transnational nature of transplant tourism practices.

In this Chapter, I will examine the existing branches of international law which prohibit certain aspects of transplant tourism. In particular, focus will be placed on three international law branches: international health law, international human rights law and international criminal law. Discussions on international health law will focus on resolutions and guiding principles of the World Health Assembly (WHA), which is the decision-making body of the World Health Organization (WHO).[1] In my discussions of international human rights law, I will look at various international human rights instruments which are directly or indirectly relevant in the regulation of transplant tourism. The discussions on international criminal law will address international criminal law instruments which prohibit various aspects of transplant tourism. The

1 The World Health Assembly is attended by delegates from all WHO Member States and focuses on a specific health agenda prepared by the Executive Board. The main functions of the WHA are to determine the policies of the WHO, appoint the Director-General, supervise financial policies, and review and approve the proposed programme budget. The WHA can be found online: <http://www.who.int/mediacentre/events/governance/wha/en/index.html>.

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last part of this Chapter will focus on the activities of NGOs, Transnational Advocacy Networks (TANs), epistemic communities and transplant societies which have helped guide and shape the progress made thus far in the regulation of transplant tourism under international law and the roles these organizations could play in the future prohibition of transplant tourism.

## B International Health Law

International health law is the branch of international law which focuses on global and public health governance and the regulation of health-related issues through treaty provisions, policy and ethical guidelines.[2] In international law, health is defined by the WHO as the complete physical, mental and social well-being of an individual and not merely the absence of disease or infirmity.[3] Due to the importance placed on the attainment of good health by everyone, certain health matters have been enshrined as human rights protected by a number of treaties and soft laws.[4] Some of the key health issues regulated by international law include the prevention of communicable diseases, sexual and reproductive health, nutrition, substance abuse, occupational health, equal access to health

2 The terms "global" and "public" health are interchangeable and refer to science and art of globally "preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private, communities and individuals": Charles-Edward Winslow, "The Untilled Fields of Public Health" (1920) 51:1306 Science 30; David Rosner & Linda Fried, "Traditions, Transitions, and Transfats: New Directions for Public Health" (2010) 125:1 Pub Health Rep 3; Shannon Houser *et al,* "Expanding the Health Information Management Public Health Role" (2009) 6 Perspect Health Inf Manag 1.

3 Preamble to the *Constitution of World Health Organization* as adopted by the International Health Conference, New York, 19 June–22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of WHO, no. 2, p. 100) and entered into force on 7 April 1948; Frank Grad, "The Preamble of the Constitution of the World Health Organization" (2002) 80:12 Bull World Health Organ 981. The inclusion of the phrase "social wellbeing" in the above definition has however been criticized as being too expansive and was omitted from the *International Covenant on Economic, Social and Cultural Rights,* GA Res. 2200A (XXI), 21 UN GAOR Supp. (No 16) at 49, UN Doc. A/6316 (1966); 993 UNTS 3; 6 ILM 368 (1967), (ICESCR).

4 "Declaration of Alma-Ata International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978" (2004) 47:2 Development 159; Danwood Chirwa, "The Right to Health in International Law: Its Implications for the Obligations of State and Non-State Actors in Ensuring Access to Essential Medicine" (2003) 19 S A J Human Rts 541. See also the ICESCR which is the principal UN treaty which guarantees the right to health, *ibid*; *infra*, notes 80–91.

and actions which tend to affect the health of individuals negatively. The principal UN body which makes regulations and lays down standards relating to international public health is the WHO.[5] Health-related issues do not, however, exist in a vacuum and depend on other human rights for their existence. Because of this inclusive nature of health-related issues and their dependence on other human rights which are commonly referred to as "social determinants of healthcare," health law issues at international law are also regulated by other UN bodies and can be found in a wide range of international human rights instruments.[6]

### 1 *International Health Law Instruments on Transplant Tourism*

International health law currently regulates transplant tourism issues using WHA resolutions and guiding principles. The first unified international law instrument to focus on the development of guiding principles which should regulate the practice of national organ transplantation is the *WHA40.13 Development of Guiding Principles for Human Organ Transplantation* (*Resolution WHA40.13*) which was adopted by the 40th session of the WHA in May 1987.[7] The drafting of *Resolution WHA40.13* was influenced by the need to safeguard existing human rights, especially those guaranteed and protected by the *Universal Declaration of Human Rights* (UDHR)[8] and the

5 The WHO is the directing and coordination authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to States and monitoring and assessing health trends. All States which are members of the UN may become members of the WHO by accepting its Constitution. Other States may become members by application. There are currently 194 WHO member states. The WHO can be found online: <www.who.int>

6 Per the WHO, social determinants of health are "the conditions in which people are born, grow, live, work and age." Some major social determinants of health have been enumerated in Article 11, *General Comment No. 14 on the Right to the Highest Attainable Standard of Health* (*Article 12 of the International Covenant on Economic, Social and Cultural Rights*), E/C.12/2000/4, and include access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health: World Health Organization, "What are Social Determinants of Health?," (Geneva: WHO, 2013), online: <http://www.who.int/social_determinants/sdh_definition/en/index.html>; David Blane *et al, Health and Social Organization: Towards a Health Policy for the 21st Century* (London: Taylor & Francis, 1996).

7 World Health Assembly, *Handbook of Resolutions and Decisions of the World Health Assembly and Executive Board*, Vol. 3, 3rd ed (Geneva: World Health Assembly, 1993) at 87.

8 *Universal Declaration of Human Rights*, GA Res. 217 (III), UN GAOR, 3d Sess., Supp. No. 13, UN Doc. A/810 (1948) 71.

*WHO Constitution*.[9] In particular, the drafters of *Resolution WHA40.13* were concerned about the growing practice of organ commodification and transplant commercialization and felt the need to develop international standards and principles which should inform national regulation of these practices. These principles were, however, not contained in *Resolution WHA40.13*. Essentially, the purpose of *Resolution WHA40.13* was to open discussions on the topic and encourage research on the development of appropriate guiding principles.[10] The text of these principles was the focus of *WHA44.25 Guiding Principles on Human Organ Transplantation* (*Resolution WHA44.25*) which was passed four years later.[11]

Before *Resolution WHA44.25* was passed in 1991 as a set of guiding principles for organ transplantation, the WHA adopted *WHA42.5 Preventing the Purchase and Sale of Human Organs* (*Resolution WHA42.5*) in 1989.[12] In 1989, there were no national laws prohibiting the sale of organs in transplant States. The WHO through the WHA saw the need for States to take direct action in preventing the sale of human organs through legislation and other measures. In the preamble of *Resolution WHA42.5*, the WHA noted that the prohibition of the sale of human organs was necessary to prevent the exploitation of human distress, particularly in vulnerable groups, and to further the recognition of the ethical principles which condemn the buying and selling of organs for the purposes of transplantation.[13] As a means of discouraging the sale of human organs, a direct responsibility was placed on States to take appropriate measures to prevent the sale and purchase of human organs for transplantation.[14] In particular, States were advised to introduce legislation to prevent organ trafficking when it could not be prevented by other measures.[15] *Resolution WHA42.5* is, however, silent on what these "other measures" are. They could include the adoption of guiding principles by professional bodies involved in organ transplants and the strengthening of regulatory and enforcement procedures. However, it is clear from the WHO directive that the international community is reluctant to

9 See Preamble, WHA 40.13, *supra* note 7.

10 The Institute for Domestic and International Affairs, Inc., "Commercialization of the Human Body" (New Brunswick: IDIA, 2009) at 4.

11 World Health Organization, "Guiding Principles on Human Organ Transplantation" (1991) 337:8755 The Lancet 1470–1.

12 World Health Assembly, *Preventing the Purchase and Sale of Human Organs* (Geneva: World Health Organization, 1989), online: <http://apps.who.int/iris/handle/10665/172138>.

13 See Preamble, *Resolution WHA42.5*, *ibid.*

14 *Ibid,* article 1.

15 *Ibid,* article 2.

recommend the use of legislation as a means of controlling transplant tourism. This unwillingness did not stop States from prohibiting transplant tourism practices through legislation. In 1994, the first national law prohibiting the sale of organs in transplant States was passed in India, five years after *Resolution WHA42.5*.[16]

In response to the above two resolutions, especially Paragraph 1 of *Resolution 40.13* which requested the Director-General to study the possibility of developing appropriate guiding principles for human organ transplants, the WHA in 1991 adopted *Resolution WHA44.25* endorsing a set of guiding principles on human organ transplantation.[17] *Resolution WHA44.25* is made up of nine principles touching on various aspects of organ transplantation. This was the first of three guiding principles on organ transplantation to be developed by the WHA and it placed emphasis on voluntary donation, non-commercialization of organs, genetic relation of recipients to donors, fair distribution of organs and a preference for deceased over living donors as sources for transplant organs.[18] In particular, *Resolution WHA44.25* proposed the prohibition of various activities relating directly to transplant tourism such as the traffic in human organs for payments, the advertisement of organs for sale or profit and the removal and implantation of organs by health professionals who have knowledge of the occurrence of commercial transactions.[19] *Resolution WHA44.25* was instrumental in the development of national legislation in various States and professional codes on transplant tourism.[20] In particular, the years following *Resolution WHA42.5* witnessed the enactment of national laws prohibiting the sale of human organs in transplant States like India, the Philippines and Pakistan.[21]

In spite of the attention organ commercialization received under both national and international law in the 1990s, there was little done to address transplant tourism as a global phenomenon. This was soon to change in the early 2000s when the WHO began to discuss the impact of organ commercialization on communities

16 See the *Transplantation of Human Organ Act*, Act No. 42 of 1994 (India).

17 *Resolution WHA44.25, supra* note 11.

18 *Ibid*, Guiding Principles 1, 3, 5, 6 & 9.

19 *Ibid*, Guiding Principles 5, 6 & 7; Bernard Dickens, "World Health Organization Guidelines on Transplantation and the WTO Task Force" (1998) 30 Transplant Cli Immunol 83.

20 World Health Organization, *Human Organ and Tissue Transplantation: Report by the Secretariat* (Geneva: EB112/5 2 May 2003).

21 India passed the *Transplantation of Human Organ Act*, *supra* note 16; the Department of Health of the Philippines adopted *Administrative Order No. 124* in 2002; In Pakistan, the *Transplantation of Human Organs and Human Tissue Ordinance* was passed in 2007.

around the world and the transnational nature of the practice. These discussions began in 2003 with a meeting organized by the WHO in Madrid which focused in part on the rapid development of transplant tourism.[22] The report of the Madrid meeting was later adopted by the WHO in its 57th Assembly in April 2004[23] and was in the same year included in *WHA57.18 Human Organ and Tissue Transplantation* (*Resolution WHA57.18*).[24] Among its provisions, Article 1(5) of *Resolution WHA57.18* urged WHO member states to take measures to protect poor and vulnerable groups from "transplant tourism" and the sale of tissues and organs. This was the first time the term "transplant tourism" was used in a WHO resolution on organ transplantation.

Although *Resolution WHA57.18* focused on transplant tourism, it did not have any significant impact on the practices globally. As with the resolutions before it, *Resolution WHA57.18* placed a direct duty on States to ensure that they bring an end to transplant commercialization activities and protect their nationals from the negative impacts of the practice. On their part, States failed to pass new national laws or policies prohibiting or discouraging transplant tourism practices.[25] This was to change in 2008 which was a turnaround year for transplant tourism both nationally and internationally. Apart from the wave of enactment of national laws prohibiting transplant tourism, the amendment of existing laws in States like the Philippines and the development of the *Declaration of Istanbul*,[26] the WHA revised its 1991 guiding principles on human organ transplantation and adopted the 2008 *WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation.*[27] The 2008

22 World Health Organization, *Ethics, Access and Safety in Tissue and Organ Transplantation: Issues of Global Concern, Madrid, Spain* (Geneva: World Health Organization, 2004), online: <http://www.who.int/ethics/topics/en/madrid_report_final.pdf>.

23 World Health Organization, *Human Organ and Tissue Transplantation: Report by the Secretariat* (Geneva: World Health Organization, 2004).

24 World Health Organization, *Human Organ and Tissue Transplantation* (Geneva: World Health Organization, 2004), online: <http://www.who.int/transplantation/en/A57_R18-en.pdf>.

25 In Canada for instance, the Canadian Society of Transplantation and the Canadian Society of Nephrology did not pass their joint policy statement on organ trafficking or transplant tourism until 2010. See John Gill *et al*, "Policy Statement of Canadian Society of Transplantation and Canadian Society of Nephrology on Organ Trafficking and Transplant Tourism" (2010) 90:8 Transplant 817.

26 "The Declaration of Istanbul on Organ Trafficking and Transplant Tourism" (2008) 3:5 Clin J Am Soc Nephro 1227–1231.

27 World Health Organization, "WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation" (2010) 11:4 Cell Tissue Bank 413–9.

Guiding Principles reformulated the principles and commentaries contained in *Resolution WHA44.25*. In addition, it included two new principles.[28] The most important changes made by the 2008 guiding principles are the broadening of its principles to include cells and tissues and not just organs, better protection of minors and inclusion of more elaborate provisions against organ commercialization.[29]

The 2008 Guiding Principles were updated in 2010 by *WHA63.22 Human Organ and Tissue Transplantation* (*Resolution WHA63.22*).[30] Unlike all the WHA resolutions before 2010 which focused on organ transplantation in general, the focus of *Resolution WHA63.22* was transplant commercialization, organ commodification and the protection of vulnerable populations from exploitation resulting from transplant tourism activities. In particular, *Resolution WHA63.22* urged States to implement the 2008 Guiding Principles in their individual laws, policies and legislation regarding organ donation and transplantation.[31] States were also urged to oppose organ trafficking and organ tourism activities and implement systems for altruistic voluntary non-remunerated organ donation.[32] As with the resolutions before it, *Resolution WHA63.22* left the implementation of its principles to States. Though a few States like India reviewed their organ transplant laws to include provisions dealing directly with transplant tourism, the transplant laws and policies of most States have remained the same in spite of this recent WHA resolution. *Resolution WHA63.22* of 2010 remains the most recent resolution passed by the WHA on organ transplants.

The general attitude of States to the various WHA resolutions is a direct reflection of the nature of resolutions in international law. Aside from a few resolutions such as binding decisions of the UN Security Council, resolutions of international organizations are usually soft laws which are merely written motions adopted by a deliberating body which show the consensus of that

28 *Ibid*, Guiding Principles 10 & 11. By these new principles, States are encouraged to put systems in place which would ensure the safety of both the donors and recipients alike. States are also encouraged to ensure that the entire donation and transplantation procedure is transparent while ensuring that the privacy and autonomy of both the donors and recipients are protected.

29 *Ibid*, Guiding Principles 1, 4, 5, 6, & 7.

30 World Health Organization, *Human Organ and Tissue Transplantation* (Geneva: World Health Organization, 2010), online: <http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_R22-en.pdf?ua=1>.

31 *Ibid,* Article 2(1).

32 *Ibid*, Article 2(2&3).

body on a particular matter or state of affairs.[33] Though there are resolutions in international law which have brought about major reforms in the subject matter which they address such as the *Declaration of Istanbul*[34] dealing with transplant tourism and the 1996 *Declaration and Agenda for Action*[35] on child sex tourism (CST), WHA resolutions are not legally binding instruments. Thus, while the various WHA resolutions have led to certain reforms dealing with transplant tourism in some States and have laid down useful guidelines for States to implement in their policies against transplant tourism, they have generally not led to legislation against transplant tourism in most States. Another shortcoming of these resolutions is that they are not always effective in changing the conduct of States as they do not create the same type of obligations as those created by treaties and customary international law (CIL). Resolutions can, however, influence State conduct and lead to the development of international law. This will be discussed in greater detail in Chapter 5.

## C International Human Rights Law

Human rights principles lay down standards for treatment which all individuals are inherently entitled to by virtue of their being human. It is a powerful medium for safeguarding individuals from abuse.[36] The human rights which are protected by universal and regional international law are also protected at the domestic level by national laws and are commonly viewed as universal, inalienable and based on the belief that all people are equal and deserve equal treatment. The field of international human rights law is, unfortunately, almost silent on the prohibition of transplant tourism. This is in spite of the fact that there are various meeting points between transplant tourism and international human rights. International human rights law could play a

33 See generally on soft laws: Dinah Shelton, "Compliance with International Human Rights Soft Law" (1997) 29 Stud Transnat'l Legal Pol 120–7.

34 The *Declaration of Istanbul*, *supra* note 26.

35 The *Stockholm Declaration and Agenda for Action*, adopted at the First World Congress against Commercial Sexual Exploitation of Children, Stockholm, Sweden, 27–31 August 1996.

36 Magdalena Sepulveda *et al*, *Human Rights Reference Handbook*, 3rd ed (Colon, Costa Rica: University of Peace, 2004) at 3; Hans Schmitz & Kathryn Sikkink, "International Human Rights" in Walter Carlsnaes *et al,* eds, *Handbook of International Relations* (London: Sage, 2002) at 827; Jack Donnelly, "Human Rights and Human Dignity: An Analytic Critique of Non-Western Conceptions of Human Rights" (1982) 76:2 Am Pol Sc Rev 304.

fundamental role in the prohibition of transplant tourism as it leads to major human rights abuses. A very common human rights abuse brought about by transplant tourism is the violation of the personal dignity and bodily integrity of organ vendors who offer their organs in exchange for money.[37] This is especially true in cases where the vendors are left financially, physically and emotionally worse off than they were before the sale took place.[38] The bodily integrity of individuals is also violated when organs are harvested without prior or valid consent. Two ready practices which come to mind here are those relating to the use of organs from children when such use is against the best interests of the child and the harvesting of organs from prisoners and persons in confinement in suspicious circumstances, as is the practice in China.[39]

As with other branches of international law, the rights and duties under international human rights law are safeguarded by treaty law, CIL and, to a lesser extent, general principles of law. Today, international human rights law relies heavily on treaties. The rights in UN human rights treaties have their origin in the *Universal Declaration of Human Rights* (UDHR).[40] UN treaties also remain one of the major routes for enforcing international human

37 Charles Fried, *Right and Wrong* (Cambridge: Harvard University Press, 1978) at 142.

38 See Tsuyoshi Awaya *et al*, "Failure of Informed Consent in Compensated Non-Related Kidney Donation in the Philippines" (2009) 1:2 Asian Bio Rev 142.

39 For China, see Zaki Zaher, "Transplantation in Asia: Meeting the Challenges" (2004) 36:7 Transplant Proc 1861; Jiefu Huang *et al*, "A Pilot Programme of Organ Donation after Cardiac Death in China" (2012) 379:9818 The Lancet 862; Allison Owen, "Death Row Inmates or Organ Donors: China's Source of Body Organs for Medical Transplantation" (1995) 5:2 Ind Int'l & Comp L Rev 495. For children, the general principle in all actions concerning them is that their best interests should be a primary consideration: article 3, *Convention on the Rights of the Child,* GA Res. 44/25, annex, 44 UN GAOR Supp. (No. 49) at 167, UN Doc. A/44/49 (1989); 1577 UNTS 3; 28 ILM 1456 (1989). The CRC also provides in its preamble that children should be brought up in the "spirit of dignity" which automatically excludes any act which is bound to interfere with the bodily integrity of any child.

40 UDHR, *supra* note 8. The UDHR was passed in 1948 to give effect to the human rights provisions of the 1945 *Charter of the United Nations*, (1945) ATS 1/59 Stat. 1031; TS 993; 3 Bevans 1153 (UN Charter). The UN Charter singlehandedly brought fundamental human rights into the sphere of modern international law. However, the UDHR is not in and of itself binding as it is a General Assembly resolution. It is however considered to be evidence of CIL. See Hurst Hannum, "The Status of the Universal Declaration of Human Rights in National and International Law" (1998) 25:1 Geo J Int'l L 290 & 293; Sepulveda, *supra* note 36 at 5.

rights as they codify most human rights principles.[41] States generally seek to conduct their activities in accordance with their treaty obligations.[42] Whether or not this desire to fulfil treaty obligations translates into actual compliance by States remains debatable.[43] Many factors affect treaty compliance including States' national interests and their financial and infrastructure resources.[44]

While some international human rights instruments can be applied directly to certain aspects of transplant tourism, the application of others can only be achieved through the stretching of their principles. Some of the key international human rights instruments which relate to transplant tourism are the *Universal Declaration of Human Rights* (UDHR), the *International Covenant on Economic, Social and Cultural Rights* (ICESCR)[45] and the *International Covenant on Civil and Political Rights* (ICCPR).[46] Aside from these instruments, provisions relevant to transplant tourism can also be found in other human rights instruments such as the *Convention on the Rights of the Child* (CRC)[47] and the *Convention against Torture and Other Cruel, Inhuman or Degrading*

41 It should however be noted that many of the human rights obligations under international law can also be found in CIL. See Louis Sohn, "The Human Rights Law of the Charter" (1977) 12 Tex Int'l L J 133; Bruno Simma & Philip Alston, "The Sources of Human Rights Law: Custom, Jus Cogens, and General Principles" (1988) 12 Aust YBIL 84.

42 This sense of obligation is derived mainly from the principle embodied in the maxim *pacta sunt servanda* which literally means that agreements must be kept. This principle is encapsulated in Article 26 of the *Vienna Convention on the Law of Treaties*, UN Doc. A/Conf.39/27; 1155 UNTS 331; 8 ILM 679 (1969); 63 AJIL 875 (1969). See the *North Sea Continental Shelf Cases* (*Federal Republic of Germany v Netherlands; Federal Republic of Germany v. Denmark*), (1996) ICJ Rep 3. See generally Hans Wehberg, "Pacta Sunt Servanda" (1959) 53:4 Am J Intl L 781.

43 George Downs & Michael Jones, "Reputation, Compliance, and International Law" (2002) 31:1 J Legal Stu S96; *Contra*: Louis Henkin believes "almost all nations observe almost all principles of international law and almost all of their obligations almost all of the time." See Louis Henkin, *How Nations Behave: Law and Foreign Policy*, 2nd ed (Columbia: Columbia University Press, 1979), cited in Harold Koh, "Why Do Nations Obey International Law?" (1997) 106 Yale L J 2599.

44 Oona Hathaway, "Do Human Rights Treaties Make a Difference?" (2002) 111:8 Yale L J 2005–6; Ryan Goodman & Derek Jinks, "Measuring the Effects of Human Rights Treaties" (2003) 14:1 EJIL 172.

45 ICESCR, *supra* note 3.

46 *International Covenant on Civil and Political Rights*, GA Res. 2200A (XXI), 21 UN GAOR Supp. (No 16) at 59, UN Doc. A/6316 (1966); 999 UNTS 302.

47 CRC, *supra* note 39.

*Treatment or Punishment* (CAT).[48] The UN human rights treaties are monitored by treaty committees and are accompanied by protocols which are relevant in the interpretation and application of the treaties.[49] Optional protocols are separate treaties annexed to parent treaties which provide additional details on substantive portions of the treaty or provide for procedures under the parent treaty. The human rights treaty or an optional protocol empower the treaty committee with powers to receive and review petitions submitted by individuals, subject to the jurisdiction of the State Party.[50] It is possible for a State to be a party to a treaty and not be a party to an optional protocol to the treaty.

## 1 *International Human Rights Instruments Relevant to Transplant Tourism*

### i Universal Declaration of Human Rights

A starting point for most discussions on human rights is the UDHR as it was the first globally recognized and accepted international law instrument which established a standard for civil, political, economic, social and cultural rights with the intention of protecting these rights from breaches.[51] The UDHR sets out rights which all humans are entitled to and which States should aspire to safeguard in a non-discriminatory manner. Though not a legally binding document, at least parts of the UDHR codify binding CIL and the UDHR remains an important reference point for discussions on what human rights are and how they are to be protected.[52] As noted above, the WHO did not develop any instrument on organ transplantation until 1987, meaning that the UDHR was passed before the WHO started focusing on the development of guiding principles for organ acquisition and transplantation. There are a few UDHR provisions which are relevant in addressing certain human rights breaches brought about by transplant tourism practices.

48 *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,* GA Res. 39/46, annex, 39 UN GAOR Supp. (No. 51) at 197, UN Doc. A/39/51 (1984); 1465 UNTS 85.

49 John Currie *et al*, *International Law: Doctrine, Practice, and Theory,* 2nd ed (Ontario: Irwin Law, 2014) at 655–656. See discussion of treaty committees *infra* notes 184–174.

50 United Nations, *Treaty Handbook* (Geneva: United Nations Publication, 2002–2012) at 69. Note that the decisions of UN treaty committees are merely persuasive and do not bind the States Parties.

51 Hilary Landorf, "The Universal Declaration of Human Rights" (2012) 76:5 Soc Edu 247.

52 Mary Glendon, *A World Made New: Eleanor Roosevelt and the Universal Declaration of Human Rights* (New York: Random House LLC, 2001) at XVI; Alejo Labrador, "The Universal Declaration of Human Rights" (1953) 28:6 Phil L 830. Note that though not binding, the UDHR is considered to be evidence of CIL: see Hannum, *supra* note 40 at 290.

The UDHR does not directly provide for the right to health. However, article 25 of the UDHR provides for the right to an adequate standard of living for all individuals adequate for their health and well-being.[53] By providing for this right, the drafters of the UDHR indirectly placed a duty on States to ensure that individuals have access to good health by acknowledging the connection between the health and well-being of individuals and the standard of living they can afford.[54] Article 25(1) also provides for the right to security of individuals in the event of sickness or disability.[55] Practices such as the acquisition of organs in situations which could potentially affect the health of the donor or recipient would run counter to the provisions of article 25. Even though the UDHR made only passing reference to the right to health, this right was later expanded by article 12 of the ICESCR.[56]

At the core of the UDHR is the concept of dignity of person.[57] Dignity of person, or human dignity, is one of the most fundamental theories of international human rights, so much so that it has often been treated as being equivalent to a human right.[58] The concept of dignity was first introduced into international human rights in the preamble of the *UN Charter* which was later included in article 1 of the UDHR.[59] Both the ICCPR and the ICESCR state

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53 Article 25 of the UDHR, *supra* note 8, provides: "(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control …"

54 See Alicia Yamin, "The Right to Health under International Law and its Relevance to the United States." (2005) 95:7 Am J Pub Health 1156.

55 Article 25(1), UDHR, *supra* note 8.

56 See *infra* notes 78–86.

57 The UDHR has in fact been credited as being the instrument which popularized the use of dignity in human rights discussions: Christopher McCrudden, "Human Dignity and Judicial Interpretation of Human Rights" (2008) 19:4 EJIL 655.

58 See Tom Harkin, "Human Rights and Foreign Aid: Forging an Unbreakable Link" in Peter Brown & Douglas MacLean, eds, *Human Rights and U.S. Foreign Policy: Principles and Applications* (Maryland: Lexington Books: 1979) at 15; Adamantia Pollis & Peter Schwab, "Human Rights: A Western Construct with Limited Applicability and Introduction" in Adamantia Pollis & Peter Schwab, eds, *Human Rights: Cultural and Ideological Perspectives* (New York: Praeger, 1980) at 4; Asmarom Legesse, "Human Rights in African Political Culture" in Kenneth Thompson, ed., *The Moral Imperatives of Human Rights: A World Survey* (Lanham: University Press of America, 1980) at 132.

59 Article 1 of the UDHR, *supra* note 8, provides that "All human beings are born free and equal in dignity and rights …"

that human rights "derive from the inherent dignity of the human person."[60] Human dignity supplied a theoretical basis on which all other human rights were guaranteed as it was a common factor which united the various States targeted by the drafters of the UDHR.[61] In spite of the pivotal role it plays in the existence of other human rights, the exact meaning of human dignity remains elusive.[62] An instructive description of human dignity as used in the UDHR is that it is connected to the self-worth of an individual.[63] As discussed in Chapter 2, the most common argument against the commodification of human organs is that it demeans the dignity of individuals by treating a human as a means and not an end.[64] Exploiting the desperation of individuals, to the extent that they are willing to trade an organ for money which leaves them in no better situation than they were before the transaction, is quite demeaning. It might also lead to health complications and lower standards of living. It can be argued that transplant tourism goes against the spirit and intent of the UDHR.[65]

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60 See preamble of the ICESCR & ICCPR, *supra* notes 3 & 46.

61 McCrudden, *supra* note 57 at 677.

62 The European Court of Human Rights noted that dignity is a "particularly vague concept, and one subject to random interpretation.": *Siliadin v France*, (no. 73316/01), Eur. Ct. H.R. 30 (2005); Ruth Macklin, "Dignity is a Useless Concept" (2003) 327:7429 BMJ 1419.

63 Dignity is derived from the Latin word "*dignus*" which means worthy: Elaine Mairis, "Concept Clarification in Professional Practice – Nursing" (1994) 19:5 J Adv Nurs 947; Jane Haddock, "Towards Further Clarification of the Concept of 'Dignity' " (1996) 24:5 J Adv Nurs 924.

64 Immanuel Kant, "Groundwork of the Metaphysics of Morals" in Mary Gregor, ed, *Cambridge Texts in the History of Philosophy* (Cambridge: Cambridge University Press, 1998) at 38; Immanuel Kant, *Ethical Philosophy: The Complete Text of Grounding for the Metaphysics of Morals, and Metaphysical Principles of Virtue, Part II of the Metaphysics of Morals* (Indianapolis: Hackett Publishing, 1983) at 36; Christine Korsgaard, "Fellow Creatures: Kantian Ethics and Our Duties to Animals" (2004) Tanner Lectures on Human Values 24 3; Paul Flaman, "Organ and Tissue Transplants: Some Ethical Issues," in Mervyn Lynch & Naomi Stinson eds, *Topics in Bioethics for Science and Religion Teachers: Reading and Study Guide*, (Edmonton: Edmonton Catholic Schools and St. Albert Catholic Schools, 1994) at 31–46; Teo Bernard, "Is the Adoption of More Efficient Strategies of Organ Procurement the Answer to Persistent Organ Shortage in Transplantation" (1992) 6:2 Bioethics 125; Agneta Sutton, "Commodification of Body Parts" (2002) 325:7356 BMJ 114.

65 *Contra*, Thomas Hill, *Dignity and Practical Reason in Kant's Moral Theory* (Ithaca: Cornell University Press, 1992) at 38–41; Michael Gill & Robert Sade, "Paying for Kidneys: The Case against Prohibition" (2002) 12:1 Kennedy Inst of Ethics J 26.

Furthermore, in some instances, transplant tourism subject's organ vendors and "donors" to cruel or degrading treatment and even death. A ready example of how organ donors can be treated in a cruel or degrading manner can be found in reports on how organs are acquired from prisoners on death row in China. These organs are used to feed the demand for organs by both nationals and foreigners.[66] Under a 1984 *Temporary Rules Concerning the Utilization of Corpses or Organs from the Corpses of Executed Criminals*, organs from executed prisoners can be used for transplant and research purposes.[67] Unless the body goes unclaimed, the organs can only be used with the consent of the family.[68] In practice, however, there have been reports by Human Rights Watch and hearings before the US Congress which allude to the fact that standard procedures for the execution of prisoners in China are not always complied with and, in some cases, prisoners are abused and tortured before and during the organ extraction process.[69] Abuses such as these and cases where individuals are tortured and sometimes killed for their organs violate article 5 of the UDHR which prohibits torture or cruel, inhuman or degrading treatment or punishment.[70]

By emphasising the importance of the attainment of high health standards by individuals and the importance of safeguarding the inherent dignity of

66 Allison Owen, "Death Row Inmates or Organ Donors: China's Source of Body Organs for Medical Transplantation" (1995) 5:2 Ind Int'l & Comp L Rev 495.

67 Joan Hemphill, "China's Practice of Procuring Organs from Executed Prisoners: Human Rights Groups Must Narrowly Tailor their Criticism and Endorse the Chinese Constitution to End Abuses" (2007) 16:2 Pacific Rim L & Pol J 431.

68 *Temporary Rules Concerning the Utilization of Corpses or Organs from the Corpses of Executed Prisoners,* 1984. See Hemphill, *supra* note 67 at 432; Jane Macartney, "China to 'Tidy Up' Trade in Executed Prisoners' Organs," *The Times* (3 December 2005), online: <http://www.thetimes.co.uk/tto/news/world/asia/article2612313.ece>.

69 There is a particular case that was reported in which kidneys and skin were extracted from an executed prisoner who was partially dead and continued to breathe even after the extraction process. See Dr. Wang Guopi's account of this case in "Organs for Sale: China's Growing Trade and Ultimate Violation of Prisoners' Rights" (2001) Hearing Before the Subcomm. on Intl. Operations and Human Rights of the H.R. Comm. on Intl. Relations, 107th Cong. at 57–58, online: <http://democrats.foreignaffairs.house.gov/archives/107/73452.pdf>. See also Hemphill, *supra* note 67 at 432; See David Rothman's account of the execution and organ extraction process in David Rothman, "Bodily Integrity and the Socially Disadvantaged: The traffic in Organs for Transplantation," in Bethany Spielman ed, *Organ and Tissue Donation: Ethical, Legal and Policy Issues*, (Carbondale: Southern Illinois University Press, 1996) at 39.

70 The prohibition of torture or cruel, inhuman or degrading treatment or punishment can also be found under treaty law such as article 7 of the ICCPR and the *Torture Convention*. China is a party to both conventions.

individuals, the UDHR inadvertently laid down the foundation for future protection of individuals against transplant tourism. This foundation continues to be built on. The application of these UDHR provisions depends largely on the nature of the UDHR provision in question. Core protections like the prohibition against torture or cruel treatment in article 5 have been accepted as codifications of CIL norms due to the convergence of extensive, continuous and reiterated practice and of *opinio juris* of these rights and freedoms.[71] The legal status of protection of human dignity and the right to health, however, remains vague. Due to these differences, the conclusion whether or not the UDHR protects individuals from transplant tourism depends largely on what provision of the UDHR is being considered.

The vagueness of some of the UDHR provisions does not, however, make them ineffective. This is because the UDHR has acted as a model for other human rights treaties, national laws, constitutions and regulations with enforceable provisions.[72] In particular, it has led to two UN human rights treaties, the: ICESCR[73] and ICCPR.[74] These two core human rights instruments contain principles which can be expanded to cover transplant tourism cases. They have also given rise to other international law instruments dealing with various aspects of human rights such as the *Convention on the Elimination of all forms of Discrimination against Women* (CEDAW),[75] CRC[76] and CAT.[77]

### ii International Covenant on Economic, Social and Cultural Rights

The ICESCR entered into force in 1976, laying down human rights which States parties are to adopt "with a view to achieving progressively."[78] The rights under the ICESCR are progressive rights which States undertake to fulfill according to the

71 Sohn, *supra* note 41 at 133; Hannum, *supra* note 40 at 289; Bruno Simma & Philip Alston, "The Sources of Human Rights Law: Custom, Jus Cogens, and General Principles" (1988) 12 Aust. YBIL 91; Muhammad Haleem, "The Domestic Application of International Human Rights Norms," in Rajsoomer Lallah, Developing Human Rights Jurisprudence, the Domestic Application of International Human Rights Norms 33 (London, Commonwealth Secretariat, 1998) at 97.

72 Hannum, *supra* note 40 at 289.

73 *Supra* note 3. There are currently 164 parties to this treaty.

74 *Supra* note 46. There are currently 168 parties to this treaty.

75 *Convention on the Elimination of all Forms of Discrimination against Women*, GA Res. 34/180, 34 UN GAOR Supp. (No. 46) at 193, UN Doc. A/34/46; 1249 UNTS 13; 19 ILM 33 (1980).

76 CRC, *supra* note 39

77 CAT, *supra* note 48.

78 Article 2(1), ICESCR, *supra* note 3.

maximum of their available resources over a period of time, although aspects of their obligations are of immediate effect.[79]

Of particular relevance to transplant tourism under the ICESCR is the right to health in article 12 of the Covenant. Article 12(1) states that: "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[80] The ICESCR is the principal UN treaty which guarantees the right to health.[81] Health is seen as "the right to an effective and integrated health system encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all."[82] This definition of the right to health places emphasis not just on health issues but also on the underlying social determinants of health which are *condiciones sine quibus non* for the enjoyment of the right to health.[83] Shedding more light on article 12 of

79 *Ibid*, article 2(1); *CESCR General Comment No. 3: The Nature of States Parties' Obligation (Article 2 Para. 1 of the Covenant)* E/1991/23. In spite of the caveat, not all aspects of this right are to be fulfilled in the long term. While a State's financial situation and lack of resources might affect the full implementation of the principles which make up the right to health, they have an immediate duty to guarantee certain aspects of the right to health to the maximum of their financial resources to individuals within their territory. At the very least, States must ensure that they guarantee the right to health in a non-discriminatory manner and take concrete and deliberate steps towards the realization of the right: "The Right to Health" (Geneva: World Health Organization, 2008) Fact Sheet No. 31 at 5.

80 The article goes on to enumerate certain steps which States Parties are to take in order to ensure the realization of this right. See article 12, ICESCR, *supra* note 3.

81 The right to health can also be found under article 25, UDHR, *supra* note 8; article 12, CEDAW, *supra* note 75; article 24, CRC, *supra* note 39; and article 16, *African Charter on Human and Peoples' Rights,* OAU Doc. CAB/LEG/67/3 rev. 5, 1520 UNTS 217; 21 ILM 58 (1982).

82 Paul Hunt & Gunilla Backman, "Health Systems and the Right to the Highest Attainable Standard of Health" (2008) 10:1 Health Hum Rts 81.

83 The term "social determinants of healthcare" is used to describe other rights which are prerequisites for the enjoyment of the right to health. Per the WHO, social determinants of health are "the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels." It is almost impossible to list out all the factors which are "social determinants of health." Some of the major factors are contained in *General Comment No. 14* and include access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health: World Health Organization, "What are Social Determinants of Health" (Geneva: World Health Organization, 2013), online: <http://www.who.int/social_determinants/sdh_definition/en/index.html>; Article 11, *General Comment No. 14, supra* note 6.

the ICESCR is *General Comment No. 14 on the Right to the Highest Attainable Standard of Heath* (*General Comment No. 14*).[84] Article 8 of *General Comment No. 14* describes the right to health as a right which contains both freedoms and entitlements. While the freedoms include the right to control one's health and body, including sexual and reproductive freedom and the right to be free from interference, the entitlements on the other hand include the right to a system of health protection which provides "equality of opportunity for people to enjoy the highest attainable level of health."[85] No matter the definition or description of the right to health adopted, it is instructive to note that the right to health does not mean the right to be healthy, as a State cannot guarantee the health of all its nationals or legal aliens. The right, however, places an obligation on States to provide access to services relevant for the enjoyment of this right.[86]

The specific obligations placed on States under article 12 of the ICESCR can be found in article 12 of *General Comment No 14* under the headings of availability, accessibility, acceptability and quality (AAAQ). These standards can also be used to ascertain whether transplant and tourist States are currently meeting their obligations under article 12. Availability refers to the existence of sufficient quantity of public health and healthcare facilities, goods and services and programs in a State.[87] It also includes the availability of social determinants of health such as safe and potable drinking water. Accessibility refers to the right of everyone to access healthcare facilities, goods and services without discrimination and includes physical, economic and information accessibility.[88] Acceptability refers to the ability of healthcare facilities, goods and services to be sensitive to and respectful of the various cultures and differences of various individuals who access these facilities, goods and services.[89] Quality refers to how scientific, medically appropriate and current the healthcare facilities, goods and services are.[90] In addition to these core obligations, States have a specific duty to respect, protect and fulfill the right to health.[91]

84 *Ibid.*

85 *Ibid,* article 8.

86 *Ibid*; Eleanor Kinney, "The International Human Right to Health: What Does This Mean for our Nation and World?" (2001) 34:4 Ind L Rev 1468.

87 Article 12(a), *General Comment No. 14, supra* note 6.

88 *Ibid,* article 12(b).

89 *Ibid,* article 12(c).

90 *Ibid,* article 12(d).

91 See *ibid* articles 34–37.

Of all the above standards, the first two, availability and accessibility, have a direct relationship with tourist and transplant States respectively. As discussed in Chapter 1, scarcity is the major factor which has led to the trade in human organs and transplant tourism.[92] In the case of transplant tourism, however, the availability issue does not relate to a lack of transplant facilities or practitioners beyond that which States usually experience, but a lack of available organs needed for transplantation. If nationals of tourist States could access organs for transplantation in their own States, there would be no reason for them to source these organs from transplant States. This scarcity does not, however, imply that tourist States are violating their right to health obligations under international human rights law. This failure will only arise if it can be shown that they are not doing all that they can do to make more organs available for transplantation. While tourist States cannot compel their nationals to donate organs, they can do a lot to create awareness about organ donation issues and provide avenues for willing individuals to donate their organs. Most tourist States rely heavily on organs from posthumous donors and have a duty to ensure that organs acquired this way are properly utilized and not wasted through poor planning and scheduling, poor or delayed transportation and improper matching of organs and donees.[93]

The accessibility obligation is one which relates more to transplant States. An important aspect of the definition of transplant tourism is that it involves the devotion of resources to providing transplants to foreign patients at the expense of a State's own population.[94] In States where organs are purchased, access to organs is determined more by the ability to pay rather than need. This leads to discrimination in the distribution of organs and excludes a large portion of the local population who do not have the financial ability to pay for organs from having access to needed organs.[95] This form of discrimination violates article 2(2) of the ICESCR which places a duty on States to ensure that the rights enunciated in the Covenant are exercised without discrimination of any kind.[96] This duty to not discriminate is addressed in *General Comment*

92 Nina Parisi & Irwin Katz, "Attitudes towards Posthumous Organ Donation and Commitment to Donate" (1986) 5:6 Health Psycho 565.

93 See generally: Gerhard Opelz, "HLA Compatibility and Organ Transplant Survival: Collaborative Transplant Study" (1999) 1:3 Reviews in Immunogenetics 334; Tom Wilkinson, *Ethics and the Acquisition of Organs: Issues in Biomedical Ethics* (Oxford: Oxford University Press, 2011) at 6.

94 See Definition Section, *Declaration of Istanbul*, *supra* note 26.

95 Jeremy Haken, *Transnational Crime in the Developing World* (Washington: Global Financial Integrity, 2011) at 24.

96 Article 2(2), ICESCR, *supra* note 3.

*No. 20 on Non-discrimination in Economic, Social and Cultural Rights* (*Art. 2, Para. 2, ICESCR*) (*General Comment No. 20*).[97] Article 7 of *General Comment No. 20* describes discrimination as acts which constitute "any distinction, exclusion, restriction or preference."[98] By showing preference to foreign patients, States are contravening the provisions of article 2(2) of the ICESCR. Thus, transplant States have a duty to prevent this form of discrimination which has resulted from transplant tourism. Even more important is the duty to protect their nationals from the physical and economic harms and challenges which arise as a result of the organ sales. Although a few of these transplant States have taken the initiative to pass laws aimed at excluding foreigners from the organ acquisition stream, these initiatives need to be properly implemented and adopted by more States.[99]

iii International Covenant on Civil and Political Rights

Like the ICESCR, the ICCPR entered into force in 1976, and contains many civil and political rights, elaborating on some of the rights found in the UDHR. One purpose of the ICCPR is to obligate ratifying States to protect the inalienable human rights of individuals without discrimination of any kind such as race, color, sex, language, national or social origin or other status.[100] States Parties to the ICCPR are obligated to promote the enjoyment of a variety of political and civil rights and freedoms.[101] Some of these rights and freedoms are relevant in the prohibition of transplant tourism.

The ICCPR safeguards rights which are related to the right to health such as the right to life and the right of incarcerated individuals to be treated with dignity.[102] Cases where unsuspecting individuals are killed for their organs is a

97 See General Comment No. 20 (Non-discrimination in Economic, Social and Cultural Rights (Article 2, Paragraph 2 of the *International Covenant on Economic, Social and Cultural Rights*)) E/C.12/GC20.

98 Article 7, *General Comment No. 20*, *ibid*, describes discrimination as any action which constitutes "any distinction, exclusion, restriction or preference or other differential treatment that is directly or indirectly based on the prohibited grounds of discrimination and which has the intention or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of Covenant rights"

99 See for instance, *Revised National Policy on Living Non-Related Organ Donation and Transplantation and its Implementing Structures Amending Administrative Order* No. 2008-0004-A (June 23, 2010), (*Administrative Order No. 2010-0018*) of the Philippines.

100 See preamble and article 2(1), ICCPR, *supra* note 46.

101 These rights and freedoms include the right to life, freedom of speech and the right to liberty of movement. See articles 3, 6, 9 & 12, ICCPR, *ibid.*

102 *Ibid,* articles 6 & 1.

clear violation of their right to life, as article 6(1) of the ICCPR states that no one shall be arbitrarily deprived of his right to life.[103] Under the principle of due diligence, States also have a duty to protect individuals from these actions if they are carried out by private individuals.[104] The right to life is one from which no derogation is permitted.[105] The ambit of the right to life is further qualified in *CCPR General Comment No. 6: Article 6* (*Right to Life*) (*General Comment No. 6*).[106] In States which have not abolished the death penalty, a sentence of death can only be imposed for the most serious crimes.[107] Article 10 of the ICCPR goes on to state that all persons "deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person."[108] According to article 6 of *ICCPR General Comment No. 20: Article 7* (*Prohibition of Torture, or Other Cruel, Inhuman or Degrading Treatment or Punishment*) (*General Comment No. 20*), the death penalty should be carried out in such a way as to cause "the least possible physical and mental suffering."[109]

Article 7 of the ICCPR states that "no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."[110] According to the Human

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103 For reported cases in Argentina, see Mark Hanson, "A Pig in a Poke" (1992) 22:6 Hastings Cent Rep 2; Cameron Ainsworth-Vincze, "Where Kosovo Patients Slain for Organs?: Forty Inmates Disappeared from the Stimlje Mental Asylum in 2001," Maclean's (24 November 2008), online: <http://www2.macleans.ca/2008/11/24/were-kosovo-patients-slain-for-organs/>.

104 Jan Hessbruegge, "The Historical Development of the Doctrines of Attribution and Due Diligence in International Law" (2004) 36:4 NYUJ Int'l L & Pol 268.

105 Article 4, ICCPR, *supra* note 46. The *Second Optional Protocol to the ICCPR* (OP2-ICCPR) which aims at abolishing the death penalty states that no one within the jurisdiction of a State Party to the Protocol shall be executed. See article 1, *Second Optional Protocol to the International Covenant on Civil and Political Rights*, GA Res. 44/128, annex, 44 UN GAOR Supp. (No. 49) at 207, UN Doc. A/44/49 (1989).

106 *CCPR General Comment No. 6: Article 6* (*Right to Life*) (1982) HRI/GEN/1/Rev.9 (Vol. I).

107 Such a sentence must however not be contrary to any of the provisions of the ICCPR and the *Convention on the Prevention and Punishment of the Crime of Genocide*, 78 UNTS 277 (1948). See Article 6(2), ICCPR, *supra* note 46.

108 Article 10(1), ICCPR, *supra* note 46; See also comment 3, *General Comment No. 21: Article 10* (*Humane Treatment of Persons Deprived of their Liberty*) (1992) HRI/GEN/1/Rev.9 (Vol. I), (General Comment No. 21), which states that respect for persons deprived of their liberty must be guaranteed under the same conditions as for that of free persons.

109 Article 6, *CCPR General Comment No. 20: Article 7* (*Prohibition of Torture, or Other Cruel, Inhuman or Degrading Treatment or Punishment*) (1992) HRI/GEN/Rev.9 (Vol. I); General Comment No. 20 replaces General Comment No. 7.

110 Article 7, ICCPR, *supra* note 46. The prohibition of torture is the primary focus of the CAT and is discussed below, *infra* footnotes 115–122.

Rights Committee (HRC), what amounts to torture will depend on the "nature, purpose and severity of the treatment applied."[111] Except for a few instances in which individuals are actually tortured in the process of extracting their organs, the vast majority of transplant tourism cases do not involve actual torture in the true sense of the word. This does not, however, remove transplant tourism from the coverage of article 7 of the ICCPR as the provision covers not only torture *stricto sensu* but other forms of cruel, inhuman or degrading treatment. This position is further strengthened by the fact that article 7 is supposed to complement article 10 of the ICCPR which is aimed at protecting the dignity of incarcerated individuals.[112] The objective test of what amounts to torture or degrading treatment can be applied to transplant tourism cases which almost always involve some form of degrading or inhuman treatment which is contrary to basic human values.[113] Transplant States that are ICCPR parties have a duty under article 7 to ensure that they protect their citizens and other persons under their jurisdiction from all forms of inhuman or degrading treatment by private institutions and actors.[114] The execution of these international law obligations will, however, remain a challenge for transplant or organ source States due to some obvious reasons. Aside from the fact that most transplant States lack the human resources to comply with their international law obligations, other national challenges such as poverty and corruption all work together to frustrate the efforts of transplant States. Another limiting factor is that some transplant States like China are not parties to the ICCPR and thus not bound by its provisions.

### iv Convention against Torture

The CAT also provides some form of protection to individuals from transplant tourism.[115] Its relevance to transplant tourism is, however, very limited. The CAT has its roots in article 5 of the UDHR and article 7 of the ICCPR both of which shield individuals from torture and cruel, inhuman or degrading

111 Article 4, *General Comment No. 20, supra* note 109.

112 According to article 2, *ibid*, "The prohibition in article 7 is complemented by the positive requirements of article 10, paragraph 1, of the Covenant."

113 Russell Scott, *The Body as Property*, (New York: Viking Press, 1981) at 184–186; William May, "Religious Justifications for Donating Body Parts," (1985) 15:1 Hastings Cent Rep 38.

114 According to article 10, *General Comment No. 20*, *supra* note 109, "enforcement personnel, medical personnel, police officers and any other persons involved in the custody or treatment of any individual subjected to any form of arrest, detention or imprisonment must receive appropriate instruction and training" on how to properly treat persons in their custody. States are also to inform the committee on how the training and instructions and prohibition under article 7 forms part of their operational rules and ethical standards.

115 CAT, *supra*, note 48. There are currently 160 parties to this treaty.

treatment or punishment. The CAT went a step further by establishing an international regime for the prosecution of torturers.[116] The CAT defines torture as "severe pain or suffering … inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity."[117] Article 16 of the CAT also defines "acts of cruel, inhuman or degrading treatment or punishment" as those carried out by the instigation, consent or acquiescence of a public official or other persons acting in an official capacity.[118] These definitions automatically remove most transplant tourism practices from the coverage of the CAT as the acts comprising transplant tourism are often carried out by private actors without the involvement of the State or its officials.[119] Although the CAT does not directly deal with acts of torture or degradation carried out by private actors, this does not exempt private persons from liability for such acts. States have a duty to exercise due diligence in preventing and addressing wrongs committed by private individuals.[120] In addition, nationally, the constitution and criminal law provisions of some States have provisions aimed at protecting their nationals from acts of torture by private citizens.[121]

The limitation of the CAT does not, however, make it insignificant in the prohibition of transplant tourism. The CAT still applies to the situations where torture and inhumane treatment are connected to transplant tourism in States which are

116 David Steward, "The Torture Convention and the Reception of International Criminal Law within the United States" (1991) 15:2 Nova L Rev 449.

117 Article 1, CAT states: "For the purposes of this Convention, the term "torture" means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions."

118 Article 16, CAT, *supra* note 48.

119 The definitions under articles 1 and 16 of CAT automatically limits the coverage of this Convention and distinguishes it from the ICCPR which applies to the actions of both the government and its agents and those of private individuals. Even where the transplant hospital is government owned, the activities of the medical doctors would still not be covered by these provisions. See article 7, ICCPR, *supra* note 46; article 10, *General Comment No. 20*, *supra* note 109.

120 *Ibid.*

121 See for instance section 320A, Queensland *Criminal Code Act* 1899 which states that "a person who tortures another person commits a crime."

CAT contracting parties. The CAT will be relevant in China, for instance, where it is alleged that prisoners are tortured and subjected to inhuman treatment when their organs are extracted by government employees, partly to fuel transplant tourism practices.[122] However, China's CAT obligations do not address major transplant tourism issues nor would it lead to its eradication in the State. This is due to the fact that the CAT does not directly deal with transplant tourism: it only deals with the process by which the organs are harvested.

### v Convention on the Rights of the Child

The CRC is a treaty which creates new rights and extends general human rights provisions contained in the UDHR, ICESCR and the ICCPR to children.[123] The CRC expands on the principles contained in the *Geneva Declaration on the Rights of the Child* of 1924[124] and the *Declaration of the Rights of the Child* of 1959[125] and makes them binding on contracting parties. Children are not spared from the horrors of transplant tourism as there are reported cases of children being abducted for the purpose of harvesting their organs.[126] In March 2014, members of a Mexican cartel which specializes in abducting children and harvesting their organs were arrested. The children were reportedly transported by the cartel in refrigerated containers inside vans.[127] In November 2016, *The Telegraph* also reported a story about a teacher in a school for orphans and teenagers in Ukraine accused of plotting to sell a 13-year-old student to organ harvesters.[128]

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122 China ratified the *CAT* in 1988 and is thus bound by its provisions. See Rosemary Foot, *Rights Beyond Borders: The Global Community and the Struggle over Human Rights in China* (Oxford: Oxford University Press, 2000) at 103.

123 CRC, *supra* note 39. There are currently 196 parties to this treaty. See generally on the CRC: Rachel Hodgkin & Peter Newell, *Implementation Handbook for the Convention on the Rights of the Child*, 3rd ed (New York: UNICEF, 2007).

124 *Geneva Declaration of the Rights of the Child* of 1924, adopted Sept. 26, 1924, League of Nations O.J. Spec. Supp. 21, at 43 (1924).

125 *Declaration of the Rights of the Child* of 1959, Proclaimed by General Assembly Resolution 1386(XIV) of 20 November 1959.

126 See generally: Maria Morelli, "Organ Trafficking: Legislative Proposals to protect Minors" (1994) 10:1 Am U J Int'l L & Pol'y 917; Paras. 20–21, UN Committee on the Rights of Persons with Disabilities, *Concluding observations on the Initial Report of Ukraine*, 2005, CRPD/C/UKR/CO/1.

127 "Child Organ Trafficking Ring Busted by Mexican Police," CBC News (March 27, 2014), online: <http://www.cbc.ca/news/world/child-organ-trafficking-ring-busted-by-mexican-police-1.2576492>.

128 Jack Losh, "Ukrainian Teacher Accused of Trying to Sell Student to Organ Harvesters," The Telegraph (22 November, 2016), online: <http://www.telegraph.co.uk/news/2016/11/22/ukrainian-teacher-accused-trying-sell-student-organ-harvesters/>. See also the 2013 story

Article 3 of the CRC lays down the general consideration for dealing with issues involving children. In all cases involving children, the best interests of the child is to be a paramount consideration and any action which works against the interest of a child should be discouraged and avoided.[129] Applying this principle, the CRC lays down several rules which contracting parties are to comply with in relation to children. Although the CRC does not have any specific provision on organ transplant or transplant tourism, some of its provisions can be used to offer some protection to children from the harms of transplant tourism. Article 6 reaffirms the right to life of children and encourages contracting parties to promote the survival and development of children.[130] In order to ensure the highest possible survival rates, article 24 recognizes the right of children to the enjoyment of the highest attainable standard of health. In safeguarding this right, contracting parties are to take appropriate measures to diminish infant and child mortality and to ensure the provision of adequate health care.[131] Transplant tourism activities which involve children clearly compromise their health and endanger their lives. It is for this reason that

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of a Somalian girl who was trafficked into the UL with the intention of harvesting her organs: Steven Swinford, "Girl Smuggled into Britain to have her 'Organs Harvested'," The Telegraph (18 October, 2013), online: <http://www.telegraph.co.uk/news/uknews/crime/10390183/Girl-smuggled-into-Britain-to-have-her-organs-harvested.html>.

129 For more on the principle of the "best interests of the child" see *General Comment No. 14 (2013) on the Right of the Child to Have his or her Best Interests Taken as a Primary Consideration (Art. 3, Para. 1)*, CRC/C/GC/14.

130 Article 6(1)(2), CRC, *supra* note 39. Article 27 of the CRC also recognizes the right to every child to adequate standard of living necessary for his or her development.

131 Article 24(2)(a-f), CRC, *ibid.* For an elaborate discussion of this right, see General Comment No. 15 (2013) *on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (Art. 24)*, CRC/C/GC/15. The protection given to children is also extended to children who are mentally and physically disabled. The CRC provides that mentally and physically disabled children should be allowed to enjoy a full and decent life. See article 23, CRC, *ibid*. This extension of protection to mentally and physically disabled children is important as these has been reported cases of children being killed or abducted from health care facilities for their organs. The Daily News of May 14, 2013 reports of a girl with a mild case of hydration who was taken to a hospital in India for treatment. She later died and when her body was recovered it was noticed that all he r internal organs were missing. It is suspected that her organs were used for transplant tourism purposes. See Carol Kuruvilla, "British Girl, 8, Killed in Indian Clinic in Attempt to Take her Organs, Parents Say.," Daily News (14 May, 2013), online: <http://www.nydailynews.com/news/world/british-girl-killed-indian-clinic-botched-attempt-harvest-organs-parents-article-1.1344022>.

some States do not allow organ donation by children. Like the UDHR, ICESCR and ICCPR, the CRC also protects children from all forms of exploitation, torture, inhuman or degrading treatment, and physical or mental abuse.[132] These provisions are broad and cover all cases of violence against children.[133]

The CRC provisions which offer the most protection to children from transplant tourism can be found in articles 11, 21 and 22. Article 11 places a duty on States Parties to take measures to combat the illicit transfer of children abroad.[134] Article 21 goes further to protect children from fraudulent adoption practices. States are to ensure that children are only adopted after proper screening by the appropriate authorities.[135] This provision is especially important in States where children are removed under the guise of being adopted only to end up as victims of child trafficking and, in some cases, transplant tourism.[136]

Article 35 of the CRC places a direct duty on States to protect children from abduction, sale or trafficking.[137] It states that contracting parties should take all measures to prevent the abduction, sale or traffic of children in any form or for any purpose.[138] This duty placed on States Parties is elaborated in the *Second Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography* (OP2-CRC or Protocol)[139] which places a duty on its States Parties to ensure that the transfer of organs of children for profit is prohibited under their criminal or penal laws.[140] This

132 See articles 36 (exploitation), 37 (torture, inhuman or degrading treatment) and 19 (protection from all forms of violence) CRC, *ibid.*

133 See Paragraph 17, *General Comment No. 13 (2011): The Right of the Child to Freedom from all Forms of Violence*, CRC/C/GC/13. The Committee on the Rights of the Child stated here that there are no exceptions to article 19(1) which protects children from all forms of violence. See also Kimberly Svevo-Cianci *et al*, "The new UN CRC General Comment 13: 'The Right of the Child to Freedom from all Forms of Violence' Changing how the World Conceptualizes Child Protection." (2011) 35:12 Child Abuse Negl 979.

134 Article 11, CRC, *supra* note 39.

135 *Ibid*, article 21(a).

136 The greatest number of reported cases of adoption for organ and other trafficking are those related to Latin American States See generally: Andrea Cardarello, "The Movement of the Mothers of the Courthouse Square: 'Legal Child Trafficking,' Adoption and Poverty in Brazil" (2009) 14:1 J Latin Am & Car Anthrop 140.

137 Article 35, CRC, *supra* note 39.

138 States are encouraged to use appropriate national, bilateral and multilateral measures to achieve this goal.

139 *Optional Protocol to the Convention on the Rights of the Child on the Sale of children, Child Prostitution and Child Pornography*, G.A. Res. 54/263, Annex II, 54 U.N. GAOR Supp. (No. 49) at 6, U.N. Doc. A/54/49 (2000).

140 Article 3(1)(a)(1)(b), OP2-CRC, *ibid.*

Protocol is the product of the 1996 *Stockholm Declaration and Agenda for Action*[141] which challenged States to give high priority to action against the commercial exploitation of children.[142] The OP2-CRC, however, goes beyond the penalization of organs trafficking nationally. It also places a duty on OP2-CRC States to prosecute these offenses whether they are committed domestically or transnationally.[143] Article 4(2) of the OP2-CRC gives further credence to this mandate by allowing States parties to assume jurisdiction over offences under the treaty where the offender is a national or habitual resident of the State or where the victim is a national of the State.[144]

To some extent, some mandates under the OP2-CRC have been fulfilled. Most transplant and tourist States have laws which penalize the sale of organs. A lot of progress has been recorded in preventing child prostitution. Various States have extended their criminal legislation to prosecute their own citizens for CST which occurs abroad.[145] Although the CRC and the OP2-CRC have given rise to better protection for minors from transplant tourism, the treaties cannot be said to be transplant tourism-centric in that they only offer partial protection. Another obvious drawback of the CRC is that it applies only to children (usually under the age of 18), who are just a minority of individuals damaged by transplant tourism. Most victims affected by transplant tourism are adults.

### 2 *Enforcement of UN Human Rights Law*

The enforcement of international human rights law is equally as important as the provisions creating these rights. Except for a few unregulated activities like transplant tourism, in most cases, what is lacking is not the absence of laws prohibiting a given behaviour, but the absence of strong enforcement mechanisms. International human rights law is not short on enforcement mechanisms as there are various channels via which international human rights obligations can be enforced and human rights breaches remedied. Broadly, these channels can be divided into two: enforcement at the international law level and enforcement by national legal systems.

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141 *Stockholm Declaration and Agenda for Action*, *supra* note 35.

142 *Ibid,* paragraph 12, Commitment 1.

143 Article 3(1), OP2-CRC, *supra* note 139.

144 *Ibid*, article 4(2).

145 See section 105(b), *Prosecutorial Remedies and Other Tools to End the Exploitation of Children Act*, Pub. L. 108–21, 117 Stat. 650, S. 151, enacted April 30, 2003, (US *Protect Act*); section 72 of the UK *Criminal Justice and Immigration Act* 2008 (c.4); section 7(4.1) of the *Criminal Code* of Canada, RS 1985, c. C-46. This matter will be dealt with extensively in Chapter 6 of this publication.

At international law, the UN has created Charter-based and treaty-based bodies to help address specific human rights issues. Although these bodies cannot impose binding decisions on UN members or States Parties to the UN human rights treaties, they play major roles in the enforcement of treaty obligations and ensure that human rights principles are respected and implemented by UN States Parties. The instruments issued by UN human rights treaty bodies also have persuasive authority over international and domestic courts and influence their decisions. The main UN Charter-based human rights body is the Human Rights Council (Council).[146] The Council is responsible for promoting respect for human rights and has addressed various conflicts and human rights issues around the world.[147]

UN human rights treaties have committees which aim at ensuring that the contracting parties comply with their obligations.[148] These committees have various functions.[149] Article 28 of the ICCPR creates the HRC which has competence to receive written communications from a State Party if it feels that another State Party is not meeting its obligations under the ICCPR.[150] The HRC also collects reports from States Parties to monitor how the rights under the ICCPR are implemented and makes concluding observations based on these reports.[151] Another function of the HRC is to publish interpretations of the rights in the ICCPR through the publication of general comments like General Comments No. 6 and 20 discussed above.[152]

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146 The UN Human Rights Council replaced the UN Commission on Human Rights which was established by UN Economic and Social Council (ESOCOC) as empowered by article 68 of the *UN Charter*: United Nations, Resolution Adopted by the General Assembly (A/RES/60/251) (General Assembly, 2006), online: <http://www2.ohchr.org/english/bodies/hrcouncil/docs/A.RES.60.251_En.pdf>. Other UN human rights bodies include the Office of the High Commissioner for Human Rights and UN Commission on the Status of Women.

147 See para. 2, General Assembly Resolution A/RES/60/251, *ibid;* Maximilian Spohr, "United Nations Human Rights Council: Between Institution-Building Phase and Review of Status" in Armin Bogdandy & Rudiger Wolfrum, eds, *Max Planck Yearbook of United Nations Law*, Vol. 14 (Netherlands: Brill, 2010) at 176.

148 There are currently 10 human rights treaty committees which include the Human Rights Committee (ICCPR); the Committee on Economic, Social and Cultural Rights (ICESCR); the Committee on the Rights of the Child (CRC) and the Committee on the Elimination of Discrimination against Women (CEDAW). See Currie *et al*, *supra* note 49 at 655–656.

149 See Currie *et al*, *supra* note 49 at 656.

150 See article 41, ICCPR, *supra* note 46. Article 42 further grants the Committee power to appoint an ad hoc Conciliation Commission to help in the amicable resolution of disputes between States Parties.

151 *Ibid*, article 40.

152 Though not annexed to treaties, general comments are relevant in their interpretation and are indispensable when it comes to understanding and applying key international human rights instruments.

The *First Optional Protocol to the ICCPR* (OP1-ICCPR) grants the HRC power to receive communications from individuals claiming to be victims of the violation of individual rights under the ICCPR.[153] However, before an individual can bring a complaint before the HRC, all domestic remedies within the State must have been exhausted.[154] The individual's State must also be a party to both the ICCPR and the OP1-ICCPR.[155] Although the HRC issues views in response to a communication/petition, these views are not legally binding on ICCPR States Parties. They are sometimes used by domestic and international courts as persuasive indications of the interpretation of the treaty. In addition, the direct complaint mechanism will not provide any real remedy to someone who has been the victim of transplant tourism. Once an organ is removed from the body of an individual, there is no way of remedying that violation as it concerns that particular individual. It can only serve as a means of preventing future breaches if the ICCPR State involved takes appropriate steps to do so.

The ICESCR has a Committee on Economic, Social and Cultural Rights (CESCR or Committee).[156] Like the HRC, the CESCR receives periodic reports from States Parties on their implementation of the provisions of the ICESCR and makes concluding observations based on these reports. It also publishes General Comments which elaborate on the meaning and content of the ICESCR. With the coming into force of the *Optional Protocol to the International Covenant on Economic, Social and Cultural Rights* (OP-ICESCR) in 2013, the functions of the Committee were extended.[157] The Committee now has powers

153 Preamble and article 1, *Optional Protocol to the International Covenant on Civil and Political Rights*, GA Res. 2200A (XXI), 21 UN GAOR Supp. (No. 16) at 59, UN Doc. A/6316 (1966); 999 UNTS 302. The ability of individuals to make complaints to human rights treaty committees is also available under the following treaties/protocols: *CEDAW* (The Committee on Elimination of Discrimination against Women); *CAT* (Committee against Torture); *International Convention on the Elimination of Racial Discrimination* (Committee on the Elimination of Racial Discrimination); *Convention on the Rights of Persons with Disabilities* (Committee on the Rights of Persons with Disabilities); *International Convention on the Protection of all Persons from Enforced Disappearance* (Committee on Enforced Disappearances); ICESCR (Committee on Economic, Social and Cultural Rights); and the CRC (Committee on the Rights of the Child).

154 Article 2, OP1-ICCPR, *supra* note 153.

155 Like the ICCPR, most treaties provide for the ability of individuals to bring petitions in separate protocols. Other treaties like the CAT may consider individual complaints against States Parties who have made certain declarations. See article 22, CAT, *supra* note 48.

156 The Committee was established under *ECOSOC Resolution* 1985/17 of 28 May 1985.

157 *Optional Protocol to the International Covenant on Economic, Social and Cultural Rights,* GA Res. 63/117, UN GAOR, 63d Sess, Supp No. 49, UN Doc. A/RES/63/117, (2008).

to receive communications from individuals who feel their rights have been breached.[158] Reports can only be made by individuals from States that are parties to both the ICESCR and the Protocol.[159] The Committee also has the right to receive inter-state communications and try to settle disputes between States Parties.[160] Whenever the Committee receives information which indicates grave or systematic violations by States of any of the rights set out in the ICESCR, it has the right to examine any such information and submit observations based on the information concerned.[161]

The CRC has a Committee on the Rights of the Child (CRC Committee or Committee) established under article 43 of the CRC.[162] Like the other human rights committees, the CRC Committee sees to the effective implementation of the treaty's provisions and monitors and examines the progress made by States Parties in realizing their obligations under the treaty. In achieving this goal, States Parties are to submit reports to the CRC Committee on their progress made in enforcing the CRC rights and the first two optional protocols and the Committee makes concluding observations thereon.[163] The Committee also issues general comments.[164] With the coming into force of *the Third Optional Protocol to the Convention on the Rights of a Child on a Communications Procedure* (OP3-CRC), children in States who are parties can now submit individual complaints regarding specific violations of their human rights under the CRC, OP3-CRC and OP2-CRC and there is also an inquiry process when there is information indicating grave or systematic violations by States Parties of rights set forth in the CRC and its protocols.[165] The CRC can also receive inter-state communications when a State Party feels that another State Party is not fulfilling its obligations under the CRC, OP3-CRC or OP2-CRC.[166]

CAT has it own Committee against Torture (CAT Committee) established under article 17 of the Convention.[167] The CAT Committee collects reports from

158 Article 1(1), *ibid.*

159 *Ibid,* article 1(2).

160 *Ibid,* article 10.

161 *Ibid,* article 11.

162 Article 43, CRC, *supra* note 39.

163 *Ibid,* article 44; article 12, OP2-CR, *supra* note 139.

164 Article 45, CRC, *ibid.*

165 Articles 5 & 13, *Third Optional Protocol to the Convention on the Rights of a Child on a Communication Procedure*, GA Dec 66/138, UN GAOR, 66 Sess. 64, UN Doc. A/RES/66/138 (2011).

166 Article 12, OPIC. These communications will only be valid where both states have made declarations under the treaties: article 12(2), OPIC.

167 Article 17, CAT, *supra* note 48.

States Parties on steps taken to fulfill their undertaking under the Convention and makes general comments based on those reports.[168] Under the Convention, the CAT Committee has powers to investigate well-founded allegations of systematic tortures in territories of States Parties and submit observations based on its investigations.[169] Other functions of the CAT Committee under the Convention includes the right to receive inter-State communications and the right to receive communications from individuals in States Parties who feel their rights have been breached.[170] The CAT Committee also has powers under the 2006 *Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment* (*OPCAT*)[171] which established an international and domestic inspection system for places where people are deprived of their liberty.[172] The investigative powers of the CAT were extended under the OPCAT to include visits to places in States where persons have been deprived of their freedom with a view of protecting such persons against torture, cruel, inhumane or degrading treatment or punishment.[173] These functions are carried out by a Subcommittee on Prevention which has the right to make recommendations to visited States on how to protect persons deprived of their liberty from violations under the Convention and National Preventive Mechanisms (NPMs) must also be established to visit places of confinement.[174]

International human rights law obligations can also be enforced at the State level. Even though transplant tourism has many international elements, it is essentially a series of acts carried out at the State level by the State itself, its agencies and by private individuals. States get directly involved in transplant tourism when they supply organs used in the trade as is the case in China or when illegal organ transplant operations are carried out in State-run transplant centers. It is thus understandable that human rights treaties always place a direct duty on States to enforce the obligations created by the treaties. Because

168 *Ibid*, articles 17 & 19.

169 *Ibid*, article 20.

170 *Ibid*, article 21 & 22.

171 *Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment,* UN Doc. A/RES/57/199 (2003); 42 ILM 26 (2003).

172 *Ibid*, article 1.

173 *Ibid*, article 4.

174 *Ibid*, articles 2, 11 & 12, OPCAT. Article 2 establishes the Subcommittee on Prevention of Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment of the Committee against Torture (Subcommittee on Prevention) with several investigative powers under the OPCAT. China is not a party to OPCAT and thus does not benefit from its monitoring activities.

of their obligations under human rights treaties, States have a duty to prevent the abuse of human rights within their territories and address activities within their territories which can potentially lead to the violation of human rights.[175] States need to ensure that they are not directly involved in practices which promote any part of the organ trade.

The above noted duty of States extends beyond active participation to the due diligence obligation of States which requires them to pass laws and enforcement mechanisms aimed at bringing an end to transplant tourism within their territories or ensuring that their nationals do not participate in transplant tourism extraterritorially. The majority of transplant tourism activities are carried out by private individuals such as organ brokers and doctors working in private clinics. International law extends this duty of States to protect individuals subject to their jurisdiction beyond the wrongs committed by the State or its agents to wrongs committed by private persons.[176] This latter duty is encompassed in the principle of due diligence and applies where a State has failed to take steps in preventing these acts from occurring, prosecuting the breach and punishing the wrongdoer.[177] In the 1988 case of *Velasquez Rodriguez v Honduras* (*Velasquez Case*), the Inter-American Court of Human Rights summed up this duty when it held that States have a duty to ensure the free and full enjoyment of the rights under the *American Convention on Human Rights*[178] to persons within their jurisdiction and fail to do so if they allow private persons or groups to act freely to the detriment of the rights recognized by the Convention.[179] Under international human rights law, the principle of due diligence can be found in some international human rights instruments,

175 Robert McCorquodale & Penelope Simons, "Responsibility Beyond Borders: State Responsibility for Extraterritorial Violations by Corporations of International Human Rights Law" (2007) 70:4 Modern L Rev 599.

176 States are responsible for the actions of individuals exercising the State's "machinery of power and authority": Gordon Christenson, "Attributing Acts of Omission to the State" (1991) 12 Mich J Int'l L 322; For more on when a State is responsible for the actions of individuals acting on its behalf, see the ruling of the ICJ in the *Case Concerning the Military and Paramilitary Activities in and against Nicaragua* (*Nicaragua v. USA*) (1986) ICJ Rep at 14.

177 See Hessbruegge, *supra* note 104 at 268.

178 *American Convention on Human Rights, "Pact of San José,"* OAS Treaty Series No. 36; 1144 UNTS 123; 9 ILM 99 (1969).

179 See *Velasquez Rodriguez v Honduras* (1988) Inter-Am. Ct. H. R. (Ser. C) No. 4, para. 176; Stephanie Farrior, "The Due Diligence Standard, Private Actors and Domestic Violence" in Carrie Walling & Susan Waltz, eds, *Human Rights: From Practice to Policy* (Michigan: University of Michigan, 2011) at 74.

like those preventing violence against women.[180] This principle also applies to human rights obligations under other international human rights instruments, whether or not specifically provided for. Article 8 of *General Comment No. 31* (*Nature of the General Legal Obligation on States Parties to the Covenant*) (Article 2, ICCPR) states that States Parties will be in violation of article 2 of the ICCPR if they fail to exercise due diligence to "prevent, punish, investigate or redress" harm caused by private persons or entities.[181] States are to ensure that they create an environment in which private actors are prevented from depriving individuals of their human rights. This duty to protect individuals from the actions of third parties has been specifically extended to protect foreigners within a State's territory.[182] In transplant tourism cases, to fulfil due diligence obligations, States ought to put in place the necessary infrastructure, laws and enforcement machineries which will protect both their nationals and foreigners who come into their States seeking to benefit from transplant tourism from harm. The major transplant States have in recent years tried to do this through the enactment and amendment of laws regulating transplant tourism.[183] Though this has reduced transplant tourism practices within their territories, it has also led to the establishment of new markets in other States.

The duty of a State to diligently safeguard the rights of individuals extends beyond its immediate territory to territories which it controls abroad. In *Legal Consequences of the Construction of a Wall in the Occupied Palestine Territory* (*Israeli West Bank Barrier Case*),[184] the International Court of Justice (ICJ) held that while the jurisdiction of a States is primarily territorial, it can sometimes be

180 The *Declaration on the Elimination of Violence against Women* advices States to "exercise due diligence to prevent, investigate and … punish acts of violence against women, whether those acts were perpetrated by the state or by private persons.": article 4(c), *Declaration on the Elimination of Violence against Women*, GA Res. 48 UN GAOR Supp. (No. 49) at 217, UN Doc. A/48/49 (1993). See also article 7, *Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women* (*Convention of Belem do Para*), 33 ILM 1534 (1994); Radhika Coomarswamy, "Reinventing International Law: Women's Rights as Human Rights in the International Community" (1997) 23:3–4 Comm L Bull 1249.

181 See article 8, *General Comment No. 31* (*Nature of the General Legal Obligation on States Parties to the Covenant*) (Article 2, ICCPR) U.N. Doc. CCPR/C/21/Rev.1/Add.13 (2004)

182 See the decision of the General Claims Commission (American-Mexican Claims Commission) in *Thomas H. Youmans* (US) *v United Mexican States* [1926] 4 RIAA 110.

183 See discussions on Pakistan, India and the Philippines in Chapter 3.

184 *Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territory*, ICJ General List No. 131, Advisory Opinion, 9 July 2004.

exercised outside the territory of the State.[185] This duty of States to individuals on territories which they control arises directly from express and implied treaty provisions. For this duty to arise, however, a State must have effective jurisdiction over that external territory.[186] Article 2(1) of the ICCPR, for instance, states that member states are to ensure that individuals in their territories and *subject to their jurisdiction* enjoy the rights in the treaty.[187] As regards the ICCPR, the ICJ noted that a State Party is bound to comply with its provisions and respect the rights of individuals when exercising powers outside its territory, a point which has also been made by the HRC in some of its instruments.[188] The ICJ thus concluded that the ICCPR binds its States Parties when they are exercising jurisdiction in a foreign territory.[189] The ICJ also noted that the ICESCR is also applicable in respect of acts done by a State in the exercise of its jurisdiction outside its own territory.[190] The effect of the application of these provisions to transplant tourism is that ICCPR, ICESCR and CRC States Parties have extraterritorial obligations under these treaties when they control/occupy foreign territory.

### 3 *Challenges of Enforcing Human Rights Law*

The application of the above international human rights instruments to transplant tourism cases is, however, not without challenges. First, although a lot of

185 *Ibid*, para. 109.

186 It does not seem to matter whether or not the jurisdiction of the controlling state is legal under international law. Though the ICJ views the status of the West Bank as that of military occupation, this status does not diminish Israel's international law responsibilities to its inhabitants. See Para. 78. This view by the ICJ has its roots in the definition of an occupied territory under Article 42 of the *Regulations Respecting the Laws and Customs of War on Land* which is an annex to The Hague Convention (IV) of 18 October 1907. See also Fania Domb, "The Separation Fence in the International Court of Justice and the High Court of Justice: Communities, Differences and Specifics" in Michael Schmitt & Jelena Pejic, eds, *International Law and Armed Conflict, exploring the Faultlines: Essays in Honor of Yoram Dinstein* (Leiden: Martinus Nijhoff Pub., 2007) at 511.

187 See article 2(1), ICCPR, *supra* note 46. See also article 2(1), CRC, *supra* note 39.

188 See: See article 10, *General Comment No. 31, supra* note 181; *Lilian Celiberti de Casariego v Uruguay*, Communication No. R.13/56, UN Doc. Supp. No. 40 (A/36/40), at 185 (1981); *Mabel Pereira Montero v Uruguay*, Communication No. 106/1981, UN Doc. Supp. No. 40 (A/38/40), at 186 (1983); Carsten Hoppe, "Passing the Buck: State Responsibility for Private Military Companies" (2008) 19:5 Euro J Int'l L 995.

189 Para 111, *Israeli West Bank Barrier Case*, *supra* note 184; Alexander Orakhelashvili, "Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territory: Opinion and Reaction" (2006) 11:1 J Conf Sec L 124.

190 See article 14 of the ICESCR which has elements of extraterritorial jurisdiction. See also article 16, ICESCR, *supra* note 3.

the protection which could be extended to organ vendors under the ICCPR is hinged on the principle of dignity, the exact meaning of this principle remains elusive. Secondly, although States have a duty to secure the right to health of their nationals under the ICESCR, this duty is to be realized in a progressive manner, subject to the financial ability of the State. The prohibition of transplant tourism activities cannot be left to rest on the financial resources of transplant States, but must be a joint effort between transplant and tourist states. This is especially so as transplant States are mostly States with fewer resources than tourist States and will most likely lack the financial ability to tackle transplant tourism on their own. Most transplant States are also exempted from guaranteeing the rights under the ICESCR to non-nationals.[191] There could thus be little or no protection for non-nationals brought into these States through human trafficking or other means for transplant tourism.

Thirdly, though domestic courts can use their criminal laws to convict nationals who violate some provisions of the various human rights instruments that have been implemented domestically through the State's criminal laws (like those involving torture), there have not been many convictions as a result of the breach of these domesticated international human rights duties. A further challenge which domestic courts in transplant States will face is that the beneficiaries in transplant tourism cases are foreigners who the transplant State courts do not have jurisdiction over once they have left the State. It will thus be impossible for transplant State courts to exercise control over these individuals even when their organ vendor nationals are victims of transplant tourism. This limitation is because, failing the existence of a permissive rule to the contrary, jurisdiction under international law is first and foremost restricted to the territory of a State.[192] The situation is further complicated as tourist States do not have laws against transplant tourism. The effect of this is that transplant tourism remains legal in certain parts of the world.

## 4 *Regional Human Rights Systems*

### i Overview

The regional human rights systems are made up of relatively independent coherent human rights sub-regimes which operate within the larger framework of international human rights.[193] They provide a better environment for

191 See article 2(3), ICESCR, *supra* note 3.

192 See the *Case of the s.s. "Lotus"* (*France v. Turkey*) (1927), P.C.I.J. Series A, No. 10 at 28.

193 Jack Donnelly, *Universal Human Rights in Theory and Practice* (Ithaca: Cornell University Press, 2003) at 138.

addressing human rights breaches in the regions which they govern due to geographic proximity.[194] There are currently three key regional human rights systems: the African system built around the African Union (AU) and the *African Charter on Human and Peoples' Rights* (*Banjul Charter*);[195] the Inter-American system built on the Organization of American States (OAS),[196] the *American Declaration on the Rights and Duties of Man*[197] and the *American Convention on Human Rights* (*Pact of San José*)[198] and the European system under the auspices of the Council of Europe (COE), with the *European Convention for the Protection of Human Rights and Fundamental Freedoms* (*European Convention*), its Protocols and some thematic human rights treaties.[199] Although there is currently no regional human rights regime in Asia, some States within that region belong to the Association of Southeast Asian Nations (ASEAN) which has the protection of human rights as part of its mandate.[200] The different regional

194 William Buss *et al*, "Regional Human Rights Regimes: A Comparison and Appraisal" (1987) 20:4 Vand J Transnat'l L 590.

195 Coming into effect in October1986, the *African Charter* is the only regional human rights treaty which protects the entire range of human rights (civil, economic, political, social and cultural). See *African Charter, supra* note 81. For more on the *African Charter*, see the African Union website: <http://www.au.int/>. Other relevant human rights treaties under the African system include the African Charter on the Rights and Welfare of the Child, CAB/LEG/24.9/49 (1990) and the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, CAB/LEG/66.6 (Sept. 13, 2000); 1 Afr. Hum. Rts. L.J. 40 (2001).

196 The OAS came into being in 1948 after the signing of the *Charter of the OAS*. It was established to achieve "an order of peace and justice, to promote their solidarity, to strengthen their collaboration, and to defend their sovereignty, their territorial integrity, and their independence." See article 1, *Charter of the Organization of American States* 119 UNTS 3.

197 See *American Declaration on the Rights and Duties of Man* 43 AJIL Supp. 133 (1949).

198 *Supra* note 178; The Convention has not been ratified by Canada, the United States and several English-speaking Caribbean States. See Alvaro Paul, "Controversial Conceptions: The Unborn and the American Convention on Human Rights" (2012) 9:2 Loyola Uni Chi Int'l L Rev 209. The Inter-American system also has its own economic, social and cultural rights treaty called the *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights,* OAS Treaty Series No. 69; 28 ILM 156 (1989), and various thematic human rights treaties.

199 See *European Convention for the Protection of Human Rights and Fundamental Freedoms,* 1950, 23 UNTS 221 Eur. T.S. 5. The *European Convention* and its protocols can be found online: <http://www.echr.coe.int/Documents/Convention_ENG.pdf>. Like the Inter-American system, the European System also has its own economic, social and cultural rights instrument called the *European Social Charter* (Revised), ETS No. 163.

200 ASEAN is an organization made up of 10 Asian states: The Philippines, Vietnam, Singapore, Thailand, Cambodia, Indonesia, Myanmar, Malaysia, Brunei Darussalam and Lao PDR. Its

human rights treaties all seek to protect the inherent dignity of humans and prohibit torture, inhuman or degrading treatment. Article 5 of the *Banjul Charter* lays down the general rule that every individual has the right to have their dignity respected. It goes on to state that all forms of exploitation, degradation, torture, inhuman and degrading treatment shall be prohibited.[201] Article 5(1) of the *Pact of San José* provides that everyone's physical, moral and mental integrity should be respected.[202] Article 5(2) goes on to state that no one is to be subjected to torture, cruel, inhuman or degrading treatment.[203] Unlike the principle of dignity of person under the UDHR which is unenforceable, both the *Banjul Charter* and *Pact of San José* elevate the concepts of dignity and integrity to the status of human rights which are enforceable. In the *Velasquez Case*, the Inter-American Court of Human Rights held that the Honduran government had violated article 5 of the *Pact of San José* by not fulfilling its obligation to protect the student's right to humane treatment.[204] Under the European system, Article 3 of the *European Convention* offers the same level of protection as the *Banjul Charter* and the *Pact of San José*.[205]

### ii COE Trafficking in Human Organs Convention

Treaty prohibition of transplant tourism received a major boost under the European human rights system in July 2014 when the COE Committee of Ministers adopted the *Council of Europe Convention against Trafficking in Human Organs* (*Trafficking in Human Organs Convention* or Convention).[206]

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aims include the advancement of economic and cultural growth among state members and the protection of regional peace. In 2009 it established the ASEAN Intergovernmental Commission on Human Rights to promote and protect human rights in the region. See generally Michelle Kelsall, "The New ASEAN Intergovernmental Commission on Human Rights: Toothless Tiger or Tentative First Step?" (2009) 90 Asia Pac Issues 1; Tan Hsein-Li, *The ASEAN Intergovernmental Commission on Human Rights: Institutionalizing Human Rights in Southeast Asia* (Cambridge: Cambridge University Press, 2011); James Munro, "The Relationship Between the Origins and Regime Design of the ASEAN Intergovernmental Commission on Human Rights (AICHR)" (2011) 15:8 The Int'l J Hum Rts 1184.

201 Article 5, *African Charter, supra* note 81.

202 Article 5(1), *Pact of San José, supra* note 178.

203 *Ibid*, article 5(2).

204 See *Velasquez Case*, *supra* note 179 at paras. 184 & 194; Amy Dwyer, "The Inter-American Court of Human Rights: Towards Establishing an Effective Regional Contentious Jurisdiction" (1990) 13:1 B.C. Int'l & Comp L Rev 127.

205 Article 3 provides that "No one shall be subjected to torture or to inhuman or degrading treatment or punishment."

206 *Council of Europe Convention against Trafficking in Human Organs*, CETS No. 216.

The adoption of this regional instrument marked a significant milestone in the prohibition of transplant tourism as it is the first treaty to focus not just on organ trafficking but also on transplant tourism. To date, the Convention has been signed by 20 States including tourist States such as the UK and transplant States like Moldova and Turkey.[207] It has also been ratified by 5 States and will come into force on March 1, 2018.[208]

The aims of the Convention are to prevent trafficking in organs by requiring States Parties to criminalize various acts involved in the practice of trafficking in human organs and foster co-operation at the national and international levels against organ trafficking.[209] In order to cover every possible organ trafficking situation, the Convention defines trafficking in humans broadly to mean any illicit activity in respect of human organs.[210] Travelling for the purpose of organ transplantation where the transplantation is carried out through illegal means falls within the definition of trafficking in human organs. Under article 4 of the *Trafficking in Human Organs Convention*, each State Party undertakes to establish criminal offences where organs are removed without the free and informed consent of the "donor" and where financial or comparative advantage has been received by a living donor, or by a third party in the case of a deceased donor.

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207 The COE has 47 member states located throughout Europe which can proceed to sign and ratify the *Trafficking in Human Organs Convention*, and a few more specified States (Canada, Holy See, Japan, Mexico and USA) are also eligible to become contracting parties. Five ratifications including at least three member States of the Council of Europe are needed for the Convention to enter into force. As at November of 2017, the Convention has been signed by Albania, Austria, Belgium, Czech Republic, Greece, Ireland, Italy, Latvia, Luxembourg, Malta, Norway, Poland, Portugal, Republic of Moldova, Russian Federation, Spain, Switzerland, Turkey, Ukraine and UK. The *Trafficking in Human Organs Convention* has been ratified by Albania, Czech Republic, Malta, Norway and Republic of Moldova.

208 For updates on signatures and ratifications of the treaty, see the COE website, online: <https://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/216/signatures?p_auth=2SFgGGr3>.

209 See article 1, *Trafficking in Human Organs Convention, supra* note 206; According to a 2015 COE report, the Convention was drafted because "Trafficking in human organs violates the dignity of human beings and the integrity of the human body, and it undermines the trust in the efficiency and fairness of the public health system. It also raises serious ethical issues." See European Committee on Crime Problems (CDCP), Council of Europe, *International High-Level Conference on the Fight against Trafficking in Human Organs*, 25–26 March 2015, Santiago de Compostela, Spain, online: <http://www.coe.int/t/dghl/standardsetting/cdpc/conference/Conclusions%20Santiago.pdf>.

210 Article 2, *Trafficking in Human Organs Convention, supra* note 206.

An effective tool contained in the *Trafficking in Human Organs Convention* is that it requires States to exercise extraterritorial criminal jurisdiction over offences under the Convention. In doing this, the Convention employs the jurisdictional principles of territory, nationality and passive personality.[211] By article 10 of the Convention, States are to exercise jurisdiction over offences which are committed on its territory (including a ship flying its flag and on board an aircraft registered under its laws), by its nationals or habitual residents and against its nationals or habitual residents.[212] In order to achieve these goals, international co-operation is encouraged between Convention parties by way of reciprocal legislation, bilateral treaties of extradition, mutual legal assistance, etc.[213] Since transplant tourism always involves more than one State, the ability of a State to exercise extraterritorial prescriptive jurisdiction in its criminal legislation under international law is essential to prosecute offenders. Aside from the extension of the criminal jurisdiction of States parties under the Convention, another possible advantage of the *Trafficking in Human Organs Convention* is that it could persuade other regions to pass similar conventions in future. If most regions come on board with their own identical/equivalent regional treaty, the UN, through the WHO would be more likely to consider drafting a multilateral treaty against transplant tourism.

The shortcomings of the *Trafficking in Human Organs Convention* include the fact that, as a regional instrument, only a limited number of States can sign and ratify it.[214] Currently, the Convention has been signed by 20 States, with 5 ratifications.[215] The Convention is scheduled to come into force on March 1, 2018.[216] If all or most of the relevant States, especially the key European tourist States like the UK, and transplant States like Italy, Romania and Turkey follow

211 These principles will be discussed in greater details in Chapter 6 of this publication.

212 See article 10(1) & (2), *Trafficking in Human Organs Convention, supra* note 206. Article 10(1) states: "Each Party shall take such legislative or other measures as may be necessary to establish jurisdiction over any offence established in accordance with this Convention, when the offence is committed: (a) in its territory; or (b) on board a ship flying the flag of that Party; or (c) on board an aircraft registered under the laws of that Party; or (d) by one of its nationals; or (e) by a person who has his or her habitual residence in its territory." Article 10(2) also states that States parties are to exercise criminal jurisdiction where the offence is committed against a national or someone who habitually resides within its territory.

213 See article 17, *Trafficking in Human Organs Convention, supra* note 206.

214 *Ibid,* article 28.

215 As noted earlier, the act of signing obligates the States not to do anything which goes contrary to the spirit of the instrument.

216 See article 28(3), *Trafficking in Human Organs Convention, supra* note 206. See also note 208 supra.

the lead of the Republic of like Moldova and ratify the Convention, it could be a very effective tool for regulating transplant tourism in not only the ratifying States but also in third party States as it would deter nationals from the latter States from traveling to the Convention States for transplant tourism purposes. A second shortcoming of the Convention as it relates to transplant tourism is that it does not cover all transplant tourism scenarios because the focus of the Convention is organ trafficking and not transplant tourism. There are two ways of addressing this shortcoming. The first is to include additional provisions in the treaty which are geared towards the prohibition of transplant tourism. The second is to have a separate treaty on transplant tourism. This will ensure that every facet of transplant tourism is effectively covered by treaty law. A third shortcoming of the Convention is that it gives States the option of choosing whether or not to criminalize the removal of human organs from living donors in exceptional cases.[217] If States take advantage of this reservation, States Parties to the Convention can decide not to prosecute individuals who engage in transplant tourism activities as a large percentage of transplant tourism involves the use of organs from living donors. Another important shortcoming of the Convention as it affects transplant tourism is that States can choose not to prosecute their nationals or habitual residents for offences under the Convention.[218] As will be discussed in Chapter 6, the nationality principle of jurisdiction is relevant in the prosecution of transplant tourism offences. A reservation excluding nationals and habitual residents from the ambits of the Convention could affect the enforcement of the Convention negatively.

### iii Concluding Thoughts on Regional Human Rights Systems

The provisions of the major regional human rights treaties have the same potential and are subject to the same criticisms as the ICCPR and ICESCR. However, an advantage they have over general international law instruments is that they have greater chances for success compared to the UN human rights instruments due to the relatively smaller number of States involved. Under the European human rights system, for instance, all the possible tourist States are parties to the *European Convention* and their duty not to subject individuals to torture, inhuman and degrading treatment or punishment can be better monitored by the European Court of Human Rights.[219] The same, however, cannot be said about the Asian region which is devoid of any human rights treaty

217 *Ibid*, article 4(2).

218 *Ibid*, article 10(3).

219 Article 3 & 19–37, *European Convention*, *supra* note 199.

regime. This void is especially relevant because Asia is a very significant region in transplant tourism practices as it is the location of many of the current transplant States. Thus, Asian States are only bound by the obligations under the major UN human rights treaties which they have ratified. As States Parties to these treaties, Asian States have a duty not only to safeguard the health and wellbeing of their nationals but also to protect them from torture or inhuman treatment whether by the State or private actors.[220]

## D International Criminal Law

International criminal law is another branch of international law which is relevant in the prohibition of transplant tourism. Its relevance comes not from the existence of international criminal law instruments on transplant tourism, but from how useful some of its enforcement mechanisms are to the prohibition of transplant tourism. Compared to other branches of international law, codified international criminal law is relatively new and still in the process of formation.[221]

International criminal law was designed to proscribe and prosecute crimes which are viewed by the international community as serious atrocities and make the perpetrators of such crimes criminally accountable.[222] It has its roots in CIL which has long prohibited crimes which are viewed by the international community as heinous.[223] The atrocities of the Second World War, however, led to major developments in international criminal law treaties and changed the enforcement dynamics of international criminal law.[224] The 1940s was a

220 See article 12, ICESCR, *supra* note 3; articles 7 & 10, ICCPR, *supra* note 46; article 24, CRC, *supra* note 39.

221 Antonio Cassese, *Cassese's International Criminal Law* (Oxford; Oxford University Press, 2013) at 4; Gideon Boas *et al*, *International Criminal Law Practitioners Library*, Vol. 1 (Cambridge: Cambridge University Press, 2007) at XIII.

222 See Currie *et al*, *supra* note 49 at 905. The gravity of an act and the impact it has on a significant portion of the international community are some factors which are taken into consideration in the establishment of international criminal offences.

223 Yoram Dinstein, "International Criminal Law" (1985) 20:2–3 Isr L Rev 207.

224 The *London Agreement for the Prosecution and Punishment of the Major War Criminals of the European Axis* (1945) 82 UNTS 280, (*London Agreement*) led to the establishment of the International Military Tribunal (IMT) which sat in Nuremberg. See also the 1946 International Military Tribunal for the Far East (IMTFE) which tried leaders of Empire of Japan for war crimes. See generally on war crimes tribunals: Telford Taylor, "The Nuremberg Trials" (1955) 55:4 Colum L Rev 488; *contra* Kenneth Anderson, "Nuremberg

significant period in the development of international criminal law as five international criminal law treaties were passed during this decade.[225] Codified international criminal law leads to the prosecution of a wide range of crimes in international and domestic courts and tribunals including piracy, slavery and terrorism.[226]

### 1 *International Criminal Law Instruments Relevant to Transplant Tourism*

From its roots in CIL, international criminal law now has an increasing number of treaties which prohibit various crimes under international law. In the area of transplant tourism, although there is no international criminal law instrument which prohibits transplant tourism practices expressly, the *Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children* (*Trafficking Protocol*) offers limited protection to individuals who are victims of transplant tourism.[227] The *Trafficking Protocol* is a protocol to the *Convention against Transnational Organized Crime*.[228] Under the *Trafficking Protocol*,

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Sensibility: Telford Taylor's Memoir of the Nuremberg Trials" (1994) 7:1 Harvard Human Rts J 2; Theodor Meron, "War Crimes in Yugoslavia and the Development of International Law" (1994) 88:1 Am J Int'l Law 78; Payam Akhavan, "The International Criminal Tribunal for Rwanda: The Politics and Pragmatics of Punishment" (1996) 90:3 Am J Int'l Law 501; Morris Virginia & Scharf Michael, *The International Criminal Tribunal for Rwanda* (New York: Transnational Publishers, 1998).

225 *Convention on the Prevention and Punishment of the Crime of Genocide*, 78 UNTS 277 (1948); *Geneva Convention Relative to the Protection of Civilian Persons in Time of War*, 75 UNTS 287 (1949) (Fourth Geneva Convention); *Geneva Convention Relative to the Treatment of Prisoners of War* (Third Geneva Convention), 75 UNTS 135 (1949); *Geneva Convention for the Amelioration of the Condition of the Wounded, Sick and Shipwrecked Members of Armed Forces at Sea* (Second Geneva Convention), 75 UNTS 85 (1949); and *Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field* (First Geneva Convention), 75 UNTS 31 (1949).

226 See generally articles 14–21, *Convention on the High Seas* 13 UST 2312; 450 UNTS 11; articles 100–107, *UN United Nations Convention on the Law of the Sea*, 1833 UNTS 3; 21 ILM 1261 (1982) and article 6, *Supplementary Convention on the Abolition of Slavery, the Slave Trade, and Institutions and Practices Similar to Slavery*, 226 UNTS 3/ 1958 ATS 3.

227 *Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children*, Supplementing the *United Nations Convention Against Transnational Organized Crime*, UN Doc. A/55/383 at 25 (2000); UN Doc. A/RES/55/25 at 4 (2001); 40 ILM 335 (2001). There are 169 parties to the Protocol including Canada, the US, China, the Philippines and India.

228 *Convention against Transnational Organized Crime,* 40 ILM 335 (2001); UN Doc. A/55/383 at 25 (2000); UN Doc. A/RES/55/25 at 4 (2001). There are 186 parties to this Convention including Canada, the US, China, the Philippines and India.

States Parties are required to pass domestic laws criminalizing offences as designated in the Protocol.[229] Thus, unlike some international crimes where individuals are prosecuted at the international level by international tribunals, the *Trafficking Protocol* relies on the courts of States Parties to prosecute trafficking crimes under their domestic laws.[230]

When implemented by States Parties, the provisions of the *Trafficking Protocol* can be used to prosecute persons engaged in transplant tourism activities in limited situations. Article 3(a) of the *Trafficking Protocol* defines trafficking in persons to include the recruitment, transportation, or transfer of individuals for the purpose of removing their organs.[231] This provision seeks to protect individuals from being used as human cargo for the purposes of organ extraction, whether or not such individuals consent to be trafficked for this purpose. However, not all individuals trafficked for the purpose of organ extraction are covered by the *Trafficking Protocol*. For the provisions of the *Trafficking Protocol* to be invoked, there must be some form of organized recruitment by an organized criminal group.[232] The only exception to this rule is where children are involved.[233] Some intermediaries and organ brokers can be considered to be "organized criminal groups" especially when they are part of an established network involving members which cut across various professions needed in the execution of transplant tourism practices with links in various States. However, there are transplant tourism cases which involve trafficking without the use of organised recruitment by organised criminal groups.[234] Victims of the latter practices are thus left without protection under

229 Article 5(1), *Trafficking Protocol, supra* note 127. The *Trafficking Protocol* has led to the promulgation of localized laws in certain states, the most notable being the *Victims of Trafficking and Violence Protection Act* of 2000, Pub. L. 106–386, (TVPA).

230 *Ibid.*

231 Article 3(a) of the *Trafficking Protocol*, *supra* note 127, defines "Trafficking in Persons" as the "recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the *removal of organs*."

232 *Ibid*, article 4.

233 *Ibid*, article 3(c).

234 An example of this is when individuals place advertisements for the sale of their organs or personally seek out avenues where they can sell their organs to foreigners.

the *Trafficking Protocol*. This shortcoming could be remedied in the drafting or amendment of domestic implementing laws by *Trafficking Protocol* States Parties. State laws could be expanded to include all forms of trafficking for the purpose of organ removal.

### 2 *Enforcement of International Criminal Law*

The prosecution of crimes under international criminal law depends on the type of offence that has been committed. Core crimes like genocide, war crimes and crimes against humanity are often prosecuted by international prosecutorial mechanisms which have been put in place to try such offences.[235] Other international crimes are dealt with at the State level through domestic courts. These include some crimes committed extraterritorially. There are a number of bases for the exercise of extraterritorial prescriptive jurisdiction by States under international law, namely, the territoriality, nationality, passive personality, protective and universal bases.[236] Generally, States are able to exercise prescriptive extraterritorial criminal jurisdiction unless there are prohibitive rules which prevent them from doing so.[237] The extraterritorial criminal jurisdiction principle has its roots in international law and has been applied by many States, often pursuant to multilateral treaty obligations, in the prosecution of offences like CST.[238] States also have the power to prosecute individuals who have committed certain core international crimes even where there

235 See e.g. the International Criminal Tribunal for Former Yugoslavia (ICTY), *Statute of the International Tribunal for the Prosecution of Persons Responsible for Serious Violations of the International Humanitarian Law Committed in the Territory of the Former Yugoslavia since 1991*, U.N. Doc. S/25704 at 36, annex (1993) and S/25704/Add.1 (1993), adopted by SC on 25 May 1993, U.N. Doc. S/RES/827 (1993); Theodor Meron, "War Crimes in Yugoslavia and the Development of International Law" (1994) 88:1 Am J Int'l Law 78.

236 Extraterritorial criminal jurisdiction refers to the ability of States to exercise criminal jurisdiction outside their territorial limits. The exercise of this form of jurisdiction will be discussed in greater detail in Chapter 6 of this publication. See generally Anthony Colangelo, "What is Extraterritorial Jurisdiction?" (2014) 99:6 Cornell L Rev 1303.

237 See *Lotus Case, supra* note 192 at para. 46.

238 *Ibid* at 19. Various States also have extended their criminal legislation to prosecute their own citizens for CST which occurs outside their own State. The authorization for the exercise of this power comes from article 4(2), OP2-CRC, *supra* note 148. In the United States, section 105(b) the *Prosecutorial Remedies and Other Tools to End the Exploitation of Children Act,* Pub. L. 108–21, 117 Stat. 650, S. 151, enacted April 30, 2003, makes it an offence for nationals to travel abroad for the purpose of engaging in any illicit sexual conduct. Similar provisions can be found in See section 72, *Criminal Justice and Immigration Act*, UK, *supra* note 145 and section 7(4.1) of the *Criminal Code* of Canada, *supra* note 145.

is no direct connection between the State and the individual under the base of universal jurisdiction.[239] The universal principle of jurisdiction is applied to crimes which are regarded as most heinous by the international community, e.g. genocide.[240]

In Chapter 6, I will be making a case for the extension of the exercise of a State's extraterritorial criminal jurisdiction to cover offences relating to transplant tourism based on territorial, nationality and passive personality principles of jurisdiction. Given that many transplant States have so far been unable to stop transplant tourism within their territories, prosecution of organ transplant tourists by their States of origin could be an effective means of curtailing their activities.

## E The Influence of Transnational Advocacy Networks and Epistemic Communities in Organ Transplantation and Transplant Tourism Areas

The activities of national and transnational advocacy groups which focus on organ transplantation, nephrology and transplant tourism must also be explored as their contributions to the movement towards the eradication of transplant tourism cannot be overlooked. These groups often advocate for a particular cause, help represent the interests of weak State actors and blur the lines between local players, States sovereignty and the international community.[241] They are quite varied and operate at various national, regional and international levels.[242] These groups aim at influencing and enforcing national and international laws, rules, policies, norms and practices.[243] They are sometimes

239 See *Currie et al, supra* note 49 at 510.

240 See *Case Concerning the Arrest Warrant of 11 April 2000* (*Democratic Republic of the Congo v. Belgium*) (2002) ICJ Rep at 3; *A.G. Israel v Eichmann* (1961) 36 I.L.R. 5 (Dist. Ct. Jerusalem) at 19.

241 Teng Fu, "Globalization, Global Environmental Problems, and Transnational Advocacy Networks" in Maryann Love, *Beyond Sovereignty: Issues for a Global Agenda* (Cengage Learning, 2010) at 315; Margaret Keck & Kathryn Sikkink, Activists beyond Borders: Advocacy Networks in International Politics (Ithaca: Cornell University Press, 1998) at 35.

242 Margaret Keck & Kathryn Sikkink, "Transnational Advocacy Networks in International and Regional Politics" (1999) 51:159 Int'l Soc Sc J 92.

243 David Trubek *et al,* "Transnationalism in the Regulation of Labor Relations: International Regimes and Transnational Advocacy Networks" (2000) 25:4 Law Soc Inq 1194.

referred to as Transnational Advocacy Networks (TANs) due to their ability to influence changes which in turn impact States and their behaviour. TANs is a blanket term used to refer to a variety of NGOs, international organizations, governments, social movement organizations, societies and foundations linked together in a voluntary network that operate across national borders and are interested in developing rights and obligations between political actors and members of societies.[244] They also include smaller interest groups like churches and trade unions.

Due to their independence, connection and affiliation to their various fields of interest, TANs can influence change within their interest areas.[245] This is often achieved through the process of policy making, lobbying for national and international legal and policy reforms, sponsoring fora where burning issues can be discussed and endorsing actions which help further their missions. Unlike the UN and its agencies, TANs have closer ties with, knowledge of and experience concerning their various subject matters and are thus more flexible in adapting to local needs. Due to their influence, TANs are able to communicate at all levels and multiply the opportunities for dialogue and exchange.[246] Though the impact of TANs is more visible in fields such as environmental protection, labor issues and women's rights, there is currently a non-exhaustive list of organizations and societies which are interested in organ transplant issues and actively participate in the move to bring an end to transplant tourism.[247] This participation comes in the form of lobbying for national and international laws on transplant tourism, making policies on organ transplantation and transplant tourism and endorsing transplant tourism instruments.

244 Charli Carpenter, "Setting the Advocacy Agenda: Theorizing Issue Emergence and Nonemergence in Transnational Advocacy Networks" (2007) 51:1 Int'l Studies Q 101; Trubek *et al,* supra note 243 at 1194.

245 Keck & Sikkink, *supra* note 242 at 98; Kathrin Zippel, "Transnational Advocacy Networks and Policy Cycles in the European Union: The Case of Sexual Harassment" (2004) 11:1 Soc Pol 63.

246 Keck & Sikkink, *supra* note 242 at 89.

247 E.g.: The Transplantation Society, World Medical Association, Organs Watch, MOHAN Foundation, American Society of Nephrology, Asian Pacific Society of Nephrology, British Transplant Society, Canadian Society of Transplantation, Council of European Committee on Organ Donation, European Transplant Coordinators Organization, International Pediatric Transplantation Association, International Society of Heart and Lung Transplantation, Transplant Society of Latin America and the Caribbean, World Transplant Games Federation.

There are some notable global legal and policy reforms in the practice of organ transplantation and transplant tourism in particular which can be traced to the activities of these transplant organizations and societies. Most of these reforms can be noticed in global policy changes on the acquisition of organs. Though only a handful of transplant States have laws aimed at prohibiting transplant tourism, many States have organ transplant policies, with aspects dedicated to transplant tourism. These policies, which are almost always the product of national transplant societies, remain the only national instruments on transplant tourism in most States.[248] In Canada, for instance, although the various provincial laws on organ transplantation are silent on transplant tourism, the *Policy Statement of the Canadian Society of Transplantation and the Canadian Society of Nephrology on Organ Trafficking and Transplant Tourism* reflects a firm desire on the part of transplant professionals to discourage transplant tourism.[249] Even though these policy documents are not enforceable, they show the consensus of the relevant parties on transplant tourism and could be instrumental in influencing the formation of domestic and international laws against transplant tourism practices in the future. An example of the impact policy documents and soft laws can have in the formation of laws can be found in the development of national laws which now penalize nationals who travel abroad to engage in CST.[250] These laws have their root in the 1996 *Declaration and Agenda for Action* on CST.[251]

Of all the existing NGOs and transplant societies which have transplant tourism as a focus, two stand out for the role they play in building the current global awareness of transplant tourism issues. These are The Transplantation Society (TTS) and the International Society of Nephrology (ISN). Though primarily concerned with the development of science, ethical and clinical practice in the various fields which they govern, these two societies have championed the move towards bringing an end to transplant tourism. Paramount among their various achievements is the role they played in the drafting and adoption of the *Declaration of Istanbul*.[252] The initial text of the Declaration was drafted in 2007 by a steering committee which was convened by both societies and, later in 2008, it was adopted by participants in the International Summit on Transplant Tourism

248 See for instance the World Medical Association, *Statement on Human Organ Donation and Transplantation* which has been adopted by the American Medical Association.

249 *Gill et al, supra* note 25.

250 See for instance section 7(4.1), *Criminal Code* of Canada, *supra* note 145.

251 The *Stockholm Declaration and Agenda for Action*, *supra* note 35.

252 *Declaration of Istanbul*, *supra* note 26.

and Organ Trafficking, also convened by both societies.[253] The *Declaration of Istanbul* has singlehandedly led to more global reforms in the regulation of transplant tourism than any other instrument. Aside from being endorsed by over 100 transplant organizations around the world, the *Declaration of Istanbul* has led to new or improved organ transplant legislation which focus on transplant tourism in States such as Pakistan and the Philippines.[254]

Outside the groups mentioned above, there is another set of key players who are very relevant in effecting policy changes globally. This group of individuals belongs to a network of knowledge-based professionals with recognized expertise and competence in particular fields and an authoritative claim to policy-relevant knowledge within those fields.[255] They are often referred to as epistemic communities and are useful in the development of policies especially where States are unable to arrive at international cooperation. Epistemic communities have been described as a group of individuals with a "shared set of normative and principled beliefs … shared causal beliefs … shared notions of validity … and a common policy enterprise."[256] Working independently and in institutional settings, these groups often advocate for a particular cause, help represent the interests of weak State actors and blur the lines between local players, States sovereignty and the international community.[257]

As a network of professionals, epistemic communities include a wide range of individuals, working independently and in institutional settings. In the promotion of efforts against organ trade and transplant tourism, the relevant epistemic community comprises medical doctors including nephrologists, ethicists,

253 The Steering Committee of the Istanbul Summit, "Organ Trafficking and Transplant Tourism and Commercialism: The Declaration of Istanbul" (2008) 372:9632 The Lancet 5; Francis Delmonico, "The Development of the Declaration of Istanbul on Organ Trafficking and transplant Tourism" (2008) 23:11 Nephrol Dial Transplant 3381.

254 Frederike Ambagtsheer & Williem Waimar, "A Criminology Perspective: Why Prohibition of Organ Trade in not Effective and How the Declaration of Istanbul can Move Forward" (2012) 12:3 Am J Transplant 571. For a list of endorsing organizations, see the *Declaration of Istanbul's* website: <http://www.declarationofistanbul.org/index.php?option=com_content&view=article&id=74&Itemid=56>.

255 Peter Hass, "Introduction: Epistemic Communities and International Policy Coordination" (1992) 46:1 Int'l Org 3.

256 *Ibid.*

257 Teng Fu, "Globalization, Global Environmental Problems, and Transnational Advocacy Networks" in Maryann Love, *Beyond Sovereignty: Issues for a Global Agenda* (Belmont: Wadsworth, 2010) at 315; Margaret Keck & Kathryn Sikkink, *Activists beyond Borders: Advocacy Networks in International Politics* (Ithaca: Cornell University Press, 1998) at 35.

researchers and other organ transplant professionals.[258] Institutionalization happens when they come together during a policy-making process or when they are an organized group like the key players of TANs. There are various ways in which members of transnational epistemic communities can be instrumental in bringing about policy changes. According to Peter Hass, two such ways are by directly identifying policies for decision makers or by illuminating the salient dimensions of an issue from which the decision makers may then deduce their interests.[259] Hass goes on to describe a chain of activities in which decision makers can influence the interests and behaviors of other States which could in turn lead to international policy coordination or changes.[260]

TANs and epistemic communities are especially relevant in Asia where there is no formal regional human rights system. They are relevant in ensuring that human rights standards are implemented in this region. Above I discussed the impact of the *Declaration of Istanbul*. This impact is also felt in Asian States where it has led to new or improved organ transplant laws which focus on transplant tourism in States such as Pakistan and the Philippines. In the prevention of transplant tourism and promotion of ethical standards in organ transplantation for instance, the Middle East Society for Organ Transplantation (MESOT) organizes meetings and annual conferences on the improvement of transplantation practices in the Asian region.[261] MESOT is made up of 23 States including Pakistan, Egypt, Ukraine and Iraq.[262] In China, the NGO called Doctors Against Forced Organ Harvesting (DAFOH) is made up of medical doctors of various specialities united with the aim of stopping the practice of illegal organ harvesting in China.[263] TTS was very instrumental in the development of the *Hangzhou Resolution* in 2013 in China which is an important step in the development of best practices for organ donation and transplantation in China.[264] Judging from the advances made thus far in the prohibition of transplant tourism through the work of epistemic communities,

258 Fikresus Amahazion, "Epistemic Communities, Human Rights, and the Global Diffusion of Legislation against the Organ Trade" (2016) 5:4 Soc Sci 1.

259 Hass, *supra* note 255 at 4. See also Anthony Zito, "Epistemic Communities, European Union Governance and Public Voice" (2001) 28:6 Sci Pub Pol 465.

260 Hass, *ibid*.

261 Amahazion, *supra* note 258 at 10.

262 For a complete list of States who are members of MESOT, see the MESOT website, online: <http://www.mesot-tx.org/history/countries.php>.

263 For more on DAFOH, visit their website, online: <http://www.dafoh.org/>.

264 Amahazion, *supra* note 258 at 16.

there is bound to be more progress in the way transplant tourism is prohibited in future.

## Conclusion

International law has always been relevant in setting standards and creating norms which influence the ways States legislate on various crimes or human rights breaches. So far, transplant tourism has not benefitted much from international law regulation as the activity remains almost unprohibited. As seen through the examination of the three branches of international law which are most relevant to the regulation of transplant tourism, there are very few international law principles or instruments which focus directly on transplant tourism practices. As will be seen in Chapter 5, there is currently no CIL norm against transplant tourism although there is an emerging norm that is still in its very early stages of development. The application of international human rights and criminal law treaties which cover certain aspects of organ trafficking and acquisition to transplant tourism cases are limited. For now, treaty provisions which govern the prohibition of torture and cruel treatment, the preservation of human dignity, the right to life and the right to health can be used to prohibit transplant tourism at international law. In most cases, these treaty provisions must be stretched for them to apply to transplant tourism.

At the regional level, some progress has been made under the European system with the development of the *Trafficking in Human Organs Convention* which has certain provisions which relate to transplant tourism. It is hopeful that after the Convention comes into force in March of 2018, it will discourage transplant tourism practices in the ratifying States. The possibility of regional human rights treaties against transplant tourism developing in Asia is very slim as there is no established human rights system there. The absence of such a system in Asia is worrisome as a lot of the transplant States involved in transplant tourism are in Asia with new Asian States becoming more involved in transplant tourism after India, the Philippines and Pakistan developed laws which offer better protection to their nationals from transplant tourism practices.

In sharp contrast to the slow creation of international and regional law instruments on transplant tourism, there are an abundance of soft law instruments against transplant tourism practices. Most of these instruments are WHA resolutions and guiding principles issued by the WHO. These soft law instruments set out various policies, best practices and directives on transplant tourism which should inform state action. TANs and epistemic communities have

also been relevant in the creation of soft laws against transplant tourism. In the Asian region where there is no established human rights system, the activities of TANs and epistemic communities have gone a long way in setting and maintaining transplant standards in the region. The *Declaration of Istanbul* has had a great impact in the way some States currently create policies and legislate against transplant tourism. What is currently needed at international law is a model for global application which contain rules and principles that focus solely on transplant tourism and provides avenues for transplant tourism activities to be penalized at both the international and national levels. In the next two Chapters, I will focus on the development of such a model starting with an examination of the various sources of international law in Chapter 5. This examination will determine their suitability for use in the creation of a model against transplant tourism.

CHAPTER 5

# Developing an International Law Model for Transplant Tourism

## A Introduction

Although international law is principally concerned with the regulation of State activities, it sometimes regulates the activities of individuals. An example of the interaction between international law and individuals can be traced back to the charters establishing the various war and military tribunals aimed at prosecuting individuals responsible for serious violations of international criminal law committed in various States.[1] In the last few decades, we have witnessed more focus of international law on the regulation of the activities of individuals especially in the drafting of international human rights, humanitarian and criminal law instruments. An example of this can be found in human rights treaty enforcement provisions allowing individuals to make direct complaints to treaty-based human rights committees when their rights have been violated.[2] My discussion of international health law, international human rights law and international criminal law instruments in the previous Chapter dealt with this point extensively. In Chapter 4, I examined the nature, historical development, advantages and drawbacks and relevant provisions of instruments under the above three branches of international law. I also looked at the relevance of key instruments under the three branches of international law to the regulation of certain aspects of organ commercialization and transplant tourism. I concluded Chapter 4 with a section on the contribution of Transnational Advocacy Networks (TANs) and epistemic communities to the prohibition of transplant tourism.

1 See e.g., *Charter of the International Military Tribunal* (*Nuremberg Charter*) (1945) 82 UNTS 279 created after World War II to try war and other crimes.

2 See e.g., the Human Rights Committee (HRC) which has the power to receive communications from individuals claiming to be victims of the violation of rights provided under the *International Covenant on Civil and Political Rights*, GA Res. 2200A (XXI), 21 UN GAOR Supp. (No 16) at 59, UN Doc. A/6316 (1966); 999 UNTS 302. See preamble and article 1, *Optional Protocol to the International Covenant on Civil and Political Rights*, GA Res. 2200A (XXI), 21 UN GAOR Supp. (No. 16) at 59, UN Doc. A/6316 (1966); 999 UNTS 302.

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Continuing from the discussion in Chapter 4, in this Chapter, I will take a closer look at the sources of international law and examine how suitable and feasible these sources are in the development of an international law model to prohibit transplant tourism. To achieve this goal, I will examine the characteristics, advantages and limitations of the various sources of international law as they relate to the prohibition of transplant tourism. Although technically not a source of international law, I will also discuss relevant international law resolutions and guidelines, referred to as "soft law," due to the important role soft law plays in bringing about change in the way certain practices are regulated by both international law and national laws.

## B Sources of International Law

In modern international law, article 38(1)(a)-(c) of the *Statute of the International Court of Justice* (*ICJ Statute*) is generally recognized as the definitive statement of the sources of international law.[3] It states:

> (1) The Court, whose function is to decide in accordance with international law such disputes as are submitted to it, shall apply:
>
> a. international conventions, whether general or particular, establishing rules expressly recognized by the contesting states;
>
> b. international custom, as evidence of a general practice accepted as law;
>
> c. the general principles of law recognized by civilized nations;
>
> d. subject to the provisions of Article 59, judicial decisions and the teachings of the most highly qualified publicists of the various nations, as subsidiary means for the determination of rules of law.[4]

3 See article 38(1), *Statute of the International Court of Justice*, 3 Bevans 1179; 59 Stat. 1031; T.S. 993; 39 AJIL Supp. 215 (1945). This provision of the *ICJ Statute* is a slight amendment of article 38 of the *Statute of the Permanent Court of International Justice*, 6 LNTS 379; 114 BFSP 860; 17 AJIL Supp. 115 (1923).

4 Article 38(1) *ICJ Statute*, *supra.* Note that article 38(1)(d) is not a source of international law but provides evidence for determining the sources in (a) to (c). See Aldo Borda, "A Formal Approach to Article 38(1) (d) of the ICJ Statute from the Perspective of the International Criminal Courts and Tribunals" (2013) 24:2 Euro J Int'l L 649; John Currie *et al*, *International Law: Doctrine, Practice, and Theory*, 2nd ed (Ontario: Irwin Law, 2014) at 139.

The first source of international law provided by article 38(1)(a) of the *ICJ Statute* are international conventions mostly referred to as treaties. Other terms used to refer to international conventions include covenants, protocols, pacts, charters and agreements.[5] Treaties are binding agreements between States or other subjects of international law like international organizations (e.g. UN). These agreements can be between two (bilateral) or more (multilateral) States or intergovernmental organizations. The *Vienna Convention on the Law of Treaties* (*Vienna Convention*) defines treaties as international agreements "concluded between States in written form and governed by international law, whether embodied in a single instrument or in two or more related instruments and whatever its particular designation."[6] A treaty enters into force at such a time or under such conditions as agreed on by the parties to the treaty.[7] Unlike customary international law (CIL) which automatically binds all States, treaties are only binding on States who consent to be bound by the treaty through signature and ratification. Due to the complex and multifaceted nature of most international law issues, international law relies more and more on the use of treaties as they can be drafted in ways which cover the full ambit of a field or principle. Transplant tourism, for instance, which is a multifaceted concept would be best regulated by a treaty.

Treaties have a dual existence. By their very nature, treaties apply on the international law level and regulate the activities of States and other subjects of international law. Treaty provisions also can have domestic application. The means via which a treaty applies within the domestic legal system of a State depends on the rules of the State in question. Generally, there are two different theories which regulate the relationship between international law and national law. Some States adopt the monist approach which views international law treaties as self-executing.[8] Monist States are made up mainly of civil law States such as France.[9] In monist States, treaties apply automatically in domestic law upon ratification and sometimes take pre-eminence over

5 Currie, *supra* at 48; Krista Schefer, *International Investment Law: Text, Cases and Materials* (Cheltenham: Edward Elgar Pub., 2013) at 18.

6 Article 2, *Vienna Convention on the Law of Treaties*, UN Doc. A/Conf.39/27; 1155 UNTS 331; 8 ILM 679 (1969); 63 AJIL 875 (1969). Canada acceded to the *Vienna Convention* on October 14, 1970.

7 *Ibid*, article 24.

8 Anthony Aust, *Modern Treaty Law and Practice*, (Cambridge: Cambridge University Press, 2000) at 146.

9 See articles 52–55, *French Constitution of October 4, 1958* (*La Constitution du 4 Octobre 1958*)

national laws.[10] Other States adopt the dualist approach which views both systems as separate and require a formal act for international law treaties to be applied in their national courts.[11] This formal act may include the transformation of the treaty into domestic legislation. Dualist States are often common law States like Canada. For a treaty to be enforced by Canadian courts, it must be ratified and, in most cases, transformed and implemented by a Canadian statute.[12] The treaty legislating body depends on whether the subject matter of the treaty falls within federal or provincial legislative powers.[13] Dualist States are still bound by untransformed treaties under international law.[14]

The second source of international law provided by article 38(1)(b) of the *ICJ Statute* is customary international law (CIL). Subject to a few limited exceptions, CIL is universal and binding on all States whether or not those States expressly consented to the formation of the CIL norm in question.[15] CIL is formed when there is sufficient State practice accompanied by *opinio juris*.[16] As will be seen, there are several qualifications to this definition. For a CIL to form and bind all States, two elements need to be present. The first is an objective element which consists of sufficient "general practice" of States which

10 *Ibid,* article 55; Antonio Cassese, *International Law in a Divided World* (Oxford: Clarendon Press, 1992) at 82.

11 Gerrit Ferreira & Anel Ferreira-Snyman, "The Incorporation of Public International Law into Municipal Law and Regional Law Against the Background of the Dichotomy between Monism and Dualism" (2014) 17:4 Potchefstroom Elec L J 1471.

12 *Baker v Canada* (*Minister of Citizenship and Immigration*), [1999] 2 SCR 817, para. 69; *Francis v The Queen*, [1956] SCR 618, at 621; *Capital Cities Communications Inc. v Canadian Radio-Television Commission*, [1978] 2. SCR 141 at 172. Note that where there is already a national statute in place which already complies with the said treaty, there will be no need for another implementing statute to be passed.

13 The federal government can implement treaties covering federal matters while provincial governments implement treaties on areas within their provincial jurisdiction. See *A.G. Canada v A.G. Ontario et al.* (*Labour Conventions Reference*), [1937] AC 326.

14 See *Baker v Canada*, *supra* note 12.

15 The exceptions to this rule include the rules governing persistent objectors, regional treaties and bilateral agreements. These exceptions are discussed in greater details in footnotes 110–115; See generally, *Asylum Case* (*Columbia v Peru*) (1950) ICJ Rep. 266; Hersch Lauterpacht, *The Development of International Law by the International Court* (Cambridge: Cambridge University Press, 1958) cited in Anthony D'Amato, "The Concept of Special Custom in International Law" (1969) 63 Am J Int'l L 211; Ted Stein, "Approach of the Different Drummer: The Principle of the Persistent Objector in International Law" (1985) 26:2 Harv Int'l L J 457; Jonathan Charney, "The persistent Objector Rule and the Development of Customary International law" (1985) 56:1 Year Book of Int'l Law 1.

16 Currie, *supra* note 4 at 116.

must have occurred over a specific period of time. The second is a subjective and sometimes ambiguous element known as *opinio juris* which requires that the practice of that custom be the result of some form of legal obligation.[17] In order for a rule of CIL to exist, there has to be the confluence of substantially uniform, repeated practice by a sufficient number of States over time accompanied by the belief that such practices are required or prohibited by law. The application of this rule is, however, not straightforward as even the ICJ is not always consistent in its reasoning of what amounts to uniform and substantial state practice.[18]

The objective element for the existence of CIL and the raw material of CIL which both "defines and limits it" is state practice.[19] What will serve as evidence of state practice will depend on the circumstances of each case. In considering evidence of state practice, the ICJ has relied both on the actions and inactivity of the States in question. The ICJ has also relied on their written communications and other evidence of state practice such as pleadings before international tribunals, communications at international organizations, national legislation and case law and the opinions of relevant State officials made during the execution of State duties.[20] For state practice to be sufficient as CIL, it has to be extensive and substantially uniform.[21] Although absolute uniformity is not required for state practice to be valid, a greater degree of uniformity is sought when the time period which evidences the custom is short or where the practice proves a regional or bilateral CIL norm[22] The density and generality

17 See *North Sea Continental Shelf Cases* (*Federal Republic of Germany v Netherlands; Federal Republic of Germany v Denmark*), (1969) ICJ Rep. 3, page 44. Para. 76.

18 Mark Weisburd, "The International Court of Justice and the Concept of State Practice" (2009) 31:2 U Pa J Int'l L 295.

19 *Case Concerning Rights of Passage over Indian Territory* (1960) ICJ Rep. 6 at 99; Karol Wolfke, *Custom in Present International Law*, 2nd ed (Dordrecht; Martinus Nijhoff Pub., 1993).

20 See *Fisheries Jurisdiction Case* (*United Kingdom v Iceland*) (*Jurisdiction of the Court*), (1974) ICJ Rep. 3, paras. 13–23. See also *Case Concerning Military and Paramilitary Activities in and Against Nicaragua* (*Nicaragua v United States of America*), (1986) ICJ Rep. 14.

21 According to Kunz, the practice must have been "continued and repeated without interruption of continuity." See Josef Kunz, "The Nature of Customary International Law" (1953) 47:4 Am J CIL 666. In the *Fisheries Case*, the court advised that the practice be "constant and sufficiently long." See *Fisheries Case* (*United Kingdom v Norway*) (1951) ICJ Rep. 116 at 138.

22 In the *North Sea Continental Shelf Cases, supra* note 17 at para. 74, the ICJ held that although the passing of a short period of time is not in itself a bar on the formation of a

of the practice required will vary according to the nature of each case.[23] The practice need not be universal as not all States may have had the opportunity to engage in the practice.[24] A few variations in practice are allowed as long as those variations do not change the nature of the practice.[25] Passage of time is also an important factor to consider in the establishment of a rule of CIL. How long this time period should be will depend on the facts of each case. In the *North Sea Continental Shelf Cases* (*Federal Republic of Germany v. Netherlands; Federal Republic of Germany v. Denmark*), the ICJ noted that although a rule of CIL might develop within a short period of time, it is important that there be widespread practice which should include practice by the States whose interests are specifically affected.[26]

The second element for the existence of CIL is that the practice must be more than a mere habit performed by States. The practicing State must not believe that its habit is discretionary in nature.[27] The States undertaking the practice must do so as a result of some form of legal obligation.[28] Practices undertaken by States for a long period of time without the belief on the part of those States that they were legally obligated to act that way might be seen as acts "motivated only by consideration of courtesy, convenience or tradition, and not by any sense of legal duty."[29] This belief on the part of States

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new rule of CIL, during that short period of time the practice must have been extensive and virtually uniform. see also *Nicaragua Case*, *supra* note 20 at para. 184.

23 Vladimir Degan, *Sources of International Law* (Leiden: Martinus Nijhoff Pub., 1997) at 152.

24 See *North Sea Continental Shelf Cases, supra* note 17 at para. 74. See generally the judgement of ICJ in the *Fisheries Case, supra* note 21 at 128.

25 See *Fisheries Case, supra* note 21, at 138 where the ICJ stated that "too much importance need not be attached to a few uncertainties or contradictions, real or apparent."

26 *North Sea Continental Shelf Cases, supra* note 17 at 42; It has been argued that due to the current speed at which legal regulations are required in recent times, the importance of time factor in the formation of customs has greatly diminished. Thus a few years is sufficient for a custom to form at international law so long as the coincidence of state practice and legal obligation can be shown. See Mihail Niemesch, "Customary Law as the Main Source of International Law" (2015) 3 J L Admin Sc 85.

27 See *Rights of Passage Case*, *supra* note 19 at 40.

28 Slama Lynn, "*Opinio Juris* in Customary International Law" (1990) 15:2 Okla City U L Rev 618; In the *North Sea Continental Shelf Cases, supra* note 17, the ICJ stated that the practice of States must be carried out in such a way "as to be evidence of a belief that this practice is rendered obligatory by the existence of a rule of law requiring it." See para. 77.

29 *North Sea Continental Shelf Cases, ibid;* see also *Asylum Case, supra* note 15 at 286 where the ICJ noted that the practice of a mutual custom by States inspired by mutual feelings of toleration and goodwill is not an evidence of any feeling of legal obligation.

that they are legally obligated to practice a custom is referred to as *opinio juris sive necessitatis* or *opinio juris*.[30] What constitutes *opinio juris* is very difficult to define or explain with clarity.[31] In spite of the uncertain nature of this element, the ICJ has stressed the importance of *opinio juris* in cases.[32] Because of its subjective nature, courts have had to look at the facts of each case in order to arrive at a decision whether or not the States acted in a way which shows legal obligation.

Treaties and CIL remain the major sources of international law. These two sources also interact with each other in several ways. Although distinct from each other, it is possible for certain treaty provisions to reflect CIL norms. This happens in three ways. The first way is for a new treaty to codify existing rules of CIL. This can be found in treaties such as the *Vienna Convention* and the *UN Convention on the Law of the Sea*.[33] The second possibility is where a treaty provision crystallizes a developing rule of customary law thus transforming a developed practice into an existing law.[34] The third possibility is where a rule of CIL is formed later, influenced by a treaty article.[35] This makes the treaty article norm creating and the new CIL binds States which are not party to the treaty as a customary norm.[36] In order for a treaty provision to lead to the creation

30 *Opinio juris sive necessitatis* is a Latin phrase which literally means a conviction that the rule is obligatory. It is the conviction of states that a particular practice, rule or action is obligatory or accepted as law: Jo Salma, "*Opinio Juris* in Customary International Law" (1990) 15:2 Okla City U L Rev 605; Henry Steiner & Detlev Vagts, *Transnational Legal Problems*, 3rd ed (New York: The Foundation Press, 1986) at 290; David Bederman, *International Law Frameworks* (New York: Foundation Press, 2001) at 15; See generally *North Sea Continental Shelf Cases, supra* note 17; *Nicaragua Case, supra* note 20 at 98–99.

31 Mark Chinen, "Game Theory and Customary International Law: A Response to Professors Goldsmith and Posner" (2001) 23 Mich J Int'l L 178; see also Lynn, *supra* note 28 at 619.

32 See the *Case of the S.S. Lotus* (*France v Turkey*) (1927), P.C.I.J. Series A, No. 10 at 28; *North Sea Continental Shelf Cases, supra* note 17 at 44; *Asylum Case, supra* note 15 at 277; *Rights of Passage Case, supra* note 19 at 40; *Case Concerning the Continental Shelf* (*Libyan Arab Jamahiriya/Malta*), (1985) ICJ Rep. 13; *Fisheries Jurisdiction Case, supra* note 20 at 3.

33 *United Nations Convention on the Law of the Sea* 1833 UNTS 3; 21 ILM 1261 (1982).

34 Andre Ferreira *et al*, "Formation and Evidence of Customary International Law" (2013) 1 UFRGSMUN/UFRGS Model UN J 193.

35 This was an argument made in the *North Sea Continental Shelf Cases* by Denmark and Netherlands when they argued that principle of equidistance was a rule of customary international law by virtue of article 6 of the 1958 *Geneva Continental Shelf Convention* and subsequent state practice. See *North Sea Continental Shelf Cases, supra* note 17, paras. 69 & 70.

36 *North Sea Continental Shelf Cases, supra* note 17 at para. 71.

of a CIL it has to meet several conditions.[37] When there exists both a treaty and a rule of CIL on the same subject matter, both norms retain an individual and separate existence.[38] All States will be bound by this rule either as a treaty contracting party or by virtue of the universality of the application of the CIL norm. Where there are conflicts between treaty provisions and rules of CIL, the prevailing rule will depend on the circumstance of each case. Generally, as between parties to that treaty, the treaty prevails.[39] However, this rule will not apply where the CIL is a fundamental principle of international law from which no derogation is permitted (*jus cogens* or peremptory norm).[40]

The third source of international law provided by article 38(1)(c) of the *ICJ Statute* are general principles of law "recognized by civilized nations." Today they are referred to as general principles of law of nations (general principles).[41] General principles are essentially supplementary sources of international law which are found in different domestic legal systems. The ICJ has made several pronouncements about the nature of general principles. In the *North Sea Continental Shelf Cases*, general principles of law were said to be "nothing other than the norms common to the different legislation of the world, united by the identity of the legal reason."[42] In the earlier case of *International Status of South-West Africa* (*Advisory Opinion*), Judge McNair noted in a separate opinion that international law has always borrowed principles and rules from national legal systems and incorporated them into its own body of rules in ways which would best work at international law.[43] This source of international law ensures that lacunae in international law are filled by domestic rules and principles.[44] Various general principles of law have been

37 In the *North Sea Continental Shelf Cases, ibid* at paras. 72–74, the Court laid down these conditions: (I) The treaty article has to be "of a fundamentally norm-creating character"; (II) there must be a "very wide spread and representative participation in the convention" especially by States whose interests are being affected; (III) State practice should have been "extensive and uniform."

38 *Nicaragua Case, supra* note 21 at para. 178.

39 See Currie, *supra* note 4 at 131; *Nicaragua Case*, *supra* note 20 at 14.

40 See article 53, *Vienna Convention, supra* note 6.

41 In *North Sea Continental Shelf Cases, supra* note 17 at 133, Judge Ammoun noted that the phrase "recognized by civilized nations" is outdated, incompatible with the provisions of the *United Nations Charter* and belonged to the colonial era. Thus, principles of laws of all nations come under this heading. See generally Jaye Ellis, "General Principles and Comparative Law" (2011) 22:4 The European J Int'l L 949.

42 *North Sea Continental Shelf Cases, supra* note 17 at 134.

43 See *International Status of South-West Africa* (*Advisory Opinion*) (1950) ICJ Rep. 148.

44 The Court has applied various domestic law principles in arriving at its decisions and opinions. See *North Sea Continental Shelf Cases supra* at 17 (estoppel); *Case Concerning the*

recognized by the ICJ in its judgements. These principles include the principle of acquiescence, estoppel, good faith, and unjust enrichment, corporate legal personality, res judicata, self-determination, and procedural fairness.[45]

Two domestic law principles which could be applied to the prohibition of transplant tourism are the principles of human dignity and bodily integrity. One of the ways in which the principle of human dignity exists in national legal systems is in the constitutions of various States around the world where it is prevalent. It has been estimated that about 70% of all constitutions around the world make reference to human dignity.[46] The *Canadian Charter of Rights and Freedoms,* for instance, states that no one should be subjected to cruel and unusual punishment or treatment.[47] The *Constitution of the People's Republic of China* provides in article 37 that the personal dignity of citizens is inviolable.[48] Other States around the world, including Saudi Arabia, Russia and the Democratic Republic of Congo, also have similar provisions in their constitutions.[49] Aside from constitutional provisions, the criminal codes of most States also have provisions which seek to protect the dignity of citizens. Such provisions include those which involve physical violence or interference such as assaults, battery and robbery.[50] The *Criminal Code of Canada* for instance has provisions against assaults of individuals.[51]

These principles, however, already exist in international human rights law, traced back to the *Universal Declaration of Human Rights* (UDHR).[52] In Chapter 4, I discussed how the principles of human dignity and bodily integrity

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*Temple of Preah Vihear* (*Cambodia v Thailand*) (1962) ICJ Rep. 6 at 32 (estoppel); *Nuclear Test Case* (*Australia v France*) (1974) ICJ Rep. 253 at 268 (good faith).

45 See generally *Nicaragua Case*, *supra* note 20 at 14; *International Status of South-West Africa, supra* note 43; Michelle Biddulph & Dwight Newman, "A Contextualized Account of General Principles of International Law" (2014) 26:2 Pace Intl L Rev 292.

46 Thomas Weatherall, *Jus Cogens: International Law and Social Contract* (Cambridge: Cambridge University Press, 2015) at 48.

47 See *Canadian Charter of Rights and Freedoms, The Constitution Act,* 1982, Schedule B to the Canadian Act 1982 (UK), 1982, c 11, s 12.

48 Article 38, *Constitution of the Federal Republic of China*; *Jainfu Chen et al, Implementation of Law in the People's Republic of China*, Vol. 8 (Leiden: Martinus Nijhoff Pub., 2002) at 206.

49 Weatherall, *supra* note 46 at 47.

50 Tatjana Hornle & Mordechai Kremnitzer, "Human Dignity as a Protected Interest in Criminal Law" (2012) 44:1–2 Isr L Rev 149.

51 See ss 264.1–273, *Criminal Code* of Canada, R.S. 1985, c. C-46.

52 *Universal Declaration of Human Rights*, GA Res. 217 (III), UN GAOR, 3d Sess., Supp. No. 13, UN Doc. A/810 (1948) 71.

have been used as major arguments against transplant tourism. Though not expressly provided as human rights under CIL or treaty law, these sister concepts find expression in other human rights prohibitions like the prohibitions against torture, inhuman and degrading treatment. So far, aside from concurring and dissenting opinions of individual members of the ICJ, the Court has yet to use the principle of human dignity in the human rights context in arriving at its decisions.[53] I can conclude that general principles relating to transplant tourism have yet to be applied by the ICJ in its judgments and opinions. Thus, I will not be carrying out any in-depth examination of general principles in this Chapter.

Aside from the formal sources of international law stated in article 38(1)(a)-(c) of the *ICJ Statute*, there are other international law quasi-legal instruments collectively referred to as soft law which sometimes influence the development international law. "Soft law" is an umbrella term used to describe a group of instruments such as principles, guidelines, resolutions of the organs of international organizations, codes of conduct and action plans which reflect the intentions and consensus of the drafters but which are not legally binding.[54] An exception to the rule that soft law is not binding are Security Council resolutions that are decisions made under articles 25 or 48 of the *Charter of the United Nations* (*UN Charter*).[55] Like hard law, soft law exists in both national and international law. Within national legal systems, soft law mostly takes the form of policy documents which reflect principles which an organization or group of professionals expect their members to be guided by. An example of such a policy document relevant to transplant tourism is the *Policy Statement of Canadian Society of Transplantation and Canadian Society of Nephrology on Organ Trafficking and Transplant Tourism*.[56] Other forms of national policy documents include guidelines used to interpret legislation or

53 Christopher McCrudden, "Human Dignity and Judicial Interpretation of Human Rights" (2008) 19:4 EJIL 682; Judge Tanaka in *South West Africa Cases* (*Ethiopia v South Africa; Libya v South Africa*) (1966) ICJ Rep. 6 at 308–312; Judge Shahabuddeen in the *Legality of the Threat or Use of Nuclear Weapons, Advisory Opinion*, (1996) ICJ Rep. at 383.

54 See generally Dinah Shelton, "Compliance with International Human Rights Soft Law" (1997) 29 Stud. Transnat'l Legal Pol 120–127; Arnold Pronto, "Understanding the Hard/Soft Distinction in International Law" (2015) 48:4 Vanderbilt J. Transnat'l L 942.

55 *Charter of the United Nations*, (1945) ATS 1/59 Stat. 1031; TS 993; 3 Bevans 1153.

56 See John Gill *et al*, "Policy Statement of Canadian Society of Transplantation and Canadian Society of Nephrology on Organ Trafficking and Transplant Tourism" (2010) 90:8 Transplant 817.

regulation.[57] At international law, soft law refers to written instruments other than binding treaties which prescribe a certain standard of behavior, predominantly with the aim of influencing the attitude and actions of States and other international law bodies in regards to their subject matter. Their degree of significance depends largely on the composition of the drafting bodies and the contents of the soft law instrument.

Soft law is developed by a wide range of bodies after a period of deliberation. Soft law creating bodies include intergovernmental organizations like the UN and its agencies, non-governmental organizations, governments, scholars and civil society groups. The UN is responsible for the creation of a number of soft law instruments. These include UN General Assembly (GA) resolutions, and resolutions and guidelines issued by other UN bodies (e.g. Human Rights Council).[58] The type of soft law resolution created by a UN agency such as the World Health Organization (WHO) often reflects the focus of that agency. As discussed in Chapter 4, the World Health Assembly (WHA), for instance, oversees drafting health-related resolutions under the umbrella of the WHO.[59] Resolutions drafted by the WHA include *WHA44.25 Guiding Principles on Human Organ Transplantation* (*Resolution WHA44.25*) and *WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation*.[60] There are other organs of the UN which draft many resolutions. The International Law Commission, for instance, is responsible for drafting numerous draft articles which later on get transmitted into treaties.[61] All UN human rights

57 Examples of these can be found in the Guidelines to the *Investment Canada Act*, RSC 1985, c 28 (1st Supp.). Some of these guidelines include those relating to Related Business, Administrative Procedures and Corporate Social Responsibility.

58 See for example the *UN Guiding Principles on Business and Human Rights*, online: <http://www.ohchr.org/Documents/Publications/GuidingPrinciplesBusinessHR_EN.pdf>.

59 The World Health Assembly is the decision-making body of the WHO. The WHA can be found online: <http://www.who.int/mediacentre/events/governance/wha/en/index.html>.

60 World Health Organization, "Guiding Principles on Human Organ Transplantation" (1991) 337:8755 The Lancet 1470–1; World Health Organization, "WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation" (2010) 11:4 Cell Tissue Bank 413–9.

61 The International Law Commission (ILC) is a subsidiary organ of the UN General Assembly whose object is the promotion of the progressive development of international law and its codification. As an organ of the UN, it is responsible for the drafting of notable treaties like the *Vienna Convention* (*supra* note 6) and resolutions such as the *Draft Articles on the Responsibility of States for Internationally Wrongful Acts* (2001) Supp. No. 10 (A/56/10), chp. IV.E.1 which has been cited by the ICJ. See *Gabčíkovo-Nagyamaros Project* (*Hungary/Slovakia*), (1997) ICJ Rep. 7. For more on the powers and functions of the ILC see the *Statute of the International Law Commission*, GA Resolution 174 (II).

committees issue General Comments or General Recommendations aimed at interpreting and fleshing out provisions of the instruments.[62] Other types of international soft law instruments are policy documents, codes of conduct, memoranda of understanding, guidelines and declarations issued by international organizations or States and are used in various international law fields such as environmental law, trade law, arms control and human rights.[63]

## C Relationship between International Law Sources and Transplant Tourism

### 1 *Treaties*

#### i Treaties on Transplant Tourism

Treaties by their very nature and effect remain an attractive medium for the prohibition of transplant tourism. Prior to July 2014, there were no treaties which focused on transplant tourism. The only treaties in existence were and are those which address various aspects of organ commercialization and trafficking. These treaties can be divided into two major groups. The first group is made up of general human rights treaties which deal with the rights to health, life and dignity of the person, and the prohibition of torture and other cruel, inhuman or degrading treatment or punishment. These rights can be extended to protect individuals from some of the dangers of transplant tourism and have their origins in the UDHR. Article 12 of the *International Covenant on Economic, Social and Cultural Rights* (ICESCR), for instance, safeguards the right to health and other social determinants of heath.[64] The *International Covenant on Civil*

62 Kerstin Mechlem, "Treaty Bodies and the Interpretation of Human Rights" (2009) 42:3 Vand J Transnat'l L 926–927; See also article 40(4), ICCPR, *supra* note 2.

63 Currie, *supra* note 4 at 152. I discuss the effects of soft laws in greater details below. See footnotes 175–183.

64 See article 12, *International Covenant on Economic, Social and Cultural Rights,* GA Res. 2200A (XXI), 21 UN GAOR Supp. (No 16) at 49, UN Doc. A/6316 (1966); 993 UNTS 3; 6 ILM 368 (1967). Other international law treaties which provide for the right to health include: article 12, *Convention on the Elimination of all Forms of Discrimination against Women,* GA Res. 34/180, 34 UN GAOR Supp. (No. 46) at 193, UN Doc. A/34/46; 1249 UNTS 13; 19 ILM 33 (1980); article 24, *Convention on the Rights of the Child,* GA Res. 44/25, annex, 44 UN GAOR Supp. (No. 49) at 167, UN Doc. A/44/49 (1989); 1577 UNTS 3; 28 ILM 1456 (1989); and article 16, *African Charter on Human and Peoples' Rights,* OAU Doc. CAB/LEG/67/3 rev. 5, 1520 UNTS 217; 21 ILM 58 (1982).

*and Political Rights* (ICCPR) is another relevant treaty which offers protection to individuals from transplant tourism practices.[65] Article 6 of ICCPR provides for the right to life which is a right which does not permit any derogation.[66] Transplant tourism activities such as those which have the ability to deprive individuals of their lives violate this provision.[67] The right to life can also be found in other treaty provisions like article 6 of the *Convention on the Rights of the Child* (CRC).[68]

The ICCPR also provides for rights which deal with bodily integrity and the inherent dignity of individuals. Article 10 protects incarcerated individuals from inhumane or undignified Treatment.[69] Article 7 of the ICCPR states that "no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."[70] The Human Rights Committee (HRC) has extended the provisions of article 7 to cover the acts of private individuals.[71] Other relevant treaties which protect against torture or degrading treatment include the CRC[72] and the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (CAT).[73] All these treaty provisions together aim at protecting individuals from actions which cause harm to them physically or emotionally. Where these activities are linked to transplant tourism, affected parties can find redress under these treaties. Although the treaty provisions

65 Article 4, ICCPR, *supra* note 2; *CCPR General Comment No. 6: Article 6* (*Right to Life*), 30 April 1982.

66 See article 6, ICCPR, *supra* note 2.

67 Where the State actively participates in the procurement of organs to feed transplant tourism practices, that State will be in violation of this right. An example of this is the harvesting of organs from prisoners in China who are executed for offences which are not deemed to be the most serious crimes. States also have a duty to protect individuals from the harmful acts of private citizens under its duty to exercise due diligence. Note that China is not a party to the ICCPR. See comments 2 & 6, *CCPR General Comment No. 20: Article 7* (*Prohibition of Torture, or Other Cruel, Inhuman or Degrading Treatment or Punishment*) (1992) HRI/GEN/Rev.9 (Vol. 1).

68 Article 6, CRC, *supra* note 64.

69 Article 10(1), ICCPR, *supra* note 2; See also comment 3, *General Comment No. 21: Article 10* (*Humane Treatment of Persons Deprived of their Liberty*) (1992) HRI/GEN/1/Rev.9 (Vol. 1) (General Comment No. 21).

70 Article 7, ICCPR, *supra* note 2; See also *General Comment No. 20, supra* note 67.

71 See comment 2, *General Comment No. 20, ibid.*

72 See articles 36, 37 & 19, CRC, *supra* note 64.

73 *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,* GA Res. 39/46, annex, 39 UN GAOR Supp. (No. 51) at 197, UN Doc. A/39/51 (1984); 1465 UNTS 85.

offer only limited protection to individuals from transplant tourism activities, they remain relevant.[74]

The second group of treaties is made up of particular international human rights and criminal law treaties which have specific provisions on organ commercialization and trafficking. Unlike the treaties considered above, this group of treaties have provisions geared at key elements of transplant tourism. A lot of transplant tourism cases involve organ trafficking in one form or another and treaty provisions which address this element of the practice are indispensable in the overall regulation of transplant tourism. The *Second Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography* (OP2-CRC),[75] for example, places a duty on States Parties to ensure that the transfer of organs of children for profit are prohibited under their criminal or penal laws.[76] Another treaty which prohibits organ trafficking is the *Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children* (*Trafficking Protocol*).[77] Among its provisions geared towards the prohibition of human trafficking, article 3(a) of the *Trafficking Protocol* protects individuals from trafficking where it involves organ removal.[78] The drawback of these treaties is that they only cover the limited cases where children or human trafficking are involved. Transplant tourism as we know has more components than organ trafficking and commercialization.

Although not yet in force, in July 2014, the Committee of Ministers of the Council of Europe (COE) adopted the *Council of Europe Convention against Trafficking in Human Organs* (*Trafficking in Human Organs Convention* or Convention).[79] This is the first treaty which focuses specifically on some of the components of transplant tourism and explicitly prohibits them. As discussed in Chapter 4 of this publication, article 4 of the *Trafficking in Human Organs*

74 The limitations of these treaties lie in the fact the they are often directed towards a specific group of individuals like children (CRC) or the actions of specific groups of people like the government and its agents. See articles 1 and 16, CAT, *ibid.*

75 *Optional Protocol to the Convention on the Rights of the Child on the Sale of children, Child Prostitution and Child Pornography*, GA Res. 54/263, Annex II, 54 UN GAOR Supp. (No. 49) at 6, UN Doc. A/54/49 (2000).

76 *Ibid*, article 3(1)(a)(i)(b).

77 *Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children*, supplementing the *United Nations Convention Against Transnational Organized Crime*, 40 ILM 335 (2001) / UN Doc. A/55/383 (Annex II. P. 53) / [2005] ATS 27.

78 *Ibid*, article 3(a).

79 *Council of Europe Convention against Trafficking in Human Organs*, CETS No. 216.

*Convention* places a duty on States Parties to establish criminal offences where organs are removed without the free and informed consent of the "donor" and where financial or comparative advantage has been received by a living donor or by a third party in the case of a deceased donor. This duty also covers cases where these activities are committed in foreign jurisdictions.[80] This is particularly helpful as transplant tourism always involves more than one State and the ability of a State to exercise extraterritorial criminal jurisdiction is important in the successful prosecution of offenders. One major drawback of this Convention is that it permits States to make reservations to certain key provisions of the treaty.[81] For instance, States have the right not to criminalize the illegal removal of organs from living donors.[82] States can also choose not to exercise criminal jurisdiction over offences committed by its nationals, thus limiting the extraterritorial criminal jurisdiction of States.[83] Whether or not States will take advantage of these provisions remains to be seen as the application of this treaty remains in abeyance as most signing parties have yet to ratify it.

### ii Advantages and Disadvantages of Treaties as Instruments for Prohibiting Transplant Tourism

Treaties are complex instruments with various attributes and functions which can provide both advantages and disadvantages in the prohibition of transplant tourism. One of the most significant attributes of treaties is that unlike CIL, which is by its nature often undocumented, the terms of treaties are clearly written in considerable detail in one instrument which makes the rights and obligations of the parties clearer. This does not render treaties free of ambiguity as there are treaty provisions which are vague. International law, however, provides rules for the interpretation of treaties. These rules can be found in articles 31 to 33 of the *Vienna Convention*.[84] Generally, treaties are to be interpreted in good faith, in accordance with the ordinary meaning of the terms and in light of their object and purpose.[85] Most human rights treaties have treaty committees which also perform treaty interpretation functions

80 *Ibid*, articles 2, 10 & 17.

81 *Ibid*, article 30.

82 *Ibid*, article 4(2).

83 *Ibid*, article 10(3).

84 See articles 31–33, *Vienna Convention, supra* note 6. Note here that this is a codification of CIL.

85 *Ibid.*

through their general comments and other work.[86] The ICJ also interprets treaty provisions when dealing with cases before it.[87] Despite their ambiguities, treaties remain an important tool for regulating complex human rights issues like transplant tourism. Transplant tourism involves organ commercialization, organ trafficking, travel for transplant purposes and medical services used to implant the organ. A treaty could help in clearly defining these elements and ensuring that regulation covers every aspect of the offence.

Another major attribute of treaties is that, upon ratification, their terms are binding on the contracting parties which they must fulfil in good faith.[88] This compelling nature of treaties is covered under the principle of *pacta sunt servanda*.[89] Ratification of treaties is, however, voluntary and States choose which treaties to ratify in accordance with their national and international goals and policies. For example, there are key human rights treaties which have not been signed and/or ratified by some States. The ICESCR, for instance, has not been signed or ratified by about 27 States, including transplant and tourist States.[90] After ratifying a treaty, States have room to renegotiate the terms of treaties by making amendments either in the text of the treaty or in protocols.[91] This flexibility allows States to change treaties in response to changing circumstances.

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86 See for example, *General Comment No. 14 on the Right to the Highest Attainable Standard of Health* (*Article 12 of the International Covenant on Economic, Social and Cultural Rights*), E/C.12/2000/4, published by the Committee on Economic, Social and Cultural Rights.

87 Joost Pauwelyn & Manfred Elsig, "The Politics of Treaty Interpretation: Variations and Explanations across International Tribunals," in Jeffrey Dunoff & Mark Pollack, *Interdisciplinary Perspectives on International Law and International Relations: The State of the Art* (New York: Cambridge University Press, 2013) at 445.

88 See article 1, *Vienna Convention, supra* note 6, which states that treaties are "international agreements concluded between states in written form and governed by international law …"

89 *Pacta sunt servanda* literally means that agreements must be kept; See article 26 of the *Vienna Convention* which states that treaties in force are binding upon the parties to them and must be performed by them in good faith; See also *North Sea Continental Shelf Cases, supra* note 18; See generally Hans Wehberg, "Pacta Sunt Servanda" (1959) 53:4 Am J Intl Law 781.

90 States which are not ICESCR parties include transplant and tourist States like Oman, Singapore, Malaysia, Saudi Arabia and Qatar and other States like Haiti, Botswana, St. Lucia and South Sudan. For status of the ICESCR, see Office of the High Commissioner on Human Rights website: <http://indicators.ohchr.org/>.

91 Just like in the case of an original treaty, States would need to sign on to protocols and ratify them to be bound by them. E.g. of treaty amendments: The GA in resolution 50/155 of Dec. 21, 1995, approved the amendment to article 43, para. 2 of the CRC, replacing the word "ten" with "eighteen." The amendment entered into force on Nov. 18, 2002; The *Kyoto Protocol*, UN Doc FCCC/CP/1997/7/Add. 1, Dec. 10, 1997; 37 ILM 22 (1998) is an amendment

The rules governing the amendment of treaties can be found in articles 40 and 41 of the *Vienna Convention* and gives States the right to choose whether or not they wish to become parties to an amended treaty. It is possible for a State to be a party to a treaty but not to an amending protocol and vice versa.[92] States also may exclude the application of certain treaty provisions by making reservations when signing treaties. However, international law circumscribes the making of reservations.[93]

What this all means in relation to possible regional or global treaties on transplant tourism is that key transplant and tourist States can choose not to sign the treaty, thus defeating the aim of the treaty. They might also be able to ratify the treaty subject to certain reservations which might weaken the treaty controls. In the *Trafficking in Human Organs Convention*, for instance, which is yet to come into force, States can make reservations to some important provisions of the treaty like the provisions encouraging the use of extraterritorial criminal legislation by States to prosecute nationals who engage in transplant tourism activities in other States.[94] If States take advantage of this provision, it might defeat the whole aim of the treaty.

Another advantage that treaties have over CIL concerns the enforcement of their rules. Treaty drafters often include enforcement provisions in treaties aimed at the resolution of disputes between the parties to the treaty at both the international and domestic law levels. These enforcement provisions are varied and can include the establishment of treaty committees or tribunals or the treaty can state how disputes are to be resolved. UN human rights treaties create committees which are empowered with a wide range of soft powers all geared towards ensuring that States Parties comply with the provisions of the treaty.[95]

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to the *United Nations Framework Convention on Climate Change*, 1771 UNTS 107; S. Treaty Doc No. 102–38; UN Doc A/AC.237/18 (Part II)/Add. 1; 31 ILM 849 (1992).

92 For instance, though the United States has not ratified the CRC, it has ratified the *OP2-CRC*.

93 This rule is however subject to the fact that a State cannot make reservations to treaty provisions that violates the object and purpose of the treaty. A treaty might also prohibit the making of reservations to some or all of its provisions. The *Convention against Discrimination in Education* for instance provides that reservations to the convention shall not be permitted. See article 9, *Convention against Discrimination in Education*, 429 UNTS 93; *Reservations to the Convention on the Prevention of Punishment of the Crime of Genocide* (*Advisory Opinion*) (1951) ICJ Rep. 15; Articles 19, 20 & 21, *Vienna Convention*, *supra* note 6.

94 See article 30, *Trafficking in Human Organs Convention, supra* note 79.

95 See Currie, *supra* note 4 at 655. See for instance article 28 of the ICCPR, *supra* note 2, which creates the Human Rights Committee (HRC) and *ECOSOC Resolution* 1985/17 of 28 May 1985 which creates the Committee on Economic, Social and Cultural Rights (CESCR).

At the regional level, the major regional human rights treaties establish human rights courts which resolve disputes concerning the interpretation and application of the treaties.[96] Very relevant in the prohibition of transplant tourism is the fact that after ratification of a treaty, treaty law obligations are often transformed into domestic laws and enforced by national courts.[97] Another enforcement mechanism available under treaty law which is relevant to transplant tourism are provisions in treaties which permit or require States to take domestic criminal law jurisdiction over human rights offences where the offender is a national of that State, whether or not the offence was committed in the State (extraterritorial jurisdiction).[98] The relevance of the last two points is that international human rights breaches arising out of transplant tourism are best dealt with at the State level by the courts of States which have jurisdiction over the offence.

Having examined some of the key advantages of treaty law, the question which necessarily follows is whether a treaty on transplant tourism would be the preferred route for the prohibition of transplant tourism by both the international and national legal systems. There is no straightforward answer to this question as there are both advantages and disadvantages to having a treaty on transplant tourism. Aside from its ability to deal with very complex human rights issues, one major attractive quality which treaty regulation has over other forms of regulation at international law is access to an elaborate system of enforcement mechanisms. As shown in a few other areas of human rights enforcement, these tools can be very effective in ensuring that defaulters are punished for their actions. On the flip side, for treaties to be effective, States must become bound by the treaty under international law and implement the treaty into their domestic legal systems. If States lack the will to enforce the terms of a treaty, they might not be willing to sign the treaty or they may ratify the treaty but fail to implement its obligations.

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Other human rights committees include example the Committee on Economic, Social and Cultural Rights (ICESCR), the Committee on the Rights of the Child (CRC) and the Committee on the Elimination of Discrimination against Women (CEDAW).

96 See *Protocol to the African Charter on Human and Peoples' Rights* on the Establishment of the African Court on Human and People's Rights, 10 June 1998, OAU/LEG/EXP/AFCHPR/PROT (III); The European Court of Human Rights was established by article 19 of the *European Convention for the Protection of Human Rights and Fundamental Freedoms*, 1950, 23 U.N.T.S. 221 Eur. T.S. 5; The Inter-American Court of Human Rights was created under article 33 of the *American Convention on Human Rights*, OAS Treaty Series No. 36; 1144 UNTS 123; 9 ILM 99 (1969).

97 This transformation is not necessary in monist States as ratified treaties can be automatically applied by national courts.

98 See article 4(2) *OP2-CRC, supra* note 75.

Instead, perhaps the most effective method of prohibition would be to get key transplant and tourist States to reach an initial consensus on the international law formation process by developing a soft law instrument, such as a declaration or guidelines, which best reflect their wishes and intentions and which can later be transformed into binding international and/or national legal instruments. Given the response of States to the *Declaration of Istanbul* and the recent move by the Council of Europe in adopting the *Trafficking in Human Organs Convention*, the likelihood of an international law instrument on transplant tourism in the near future seems feasible.

### 2 *Customary International Law*

#### i Advantages and Disadvantages of the Evolution of Customary International Law on Transplant Tourism

There are currently very few customary international law (CIL) norms on aspects of transplant tourism such as those dealing with the prohibition of torture and the right to health. The development of general CIL norms on transplant tourism could play an important role in its prohibition. There are some advantages of having a CIL norm on transplant tourism the most important of which is that, save for a few exceptions, CIL is universally binding on all States without the need for all States to engage in the state practice that constitutes the customary norm in question.[99] This characteristic nature of CIL is in sharp contrast to treaties which do not automatically bind States.[100] Generally, CIL in the area of international human rights applies to regulate the actions of non-signatories to human rights treaties that cover the same subject matter as the customary norms.[101] CIL also serves as an important law source in the expanding branches of international criminal law and international humanitarian law, providing a normative foundation which could be instrumental in the prohibition of transplant tourism in future.[102] In spite of its significant

99 Andrew Guzman, "Saving Customary International Law" (2006) 27:1 Mich J Int'l L 119.

100 A State might however be indirectly bound by the provisions of an unratified treaty where there is a CIL norm that is identical or covers the same areas as the provisions of the unratified treaty. In that case, what binds the State is the CIL norm and not the unratified treaty.

101 The prohibition of torture under CIL is an example of such a norm. Although the prohibition of torture can be found under human rights treaties like the CAT and ICCPR, not all States are parties to these treaties. Those States are however still bound by customary law norms against torture.

102 Yoram Dinstein, "International Criminal Law" (1985) 20 Isr L Rev 207.

advantages, CIL has many limitations. Aside from the fact that CIL is hard to prove and assess, three other major limitations of CIL are that its rules of formation are very inconsistent, it accommodates exceptions to its universality and it does not have the same types and numbers of enforcement mechanisms that are contained in many multilateral and regional treaties.

A lot of CIL norms are simple, unequivocal and easy to apply.[103] There are however certain CIL norms which are abstract in nature leading to confusion about their existence, nature and application. It is sometimes difficult to state when a particular custom comes into existence or when an existing customary norm is modified.[104] As with other fields of law, the rules of CIL change to meet the new demands of the international community.[105] The formation of a new norm could lead to State violation of the current norm as a new norm automatically overrules an earlier one.[106] This is summed up in the legal maxim *lex posterior derogat legi priori* (a later law repeals an earlier one).[107] In addition, criteria that were once deemed to be strong indicators of the existence of CIL, such as the passage of time, have been held not as important in determining whether state practice is sufficient to qualifying a custom as CIL.[108] More difficult to describe with absolute certainty is the elusive concept of *opinio juris* which is very subjective in nature.

Aside from the difficulties in determining whether a CIL exists, CIL accommodates a few exceptions to the rule that all States are subject to it. For one, general CIL is subject to regional or bilateral CIL. In the *Case Concerning Rights of Passage over Indian Territory* (*Rights of Passage Case*), the ICJ stated that it found "no reason why long continued practice between two States accepted by

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103 The prohibition of torture under CIL for instance is well established and considered to be *jus cogens*. There are little doubts about what the rules against torture are.

104 Anthony D'Amato, "The Concept of Custom in International Law" (1972) 30:2 Cambridge L J 351.

105 Leonard Salter, "International Law in Transition: New Norms for Old" (1973) 7:3 Int'l Lawyer 687.

106 Joost Pauwelyn, *Conflict of Norms in Public International Law: How WTO Law Relates to other Rules of International Law* (Cambridge: Cambridge University Press, 2003) at 14.

107 *Ibid.*

108 *North Sea Continental Shelf Cases, supra* note 17 at 42. Another argument related to the time factor is that though a long period of time need not pass before a rule of customary international law can develop, sufficient time is still needed in order for a custom to be said to have been practice repeatedly. Though the treaty formation process is not a very quick one, treaties can be passed and come into force within a relatively shorter period of time than customary international law. For one, treaties are formed as a result of state agreements and are not dependent on the proof of a period of state practice.

them as regulating their relations should not form the basis of mutual rights and obligations between the two States."[109] The second exception to the universality of CIL relates to persistent objectors. Where a State has been shown to consistently and persistently deny the existence or application to it of a customary norm since the outset of the development of the state practice it is not bound by that customary norm.[110] In response to the Colombian government's argument about the existence of a particular regional custom in the *Asylum Case* (*Colombia v. Peru*), the ICJ noted that even if such a custom existed, Peru had so far rejected it and refrained from ratifying treaties which codify those customs and thus could not have been bound by it.[111] It is, however, doubtful that a State would be exempted from the application of CIL rules against grievous conduct such as torture or inhuman or degrading treatment or punishment as these are peremptory norms from which no derogation is permitted.[112]

The third major shortcoming of CIL is that it does not have as many enforcement mechanisms as treaties especially in the area of human rights. Unlike the enforcement mechanisms contained in human rights treaties which are always evolving in order to better address human rights issues, CIL does not have the same variety of direct enforcement mechanisms. This shortcoming does not, however. make CIL devoid of enforcement mechanisms. The ICJ, for instance, can decide cases involving CIL over which it has jurisdiction.[113] Aside from the ICJ, CIL can also be enforced by international criminal tribunals. The

109 See *Rights of Passage Case, supra* note 19 at 40. The Courts have however noted that regional customary international law is subject to stricter rules than general customary international law. It has to be shown that there was persistent practice of that custom and the states felt legally obligated to perform that custom. See *Asylum Case, supra* note 15 at 276; Farhad Talaie, "The Importance of Custom and the Process of its Formation in Modern International Law" (1998) 5 JCULR 33.

110 Ted Stein, "Approach of the Different Drummer: The Principle of the Persistent Objector in International Law" (1985) 26:2 Harv. Int'l L. J. 457; Jonathan Charney, "The persistent Objector Rule and the Development of Customary International law" (1985) 56:1 Year Book of Int'l Law at 1.

111 *Asylum Case, supra* note 15 at 277–278.

112 This non-derogation rule is subject to the rule that a peremptory norm can be modified by a subsequent norm of general international law of the same character. It might be argued on this point that treaties are no better than customary international law as States have the right to contract themselves out of treaties. That is true. But the aim of this exercise is not to show that treaties are a better alternative to customary international law, but to show the advantages and disadvantages of each of these sources.

113 See article 36, *ICJ Statute, supra* note 3.

statute creating the International Criminal Tribunal for the Former Yugoslavia (ICTY), for instance, grants the ICTY jurisdiction over crimes including genocide, war crimes and crimes against humanity.[114] Parts of these crimes are also prohibited by CIL.[115]

### ii Customary International Law and Transplant Tourism: Likelihood and Suitability

Despite its limitations and exceptions, CIL still remains an important source for the regulation of State behavior under international law. Unlike many other human rights fields which are currently regulated by both CIL and treaty law, transplant tourism is still a developing concept under international law with very little or no regulation, especially under CIL. In order to ascertain whether or not there are currently rules of CIL prohibiting the comprehensive practice of transplant tourism, two important questions need to be asked: First, is there currently uniform state practice by a large number of States or by key transplant and tourist States over time prohibiting transplant tourism?[116] Secondly, if the answer to the first question is yes, is there a belief on the part of those States that they are legally obligated to prohibit the behavior that constitutes transplant tourism? These are the standards by which the existence or nonexistence of a CIL is verified.[117]

Although it might be possible to argue that the answer to the first question is yes, available evidence does not support this argument. An indicative method for establishing the existence of valid state practice which evidences the existence of a rule of CIL is the availability of extensive and substantially uniform laws, rules and regulations in the various States, especially in those States whose

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114 See articles 4 & 5, *Statute of the International Tribunal for the Prosecution of Persons Responsible for Serious Violations of the International Humanitarian Law Committed in the Territory of the Former Yugoslavia since 1991*, U.N. Doc. S/25704 at 36, annex (1993) and S/25704/Add.1 (1993), adopted by SC on 25 May 1993, U.N. Doc. S/RES/827 (1993).

115 See Marie-Claude Roberge, "Jurisdiction of Ad Hoc Tribunals for the Former Yugoslavia and Rwanda over crimes against Humanity and Genocide" (1997) 37:321 Int'l Rev Red Cross 651. The International Criminal Tribunal for Rwanda (ICTR) also has similar jurisdiction. See articles 2 & 3, *Statute of the International Criminal Tribunal for the Prosecution of Persons Responsible for Genocide and other Serious Violations of the International Humanitarian Law Committed in the Territory of Rwanda and Rwandan Citizens Responsible for Genocide and other such Violations Committed in the Territory of Neighbouring States, between 1 January 1994 and 31 December 1994*, UN. Doc. S/RES/827 (1993).

116 As noted earlier, to establish sufficient state practice, the relevant practice is not necessarily that of all states but those of states whose interests are specially affected by the practice. See *North Sea Continental Shelf Cases, supra* note 17 at para. 74.

117 Article 38(1)(b), *ICJ Statute*, *supra* note 3.

interests are specially affected by the practice in question.[118] In the case of transplant tourism, this would mean that laws and regulations prohibiting transplant tourism must exist in the key transplant and tourist States affected by the practice.[119] Over the past few years, key transplant States have passed new or amended existing criminal or health laws to prohibit organ commercialization and trafficking. However, this partial legislation does not amount to a prohibition of transplant tourism in its entirety. As has been established in the previous Chapters, rules making some forms of organ acquisition and transplantation illegal is not necessarily a rule against transplant tourism as such rules typically regulate activities within the confines of one State and between nationals only of that one State. Although three transplant States (Philippines, India and Pakistan) have gone a step further to pass laws prohibiting not just organ commercialization or trafficking, but also transplant tourism, the practice of less than a handful of States is insufficient to constitute the state practice required to form CIL.[120] Other transplant States do not have any laws prohibiting transplant tourism. While the transplant States noted above that have prohibited transplant tourism are some of the States most affected by the practice, their actions cannot be seen as representing those of most key transplant States.

The willingness to prohibit transplant tourism using legislation has not been replicated by any tourist State aside from Israel.[121] Most tourist States have however participated in initiatives aimed at discouraging the practice. At the grassroots level are principles and codes of practice of professional bodies which condemn transplant tourism in these States.[122] These documents are by their nature not State documents but are merely the aspirations and codes of private professional bodies within these States. Thus, they cannot amount to relevant state practice. The governments of tourist States have also

118 See *North Sea Continental Shelf Cases, supra* note 17 at 42.

119 See *Fisheries Jurisdiction Case, supra* note 20 at paras. 13–23.

120 India passed the *Transplantation of Human Organs* (*Amendment*) *Act*, Act No. 16 of 2011, in 2011; Philippines adopted the *Amendment to the Administrative Order No. 2008-0004 on Revised National Policy on Living Non-Related Organ Donation and Transplantation and its Implementing Structure, Department of Health Administrative Order* No. 2008-0004-A (May 29, 2008) (DOH *Administrative Order No. 2008-0004-A*) *in 2008*; In Pakistan, the *Transplantation of Human Organs and Tissues Act*, 2009, Act No. VI of 2010, was passed in 2010.

121 See *the Organ Transplant Law 5768-2008*, Israeli Book of Laws.

122 In Canada for instance the Canadian Society of Transplantation and the Canadian Society of Nephrology passed their policy statement on organ trafficking in 2010. See Gill *et al, supra* note 56.

been involved in the drafting and adoption of mainly soft law international instruments geared towards the prohibition of transplant tourism. As noted in earlier Chapters, the most concrete step taken by tourist States in recent years is the endorsement of the *Declaration of Istanbul* by key organ transplant organizations and government officials within those States.[123] Aside from the *Declaration of Istanbul,* other existing soft law instruments prohibiting transplant tourism include WHA resolutions, the last of which was passed in 2010.[124] It is, however, difficult to state exactly what impact the WHA resolutions have had in the prohibition of transplant tourism. At the very least, they have helped in opening discussions on the need to prohibit the practice.

While there are currently no treaties on transplant tourism, treaties which are relevant to portions of the practice such as the CAT,[125] the *Trafficking Protocol*[126] and the *Trafficking in Human Organs Convention*[127] have been signed by both transplant and tourist States. Of all these treaties, the *Trafficking in Human Organs Convention* which is the most relevant to the prohibition of transplant tourism is not yet in force. An important observation which can be made based on the response of States to these instruments is that they are unwilling to develop a consistent and widespread practice which supports the prohibition of the entire transplant tourism practice.

Based on the above analyses, it is clear that there is currently insufficient number of national laws and international instruments prohibiting transplant tourism. National policies prohibiting transplant tourism are insufficient to amount to relevant state practice for the development of a CIL norm against transplant tourism. Judging from the practice of transplant and tourist States regarding transplant tourism, it can be concluded that there is currently no crystallized CIL prohibiting the practices that constitute transplant tourism. However, it can be said that state practice to prohibit transplant tourism is evolving. Since the first question cannot be answered in the affirmative, there is no need to explore questions dealing with *opinio juris*.

123 "The Declaration of Istanbul on Organ Trafficking and Transplant Tourism" (2008) 3:5 Clin J Am Soc Nephrol 1227–1231; For a complete list of the organizations which have endorsed the *Declaration of Istanbul*, see the Declaration's website page: <http://www.declarationofistanbul.org/about-the-declaration/list-of-endorsing-organizations>.

124 World Health Organization, *Human Organ and Tissue Transplantation* (Geneva: World Health Organization, 2010), online: <http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_R22-en.pdf?ua=1>, (*Resolution WHA63.22*).

125 CAT, *supra* note 73.

126 *Trafficking Protocol, supra* note 77.

127 *Trafficking in Human Organs Convention, supra* note 79.

Now that it has been established that there is currently no existing CIL prohibiting transplant tourism, the next question is whether there a likelihood of such CIL developing in future? If so, would CIL be the best route for tackling transplant tourism on the international law plane? CIL develops through an organic process. Though the practice of States is required for the establishment of a rule of CIL, States do not always consciously engage in these practices in a bid to establish these rules. Judging from the activities of States in recent years and the general trend towards treaty regulation in international human rights law, it is more likely than not that future international regulation of transplant tourism would take the form of a codified international law instrument such as additional comprehensive treaty law and/or soft law instruments. Having examined the several disadvantages of CIL especially those which relate to its sometimes-abstract nature, it is my opinion that a codified instrument would be the preferred mode for the prohibition of transplant tourism.

### 3 *Soft Law*

#### i Obligations Created by Soft Law

Although the term soft law covers a wide range of international instruments, a common thread which runs through these instruments is that unlike legally binding treaties and CIL, soft law instruments do not generally create binding legal obligations. A standard rule which applies to all treaties is that their provisions bind the parties who ratify them.[128] States do not have a legal obligation to obey soft law provisions as the principle of *pacta sunt servanda* is inapplicable to soft law instruments. This non-binding nature of soft laws has led some scholars to refer to them as not being law at all. According to Prosper Weil, the term "soft law" is a misnomer as they "are neither 'soft law' not 'hard law': they are simply not law at all."[129] Other positivists like H.L.A. Hart hold that for a norm to be considered law, it must impose a sense of obligation.[130] Since soft law generally does not create binding legal obligations, it should not

128 The exception to this rule is where a treaty provision is vague. See for instance article 5 of the *Convention on Biological Diversity*, 31 ILM 818 (1992) which states that each contracting party shall cooperate with one another "as far as possible and as appropriate …"

129 Prosper Weil, "Towards Relative Normativity in International Law?" (1983) 77:3 Am J Int'l L 414. See also Anthony Arend who described the term "soft law" as an oxymoron: Anthony Arend, *Legal Rules and International Society*, (Oxford: Oxford University Press, 1999) at 25.

130 H.L.A. Hart stated: "The most prominent general feature of law at all times and places is that its existence means that certain kinds of human conduct are no longer optional, but in *some* sense obligatory." See Herbert Hart, *The Concept of Law*, 2nd ed (Oxford: Clarendon Press, 1997) at 7.

be referred to as law. It is, however, incorrect to make a blanket statement that all soft laws have no binding effect as there are exceptions to this rule. For one, the resolutions of the Security Council (SC) are legally binding if they are decisions under article 25 of the *UN Charter.*[131] Secondly, although the non-binding nature of soft law also applies to resolutions of the GA by virtue of articles 10 and 14 of the *UN Charter* which limits the rights of the GA to making "recommendations," there are exceptions to this rule.[132] For example, by article 17 (1) of the *UN Charter*, GA resolutions on the UN budget are binding.[133] The ICJ has also considered other GA resolutions, such as those dealing with the admission of new members into the UN and voting procedures, as binding.[134]

Aside from the few instances shown above where soft laws are binding in nature, soft laws are also relevant in the codification of international law and as evidence of the existence of international law. There are soft laws which codify CIL. The UDHR, a UN GA resolution, at least in part, codifies customary international human rights obligations with the customary norms reflected in its terms having binding authority.[135] Soft law can be used as evidence of state practice in the determination of the existence of a rule of CIL where it can be shown that a majority of States or States whose interests are most affected by a practice have adopted and followed a soft law against that practice. In cases such as these, soft law becomes a tool for the generation and spread of consistent state practice.[136]

Soft law can also serve as evidence of *opinio juris.* In the *Case Concerning Military and Paramilitary Activities in and Against Nicaragua* (*Nicaragua*

131 See article 25, *UN Charter, supra* note 55, on the binding nature of Security Council Resolutions. See also the advisory opinion of the ICJ in *Legal Consequences for States of the Continued Presence of South Africa in Namibia* (*South West Africa*) *Notwithstanding Security Council Resolution 276* (1971) ICJ Rep. 16 at para. 113.

132 See articles 10 & 14, *UN Charter, ibid*; See also Remigiusz Bierzanek, "Some Remarks on 'Soft' International Law" (1988) 17 Pol Yearbook of Int'l Law 24.

133 See article 17(1), *UN Charter, ibid*. This rule was also made clear by the ICJ in *Certain Expenses of the United Nations* (*Article 17, Paragraph 2, of the Charter*) (1962) ICJ Rep. 151 at 164.

134 See *Competence of the General Assembly for the Admission of a State to the United Nations* (1950) ICJ Rep. 4 at 8; *Voting Procedure on Questions Relating to Reports and Petitions Concerning the Territory of South-West Africa* (1955) ICJ Rep. 67 at 76 & 77. See generally Marko Oberg, "The Legal Effects of Resolutions of the UN Security Council and General Assembly in the Jurisprudence of the ICJ" (2005) 16:5 EJIL 883.

135 In practice, however, since the UDHR has been substantially duplicated in two principal human rights treaties, the ICCPR and ICESPR), the latter two instruments are most often referred to in cases where there has been a breach of human rights.

136 Alan Boyle, "Some Reflections on the Relationship of Treaties and Soft Law" (1999) 48:4 Int'l Comp L Q 903.

*v. United States of America*) (*Nicaragua Case*), the ICJ referred to a GA Resolution, the *Declaration on Principles of International Law concerning Friendly Relations and Co-operation among States in accordance with the Charter of the United Nations,*[137] as evidence of *opinio juris* of the CIL rule against the threat or use of force.[138] In *Legality of the Threat or Use of Nuclear Weapons*, the ICJ implied that based on the involvement of all States in the adoption of UN GA resolutions concerning nuclear disarmament, all States were obligated under CIL to seek to eliminate nuclear weapons in their negotiations with other States.[139] What is however relevant in the consideration of soft law as evidence of *opinio juris* is the attitude of States to the soft law and not the mere existence of the soft law itself.[140] Traditionally, it has been argued that before soft law can be used as evidence of state practice and *opinio juris*, the soft law must be the product of official State action as opposed to the action of private actors like non-governmental organizations.[141] In line with recent developments in the evolution of soft laws such as the *Declaration of Istanbul* and the *Stockholm Declaration and Agenda for Action* where private actors worked in collaboration with State actors, it can be argued that the traditional view has been modified to require only the participation of some State actors working alongside private actors.[142]

Aside from the role it plays in evidencing the existence of CIL, the prenormative nature of soft law is also relevant in the development of treaty law with the same content as an earlier soft law. In the case of *Legal Consequences for States of the Continued Presence of South Africa in Namibia* (*South West Africa*) *Notwithstanding Security Council Resolution 276*, the ICJ noted that GA resolutions are an important stage in the development of international law.[143] The development of treaty law from soft law can be witnessed in several

137 *Declaration on Principles of International Law concerning Friendly Relations and Co-operation among States in accordance with the Charter of the United Nations*, UN Doc. A/RES/25/2625 (1970).

138 See *Nicaragua Case, supra,* note 20 at 91, para. 191.

139 See *Legality of the threat or Use of Nuclear Weapons Case*, *supra* note 53 at para. 100; Brian Lepard, *Customary International Law: A New Theory with Practical Applications* (New York: Cambridge University press, 2010) at 116.

140 Oberg, *supra* note 134 at 897.

141 Tadeusz Gruchalla-Wesierski, "Framework for Understanding 'Soft Law'" (1984) 30:1 McGill L J 54.

142 The *Stockholm Declaration and Agenda for Action*, adopted at the First World Congress against Commercial Sexual Exploitation of Children, Stockholm, Sweden, 27–31 August 1996.

143 *Supra* note 131 at para. 52.

branches of international law. The UDHR is again a good example of how soft law can transform into hard law, in this case, treaty law. Although the UDHR was passed to be an aspirational document at best, it led to the ICCPR and the ICESCR which in turn have given rise to additional human rights treaties. The development of the law of outer space is another example of how soft law could lead to the development of a treaty. The regulation of outer space started with the drafting of the *Declaration of Legal Principles Governing the Activities of States in the Exploration and Use of Outer Space*.[144] This declaration later led to the adoption of the *Outer Space Treaty* which has the same terms as the declaration with a few additions.[145]

The current prohibition of child sex tourism (CST) is another good example of how soft law can bring about changes in the way both international law and national laws prohibit this behavior. Current national laws prohibiting the practice of CST such as the *Criminal Justice and Immigration Act* of the UK,[146] the *Prosecutorial Remedies and Other Tools to End the Exploitation of Children Act* (*Protect Act*) of the US[147] and the *Criminal Code* of Canada[148] all have their roots in article 4(2) of *OP2-CRC*[149] which in turn came into being as a result of soft law, namely the 1996 *Stockholm Declaration and Agenda for Action* where participating States committed to the criminalization of commercial sexual exploitation of children through the implementation of extraterritorial criminal laws.[150] In the prohibition of transplant tourism, the recent *Trafficking in Human Organs Convention* was influenced in part by the *Declaration of Istanbul* and the 2008 *WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation*.[151]

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144 The *Declaration of Legal Principles Governing the Activities of States in the Exploration and Use of Outer* Space was adopted by GA resolution 1962 (XVIII) in 1963.

145 *Treaty on Principles Governing the Activities of States in the Exploration and Use of Outer Space, Including the Moon and Other Celestial Bodies*, 18 UST 2410, 610 UNTS 205, 6 ILM6 ILM 386 (1967).

146 See section 72, *Criminal Justice and Immigration Act* 2008 (c.4).

147 See section 105(b), *Prosecutorial Remedies and Other Tools to End the Exploitation of Children Act* (Pub. L. 108–21, 117 Stat. 650, S. 151, enacted April 30, 2003).

148 See section 7(4.1) of the *Criminal Code* of Canada, *supra* note 51.

149 Article 4(2) of the *OP2-CRC, supra* note 72, gives states the responsibility of establishing jurisdiction over certain sexual offences against children where the alleged offender is a national of that State.

150 Another example of a soft law leading to the development of a treaty is the *UNEP Guidelines on Environmental Impact Assessment* UNEP/GC14/25 (1985) which led to the *Convention on Environmental Impact Assessment in a Transboundary Context*, 1989 UNTS 310.

151 *WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation*, *supra* note 59.

Another regulatory effect of soft law is its persuasive authority. This persuasive authority can be "legal," political, practical, moral or humanitarian.[152] Soft law has the ability to persuade States to act in ways which are in line with the spirit and intention of the soft law which in turn can lead to a shift in the way a State deals with a certain issue. This persuasive nature of soft law is sometimes so strong that it can lead to domestic legal reforms in States which hitherto had no laws dealing with certain social issues. The prohibition of transplant tourism in key transplant States, for instance, is a good example of the persuasive nature of soft law. Before the *Declaration of Istanbul* was passed in 2008, there were no national laws on the regulation of transplant tourism. Most national laws on organ transplantation focused on the prevention of organ commercialization and the rules surrounding the acquisition of organs. As noted in Chapter 3, after the *Declaration of Istanbul* was passed, a few key transplant and tourist States changed their organ transplant laws and rules to reflect some of the major recommendations in the Declaration. The Philippines passed *Administrative Order No. 2008-0004-A* in 2008,[153] Pakistan passed the *Transplantation of Human Organs and Tissues Act* in 2009,[154] India passed the *Transplantation of Human Organs* (*Amendment*) *Act in* 2011,[155] and Israel passed the *Organ Transplant Law*,[156] all of which prohibit transplant tourism. The ability of soft law to bring about legal reforms sometimes goes beyond the passing and amendment of national statutes. Soft law can also be transformed into legal rules and principles when their contents are used by State courts as *rationes decidendi* for judgements handed down by those courts. In common law States, the more courts that apply a specific principle of soft law, the more a precedent is built and, over time, it becomes the law of the nation unless it is overruled by a superior court.[157]

### ii Soft Law Instruments on Transplant Tourism

Currently, there are two major groups of soft laws on transplant tourism which are of international significance. The first group covers soft laws

152 Currie, *supra* note 4 at 151.

153 DOH *Administrative Order No. 2008-0004-A, supra* note 120*;* Leonardo Castro, "The Declaration of Istanbul in the Philippines: Success with Foreigners but a Continuing Challenge for Local Transplant Tourism" (2013) 16:4 Med Health Care Philos 929.

154 *Transplantation of Human Organs and Tissues Act*, *supra* note 120.

155 The *Transplantation of Human Organs* (*Amendment*) *Act*, 2011, *supra* note 120.

156 *Organ Transplant Law, supra* note 121.

157 Brian Sheppard, "Norm Supercompliance and the Status of Soft Law" (2014) 62:4 Buff L Rev 791.

passed by international nongovernmental organizations of medical professionals like The Transplantation Society (TTS) and the International Society of Nephrology (ISN). The second group covers organ transplant resolutions passed by an intergovernmental organization, in this case, the World Health Assembly (WHA) which is the decision-making body of the WHO. In the first group is the *Declaration of Istanbul* which was adopted at the Istanbul Summit in July of 2008. Though the initial idea for the development of the *Declaration of Istanbul* was conceived by the TTS and ISN, the final draft was agreed on and passed by more than 150 representatives of scientific and medical bodies, government officials and ethicists from 78 States around the world.[158] It can thus be categorized as a hybrid form of soft law as it is the product of both the private sector and State governments. The effect of the *Declaration of Istanbul* on the global regulation of transplant tourism has been referenced throughout the body of this publication. In summary, the Declaration has impacted transplant tourism in two major ways. First, it has been adopted by over 100 transplant organizations and societies around the world.[159] By adopting the Declaration, these societies undertake to "rigorously apply the ethical principles of the Declaration in their policies, practice and activities."[160] With far reaching provisions in the Declaration dealing with organ acquisition, donation and transplantation practices, the adoption of its principles by these organizations can significantly change the way they conduct business. The second and more important impact of the Declaration is that it has led to legal reforms in a few key transplant and tourist States.[161] Without the existence of this Declaration, it would still have been possible for foreigners to legally acquire organs from nationals in transplant States with laws which currently bar organ donations to foreigners. If more States follow the examples set by these key transplant States, stronger evidence could be found for the development of a CIL norm against transplant tourism.

Hybrid soft law instruments like the *Declaration of Istanbul* can influence State conduct and lead to the development of treaty law. In the prohibition of CST for instance, the 1996 *Stockholm Declaration and Agenda for Action* which led to the

158 For a summary of the history and development of the *Declaration of Istanbul*, see the Declaration's website: <http://www.declarationofistanbul.org/about-the-declaration/history-and-development>.

159 For a list of endorsing organizations, see the *Istanbul Declaration's* website: <http://www.declarationofistanbul.org/index.php?option=com_content&view=article&id=74&Itemid=56>.

160 *Ibid.*

161 See Chapter 3 for a detailed discussion of the legal reforms in various States.

*OP2-CRC* was the product of a global partnership between governments, agencies of the UN, non-governmental organizations and individuals.[162] As noted earlier, the *Declaration of Istanbul* was one of the instruments which led to the drafting of the *Trafficking in Human Organs Convention.*[163] Hybrid soft law instruments such as the *Declaration of Istanbul* are thus effective in bringing about a revolution in the way States and the international community legislate on transplant tourism.

The second category of soft law relating to transplant tourism can be found in resolutions of the WHO. Starting in 1987, the WHO through the WHA, in a bid to safeguard the human rights contained in the UDHR and the WHO Constitution, began drafting resolutions and guiding principles creating uniform standards for organ donation and acquisition. These instruments were discussed extensively in Chapter 4 of this publication.[164] In 1991, the WHA endorsed *WHA44.25 Guiding Principles on Human Organ Transplantation*.[165] These principles focused on organ acquisition, donation and distribution and were later replaced in 2008 by a new set of Guiding Principles with more elaborate provisions on organ commercialization.[166] The last of these instruments came into being in 2010 when *Resolution WHA63.22* on *Human Organ and Tissue Transplantation* was passed.[167] This last instrument focused more on transplant commercialization, organ commodification and the protection of vulnerable populations from exploitation resulting from transplant tourism activities. These WHO instruments have influenced the drafting of instruments focused on the regulation of transplant tourism. For one, provisions of the 2004 *Resolution WHA57.18* on *Human Organ and Tissue Transplantation*[168] influenced

162 Karen Mahler, "Global Concern for Children's Rights: The World Congress Against Sexual Exploitation" (1997) 23:2 Intl Fam L Plan Persp 79.

163 See Council of Europe, European Committee on Crime Problems, "Committee of Experts on Trafficking in Human Organs, Tissues and Cells (PC-TO)," online: <http://www.coe.int/t/dghl/standardsetting/cdpc/pc_to_en.asp>.

164 The first of these instruments was *WHA40.13 Development of Guiding Principles for Human Organ Transplantation*: World Health Assembly, *Handbook of Resolutions and Decisions of the World Health Assembly and Executive Board*, Vol. 3, 3rd ed (Geneva: World Health Assembly, 1993) at 87.

165 World Health Organization, "Guiding Principles on Human Organ Transplantation" (1991) 337:8755 The Lancet 1470–1.

166 See Guiding Principles 1, 4, 5, 6 & 7, *WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation*, *supra* note 59.

167 World Health Organization, *Human Organ and Tissue Transplantation*, *supra* note 124.

168 World Health Organization, *Human Organ and Tissue Transplantation* (Geneva: World Health Organization, 2004), online: <http://www.who.int/transplantation/en/A57_R18-en.pdf>.

the drafting of the *Declaration of Istanbul*.[169] The 2008 *Guiding Principles* also influenced the drafting of the *Trafficking in Human Organs Convention*.[170]

Due to the effects the WHO resolutions are having on the global prohibition of transplant tourism and the number of international and national instruments which have adopted their provisions, it can be argued that these resolutions along with other domestic and international law instruments on transplant tourism are evidence of state practice in an evolving customary norm against transplant tourism. These instruments, however, have yet to achieve their desired effect of halting transplant tourism. One of the reasons why the WHA instruments have not recorded any significant success in the fight against transplant tourism is that there is a general unwillingness on the part of tourist States to control the activities of their nationals who travel abroad to engage in the practice. Without the imposition of legislative controls by tourist States, it is doubtful that transplant tourism can be brought to an end.

### iii The Attractions of Soft Law over Hard Law

As shown above, save for some few exceptions, soft law is generally unenforceable. While this attribute might be a disadvantage from the points of view of enforcement and compliance, States view this as an attractive advantage for several reasons. The first reason is that it allows them to retain total control over their activities and reduces their international legal obligations to other States. With soft law, States are still able to retain full control of their affairs, both internally and externally. By becoming bound by treaties, States are restricted from acting in ways which are contrary to the treaty obligations.[171] Unlike soft law, States are legally obligated to fulfil their obligations under treaties and can be compelled to do so at international law through any available remedial mechanism. The legally binding quality of treaties can be particularly troubling for States that do not have a healthy record of obeying treaty provisions or which lack the financial resources needed for the proper implementation of and compliance with treaty provisions.[172] It is for reasons such as these that States apply caution before ratifying treaties. Soft law allows States

169 See preamble, *Declaration of Istanbul, supra* note 123.

170 See Council of Europe, European Committee on Crime Problems, "Committee of Experts on Trafficking in Human Organs, Tissues and Cells (PC-TO)," *supra* note 163.

171 Oona Hathaway, "Why Do Countries Commit to Human Rights treaties" (2007) 4:51 J Conflict Res 589.

172 Generally, developing States find the implementation of treaty provisions more challenging than their developed counterparts. See Abram Chayes & Antonia Chayes, "On Compliance" (1993) 47:2 Int'l Org 194.

to retain freedom of action as it provides more flexible options for endorsing States. Unlike major provisions of treaties, States can avoid implementing the more stringent provisions of soft law.[173] They can also choose which elements of a soft law they want to adopt to satisfy their needs as they arise.[174] States can also conveniently refrain from implementing certain parts of a soft law which they deem to work against their national agenda without the fear of sanctions. Accordingly, States are more likely to adopt a soft law before they sign and ratify a treaty on the same subject matter. The willingness of States to adopt soft law more readily than treaties does not however translate into a higher compliance rate for soft law. Ultimately, the national and international goals, policies, obligations, financial ability and needs of States influence their compliance rate with international law instruments.

Secondly, States love the flexibility and relatively cheaper cost of soft laws compared to treaties. It is generally easier, cheaper and faster to make and implement soft laws. Treaties are often the product of complex procedures, both at the international and national levels. Because of the nature of the obligations created by treaties, States take great care in drafting them which often translates into considerable expense and time taken in the drafting process. The formation process for soft laws is not as tedious with fewer formalities involved.[175] The process of amending soft law is also relatively easier than that for treaties. Soft law can be amended more readily to coincide with the needs of the drafters and environmental, economic and scientific changes without a lot of formalities or the need to incur heavy expenses.[176] This is not the case with treaty amendments (or protocols) which must not only be ratified but, except for monist civil law States, transformed into the national law of the ratifying State before it can be enforceable at the State level. Treaty implementation and enforcement mechanisms can also be expensive. All these costs are mitigated when soft instruments are adopted in place of binding treaties. This ease of implementation at relatively lower cost is part of the attraction of soft law.

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173 This is so even in where States undertake to perform important parts of a resolution they have adopted. They cannot be compelled to act in accordance with that undertaking.

174 Kenneth Abbott & Duncan Snidal, "Hard and Soft Law in International Governance" (2000) 54:3 Int'l Org 445.

175 Abbott & Snidal, *ibid* at 434; Sheppard, *supra* note 157 at 791; Gruchalla-Wesierski, *supra* note 141 at 41.

176 Malgosia Fitzmaurice & Olufemi Elias, *Contemporary Issues in the Law of Treaties* (Netherlands: Eleven Int'l. Pub., 2005) at 43.

Thirdly, States use soft law to test run potentially future binding legal obligations since the contents of soft law may be subsequently enshrined in treaties or domestic statutes.[177] Soft laws such as recommendations and declarations do not always remain soft and could be the first step towards creating binding international legal obligations. Through the application of soft laws and their reception by nationals, a State can tell how a future legal obligation would fare and it gives nationals a chance to adjust their activities in order to conform to future legislation.[178] Compared to CIL, soft law is a faster route to making binding obligations at international law. As we have seen in the previous section, there are several examples in international law where soft law has led to the formation of treaties especially in the realm of international human rights. Soft laws also have post-treaty transmission relevance. Even after a treaty has been produced from soft law, that soft law still remains important in the interpretation and the amplification of the terms of the treaty and may provide rules needed for the effective implementation of the treaty.[179]

## D A Binding Legal Instrument on Transplant Tourism

Having examined the sources of international law, their current provisions on or relating to transplant tourism and their advantages and disadvantages, it is evident that, just as there are an insufficient number of national laws prohibiting transplant tourism, there is also an insufficient body of international law prohibiting all aspects of transplant tourism. If transplant tourism is to be stopped, there is a need for law development at the international level due to the nature of the crime, which usually involves individuals from more than one State. Individual States working on their own have so far been unable to bring an end to transplant tourism due to various reasons beyond their control.[180] In order for there to be any notable progress in the prohibition of transplant tourism, there is a need for international cooperation among States. This cooperation would help bridge any gaps in the prohibition of transplant

177 Sheppard, *supra* note 157 at 792.

178 Jacob Gersen & Eric Posner, "Soft Law: Lessons from Congressional Practice" (2008) 61:3 Stan L Rev 586.

179 Fitzmaurice & Elias, *supra* note 176 at 43; Boyle, *supra* note 136 at 905. See for instance the role played by GA Resolutions in interpreting certain articles of the *UN Charter*.

180 The persistence of the practice in transplant States with transplant tourism laws is a testament to this fact.

tourism and ensure that all the parties to the offence are penalized irrespective of their nationality and temporal or permanent places of residence. This form of international cooperation among States is better fostered by the establishment of an international law instrument against transplant tourism. By establishing a concrete set of rules or principles by which States are to conduct their transplant activities, States would be better positioned to protect the victims of transplant tourism and fulfill their responsibilities towards the international community as a whole. These laws and principles can also be used to establish mechanisms which will aid in the enforcement of the rules both internationally and at the State level.

The format which the prohibition of transplant tourism at international law should take is an important question, the answer to which will dictate the effectiveness or otherwise of any measure taken by States and the international community as a whole. Although we are experiencing the early stages of the development of state practice prohibiting transplant tourism, it is doubtful that an international customary law norm against transplant tourism will develop in the near future. Part of the reason for this is that there seems to be a general lack of willingness on the part of the majority of States to prohibit transplant tourism. As of date, only one tourist State has adopted laws which prohibit transplant tourism and only a few transplant States have national laws against transplant tourism practices. Another reason why we are not on the verge of having an international law norm prohibiting transplant tourism is the length of time needed for the development of CIL norms. Though there are no set rules for the length of time needed for the development of a rule of CIL, there needs to be time enough for state practice to be seen to have acquired the subjective element (*opinio juris*) needed for the existence of a CIL rule.[181] The time needed to develop a customary law norm prohibiting transplant tourism could however be shorter if treaties, national laws and soft laws are adopted and implemented by a majority of the relevant States affected by transplant tourism (evidence of state practice) plus the corresponding *opinio juris*.[182] For now, international law instruments seem to be the faster route for the prohibition of transplant tourism under international law.

181 See *North Sea Continental Shelf Cases, supra* note 17 at para. 74.

182 Bing Jia, "The Relations between Treaties and Custom" (2010) 9:1 Chin J of Int'l L 92. See also the ruling of the ICJ in *North Sea Continental Shelf Cases* at para. 71 where it stated that such treaty provision must be norm-creating: "it clearly involves treating that Article as a norm-creating provision which has constituted the foundation of, or has generated a rule which, while only conventional or contractual in its origin, has since passed into the general corpus of international law."

The best option for the prohibition of transplant tourism would be the existence of national laws which not only prohibit transplant tourism practices, but also give States the ability to prosecute their nationals who get involved in transplant tourism activities abroad. This can be achieved through the use of laws with extraterritorial criminal jurisdiction. For the purpose of regularity and uniformity, these laws need to be the product of an international law instrument which clearly defines the duties, obligations and expectations of States. The choice of such an instrument would ultimately be between a treaty or a soft law instrument such as a WHO resolution or a UN GA resolution.

The above recommendation reflects the recent direction of international law regulation. There has been a paradigm shift from reliance on or a desire for CIL to written instruments such as treaties or soft instruments, especially in areas such as human rights, international criminal law, environmental law and space law. This is especially so in new areas of human activity where no international law rules exist to address the issue. Treaties remain one of the most important sources of regulation under international law. The obligation which automatically arises after a State has ratified a treaty remains a very important tool for ensuring compliance with its provisions. Be that as it may, it is difficult to get States to sign treaties, especially treaties which place a duty on the State to impose new domestic regulations or treaties with obligations that work against the interest of the State. The reception of the *Trafficking in Human Organs Convention* illustrates this issue. As of November of 2017, it has been ratified by only 5 States. It is possible to argue, however, that the *Trafficking in Human Organs Convention* has opened the door for a future multilateral treaty on transplant tourism. While this might be a possibility, I fear that most States would not readily sign such a treaty without some form of introduction via the use of soft law.

Soft law on transplant tourism has generally been better received and adopted by States. The *Declaration of Istanbul* and the WHA resolutions have been well received by States and national transplant bodies all over the world, with a few transplant States amending their organ transplant laws and policies to reflect the mandate of these soft laws. There is a greater chance of States adopting resolutions on transplant tourism than of them ratifying treaties on the subject matter. A WHA resolution on transplant tourism would be a more effective way of gradually encouraging States to change their attitude towards transplant tourism and might eventually lead to laws criminalizing transplant tourism. Before the first of these resolutions was passed in 1987, there were no national laws prohibiting the sale of human organs. But currently, almost all States with organ transplant laws have legislation making the sale of human organs outside any regulated system of compensation illegal. What is needed

now is a resolution which focuses not only on organ commercialism but also on transplant tourism. This would have the effect of bringing transplant tourism to the forefront of regulation. It will also pass a direct message to States that the international community is serious about bringing an end to transplant tourism practices. This might in turn lead tourist States to intensify their efforts in seeking alternative ways of becoming self-sufficient in acquiring organs needed for transplantation and ultimately legislate to prevent transplant tourism. However, for such an instrument to achieve its desired purpose, it must contain some key provisions, some of which are already contained in transplant tourism-related instruments such as the *Declaration of Istanbul* and the *Trafficking in Human Organs Convention*. These provisions are discussed in greater detail in Chapter 8 of this publication.

## Conclusion

In this Chapter, I examined the sources of international law and how suitable they are to prohibit transplant tourism at international law. In doing this, the various sources of international law as enumerated in article 38(1) of the *ICJ Statute* were examined. The sources looked at in detail were CIL and treaty law. While general principles of laws are an important source of international law, this source was looked at only briefly as general principles relating to transplant tourism have yet to be applied by the ICJ in its judgments and opinions, and, in any event, any relevant general principles would only provide very limited, foundational concepts that alone would be insufficient to address all the aspects of transplant tourism. Although not a source of international law, soft laws were also examined due to their importance in the development of national and international law and the significance they have had on the regulation of transplant tourism so far. The characteristics, advantages and disadvantages of the various sources of international law were looked at as well as their current provisions regulating transplant tourism. The limits and suitability of each source were also examined.

In my analyses of CIL, I concluded that there is currently no developed international customary norm prohibiting transplant tourism. Such a norm is, however, developing as some key States have started a similar practice of transplant tourism prohibition. Even with the development of CIL against transplant tourism, I concluded that the best format for transplant tourism prohibition would be the use of extraterritorial criminal laws which permit States to prosecute their nationals who engage in transplant tourism practices abroad. I also noted that these laws should be the product of a codified

international law instrument due to the current trend in international human rights prohibition, the clarity and coverage which such instruments offer and the progress made so far in prohibiting transplant tourism through soft laws and a signed regional treaty. I also noted that States will most likely respond better to a soft law instrument on transplant tourism than a treaty due to the flexibility which soft law instruments offer to States. This instrument could later be transformed into a binding treaty.

Building on my recommendations above, Chapter 6 will focus on the prohibition of transplant tourism by States using extraterritorial criminal laws. In doing this, I will examine the concept of state jurisdiction and the bases for the exercise of extraterritorial jurisdiction over offences. Various principles used by States in their exercise of extraterritorial criminal jurisdiction such as the territorial, nationality, passive personality, protective and universality principles will be discussed with focus on the first 3 principles due to their relevance to transplant tourism. Finally, I will undertake a detailed review of the current model used to prohibit CST due to the similarities between CST and transplant tourism and the relevance of that model to the future prohibition of transplant tourism. The CST model will be modified so it is relevant to the prohibition of transplant tourism.

CHAPTER 6

# The Role of Extraterritorial Criminal Legislation in the Prohibition of Transplant Tourism

## A Introduction

As an umbrella term, transplant tourism is made up of multiple activities such as travel for transplant purposes, organ trafficking and organ commercialization. As discussed in Chapter 1, of all the various possible patterns through which transplant tourism takes place, four stand out: individuals from tourist States travelling to transplant States to buy organs; individuals from transplant States travelling to tourist States to sell their organs; individuals from different tourist and transplant States travelling to a third State to buy and sell organs; and individuals from the same tourist or transplant State travelling to a third tourist or transplant State to buy and sell organs.[1] No matter the pattern adopted, a constant factor is that transplant tourism always involves individuals from more than one State and/or practices occurring in more than one State. Travel for transplant purposes is the element which distinguishes transplant tourism from organ commercialization and trafficking. Travel for transplant purposes automatically raises jurisdictional questions. Some of these questions are: If transplant tourism becomes an offence, which State can prosecute the offenders? Where does the main element of the offence take place? Can a State prosecute an offending national who commits an offence in another jurisdiction and, if so, what rules should govern the exercise of such jurisdiction?

The answers to these questions will always involve consideration of public international law rules that govern the exercise of extraterritorial criminal jurisdiction by States. As we saw in the last two Chapters, the transnational nature of transplant tourism makes it one that cannot be prohibited without the intervention of international law. In those Chapters, I examined the various branches and sources of international law in a bid to highlight existing international law rules and norms on transplant tourism. Discussions in Chapter 5 showed that although we have started seeing the early stages of international

1 Debra Budiani-Saberi & Frances Delmonico, "Organ Trafficking and Transplant Tourism: A Commentary on the Global Realities" (2008) 8:5 Am J Transplant 926.

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law prohibition of transplant tourism, there is still a lack of tangible international laws prohibiting transplant tourism practices. The Chapter ended with suggestions on how transplant tourism should be prohibited at international law. In particular, I referred to the use of extraterritorial criminal legislation by States as a means of prohibiting their nationals from engaging in transplant tourism abroad.

Continuing from the discussions in Chapter 5, this Chapter focuses on the prohibition of transplant tourism by national legal systems using public international law principles that allow States to stretch their prescriptive jurisdiction beyond their geographical boundaries. National and international systems of laws do not always work to the exclusion of the other. Public international law, especially international human rights law, often depends on national principles and national legal systems to enforce its principles. One way that this relationship between both legal systems can be applied to transplant tourism cases is by States using extraterritorial criminal laws to prohibit and prosecute nationals who travel abroad to take part in transplant tourism activities. Discussions in this Chapter will build up to my major recommendation which is for States to use extraterritorial criminal laws in the prohibition of transplant tourism. These laws would enable States prosecute their nationals who travel abroad to engage in transplant tourism activities and return to the legislating State. This recommendation is important for two reasons. First, it acknowledges the fact that transplant tourism is a transnational activity that involves participants who are not always within the immediate reach of national enforcement mechanisms or includes activities that sometimes occur outside the geographical delimitation of an enforcing State. Secondly, it illustrates the role that States must play in the enforcement of certain international law rules and norms. This recommendation also raises an important question, i.e., why is criminalization necessary in the prohibition of transplant tourism?

This Chapter starts by explaining the elements of extraterritorial criminal jurisdiction, its establishment under international law and the justification for its use. I go on to examine the rules that guide the application of extraterritorial criminal jurisdiction by States. Paramount among these rules are the various international and national principles that govern the exercise of jurisdiction by States. Here, a distinction will be drawn between prescriptive and enforcement jurisdiction of States. The child sex tourism (CST) model, used to prosecute individuals who travel abroad to engage in sexual activities with minors, will be examined because at the core of this model is the use of extraterritorial criminal laws by States. This model will be modified to suit the prohibition of transplant tourism. This Chapter will conclude with recommendations on how

States can use extraterritorial criminal laws to prohibit transplant tourism. As has been mentioned several times in previous Chapters, only five States—Israel, Spain, India, Pakistan and the Philippines—currently have national laws against transplant tourism. There is a real need to bridge the legal lacunae on transplant tourism prohibition using extraterritorial criminal laws by States that address the peculiar nature of transplant tourism.

## B The Jurisdiction of States over Persons, Property and Transactions

The jurisdiction of States is an important factor to consider in the regulation and prohibition of transnational criminal offences. Rules regulating the jurisdiction of States help determine the powers of States to regulate activities and make and enforce laws. They also set the boundaries beyond which a State cannot exercise its powers. No matter how well-meaning a State is, it cannot enforce its laws outside of its jurisdiction except in accordance with a permissive rule of public international law.[2] The rules regulating the jurisdiction of States are in place to ensure the avoidance of conflicts between States. These rules are especially important in the regulation of international offences as they often involve elements which occur in more than one State or are perpetrated by individuals who shuttle between jurisdictions. In the prohibition of transplant tourism, for instance, the rules governing the jurisdiction of States help determine whether and how States can legislate to prohibit transplant tourism practices, including the extent to which States can stretch their jurisdiction to cover transplant tourism activities which occur in other States, and the ability of States to prosecute offenders.

Generally, there are two types of State jurisdiction: territorial jurisdiction and the jurisdiction of States over persons, property and transactions.[3] Transplant tourism is governed by the latter type of jurisdiction. Under public international law, the jurisdiction of States over persons, property and transactions refers to the power of States to regulate or control persons, property and transactions within their territories.[4] In the case of *R v Hape*,

2 See the *Case of the S.S. Lotus* (*France v Turkey*) (1927), PCIJ Series A, No. 10 at 45.

3 Territorial jurisdiction refers to the sovereignty of States over persons and activities within specific landmasses, water bodies and the air. There are several established rules and doctrines which demarcate and regulate each of these types of territories. See generally, John Currie *et al*, *International Law: Doctrine, Practice, and Theory,* 2nd ed (Ontario: Irwin Law, 2014) at 311–374.

4 See Currie *et al*, *supra* at 475.

the Supreme Court of Canada (SCC) defined jurisdiction as "a State's power to exercise authority over individuals, conduct and events, and to discharge public functions that affect them."[5] States are able to perform these functions via the use of national public laws such as constitutional law, criminal law, administrative law and tax law. With the aid of these laws, States can prescribe rules of law, enforce those prescribed rules of law and adjudicate on matters regulated by those rules. These functions can be further divided into two major types of jurisdiction.[6] The first covers the power of States to enforce its laws or take other coercive actions within its territory. This type of jurisdiction is referred to as enforcement jurisdiction. The second deals with the ability of States to make laws which are applicable to persons, properties and transactions located within and outside their borders. This is referred to as prescriptive or legislative jurisdiction and involves the use of extraterritorial laws by States. Within these two types of jurisdictions are an extended network of theories and rules that set out the ambits for the application of jurisdictional powers. I will discuss each of these types of jurisdictions below with greater emphasis on prescriptive jurisdiction as it lays down the bases for the exercise of extraterritorial jurisdiction by States.

## 1 *Enforcement Jurisdiction*

Enforcement or investigative jurisdiction refers to the ability of States to execute their laws within their territories or, with the permission of another State, in that State's territory. In *R v Hape*, enforcement jurisdiction was described as "the power to use coercive means to ensure that rules are followed, commands are executed, or entitlements are upheld."[7] It involves compelling compliance and punishing noncompliance with local laws.[8] The rules governing the enforcement jurisdiction of States cover how States enforce or compel compliance with their laws either by judicial, executive or administrative actions. Subject to a few exceptions, the enforcement powers of States

5 *R v Hape* [2007] 2 SCR 292 at para. 57.

6 Cecil Olmstead, "Jurisdiction" (1989) 14:2 Yale J Int'l L 468. Writers like Bledsoe & Boczek divide the jurisdictional powers of States into three parts: prescriptive jurisdiction, enforcement jurisdiction and judicial jurisdiction. I will however be adopting the format used by writers like Currie *et al*, *supra* note 3 at 475, who merge enforcement and judicial jurisdiction together as the capacity of the courts of a State to try legal cases is part of the enforcement ability of that State. See Robert Bledsoe & Boleslaw Boczek, *The International Law Dictionary*, (Michigan: ABC-CLIO Pub., 1987) at 102–103.

7 *R v Hape, supra* note 5 at para 58.

8 Anthony Colangelo, "What is Extraterritorial Jurisdiction?" (2014) 99:6 Cornell L Rev 1311.

are narrow and generally confined to their sovereign territories. States are thus permitted to, for example, arrest individuals or confiscate properties if those individuals and properties are within their territories. This rule of international law is tied to the sovereignty of States which works in two ways. First, it protects the integrity of States and shields them from violation by the actions of other States.[9] This is especially important to protect weaker States from the actions of more powerful States. Secondly, it places a corresponding duty on all States to respect the rights of other States not to be violated.[10] International law does not permit a State to enforce its laws in the territory of another State without the permission of that other State. If a State does this without permission, it will amount to an infringement of the sovereign powers of that other State.

One of the first statements on the restrictive rules governing the enforcement jurisdiction of States was made by the Permanent Court of International Justice (PCIJ) in the *Case of the* S.S. *Lotus* (*France v Turkey*) (*Lotus Case*).[11] In that case, the PCIJ noted that: "The first and foremost restriction imposed by international law upon a State is that—failing the exercise of a permissive rule to the contrary—it may not exercise its power in any form in the territory of another State."[12] This rule, for instance, prevents a State from arresting an individual in another State without the express permission of that other State.[13] This general rule against extraterritorial enforcement jurisdiction is, however, not absolute. As the *Lotus Case* notes, this rule can be waived by "a permissive rule to the contrary."[14] The Court went on to state that these permissive rules are derived from customary international law (CIL) or treaties.[15] A good example of such a permissive rule is the CIL rule permitting universal jurisdiction

9 Malcom Shaw, "*International Law*," 5th ed (Cambridge: Cambridge University Press, 2003) at 577.

10 See the *Island of Palmas Case* (*United States v The Netherlands*), (1928) 2 RIAA 839.

11 *Lotus Case, supra* note 2 at 28.

12 *Ibid* at para. 45.

13 There have been cases where States have acted contrary to these rules and arrested individuals in other jurisdictions without the authorization of those States. While this is an obvious contravention of international law rules, they often do not affect the jurisdiction of the courts of the defaulting States to try those cases. See for instance the cases of *US v Alvarez-Machain* [1992] 504 US 655 and *A.G. Israel v Eichmann* [1961] 36 ILR. 5 (Dist. Ct. Jerusalem).

14 Cedric Ryngaert, *Jurisdiction in International Law*, 2nd ed (Oxford: Oxford University Press, 2015) at 31.

15 *Lotus Case, supra* note 2 at para. 45.

over piracy due to the fact that it is a common menace to all States.[16] As a general rule of international law, States are also permitted to enter into separate agreements granting permission to each other to exercise enforcement jurisdiction in each other's territory.[17]

The above noted limitations on enforcement jurisdiction have implications for the prohibition of transplant tourism by both transplant and tourist States. Transplant States like the Philippines and India which have laws against transplant tourism can enforce those laws against defaulters over whom they have territorial control. These include their resident nationals who sell and facilitate the sale of organs. They can also prosecute foreigners who come into their State to buy organs if the foreigners are apprehended while still physically present in that State. However, in the absence of an agreement between these transplant States and the tourist States where the organ buyers come from, transplant States are unable to enforce their rules against tourists who leave and travel back to their home States or a third State, after successful organ transplantations.[18] This automatically places the duty of enforcing transplant tourism laws against foreigners on their States of origin or permanent residence. The challenge with this system of enforcement is that the rules governing the buying and selling of organs differ from State to State. While it is illegal to buy and sell an organ in some States, it is only illegal to do one or the other in some other States.[19] Although the key tourist States have laws that make it illegal to buy and sell organs, these laws do not make it illegal to do the same in a different State. What this means is that a foreigner who travels to a transplant State to buy an organ and have it transplanted there can come back to his home State and avoid prosecution both by the transplant State, due to the limitations of their enforcement jurisdiction under public international law, and by the tourist State due to the absence of

16 See individual opinion of President Gilbert Guillaume in, *Arrest Warrant of 11 April 2000* (*Democratic Republic of Congo v Belgium*) (2002) ICJ Rep. 3 at para 5; article 19, *Convention on the High Seas* 13 UST 2312; 450 UNTS 11. See also: Roger O'Keefe, *International Criminal Law*, 1st ed (Oxford: Oxford University Press, 2015) at 18; Anja Seibert-Fohr, *Prosecuting Serious Human Rights Violations* (Oxford: Oxford University Press, 2009) at 255.

17 Shaw, *supra* note 9 at 584.

18 The right to prosecute is lost after a foreigner leaves a State. The only legal recourse of that State then would be extradition of that individual back to that State by his/her current State of residence. This is made possible by the terms of extradition treaties. The use of extradition treaties will be discussed in greater detail in the next Chapter.

19 Emily Kelly, "International Organ Trafficking Crisis: Solutions Addressing the Heart of the Matter" (2013) 54:3 BCL Rev 1318.

domestic laws in the latter State prohibiting transplant tourism. Also, extradition of such a person to the transplant State to be prosecuted might not be possible due to lack of fulfilment of the double criminality rule.[20] Thus, this current loophole in the global prohibition of transplant tourism makes the sale of human organs a crime that exempts certain individuals from prosecution by default. This legal lacuna can, however, be remedied if States can extend their legislative jurisdiction beyond their boundaries using extraterritorial laws. This is made possible through international law principles which permit States to exercise extraterritorial prescriptive jurisdiction.

## 2 *Prescriptive Jurisdiction and the Use of Extraterritorial Criminal Laws*

Extraterritorial criminal jurisdiction refers to the ability of States to exercise criminal jurisdiction beyond their territorial limits.[21] Traditionally, the jurisdiction of States is first and foremost territorial.[22] This traditional view of jurisdiction has its roots in the concept of State sovereignty which refers to the independence of States and their ability to exercise exclusive control over people, property and transactions within their territories.[23] The classic international law connection between jurisdiction and territory was made to ensure that State governments do not interfere with the sovereignty of other States, thereby avoiding conflicts. Another argument in favor of tying jurisdiction to territory is that it removes uncertainty from the exercise of jurisdiction by States.[24]

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20 The double criminality rule is a rule contained in the extradition laws of many States. By this rule, a State will not extradite a suspect to the jurisdiction of a foreign State to stand trial for breaking the laws of that foreign State if there isn't a similar law in the extraditing State. See generally: Sharon Williams, "The Double Criminality Rule and Extradition: A Comparative Analysis" (1991) 15:2 Nova L Rev 581; Sharon Williams, "The Double Criminality Rule Revisited" (2014) 27:1–2 Isr L Rev 297.

21 Colangelo, *supra* note 8 at 1312; Deborah Senz & Hilary Charlesworth, "Building Blocks: Australia's Response to Foreign Extraterritorial Legislation" (2001) 2:1 Melb J Int'l L 72.

22 *Lotus Case, supra* note 2 at 45; *Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territory*, ICJ General List No. 131, Advisory Opinion, 9 July 2004 (*Israeli West Bank Barrier Case*), para 109.

23 In the 1910 *North Atlantic Coast Fisheries Case* (*Great Britain v US*), (1961) XI RIAA at 167, the Permanent Court of Arbitration noted that an essential element of sovereignty is that it is exercised within State limits. See also: *Island of Palmas Case, supra* note 10 at 838; Winston Nagan & Aitza Haddad, "Sovereignty in Theory and Practice" (2012) 13:2 San Diego Int'l L J 435–436.

24 Michael Farbiarz, "Extraterritorial Criminal Jurisdiction" (2016) 114:4 Mich L Rev 509.

International law on jurisdiction has, however, changed over time to permit States to exercise jurisdiction over persons, events and properties outside of their jurisdiction if one or more of the accepted bases for permitting extraterritorial prescriptive jurisdiction have been satisfied. The use of extraterritorial criminal legislation by States has become more prevalent in the 21st century.[25] As a separate opinion in the 2002 ICJ case of *Arrest Warrant of 11 April 2000* (*Democratic Republic of Congo v Belgium*) (*Arrest Warrant Case*), there is "a gradual movement towards bases of jurisdiction" other than territory which reflects the current values of States.[26] The current values of States are in turn influenced by many factors. Globalization is one such factor.[27] The current affordability of global travel, advances in telecommunication and technology and the liberalization of economies around the world has made it easier for individuals to travel and enter into commercial deals which cut across States.[28] They have also increased the opportunities for individuals to commit crimes outside the jurisdiction of their home States. With the commission of extraterritorial offences comes the potential for jurisdictional claims of States to overlap.[29] Due to the above noted reasons, international law now permits States to extend the exercise of their jurisdiction to cover activities which do not occur within their territories via extraterritorial criminal legislation when one or more of the CIL principles governing extraterritorial prescriptive jurisdiction have been satisfied.

The PCIJ in the *Lotus Case* laid down the basic principles which should govern the exercise of extraterritorial criminal jurisdiction. In that case, the Court stated that:

> It does not, however, follow that international law prohibits a State from exercising jurisdiction in its own territory, in respect of any case which

25 Danielle Ireland-Piper, "Extraterritorial Criminal Jurisdiction: Does the Long Arm of the Law Undermine the Rule of Law" (2012) 13:1 Melb J Int'l L 123. See also, *Israeli West Bank Barrier Case*, *supra* note 22.

26 See Joint Separate Opinion of Judges Higgins, Kooijmans and Buergenthal in *Arrest Warrant Case, supra* note 16 at para 73.

27 Hugh King, "Extraterritorial Human Rights Obligations of States" (2009) 9:4 Hum Rts L Rev 522.

28 See for instance the *General Agreement on Trade in Services* (GATS), WTO Agreement, Annex 1B, 1869 UNTS 183; 33 ILM 1167 (1994) and the *General Agreement on Tariffs and Trade* 1994 (GATT 1994), WTO Agreement, Annex 1A, 1867 UNTS 187; 33 ILM 1153 (1994) which have liberalized international trade and made it easier for individuals to provide services in foreign jurisdictions.

29 Ireland-Piper, *supra* note 25 at 129.

> relates to acts which have taken place abroad, and in which it cannot rely on some permissive rule of international law. Such a view would only be tenable if international law contained a general jurisdiction of their courts to persons, property and acts outside their territory, and if, as an exception to this general prohibition, it allowed States to do so in certain specific cases. But this is certainly not the case under international law as it stands at present. Far from laying down a general prohibition to the effect that States may not extend the application of their laws and the jurisdiction of their courts to persons, property and acts outside their territory, it leaves them in this respect a wide measure of discretion which is only limited in certain cases by prohibitive rules; as regards other cases, every State remains free to adopt the principles which it regards as best and most suitable.[30]

This portion of the *Lotus Case* appears to grant States a wide discretion on when to exercise extraterritorial prescriptive jurisdiction, subject only to a few prohibitive rules. This interpretation of the PCIJ's opinion could, however, lead to conflicts between States as the exercise of extraterritorial prescriptive jurisdiction by a State could conflict with the national laws and policies of other States. As discussed further below, there are different bases for exercising prescriptive extraterritorial jurisdiction, some of which are more generally accepted. In practice, there are standards and guidelines which are applied to limit the ambit of the exercise of prescriptive jurisdiction by States. In the *Arrest Warrant Case,* President Gilbert Guillaume stated in an individual opinion that the exercise of prescriptive jurisdiction by a State is limited to cases where the victim or offender is a national of that State or if the crime threatens the internal or external security of the State.[31] Although the judge in the above case was willing to acknowledge the exercise of extraterritorial prescriptive jurisdiction only in very limited situations, States often exercise extraterritorial prescriptive jurisdiction in more situations. In Canada, for instance, its policy governing the exercise of extraterritorial prescriptive jurisdiction is not to exercise it in ways which could create conflict with the laws and policies of other States.[32] Generally, States exercise prescriptive jurisdiction based on five principles, namely: territorial, nationality, passive personality, protective

30 *Lotus Case, supra* note 2 at para. 46.

31 *Arrest Warrant Case, supra* note 16 at para. 4

32 Colleen Swords, "Canadian Practice of International Law at the Department of Foreign Affairs in 2001–2: Jurisdiction and Territorial Sovereignty, Extraterritorial Evidence Gathering" (2002) 40 Can YB Int'l L 494–495. In the US, prescriptive jurisdiction will not

and universality principles.[33] Each of these principles will be discussed below. Of the five principles, only the first three will be relevant in the prohibition of transplant tourism. These three principles all have extraterritorial aspects.

### i Territorial Principle

The territorial principle refers to the ability of States to make laws and rules which govern persons, property and transactions within their territories. Of all the principles governing the use of prescriptive jurisdiction by States, this is the most straightforward and dominant. As noted in discussions under the enforcement jurisdiction of States, States have sovereign rights over matters which occur within their territories and can legislate over any matter within their territories. This rule covers all persons within the territory of a State regardless of their nationality. This is a long-standing principle of international law borne of convenience and practicality. It is only logical that since States have immediate control over their nationals and transactions which occur within their territories, they are in the best position to dictate how nationals conduct their activities locally to ensure that law and order is maintained always.[34] The territorial principle of enforcement is, however, not without limitations. Under international law, certain individuals enjoy immunities from the territorial jurisdiction of States for the maintenance of peace and cooperation among States.[35] These individuals include diplomats, consular representatives, international organization officials and State representatives/officials while acting in their official capacity. The nature and extent of the immunities granted to these individuals are determined by treaty and CIL.[36]

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be exercised when it is deemed to be "unreasonable." See *Restatement (Third) of Foreign Relations Law of the United States § 403. (Limitations on Jurisdiction to Prescribe).*

33 Swords, *ibid;* Am Soc'y Int'l L, "Jurisdictional, Preliminary, and Procedural Concerns" in Diane Amann, ed, *Benchbook on International Law* (Washington DC: ASIL, 2014) at II.A-2.

34 See Shaw, *supra* note 9 at 581; Currie *et al*, *supra* note 3 at 492.

35 See Joint Separate Opinion of Judges Higgins, Kooijmans and Buergenthal in *Arrest Warrant Case, supra* note 16 at para 73; Hazel Fox, *The Law of State Immunity*, 3rd ed (Oxford: Oxford University Press, 2015) at 673.

36 There is currently a *United Nations Convention on Jurisdictional Immunities of States and Their Property,* UN Doc. A/RES/59/38 (2005), which codifies the CIL rules governing State Immunities. This instrument is however not yet in force. See also Dapo Akande & Sangeeta Shah, "Immunities of State Officials, International Crimes, and Foreign Domestic Courts" (2010) 21:4 Eur J Int'l L 815; articles 28 & 31, *Vienna Convention on Diplomatic Relations,* 500 UNTS 95; 23 UST 3227; 55 AJIL 1064 (1961); article IV, section 11, *Convention of the Privileges and Immunities of the United Nations*, 1 UNTS 15/(1949) ATS 3; article 21, *Convention on Special Missions*, 1400 UNTS 231/9 ILM 127 (1970).

The rules governing the application of the territorial principle sometimes lend themselves to complexities. There are ambiguous situations like where one part of an offence is performed on the territory of one State and the other part is performed on the territory of another State. A common analogy used is that of a man standing at the border of one State who shoots another individual in a different State.[37] Different States have taken different approaches to situations where only one component of an offence has occurred on their territory. Generally, both States where the offence is commenced and concluded will have jurisdiction to try the case. In the *Lotus Case,* the PCIJ stated that "offences, the authors of which at the moment of commission, are in the territory of another State, are nevertheless to be regarded as having been committed in the national territory, if one of the constituent elements of the offence, and more especially its effects, have taken place there."[38] In the US, the "effects test" is used to extend jurisdiction to acts which occur entirely outside the State.[39] Under Canadian law, a "real and substantial connection" test is used to determine whether a criminal act falls within the prescriptive jurisdiction of Canada. This test was first used by the Supreme Court of Canada in the case of *Libman v The Queen*.[40] Justice La Forest stated that for an offence to be subject to Canadian law and the jurisdiction of Canadian courts, "a significant portion of the activities constituting that offence" must take place in Canada.[41] He went on to state that it is sufficient that "there be a 'real and substantial link' between the offence and the country [Canada]."[42] In applying this test, the Courts try to respect other States and ensure that international comity would not be offended.[43]

The Libman test for territorial jurisdiction has far-reaching effects for the future criminal law prohibition of transplant tourism in Canada. The sale of organs is illegal in most States of the world under both national laws and ratified or transformed international human rights law. Applying the territorial principle, most States, including Canada, would have jurisdiction over organ sale

37 Shaw, *supra* note 9 at 591.

38 *Lotus Case, supra* note 2 at para 60.

39 See *US v Aluminium Co of America* (*Alcoa*) 148 F.2d 416 (2d Cir 1945); *Hartford Fire Ins. Co. v California* [1993] 509 US 764; contra "Balancing Test" in *Timberlane Lumber Co. v Bank of America* [1976] 549 F.2d 597.

40 See *Libman v The Queen* [1985] 2 SCR 178. See also the case of *SOCAN v CAIP* [2004] 2 SCR 427; *R v Hape, supra* note 5.

41 *Libman v The Queen*, *ibid* at para. 74.

42 *Ibid.*

43 *Ibid* at para. 76.

activities which occur within their territories. If, for example, a tourist travels to a transplant State with a law against organ commercialization to buy an organ and is apprehended in that transplant State, that transplant State would have jurisdiction to prosecute the tourist for the offence. The same rules would apply if an individual is brought into a tourist State for organ sales. A more complex situation would occur where, for instance, organ brokers in one State arrange for an organ sale transaction in another State. Whether a State would have jurisdiction over such a matter would depend on the test applied by that State. In Canada, the "real and substantial connection test" could cover such situations as it does not matter if the victims are harmed outside the State.[44] Preparatory activities in Canada to carry out the offence are sufficient for a link to be established between Canada and that offence.[45] Most tourist States do not however prosecute their nationals for purchasing organs in another State.[46] Tourist States are thus conducive venues for international organ brokers to thrive in.

### ii Nationality Principle

Under the nationality principle, States exercise prescriptive jurisdiction on the basis that the alleged perpetrator of an offence is one of their nationals, and, in some cases, a corporation incorporated under their laws. Here, States can exercise jurisdiction over extraterritorial actions based on this connection. This principle is based on the notion that a State is always linked to its nationals independent of location.[47] States set rules concerning nationality and citizenship based on their laws and policies.[48] In the *Nationality Decrees in Tunis and Morocco Case*, the PCIJ noted that questions of nationality are in principle within the reserved domain of States.[49] Nationality extends beyond individuals to cover ships, aircrafts and corporations.[50] Corporations are often the creation

44 *Ibid* at para. 72.

45 *Ibid.*

46 The organ transplant laws in Canada regulate only organ transplant activities within the State. In Alberta for instance, the *Human Tissue and Organ Donation Act* only penalizes the sale of organs within the province. See ss 3(2) & 13 (3), the *Human Tissue and Organ Donation Act,* SA 2006, c.H-14.5

47 Bledsoe & Boczek, *supra* note 6 at 103.

48 In Canada, several laws define who are Canadian nationals. Ss 3–5 of the *Citizenship Act*, RSC 1985, c. C-29, defines who is a Citizen and how to become a Canadian citizen.

49 See *Nationality Decrees in Tunis and Morocco Case,* PCIJ, Series B, No. 4, 1923 at 24.

50 See Herman Meyers, *The Nationality of Ships* (New York: Springer, 2012); article 91, *United Nations Convention on the Law of the Sea,* 1833 UNTS 3; 21 ILM 1261 (1982); article 17, *Chicago Convention on International Civil Aviation*, 61 Stat. 1180; 15 UNTS 295.

of domestic laws.[51] In *Barcelona Traction, Light and Power Company, Limited* (*Belgium v Spain*) the ICJ held that corporate nationality is based on where a company is incorporated or the location of its head office.[52] The benefit of the nationality principle is that it ensures that nationals cannot evade prosecution by going abroad to engage in activities which are crimes in their own States.[53] Typically, a State extends the application of its criminal laws extraterritorially to cover crimes which the State deems to be so reprehensible as to warrant the exercise of its jurisdiction extraterritorially. This decision is often a reflection of a State's policies against such activities. States also extend the exercise of their criminal legislation extraterritorially due to their obligations under international law.

Of all the principles used by States in their exercise of extraterritorial criminal prescriptive jurisdiction, the nationality principle is the one which is most relevant to transplant tourism. The reason for this is that although there are multiple persons involved in transplant tourism practices, some of whom do not have to leave their home States, transplant tourism always involves the travel of at least one person from one territory to another. The most common mode of travel involves a patient from a tourist State going to a foreign transplant State to buy an organ and undergoing the transplantation process in the transplant State. The exercise of extraterritorial jurisdiction by tourist States over their nationals will ensure that transplant patients do not escape prosecution when they return to their States of origin. Currently, due to lack of transplant tourism laws in tourist States, nationals of tourist States can travel to transplant States, purchase organs, go through the organ transplant process and return to their States of origin free from prosecution. If tourist States decide to extend their organ transplant laws to cover the actions of their nationals who engage in illegal travels for organ transplantation, it would help to bridge the gap in the global regulation and prohibition of transplant tourism.

### iii Passive Personality Principle

Like the nationality principle, the passive personality principle is linked directly to nationality and is based on the need for States to protect their nationals abroad.[54] Under the passive personality principle, a State can exercise

51 See Currie *et al*, *supra* note 3 at 505.

52 *Barcelona Traction, Light and Power Company Limited* (*Belgium v Spain*), (1970) ICJ Rep. 3 at para. 70.

53 Paul Arnell, "The Case for Nationality Based Jurisdiction" (2001) 50:4 Int'l & Comp L Q 959.

54 John McCarthy, "The Passive Personality Principle and its Use in Combatting International Terrorism" (1989) 13:3 Fordham Int'l L J 301; *Lotus Case, supra* note 2 at para. 195.

extraterritorial jurisdiction when a national of the State, outside the territory of that State, is the victim of an offence.[55] For the passive personality principle to apply, two qualifications must be met.[56] The first is that the victim must be a national of the State applying the principle. States can, however, choose to limit the individuals covered by this principle. In Canada, for instance, this principle is sometimes limited to cover only citizens and not other nationals like permanent residents.[57] The second qualification is that the act must have occurred outside the territory of the State.[58]

The application of the passive personality principle remains controversial.[59] In the *Lotus Case*, all six dissenting judges rejected the application of the principle. Per Lord Finlay, the correct response of the victim's State is to "bring pressure to bear upon the government of the offender to have him brought to justice, but it has no right to assert for this purpose in its own courts a jurisdiction which they do not possess."[60] Despite the hesitation of States to make use of the passive personality principle, it has gained more support in the last few decades. However, the acceptable usage of the passive personality principle is limited to serious crimes like terrorism, hostage taking and torture.[61] In this way, States limit their interference in the jurisdiction of other States.

The passive personality principle can now be found in treaties and national laws of States. In laying down the bases on which a State can take jurisdiction over offences under the *International Convention Against the Taking of Hostages* (*Hostages Convention*), article 5(1)(d) states that States shall exercise jurisdiction where a hostage is one of its nationals.[62] This principle has been introduced into some Canadian laws. For example, Section 8 of the *Crimes Against*

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55 Shaw, *supra* note 9 at 589; Ivan Shearer, *Starke's International Law,* 11th ed (Toronto: Butterworths, 1994) at 210; Geoff Gilbert, *Responding to international Crime* (Leiden: Martinus Nijhoff Pub., 2006) at 88.

56 *US v Yunis* [1991] 924 F.2d 1086.

57 See section 8 of the Canadian *Crimes Against Humanity and War Crimes Act*, SC 2000, c. 24. The Act adopts a very conservative application of this principle. The principle only applies when the victim is a citizen of Canada. It does not extend to permanent residents.

58 *US v Yunis, supra* note 56 at 1091.

59 Geoffrey Watson, "The Passive Personality Principle" (1993) 28:1 Texas Int'l L J 2; Robert Cryer *et al, An Introduction to International Criminal Law and Procedure* (Cambridge: Cambridge University Press, 2010) at 49; Ryngaert, *supra* note 14 at 92.

60 *Lotus Case, supra* note 2 at 56.

61 McCarthy, *supra* note 54 at 307–308.

62 See article 5(1)(d), *International Convention against the Taking of Hostages,* GA Res. 34/146 (XXXIV), 34 UN GAOR Supp. (No. 46) at 245, UN Doc. A/34/46 (1979); 1316 UNTS 205; TIAS No. 11081; 18 ILM 1456 (1979).

*Humanity and War Crimes Act* states that a person who commits an offence under the Act can be prosecuted if the victim of the offence is a Canadian citizen.[63] The passive personality principle can also be found in provisions of the *Criminal Code* of Canada.[64]

Considering the two major qualifications for the application of the passive personality principle, i.e., nationality and extraterritoriality of the offence, it may have some relevance in the prohibition of transplant tourism. As noted in the beginning of this Chapter, one slightly different transplant tourism pattern involves the transfer of an individual from a transplant State to sell his/her organ in another transplant or tourist State. The organ seller's State might be able to exercise jurisdiction over the other parties to the act if they deem that their national has been victimized. If this type of extraterritorial jurisdiction is assumed, organ brokers and traffickers can be prosecuted under the laws of transplant States from which their nationals have been trafficked abroad to sell their organs.

### iv Protective Principle

The protective principle allows States to exercise jurisdiction over individuals who commit crimes which threaten the State's security and economic interests even when those crimes are committed outside the territory of the State.[65] Essentially, any State using the protective principle is exercising its legitimate right of self-defense.[66] If this principle is not used by States as a means of exercising jurisdiction over such offences, the perpetrators might go unpunished and cause more harm in future especially since the actions of the perpetrators might not be crimes in the State where they are committed. While there is not a closed list of which offences warrant the exercise of this jurisdiction, it is used for acts which threaten the sovereignty of a State such as treason and espionage.[67] Having said this, the implementation of this principle is not governed by clear rules stating when the interest or security of a State has been sufficiently affected.[68]

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63 See section 8(a)(III), *Crimes Against Humanity and War Crimes Act*, *supra* note 57.

64 See for e.g., ss 7(2.31), 7(3.1), & 7(3.7), *Criminal Code* of Canada, RS 1985, c. C-46.

65 Shaw, *supra* note 9 at 591; Shearer, *supra* note 55 at 211.

66 Monika Krizek, "The Protective Principle of Extraterritorial Jurisdiction: A Brief History and an Application of the Principle to Espionage as an Illustration of Current United States Practice" (1988) 6:2 BU Int'l L J 339.

67 Ilias Bantekas & Susan Nash, *International Criminal Law* (London: Routledge, 2009) at 83; Alejandro Chehtman, *The Philosophical Foundations of Extraterritorial Punishment* (Oxford: Oxford University Press, 2010) at 73.

68 Shaw, *supra* note 9 at 590.

The protective principle has been introduced into national laws and treaties to ensure that certain offences do not escape prosecution. Article 5 of the *Hostages Convention* applies this principle to hostage situations.[69] Under Canadian law, section 7 of the *Criminal Code* extends the application of Canadian criminal law jurisdiction to cover offences such as offences committed on aircraft registered in Canada, offences against internationally protected persons, offences involving hostage taking, and offences relating to nuclear materials.[70] When the accused is not a Canadian citizen, the *Criminal Code* lays down additional rules for the prosecution of such an individual.[71] Since transplant tourism does not ordinarily include acts falling within the scope of the protective principle, this principle has no direct applicability to transplant tourism.

### v Universal Principle

In a broad sense, the universal jurisdiction principle permits States to exercise jurisdiction over certain offences no matter where those offences are committed, without the requirement of any connection between the State and the offence or the offender. The universal principle of jurisdiction is different from the other principles as it does not require any form of connection between a State and a person or action for it to be exercised. The exercise of universal jurisdiction by States is saved for offences which are deemed to be the most heinous by the international community.[72] It has also been suggested that offences within this group are those which involve the alleged violation of a norm of *jus cogens*.[73] International law permits the exercise of universal jurisdiction by States because it ensures that certain grievous offences do not go unpunished and reduces the chances of the perpetrators of those offences becoming repeat offenders.[74]

Understandably, the exercise of universal jurisdiction can be contentious because it gives States the power to exercise jurisdiction over matters which would ordinarily be outside their jurisdiction. This in turn could interfere with the sovereignty of other States. However, the application of this principle under international law is not without guidelines. The universal principle is usually applied to those offences which are expressly provided for by treaties

69 See article 5, *Hostages Convention, supra* note 62.

70 See section 7, *Criminal Code* of Canada, supra note 64.

71 *Ibid,* section 7(7).

72 See *Arrest Warrant Case, supra* note 16; See Shaw, *supra* note 9 at 593.

73 Shaw, *ibid* at 595.

74 Currie *et al*, *supra* note 3 at 511.

or have long been established under rules of CIL. Piracy is one such offence which is globally deemed to be subject to the universal jurisdiction of all States pursuant to both CIL and article 105 of the *UN Convention on the Law of the Sea.*[75] The application of universal jurisdiction to international crimes like genocide remain contentious. Genocide has been recognized by some States as a crime which warrants the application of universal jurisdiction.[76] While some jurists argue that the *Convention on the Prevention and Punishment of the Crime of Genocide* (*Genocide Convention*) provides for the exercise of universal jurisdiction over the offence of genocide, there are other views to the contrary.[77] A more direct method of ascertaining whether or not an offence is one over which universal jurisdiction can be exercised is to look at the laws and policies of individual States. In Canada, for instance, universal jurisdiction is exercised over the offences of genocide, crimes against humanity or war crimes committed outside Canada by section 6 of the *Crimes Against Humanity and War Crimes Act*.[78] However, in practice, Canada adopts the custodial approach and limits the exercise of this jurisdiction to instances where the accused is resident in the State.[79]

While the types of serious international crimes which fall under universal jurisdiction might remain contentious, transplant tourism is currently not an act over which States can exercise universal jurisdiction. As was noted in the

75 Article 105, *United Nations Convention on the Law of the Sea, supra* note 50. See also: article 19, *Convention on the High Seas* 13 UST 2312; 450 UNTS 11; *Arrest Warrant Case, supra* note 16 at para 5

76 See *A.G Israel v Eichmann*, *supra* note 13 at 19; Section 6, *War Crimes Act*, *supra* note 57; Covey Oliver, "The Attorney-General of the Government of Israel v. Eichmann" (1962) 56:3 Am J Int'l L 805; Amnesty International, *Eichmann Supreme Court Judgement: 50 Years on, Its Significance Today* (London: Amnesty International, 2012) at 6.

77 See the case of *Application of the Convention on the Prevention and Punishment of the Crime of Genocide* (*Bosnia and Herzegovina v. Serbia and Montenegro*), (2007) ICJ Rep. 2 at para. 183, where the court held that the obligation to prosecute genocide under article VI of the *Genocide Convention* is subject to territorial limits. *Contra*: separate opinion of Judge Lauterpacht in the same case where he argued that the Convention endorsed the application of universal jurisdiction to the crime of genocide. See generally: *Convention on the Prevention and Punishment of the Crime of Genocide*, 78 UNTS 277 (1948); Mitsue Inazumi, *Universal Jurisdiction in Modern International Law: Expansion of National Jurisdiction for Prosecuting Serious Crimes Under International Law* (Cambridge: Intersentia Publishers, 2005) at 155.

78 See section 6, *Crimes Against Humanity and War Crimes Act*, *supra* note 57.

79 See Robert Currie & Ion Stancu, "R v. Munyaneza: Pondering Canada's First Core Crimes Conviction" (2010) 10:5 Int'l Crim L Rev 836.

last Chapter, there is currently no CIL or treaty law in force prohibiting transplant tourism. If such laws do come into existence in the future, it is doubtful that transplant tourism will be seen as an offence in the same category as piracy or genocide which warrants the exercise of universal jurisdiction by any or all States over the perpetrators.

## C The Exercise of Extraterritorial Criminal Jurisdiction by Tourist States

Despite the earlier reluctance of States to exercise extraterritorial criminal jurisdiction, States have come to embrace it as being indispensable in the prohibition of certain offences. There is currently a plethora of offences over which States exercise extraterritorial criminal jurisdiction based on one or more of the five principles of extraterritorial criminal jurisdiction examined above. There are various reasons why States make use of extraterritorial criminal laws. One is where the nature of the offence includes an international element. An example of such an offence is CST which involves the commission of sexual offences against minors in foreign jurisdictions. Other reasons why States use extraterritorial criminal laws include: offences committed abroad which affect the integrity, interest or safety of that State, offences which are contrary to certain principles of that State, or the State is obligated under international law to exercise extraterritorial jurisdiction. Focusing on transplant tourism, I will below examine the use of extraterritorial criminal legislation by two key tourist States, Canada and the US. The purpose of this examination is to see how both States legislate against offences using extraterritorial criminal laws and if transplant tourism is one which would be best regulated at the State level with such laws. As will be seen below, several States adopt different approaches to the use and enforcement of extraterritorial criminal laws.

### 1 *The United States*

As with other States, the territorial principle of jurisdiction is the most common basis for the exercise of jurisdiction by the US.[80] Traditionally, US courts have been reluctant to try cases where the crime is committed in another jurisdiction, whether or not the crime involves a US citizen or is otherwise connected to the US. In 1892, the US Supreme Court stated in the case of *Huntington v*

80 Christopher Blakesley, "United States Jurisdiction over Extraterritorial Crime" (1982) 73:3 J Crim L Criminol 1114.

*Attrill* that jurisdiction in criminal matters rested solely with the judiciary of the government of the country or state where the crime was committed.[81] In restating this position, Justice Oliver Wendell Holmes in 1909 stated that "All legislation is prima facie territorial."[82] This same reasoning was applied in several 19th century and early 20th century cases in the US.[83] The mid and late 20th century witnessed a modification of this rule by the Courts which were now willing to defer to the extraterritorial application of US laws where provided for by statutes.[84] An example of a statute which encourages the extraterritorial extension of criminal jurisdiction is the *Model Penal Code* (MPC) which was passed in 1962 to standardize criminal laws in the US.[85] Adopted by most states, the Code permits jurisdiction over offences where either the conduct or result of an offence occurs within a state.[86] The application of extraterritorial criminal jurisdiction in the US, however, remains an exception. In the recent 2013 case of *Kiobel v Royal Dutch Petroleum Co*., Chief Justice Roberts restated the prevailing position that there shall be no application of extraterritorial jurisdiction unless a statute gives clear indication to the contrary.[87] This indication could be express or implied.

There are currently several US federal and state statutes which expressly or by implication provide for the application of extraterritorial criminal jurisdiction. Title 18 of the *US Code*, which regulates federal crimes and criminal procedure, uses the territorial principle to provide for the application of federal criminal law over certain conduct. Section 7 of Title 18 places some acts within the jurisdiction of the US when they occur "within the special

81 See *Huntington v Attrill* [1892] 146 US 657 at 669.

82 *Am. Banana Co. v United Fruit Co* [1909] 213 US 347 at 357.

83 In the early case of *Stewart v Jessup*, the Indiana Supreme Court made this principle clear when it stated that: "a person is not subject to conviction and punishment in this state for a crime committed outside the state." See *Stewart v Jessup* [1875] 51 Ind. 413 at 416. See also: *Brown v US* [1910] 35 App. D.C. 548 at 557; *US v Nord Deutscher Lloyd* [1912] 223 US 512 at 517; Cherif Bassiouni, *International Criminal Law Vol. II: Multilateral and Bilateral Enforcement Mechanisms* (The Netherlands: Brill, 2008) at 98.

84 See *Chief Justice Rehnquist in EEOC v Arabian Am. Oil Co.* [1991] 499 US 244 at 248.

85 1040 *Model Penal Code*, Miscellaneous 1985 (MPC); Blakesley, *supra* note 80 at 1119.

86 Section 1.03(1), MPC, *ibid.*

87 *Kiobel v Royal Dutch Petroleum Co* [2013] 113 S. Ct. 1659 at 1664; Benjamin Thompson, "Was Kiobel Detrimental to Corporate Social Responsibility?: Applying Lessons Learnt from American Exceptionalism" (2014) 30:78 Utrecht J Int'l Euro L 82; Zachary Clopton, "Replacing the Presumption against Extraterritoriality" (2014) 94:1 Boston Uni L Rev 2. Note that although *Kiobel v Royal Dutch Petroleum Co* did not concern criminal law, it deals with the *Alien Tort Claims Act* which is a jurisdictional statute for civil claims.

maritime and territorial jurisdiction of the United States."[88] Some of these acts include acts which occur on the high seas, acts which occur in aircraft belonging to the US, acts which occur in a US spacecraft when in flight, offences by or against a US national which occur outside the jurisdiction of the US and offences by or against a US national which occur on a foreign vessel scheduled to depart from or arrive in the US.[89] State laws rarely provide for the exercise of extraterritorial jurisdiction except in a few cases where there is a direct link between an act and the state. According to Charles Doyle, some instances of this include cases where some elements of an offence are committed within the state, where there is a conspiracy outside the state to commit an office within the state and where there is a conspiracy within a state to commit an act outside the state.[90]

Aside from the territorial principle, other principles have been used by the US to extend its criminal jurisdiction beyond its territory. The nationality principle for instance is used to prosecute US nationals who commit certain crimes abroad such as hostage taking and genocide.[91] The passive personality principle has been used by the US to protect its nationals abroad from activities such as terrorism.[92] The US also extends its extraterritorial criminal jurisdiction using a so-called "effects doctrine." The *US v Aluminum Company of America Case* (*Alcoa Case*) shows the use of this principle as it applies to the *Sherman Antitrust Act.*[93] In this case, the US extended its antitrust laws to cover acts which occur entirely outside the US but which have effects within the US.[94]

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88 See *Crimes and Criminal Procedure, 18 U.S.C.* § 7 for definition of "special maritime and territorial jurisdiction of the United States."

89 *Ibid.*

90 Other examples noted by him include where the victim of a homicide attacked outside the state dies in the state, were stolen property is brought into the state and where an act outside the state does not comply with a legal duty imposed by a state law. See Charles Doyle, *Extraterritorial Application of American Criminal Law* (Collingdale: Diane Pub., 2010) at 18–19.

91 See *Hostage Taking Act*, 18 U.S.C. Code § 1203; *Genocide Convention Implementation Act*, 18 U.S.C. Code § 1091

92 Brandon Chabner, "The Omnibus Diplomatic Securities and Antiterrorism Act of 1986: Prescribing and Enforcing United States Law against Terrorist Violence Overseas." (1990) 37:5 UCLA L Rev 985; *Omnibus Diplomatic Securities and Antiterrorism*, 18 U.S.C. Code § 2331 (Supp. IV 1986); *US v Yunis, supra* note 82.

93 *Sherman Antitrust Act,* 26 Stat. 209, 15 U.S.C. Code §§ 1–7.; *Alcoa Case*, supra note 39.

94 Jason Coppel, "A Hard Look at the Effects Doctrine of Jurisdiction in Public International Law" (1993) 6:1 Leiden J Int'l L 73; Austin Parrish, "The Effects Test: Extraterritoriality's Fifth Business" (2008) 61:5 Vanderbilt L. Rev 1471.

Formulating the effects doctrine in that case, Judge Learned Hand stated that it was settled law that "any State may impose liabilities, even upon persons not within its allegiance, for conduct outside its borders that has consequences within its borders which the State reprehends …"[95] He went on to state that the Act covered agreements which "were intended to affect imports and did affect them."[96]

The effects doctrine gives the US power to exercise jurisdiction over matters which have no real connection to its territory. This makes its application similar to the universal principle of jurisdiction with obvious consequences for the sovereignty of other States.[97] After the *Alcoa Case*, in consideration of the interests of other States, the Court of Appeal tried to modify the effects doctrine in the case of *Timberlane Lumber Co. v Bank of America Case*.[98] The effects doctrine was however later reinstated in the case of *Hartford Fire Ins. Co. v California*.[99] The application of the effects doctrine by the US has been criticized for increasing the likelihood for conflicts with other States which goes contrary to the paramount justification for the development of jurisdictional rules in international law.[100] Understandably, the use of the effects doctrine by the US led States like Canada to react by passing legislation which blocks the application of the effects doctrine.[101] In spite of its controversial usage, the effects doctrine has been mimicked by other jurisdictions. In the European Union, for instance, a similar doctrine is known as the "implementation test."[102]

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95 *Alcoa Case*, *supra* note 39 at 443–444; James Gathii, "Torture Extraterritoriality, Terrorism and International Law" (2003) 67 Alb L Rev 364.

96 *Alcoa Case*, *supra* note 39 at 444; Richard Beckler & Matthew Kirtland, "Extraterritorial Application of U.S. Antitrust Law: What is a 'Direct Substantial, and Reasonably Foreseeable Effect' Under the Foreign Trade Antitrust Improvements Act?" (2003) 38:11 Texas Int'l L J 13.

97 Parrish, *supra* note 94 at 1479; Michael Akehurst "Jurisdiction in International Law" (1972–73) 46 BYIL 154.

98 *Timberlane Lumber Co. v Bank of America*, *supra* note 39.

99 *Hartford Fire Ins. Co. v California*, *supra* note 39 at 796.

100 Parrish, *supra* note 94 at 1479; Gathii, *supra* note 95 at 364.

101 See ss 3, 5, 7 & 7.1, *Foreign Extraterritorial Measures Act*, RSC 1985, c. F-29; Currie *et al*, *supra* note 3 at 497.

102 Phillip Landolt, *Modernized EC Competition Law in International Arbitration* (New York: Kluwer Law Int'l, 2006) at 172; Brenden Sweeney, *The Internationalization of Competition Rules*, (London: Routledge, 2009) at 244; Morris Jeffrey, "The Implications of the Wood Pulp Case for the European Communities" (1991) 4:1 Leiden J Int'l L 75.

## 2 *Canada*

Generally, Canada tends to limit its prescriptive jurisdiction over criminal offences to offences which occur within the State. This general rule can be found in section 6(2) of the *Criminal Code* which states that, subject to the *Criminal Code*, no person shall be convicted of an offence committed outside Canada.[103] This conservative view of jurisdiction was prevalent in Canada in the early to mid-19th century, and Canadian courts refused to decide on cases which involved foreign acts even where certain elements of those offences occurred in Canada.[104] In the 1904 case of *Re Gertie Johnson* for instance, the accused who tried to procure a girl to come to Canada for an immoral purpose was discharged as the alleged acts occurred outside Canada.[105] Although Canada remains relatively conservative in its exercise of extraterritorial jurisdiction over offences which occur abroad, it embraces international law principles which support the exercise of extraterritorial criminal jurisdiction. In the exercise of extraterritorial criminal jurisdiction, the Canadian government, like most other governments, tries to ensure that there is no conflict between its laws and the sovereignty of other States.[106] As discussed earlier, in its use of extraterritorial criminal laws, Canada tries to ensure that there is a real and substantive connection between the act and Canada.[107]

There are currently a number of offences in Canada which are regulated partly using extraterritorial criminal legislation. The exercise of extraterritorial criminal jurisdiction in Canada is a power which is only exercised by the federal government.[108] The foundation of the rule which limits the exercise of extraterritorial criminal jurisdiction to the federal government in Canada can be found in section 92 of the Canadian *Constitution Act* which limits the powers of the provinces to make laws to matters which are exclusively within the provinces.[109] This rule has been upheld by the SCC in several cases.[110]

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103 See Section 6(2), *Criminal Code* of Canada, *supra* note 64.

104 Zucker Symon, "Extraterritoriality and Canadian Criminal Law" (1975) 17:2 Crim L Q 152.

105 *Re Gertie Johnson* [1904] 8 CCC 243 (B.C.S.C.); See also *R v Wettman* [1894] 1 CCC 284 (Ont. H.C.); *R v Walkem* [1908] 14 CCC 122 (B.C.C.A.).

106 See Swords, *supra* note 32 at 494.

107 See *Libman v The Queen*, *supra* note 40; *SOCAN v CAIP, supra* note 40.

108 Criminal law falls under the exclusive jurisdiction of the federal government. See ss 91 & 92, *The Constitution Act* (1867) 30 & 31 Vict., c 3.

109 The words used in section 92 of the *Constitution, ibid,* are: "In each province the Legislature may exclusively make law …" This presupposes that the powers of the Legislature to make laws in each province is exclusive to that province.

110 See the cases of *The Queen* (*Man.*) *v Air Canada* [1980] 2 SCR 303; *Unifund Assurance Co. v Insurance Corp. of British Columbia* [2003] SCR 63.

There are currently a number of federal statutes which extend the jurisdiction of Canada to offences which are committed abroad.[111] Many of these offences can be found in the *Criminal Code*. Section 7 of the *Criminal Code* in particular extends the application of Canadian criminal law jurisdiction extraterritorially to cover offences based on several principles of jurisdiction. The *Criminal Code* applies the territorial principle to offences such as hijacking, hostage taking and offences committed on Canadian aircraft or aircraft flights which terminate in Canada.[112] The nationality and passive personality principles are applied to bigamy, treason, terrorism and CST offences.[113] The universal principle is applied to the offence of piracy[114]

In many cases, Canada's use of extraterritorial prescriptive jurisdiction fulfils its obligations under treaty law. For example, based on the nationality principle, the *Chemical Weapons Convention Implementation Act* allows Canada to exercise jurisdiction over offences under the Act committed outside Canada by Canadian citizens and permanent residents.[115] In implementing its obligations under the *Rome Statute of the International Criminal Court* (*Rome Statute*), especially under article 12(2), Canada passed the *Crimes Against Humanity and War Crimes Act*.[116] This Act amended the *Criminal Code* and other statutes which limited the powers of the State to prosecute individuals for war crimes and crimes against humanity which occurred outside Canada.[117] Under section 6 of *Crimes Against Humanity and War Crimes Act*, Canada exercises jurisdiction over the offences of genocide, crimes against humanity and war crimes using the territorial, universal, passive personality

111 See for e.g.: See section 67, *National Defence Act*, RSC 1985, c. N-5; section 135, *Immigration and Refugee Protection Act*, SC 2001, c. 27; section 36.1(3), *Cultural Property Export and Import Act*, RSC 1985, c. C-51.

112 See section 7(1)(2)(3.1), *Criminal Code* of Canada, *supra* note 64.

113 See ss 7(3.73), (3.74), (3.75), (4.1), 46(3) & 290, *Criminal Code* of Canada, *supra* note 64.

114 *Ibid,* ss 74 & 75.

115 See section 22, *Chemical Weapons Convention Implementation Act*, SC 1995, c. 25. This Act was passed pursuant to the provisions of the *Convention on the Prohibition of the Development, Production, Stockpiling and use of Chemical Weapons and on their Destruction*, 1974 UNTS 45; 32 ILM 800 (1993). See Walter Krutzsch *et al, The Chemical Weapons Convention* (Oxford: Oxford University Press, 2014) at 202.

116 See article 12, *Rome Statute of the International Criminal Court*, UN Doc. A/CONF, 183/9; 37 ILM 1002 (1998); 2187 UNTS 90. See also the Canadian *Crimes Against Humanity and War Crimes Act, supra* note 57; R *v Munyaneza* [2009] QCCS 2201 at para. 58.

117 See *R v Finta* [1994] 1 SCR 701. The other Acts amended by the *Crimes Against Humanity and War Crimes Act* include the *Extradition Act*, SC 1999, c. 18 and the *Mutual Legal Assistance in Criminal Matters Act*, RSC 1985, c. 30 (4th Supp.).

and nationality principles.[118] In 2009, Désiré Munyaneza became the first person to be convicted under the Act by the Superior Court of Quebec.[119] He was convicted of several counts of genocide, crimes against humanity and war crimes allegedly committed in Rwanda in 1994.[120] He was arrested after he fled to Canada.

## 3 *The Application of Extraterritorial Criminal Jurisdiction to Transplant Tourism*

The list of offences over which the US and Canada exercise extraterritorial criminal jurisdiction shows that both States have a tradition of exercising extraterritorial criminal jurisdiction over a number of offences. Of all the principles of jurisdiction used to extend the application of criminal laws extraterritorially, the territorial and nationality principles are the least controversial. They are also the principles which are mostly used. However, the exercise of extraterritorial criminal jurisdiction in some instances remains contentious. The use of the effects doctrine by the US and other States is an illustration of how far States are willing to go to protect their interests. Another observation which can readily be made from the list of offences is that the use of extraterritorial criminal legislation is not used only for the prohibition of the most serious offences. Canada for instance regulates the offence of bigamy using extraterritorial criminal legislation.[121] The list also brings to the fore certain guidelines used by States in determining which offences should be regulated using legislation which permit the exercise of extraterritorial criminal jurisdiction. Generally, the offences over which States exercise extraterritorial criminal jurisdiction are those which are: (1) offences which are transnational in nature; (2) offences which, although committed abroad, would affect the security, interests or well-being of the State; and (3) offences which could remain unprosecuted if the option of using extraterritorial criminal legislation was not available.

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118 See Section 6, *War Crimes Act*, *supra* note 57; Fannie Lafontaine, "The Unbeatable Lightness of International Obligations: When and How to Exercise Jurisdiction Under Canada's Crimes Against Humanity and War Crimes Act" (2011) 23:2 Quebec J Int'l L 10. Note that the exercise of this principle in Canada is usually limited to cases where the accused resides in Canada: Currie & Stancu, *supra* note 79 at 836.

119 *R. v. Munyaneza*, *supra* note 116. See also the case of Jacques Mungwarere who became the second person prosecuted under the *War Crimes Act*. He was acquitted of the charges against him as they were not proved: *R v Jacques Mungwarere* [2013] ONCS 4594.

120 *Munyaneza v R* (2014) QCCA 906; Fannie Lafontaine, "Canada's Crime Against Humanity and War Crimes Act on Trial" (2010) 8:1 J Int'l Crim Jus 270; Currie & Stancu, *supra* note 79 at 830.

121 Section 290, *Criminal Code* of Canada, *supra* note 64.

Transplant tourism meets all the three criteria listed above. First, transplant tourism is by its very nature a transnational activity as it always involves the movement of individuals from one State to another. It is this travel which distinguishes transplant tourism from organ commercialization and/or organ trafficking.[122] Secondly, although individuals from tourist States who travel abroad to engage in transplant tourism activities may benefit from the transplant, transplant tourism places financial and other burdens on the healthcare system of tourist States. Due to the substandard practices which are common in the underground organ transplantation system, doctors and follow-up medical centers in tourist States sometimes have to contend with transplant tourists who have contacted infectious diseases like HIV, or suffer from organ rejection and other complications which could be fatal.[123] Lastly, since transplant tourism is not an offence in all tourist States, tourists who travel abroad to buy organs and return to their States are able to avoid prosecution. This makes transplant tourism one of the few international crimes which, except for national laws in a few States, is devoid of national and international prohibition. As discussions in Chapter 2 about the harms caused by transplant tourism show, transplant tourism is ripe for global prohibition. Since transplant tourism meets the three criteria used by tourist States in the extension of criminal legislation extraterritorially, the prohibition of transplant tourism practices should be carried out via a model which uses extraterritorial criminal legislation. Since the prevention of transplant tourism will involve the prohibition by States of the activities of their nationals, the nationality principle should form the basis for the exercise of extraterritorial criminal jurisdiction against transplant tourism. A transnational offence which is currently prohibited by States using extraterritorial criminal legislation based on the nationality principle is CST. This model will be the focus of the next part of this Chapter.

## D The Child Sex Tourism Model

### 1 *Introduction*

CST is a term used to describe the practice which involves travelling to a foreign jurisdiction to engage in sexual activities with children. The UN has defined CST as "tourism organized with the primary purpose of facilitating

122 Organ trafficking is also often transnational in nature and may be a part of the transplant tourism process.

123 Jennifer Babik & Peter Chin-Hong, "Transplant Tourism: Understanding the Risks" (2015) 17:18 Curr Infect Dis Rep 17; Muna Canales *et al*, "Transplant Tourism: Outcomes

a commercial-sexual relationship with a child."[124] CST is a compound term which includes components like travel for sexual purposes, sex with a minor, prostitution and, in some cases, child trafficking. As the name implies, CST always involves children. International law instruments such as the *Convention on the Rights of the Child* (CRC) and the *Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children* (*Trafficking Protocol*) define a child as any human being below the age of 18.[125]

Although found in many States of the world, some have distinguished themselves as hotbeds of CST. States can be divided into tourist States and destination or receiving States. Tourist States are States from which individuals who engage in CST originate. Key tourist States are the US, Canada and Australia.[126] Other tourist States include United Kingdom, Germany, Sweden, Japan and New Zealand.[127] Destination States are those States which foreigners travel to engage in CST activities. Asia has distinguished itself as a conducive continent for the practice of CST, with Thailand, the Philippines, Sri Lanka, Cambodia and Taiwan being the major destination locations for child sex tourists.[128] It has been estimated that there are over 1 million child

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of United States Residents Who Undergo Kidney Transplantation Overseas" (2006) 82:12 Transplant 1658; Ninoslav Ivanovski *et al,* "Renal Transplantation from Paid, Unrelated Donors in India: It is not only Unethical, it is also Medically Unsafe" (1997) 12:9 Nephrol Dial Transplant 2028.

124 Lin Lim, ed, *The Sex Sector: The Economic and Social Bases of Prostitution in Southeast Asia* (Geneva: ILO, 1998) at 183.

125 See article 1, *Convention on the Rights of the Child,* GA Res. 44/25, annex, 44 UN GAOR Supp. (No. 49) at 167, UN Doc. A/44/49 (1989); 1577 UNTS 3; 28 ILM 1456 (1989); article 3(d), *Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children*, Supplementing the *United Nations Convention Against Transnational Organized Crime*, UN Doc. A/55/383 at 25 (2000); UN Doc. A/RES/55/25 at 4 (2001); 40 ILM 335 (2001). These provisions accommodate a lower age for the definition of who a child in accordance with the provisions of national laws.

126 Vickie Li, "Child Sex Tourism to the Thailand: The Role of the United States as a Consumer Country" (1995) 4:2 Pac Rim L & Pol'y J 505.

127 Margaret Healy, "Prosecuting Child Sex Tourist at Home: Do Laws in Sweden, Australia, and the United States Safeguard the Rights of Children as Mandated by International Law?" (1995) 18:5 Fordham Int'l L J 1852.

128 Li, *supra* note 126 at 505; Healy, *ibid* at 1861; Paul Leung, "Sex Tourism: The Case of Cambodia" in Thomas Bauer & Bob McKercher, eds, *Sex and Tourism: Journeys of Romance, Love, and Lust* (London: Routledge, 2003) at 181; Kelly Cotter, "Combating Child Sex Tourism in Southeast Asia" (2009) 37:3 Denv J Int'l L & Pol'y 495.

prostitutes in Asia alone.[129] Destination States can also be found in Africa, Eastern Europe and Latin America.[130] CST is fueled by a number of factors, paramount among which is poverty.[131] Other factors include the lack of resources to combat CST, cultural traditions, ineffective law enforcement, immature legal systems and corruption.[132] CST has resulted in some unpleasant consequences for the child victims. For example, it has led to physical harm, psychological trauma and loss of dignity and self-worth.[133] It has also increased the exposure of the child sex tourists and victims to sexually transmitted diseases like HIV.[134]

### 2 *International Law Prohibition of CST*

International law has always concerned itself with the protection, welfare and rights of children. This concern can be noticed in the provisions of several international human rights instruments with articles which focus exclusively on the protection of children. Article 24 of the *International Covenant on Civil and Political Rights* (ICCPR), for instance, gives children the right to protection from all forms of discrimination.[135] In 1990, the CRC came into force as a treaty to safeguard the rights of children, including rights of protection. The CRC has

129 Eric Berkman, "Responses to the International Child Sex Tourism Trade" (1996) 9:2 Boston Coll Int'l & Com L Rev 399.

130 Key States here include Bolivia, Peru, Mexico, Dominican Republic, Kenya, Romania, Poland and Russia. See Healy, *supra* note 127 at 1863–1864; Benjamin Perrin, "Taking a Vacation from the Law? Extraterritorial Criminal Jurisdiction and Section 7(4.1) of the Criminal Code" (2009) 13:2 Can Cri L Rev 187–188; Kalen Fredette, "International Legislative Efforts to Combat Child Sex Tourism: Evaluating the Council of Europe Convention on Commercial Child Sexual Exploitation" (2009) 32:1 Boston Coll Int'l & Com L Rev 5.

131 See Healy, *supra* note 127 at 1869.

132 *Ibid.;* Naomi Svensson, "Extraterritorial Accountability: An Assessment of the Effectiveness of Child Sex Tourism Laws" (2006) 28:3 Loy L A Int'l & Comp L Rev 641; Elizabeth Bevilacqua, "Child Sex Tourism and Child Prostitution in Asia: What Can be Done to Protect the Rights of Children Abroad Under International Law?" (1998) 5 ILSA J Int'l & Comp L 174; Sara Austin, "Commercial Sexual Exploitation of Children: How Extraterritorial Legislation Can Help" in Don Brandt, ed, *Violence Against Women: From Silence to Empowerment* (California: World Vision International, 2003) at 41.

133 See Healy, *supra* note 127 at 1873.

134 *Ibid.*

135 See article 23, *International Covenant on Civil and Political Rights*, GA res. 2200A (XXI), 21 UN GAOR Supp. (No 16) at 59, UN Doc. A/6316 (1966); 999 UNTS 302. Other treaties which offer various levels of protection to children include the *Trafficking Protocol* and the *Convention on the Rights of Persons with Disabilities*, UN Doc. A/RES/61/106, Annex I.

been ratified by every member of the UN except for the US.[136] Aside from the US, all the key States involved in the practice of CST are CRC parties. Among the protections offered to children by the CRC, article 34 protects children from all forms of "sexual exploitation and sexual abuse."[137] In particular, it places a duty on States to take measures to prevent the exploitation of children in prostitution and other unlawful sexual practices.[138] Article 35 of the CRC mandates States to prevent the abduction, sale and traffic of children for any purpose.[139] It has been argued that article 34 of the CRC authorizes ratifying States to exercise extraterritorial adjudicative jurisdiction over their nationals for acts committed in foreign States which are also CRC parties.[140] This mandate is not clear from the wording of article 34. What is however clear from the provisions of the CRC is that CRC parties, which include all the key destination States, have an obligation to prevent CST within their borders.[141] Articles 34 and 35 of the CRC laid down the foundation for the international prohibition of CST and other child sex-related offences. Today, this foundation has developed into a standardized model of CST prohibition on both the national and international legal planes.

In the same year in which the CRC came into force, a non-governmental organization called ECPAT (End Child Prostitution, Child Pornography and Trafficking of Children for Sexual Purposes) was formed after a consultation in Thailand to help eliminate commercial exploitation of children.[142] Made up of a network of 90 civil society organizations in 82 States, ECPAT led the campaign to end the sexual exploitation of children in Asia. In 1992, more general action was taken by the UN Commission on Human Rights with the adoption of the *Programme of Action for the Prevention of the Sale of Children, Child Prostitution and Child Pornography and for the Elimination of the Exploitation of Child Labor* (*Programme of Action*).[143] Among the actions recommended by the *Programme of Action*, States were advised to pay special attention to the problem of CST through the use of legislative and other measures to prevent and combat sex

136 The CRC currently has 196 parties.

137 *Ibid*, article 34.

138 *Ibid*, article 34(b).

139 *Ibid*, article 35.

140 Perrin *supra* note 130 at 198.

141 Berkman, *supra* note 129 at 406.

142 For more about EPCAT, visit the EPCAT website, online: <http://www.ecpat.net/>.

143 *Programme of Action for the Prevention of the Sale of Children, Child Prostitution and Child Pornography and for the Elimination of the Exploitation of Child Labor,* UN Doc. E/CN.4/RES/1992/74 (5 March 1992).

tourism in both tourist and destination States.[144] This was a clear recommendation to States to consider the use of extraterritorial criminal legislation in the prohibition of CST. Four years later, in 1996, the *Declaration and Agenda for Action* were adopted at the First World Congress against Commercial Sexual Exploitation of Children in Stockholm, Sweden to further address and bring an end to the commercial exploitation of children.[145] Like the Istanbul Summit which led to the adoption of the *Declaration of Istanbul*, the World Congress was attended by representatives of State governments, non-governmental organizations, ECPAT, UNICEF and other UN agencies and other concerned organizations.[146] Under the *Declaration and Agenda for Action,* States were asked to criminalize the commercial exploitation of children and penalize all offenders involved in the practice, whether local or foreign.[147] More specifically, in the case of CST, States were to develop and implement extraterritorial criminal national laws which criminalized the acts of their nationals who engaged in CST abroad.[148] The *Declaration and Agenda for Action* marked a turning point in the global regulation of CST. Not only did it draw the attention of the international community to the need to prohibit the practice of CST, it also made it a child's right debate based on the CRC.[149]

The *Programme of Action* and the *Declaration and Agenda for Action,* along with other recommendations, later gave rise to the *Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography* (OP2-CRC) which placed a direct duty on States to use extraterritorial criminal legislation to prohibit CST.[150] There are currently 173 States which are parties to the OP2-CRC including key tourist and destination States like Thailand, the Philippines, China, Cambodia, Canada and the

144 See para 47, *Programme of Action, ibid.*

145 The *Stockholm Declaration and Agenda for Action*, adopted at the First World Congress against Commercial Sexual Exploitation of Children, Stockholm, Sweden, 27–31 August 1996.

146 *Ibid*, article rticle1, Declaration.

147 *Ibid*, article 12, The Commitment.

148 *Ibid*, Paragraph d, article 4, Protection, Agenda for Action Against Commercial Sexual Exploitation of Children.

149 *Ibid*, articles 4 & 5, The Challenge; Holly Cullen, *The Role of International Law in the Elimination of Child Labor* (Netherlands: Brill, 2007) at 55.

150 Preamble, *Optional Protocol to the Convention on the Rights of the Child on the Sale of children, Child Prostitution and Child Pornography*, G.A. Res. 54/263, Annex II, 54 U.N. GAOR Supp. (No. 49) at 6, U.N. Doc. A/54/49 (2000). The OP2-CRC was adopted by the UN GA in 2000 and entered into force on 18 January 2002.

US. In particular, article 3(1) of OP2-CRC states that States shall ensure that the sexual exploitation of children is prohibited in their criminal and penal laws whether such offences are committed domestically or transnationally.[151] Article 4(2)(a), which is a permissive clause, goes on to state that each State may take measures to establish jurisdiction over offences in article 3(1) where the alleged offender is a national or habitual resident of its territory or where the victim is a national of the State.[152] States are also to take steps to strengthen international cooperation to combat CST.[153] By using the territorial, nationality and passive personality principles of extraterritorial jurisdiction, OP2-CRC has covered any gap which existed in the global prohibition of CST.

The OP2-CRC partly influenced the development of a regional treaty against child sexual exploitation created under the auspices of the Council of Europe (COE).[154] In 2007, the *Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse* (*Lanzarote Convention or Convention*) was adopted.[155] This Convention entered into force in 2010. The *Lanzarote Convention* seeks to prevent and combat sexual exploitation and abuse of children, protect the rights of child victims of sexual exploitation and promote national and international cooperation against sexual exploitation and abuse of children.[156] Like the OP2-CRC, the *Lanzarote Convention* promotes the use of extraterritorial criminal legislation in the prohibition of child sexual exploitation and sexual abuse offences which include CST. Article 25 of the *Lanzarote Convention* directs States Parties to pass legislation over Convention offences where, among other grounds, the offence is committed in its territory, by one of its nationals or by a person who resides habitually in its territory.[157] The provision also directs States Parties to exercise extraterritorial jurisdiction where the offence is committed against one of its nationals or habitual residents.[158] With the aid of the territorial, nationality and passive personality principles of jurisdiction, the *Lanzarote Convention* seeks to ensure that nationals and habitual residents of COE States parties do not avoid prosecution for CST activities. This Convention is relatively new and it is still

151 *Ibid,* article 3(1) OP2-CRC; Perrin, *supra* note 130 at 199.

152 Article 4(2)(a) OP2-CRC, *ibid.*

153 *Ibid,* article 10.

154 Preamble, *Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse,* CETS No. 201.

155 *Ibid.*

156 *Ibid,* article 1.

157 *Ibid,* article 25(1).

158 *Ibid,* article 25(2).

difficult to ascertain what effects it will have in the fight against child sexual exploitation in COE states. It has, however, been signed by all 47 COE States and ratified by 41.[159]

Unlike the *Lanzarote Convention,* the effects of the OP2-CRC are apparent. States Parties to OP2-CRC have responded to its obligations in various ways. Some States passed laws to protect children from CST and other sexual acts committed by their nationals both locally and abroad. The US, for instance, passed the *Prosecutorial Remedies and Other Tools to End the Exploitation of Children Act* (*Protect Act*) partly to help protect children from sexual offences including sex tourism.[160] Some of the tourist States who are parties to the OP2-CRC already had laws in place which make CST an offence over which extraterritorial criminal jurisdiction can be exercised. The OP2-CRC, however, led to more judicial activism around CST and more prosecutions of offenders. In Canada, for instance, although the *Criminal Code* was amended in 1997 after the *Declaration and Agenda for Action* came into being to extend extraterritorial jurisdiction over sexual offences such as CST, the first prosecution under the amended provisions did not take place until 2005 in *R v Bakker*.[161]

### 3 *National Law Regulation and the Impact of the CST Model*

Flowing from the recommendation of the *Declaration and Agenda for Action* and the provisions of the OP2-CRC, numerous States now have extraterritorial laws which prohibit the practice of CST. Nationals of these States who travel abroad for CST can be prosecuted in their home States for their conduct abroad. It has been estimated that over 30 States currently have laws which allow the prosecution of child sex tourists who travel abroad to sexually exploit children.[162] These States include Algeria, Australia, Austria, Belgium, Cyprus, Canada, China, Denmark, Ethiopia, Finland, France, Germany, Iceland, Ireland, Italy, Japan, Laos, Luxembourg, Mexico, Morocco, Netherlands, New Zealand, Norway, Portugal, Slovenia, Spain, Sweden, Switzerland, Taiwan, Thailand, United Kingdom and the US.[163] The laws in most of these States form

159 See Chart of Signatures and Ratifications of the *Lanzarote Convention* on the Council of Europe Website, online: <http://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/201/signatures>.

160 *Prosecutorial Remedies and Other Tools to End the Exploitation of Children Act*, Pub. L. 108–21, 117 Stat. 650, S. 151, enacted April 30, 2003.

161 See *R v Bakker* [2005] BCPC 289.

162 Ronald Flowers, *Perpetrators, Predators, Prostitutes and Victims* (Springfield: Charles C. Thomas Pub., 2006) at 137; Austin, *supra* note 132 at 53.

163 *Ibid.*

part of their criminal or penal codes. In Sweden, Swedish nationals who travel abroad for child sex tourism can be prosecuted under chapter 23 of the *Swedish Penal Code*.[164] Under sections 5 and 176 of the *German Penal Code*, engaging in sexual acts with a person under 14 years of age is an offence even when the act happens extraterritorially.[165]

States with extraterritorial CST laws have recorded various degrees of success in the implementation of their laws. Australia is one State which has had a measurable amount of success with its CST law. Australia became the first State to draft anti-CST laws with extraterritorial application. In 1994, Australia passed the *Crimes* (*Child Sex Tourism*) *Amendment Act* to amend the *Crimes Act* of 1914.[166] Under the new law, it is an offence for an Australian to engage in sexual intercourse with a person under the age of 16 outside Australia.[167] The Act also makes the inducement of children under the age of 16 to engage in sexual intercourse with third parties outside Australia an offence.[168] Upholding the constitutionality of the *Crimes* (*Child Sex Tourism*) *Amendment Act* and Australia's exercise of extraterritorial jurisdiction over these offences in the case of *XYZ v Commonwealth*, the High Court of Australia stated that as a self-governing nation, Australia has the power to restrict the activities of its citizens abroad.[169] In the 1995–2007 period, at least 28 persons were charged in Australia and 19 convicted for extraterritorial child sex offences.[170]

Like Australia, the US has had considerable success convicting US nationals under its CST laws. In 1994, the US made its first real attempt to prohibit CST when it enacted *the Violent Crime Control and Law Enforcement Act* which made it illegal for US nationals to travel abroad with the intent of engaging in certain sexual acts with children under the age of 18 years.[171] Due to evidentiary challenges posed by that Act, the US enacted the *Protect Act* which provides stronger laws to protect children from child pornography, exploitation, sex

164 See chapter 23, *Swedish Penal Code* (1962:700). Note that the amendment of the *Swedish Penal Code* to include the exercise of extraterritorial powers had no connection to the practice of CST. It is a standalone law which extends to cover child sex tourism cases.

165 See ss 5 & 176, *Criminal Code in the Version Promulgated on 13 November 1998*, Federal Law Gazette (Bundesgesetzblatt) 1 p. 3322 (*German Penal Code*).

166 *Crimes* (*Child Sex Tourism*) *Amendment Act*, Act No. 105 of 1994.

167 Section 50BA, *Crimes* (*Child Sex Tourism*) *Amendment Act;* see generally, Marianna Brungs, "Abolishing Child Sex Tourism: Australia's Contribution" (2002) 8:2 Aus J Hum Rts 101.

168 Section 50BB, *Crimes* (*Child Sex Tourism*) *Amendment Act, supra* note 166.

169 *XYZ v Commonwealth* [2006] HCA 25.

170 Perrin *supra* note 130 at 204.

171 *Violent Crime Control and Law Enforcement Act* of 1994, 42 U.S.C. Code § 14141.

tourism and other sex offences in 2003.[172] Section 105 of the *Protect Act* protects children against sex tourism and makes it an offence for any citizen or permanent resident of the US to travel to a foreign State and engage in sexual acts with a person under the age of 18 years.[173] The *Protect Act* has been effective in leading to the arrests and convictions of sex tourists in the US. The Act has led to about 47 convictions between 2003 and 2008.[174] In the important case of *R v Clark*, the US Court of Appeals (CA) in 2006 upheld both the extraterritorial application of the *Protect Act* and the conviction of Clark for CST acts committed in Cambodia.[175] In 2010, in the case of *US v Bianci*, the US CA sentenced Anthony Bianci to a term of 25 years imprisonment for engaging in sexual activities with boys aged 12 to 16 in Moldova and Romania between 2003 and 2005.[176]

Not all States have recorded the same amount of convictions. Canada, for instance, has not been very successful in prosecuting Canadians under its CST law. The *Criminal Code* of Canada was amended by Bill C-27 in 1997 to make CST an offence regulated partly by extraterritorial criminal laws.[177] Referred to as the "Prober Amendment" after Rosalind Prober, the founder of Beyond Borders ECPAT, the new section 7(4.1) of the *Criminal Code* applies extraterritorial principles of jurisdiction to CST and makes it an offence for a Canadian citizen or permanent resident to commit sexual acts against children in other States.[178] However, it took 8 years before Canada prosecuted and convicted anyone under the new law in the 2005 case of *R v Bakker*.[179] Bakker was charged with offences including 7 counts of sexual offences involving children under the age of 14 in Cambodia. He was sentenced to 7 years in prison. In 2010, the constitutionality of section 7(4.1) was

172 *Protect Act*, supra note 160; Perrin *supra* note 130 at 205.

173 See section 105, *Protect Act*, *supra* note 160.

174 Perrin *supra* note 130 at 205.

175 *R v Clark* [2006] 435 F.3d 1100 CA 9 (Wash.).

176 *US v Bianci* [2010] 386 Fed. Appx. 156 (3rd Cir.). See generally: *US v Frank* [2007] 486 F. Supp. 2d 1353 (S.D.Fla.).

177 *Bill C-27, An Act to Amend the Criminal Code* (*Child Prostitution, Child Sex Tourism, Criminal Harassment and Female Genital Mutilation*) 2nd Sess., 35th Parl., 1997 (assented to 25 April 1997)

178 See ss 7(4.1), 151, 152, 153 & 155, *Criminal Code* of Canada, *supra* note 64. Beyond Borders ECPAT is a Canadian advocacy organization which promotes the rights of children to be free from sexual abuse and exploitation. It represents ECPAT International in Canada. For more about Beyond Borders EPCAT, visit the Beyond Borders EPCAT website at: <http://www.beyondborders.org/en/home/>.

179 *R v Bakker*, *supra* note 161.

questioned in the case of *R v Klassen*.[180] In that case, Kenneth Klassen was accused of committing various sex crimes with underage girls in Colombia, Cambodia and the Philippines. Dismissing the arguments of the defense, the BC SC held that section 7(4.1) of the *Criminal Code* was constitutional because Parliament has the power to enact extraterritorial legislation.[181] The Court went on to state that section 7(4.1) is justified under the nationality and universal principles of jurisdiction, the CRC, OP2-CRC, and the mass international support these treaties have received through their ratification by many States.[182] Recently in June 2015, Christopher Neil pleaded guilty to five CST and child pornography charges before the BC SC.[183] His offences involved the sexual assault of boys in Thailand, Cambodia and Vietnam for which he was incarcerated for 5 years in Vietnam. He was sentenced to 5½ years in prison.[184]

Although the prohibition of CST has recorded some successes, it has not been uniformly implemented by all the States who are parties to the OP2-CRC. There is no evidence that CST has stopped in key destination States like Thailand, Cambodia and the Philippines even though they are all parties to the OP2-CRC. On the contrary, there are reports which indicate that CST has increased in these States.[185] There are several reasons for this. The current increase in CST can be linked directly to globalization, technological advancements, the ease of world travel and the growth rate of international tourism. With more people having access to internet facilities, sex tourists can arrange for the exploitation of children over the internet with fake identities which make it more difficult for their activities to be tracked.[186] The booming international tourism industry

180 *R v Klassen* [2008] BCSC 1762.

181 *Ibid* at para. 101.

182 *Ibid.*

183 The Canadian Press, "Christopher Neil, 'Swirl Face,' Pleads Guilty to More Sex Charges" Huffpost British Columbia (17 December 2015), online: <http://www.huffingtonpost.ca/2015/12/17/convicted-pedophile-dubbed-swirl-face-pleads-guilty-in-b-c-to-5-sex-charges_n_8829898.html>.

184 The Canadian Press, "'Swirl Face' Pedophile Christopher Neil Sentenced to 5½ Years in Prison" CBC News (01 June 2016), online: <http://www.cbc.ca/news/canada/british-columbia/swirlface-christopher-neal-sentencing-1.3610153>.

185 Angela Hawke & Alison Raphael, *Offenders on the Move: Global Study on Sexual Exploitation of Children in Travel and Tourism 2016* (Bangkok: ECPAT Int'l, 2016).

186 Juriah Jalil, *Korean Approach to Online Protection for Children in Digital Era* (Melbourne: ACCAN Conference, 2013), online: <http://www.aic.gov.au/media_library/conferences/2013-accan/presentations/Abd_Jalil.pdf>.

also poses a threat to the prohibition of CST in both tourist and destination States. According to a 2016 ECPAT global study, over the past 20 years, the number of international tourists has soared from 527 million in 1995 to 1,135 million in 2014.[187] It is understandable that with the increase in the rate of tourism will come an increase in tourism-related activities, CST being one of them. Unfortunately, legal and other mechanisms set in place to tackle CST have not developed at the same rate as the tourism industry. The result is that tourists are able to use this gap to their advantage. As with other crimes, the development of new laws make offenders seek out new ways of carrying out their crimes and, in some cases, lead to forum shopping.[188] With the opening of new tourist destinations around the world, the lines between key destination and tourist States continue to blur. According to the 2016 ECPAT report, no State is currently immune from child sexual exploitation crimes.[189]

Other challenges faced in the prohibition of CST include gaps in the domestic laws, poverty, lack of resources, corruption, weak or lapses in enforcement procedures and supportive cultures and conditions in destination States. Some destination States still do not have laws which make CST illegal. There seems to be a lack of willingness on the part of destination States to pass CST laws for fear of endangering revenue flows from tourists who favor destinations with favorable criminal codes.[190] In turn, tourist States have not been entirely successful in preventing their nationals from taking part in CST. This lack of success can partly be traced to poor implementation of local laws prohibiting CST. States like Canada and the UK have recorded very few prosecutions under their respective extraterritorial CST laws.[191] One reason for this is the difficulty involved in securing the physical evidence needed to effectively prosecute individuals who commit crimes abroad.[192] Part of the evidentiary challenges involve securing testimonies from child victims, language barriers and low reporting of sexual abuse cases.[193] Another reason for some tourist States' lack of success is

187 Hawke & Raphael, *supra* note 185 at 15.

188 Fiona David, "Child Sex Tourism Legislation is no 'Paper Tiger' " (2000) 69 Platypus 36.

189 Hawke & Raphael, *supra* note 185 at page 13.

190 Fredette, *supra* note 130 at 13.

191 In the UK, section 72, *Criminal Justice and Immigration Act* 2008 (c.4).

192 Svensson, *supra* note 132 at 650. Evidentiary challenges involved in the effective implementation of extraterritorial laws will be discussed in greater detail in Chapter 7 of this publication.

193 Some of these challenges as they affect transplant tourism and their possible solutions will be discussed in the next Chapter of this publication.

that extraterritorial laws which criminalize CST sometimes have double criminality provisions which require that the offence also be an offence in the destination State.[194] Section 72(2) of the UK *Criminal Justice and Immigration Act* of 2008 contains such a caveat.[195] Accordingly, UK nationals who travel to States like Nepal, which do not have legislation against sexual exploitation of children, to commit CST acts cannot be prosecuted in the UK.[196]

Although these factors continue to challenge the global prohibition of CST, they do not render the model ineffective. Some prosecution is better than no prosecution. As has been shown, there are States like Australia and the US which have a high prosecution rate of child sex tourists. The existence of the CST extraterritorial jurisdiction model also sends a clear message to would-be defaulters that the international community views CST as unacceptable and is actively seeking ways to eradicate it. In States with high prosecution rates, a clear message is being sent to nationals that they cannot engage in CST activities abroad and escape legal liability by returning to their States of origin. The CST model provides an avenue for prosecutions which did not previously exist.[197] Also, some of the challenges faced in the prohibition of CST are peculiar to that offence and will not necessarily exist if the same model is applied to other offences.

### 4 *The Relationship between CST and Transplant Tourism*

There is a close relationship between transplant tourism and CST based on the nature of both activities, factors which fuel the practices, methods through which they are practiced and the impact they have on the societies in which they occur. These similarities make both CST and transplant tourism "sister-practices" and makes the CST model suitable for the regulation of transplant tourism.

The first similarity between CST and transplant tourism is that national variations of each practice are illegal under the criminal laws of most of the tourist and transplant/destination States involved in both types of tourism. In many States, including Canada, organ commercialization is illegal under the various organ transplant laws.[198] A lot of States also have laws which prohibit

194 Daniel Edelson, "The Prosecution of Persons who Sexually Exploit Children in Countries Other than Their Own: A Model for Amending Existing Legislation" (2001) 25:2 Fordham Int'l L J 495.

195 See section 72(2), *Criminal Justice and Immigration Act*, *supra* note 191.

196 Svensson, *supra* note 132 at 651

197 David, *supra* note 188 at 36.

198 See for instance ss 3(2) and 13(3), the *Human Tissue and Organ Donation Act* of Alberta, *supra* note 46.

sexual exploitation of children. In Canada, this prohibition can be found under the *Criminal Code*.[199] Similar laws can be found in key CST destination States. For example, the *Criminal Code of Thailand* expressly prohibits sexual offences against children.[200] Laws in the Philippines[201] and Cambodia[202] also prohibit sexual offences against children. However, the national laws which prohibit organ commercialization and child sex offences have not been successful in bringing an end to the practices. This exposes the need for a global form of prohibition which also involves tourist States. While international law has evolved to combat CST, it is almost absent in the transplant tourism context.

The second similarity between both practices is that, like transplant tourism, CST is an act which is defined by its transnational elements. While the act of engaging in sexual acts with children is unlawful under various national laws, those acts alone do not amount to CST. For an act to be classified as CST, the offending tourist must travel from one State to another to engage in the act. Like transplant tourism, there are various formats through which this international travel can take place.[203] The UN Special Rapporteur on the sale of children, child prostitution, and child pornography has noted that although poverty explains the supply side of CST, it does not explain the huge global demand which can be traced to "customers from rich countries circumventing their national laws to exploit children in other countries."[204] Another related

199 See ss 151–153, *Criminal Code* of Canada, *supra* note 79.

200 See ss 277, *Thailand Criminal Code*, B.E. 2499 (1956) as amended by the *Criminal Code* (No. 17), B.E. 2547 (2003).

201 See section 5, *Republican Act No. 7610* (*An Act Providing for Stronger Deterrence and Special Protection Against Child Abuse, Exploitation and Discrimination, and for Other Purposes*).

202 See chapter 4, *Law on Suppression of Human Trafficking and Sexual Exploitation*, 2008, NS/RKM/0208/005.

203 The most established format for the practice of CST involves tourists traveling from tourist States to destination States to engage in the practice. Other formats include the trafficking of children from other States to tourist or other destination States for sex. Article 3(a) of the *Trafficking Protocol*, *supra* note 125, defines trafficking in persons as including "the recruitment, transportation, transfer, harboring 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 … the exploitation of the prostitution of others or other forms of sexual exploitation …"

204 Commissioner on Human Rights, *Report of the Special Rapporteur on the Sale of Children, Child Prostitution, and Child Pornography* (UN CHOR, 1994, U.N. Doc. E/CN.4/1994/84) at para. 6.

similarity between both CST and transplant tourism is that the destination States for both are States with similar poor socio-economic factors. As has been noted earlier in Chapter 1, the major destination States for transplant tourism are developing States in Asia, Africa, South and Central America and Eastern Europe, including the Philippines, India, China, Pakistan, Bangladesh, Iran, Turkey, Nigeria, Egypt, Colombia, Brazil, Peru, Bolivia, Romania and Moldova.[205] The tourist States are also the same developed States in both cases.

Other similarities between both CST and transplant tourism is that they are both sustained by similar factors and have the same impact in the societies where the core acts constituting the offences occur. For transplant and destination States, acts involved in both CST and transplant tourism have their roots in poverty and the need of individuals to obtain financial resources. In both practices, the victims end up earning the least amount of money. In transplant tourism cases, the intermediaries and transplant centers receive a lot more money than the organ sellers.[206] In CST cases, most of the money made by the child prostitutes goes to pimps, and, in some cases, the parents of the child engaging in the act.[207] Both practices also continue to blossom in destination/transplant States due to factors which include the absence of suitable laws, weak enforcement procedures and corruption among law enforcement officers and other enforcement and regulatory agencies.

The impact that CST and transplant tourism have on the destination communities where the sexual offence or organ sourcing/transplant take place is also similar. I chronicled the negative effects of transplant tourism in communities in the Philippines and other parts of Asia in Chapter 2 of this publication.[208] Transplant tourism diverts health resources from the nationals of transplant States to foreigners. Other negative effects of transplant tourism practices on organ donors include loss of self-worth, discrimination, psychological trauma, sustained poverty and health risks. Child victims and communities plagued by

205 Alexis Aronowitz, *Human Trafficking, Human Misery: The Global Trade in Human Beings* (Westpoint: Praeger, 2009) at 111.

206 Jeremy Haken, *Transnational Crime in the Developing World* (Washington: Global Financial Integrity, 2011) at 1 & 23; Vanessa Chandis, "Addressing a Dire Situation: A Multi-Faceted Approach to the Kidney Shortage" (2006) 27:1 U Pa J Int'l Econ L 205.

207 Berkman, *supra* note 129 at 400–401.

208 Nancy Scheper-Hughes, "Rotten Trade: Millennial Capitalism, Human Values and Global Justice in Organs Trafficking" (2003) 2:2 J Hum Rts 199; Leigh Turner, "Commercial Organ Transplantation in the Philippines" (2009) 18:2 Cam Q Healthcare Ethics 192; Tsuyoshi Awaya *et al*, "Failure of Informed Consent in Compensated Non-Related Kidney Donation in the Philippines" (2009) 1:2 Asian Bio Rev 138.

CST suffer similar fates. They experience loss of dignity, confidence and self-esteem.[209] They are also exposed to physical harm, torture, degrading treatment and diseases.[210]

Despite the various similarities between CST and transplant tourism, there are also some differences between them which might lead to different results when the CST model is applied to transplant tourism. The most significant difference between both practices is that unlike CST, which can remain untraceable, transplant tourism activities can always be traced. At the very least, people who have had organ transplants are identifiable and traceable in tourist States. While CST thrives underground without the support of organized sectors of society, transplant tourism depends on medical professionals, established medical centers and, in some cases, the State. Thus, there are better chances for transplant tourism activities to be traced and documented than is the case with CST. Also, people who receive organs, the transplant tourists, are continually going to need postoperative care in their States of origin. They will also need to rely on their healthcare system for immunosuppressive drugs to help prevent the rejection of transplanted organs and tissues. This reliance on the healthcare system of their States increases the chances of their engagement in transplant tourism activities getting discovered through the healthcare system. This distinction will automatically eliminate some of the challenges faced in combating CST if the same model is applied to transplant tourism.

Another key distinguishing factor between CST and transplant tourism is that they are motivated by different factors. While, on the one hand, transplant tourism developed as a means of combating the global organ shortage crises and the need to preserve lives, CST, on the other hand, is an avenue for individuals to satisfy sexual habits that most, if not all, societies deem reprehensible. It might be due to this important distinction that, while more progress has been recorded in the global prohibition of CST, transplant tourism remains virtually unregulated globally. Added to this is the fact that some people view transplant tourism as a fair practice in which two individuals with equal bargaining power agree to sell and buy organs.[211] As we have seen in earlier Chapters, this assumption is wrong. Transplant tourism is a reprehensible practice in which one individual takes advantage of the poverty and desperation of another for his or her own gain.

209 See Healy, *supra* note 127 at 1873.

210 *Ibid.*

211 Gerald Dworkin, "Markets and Morals: The Case for Organ Sales," in Gerald Dworkin ed, *Morality, Harm and the Law* (Boulder, CO: Westview Press, 1994) at 156; James Taylor, *Stakes and Kidneys: Why Markets in Human Body Parts are Morally Imperative* (Aldershot: Ashgate Press, 2005) at 29.

## E The Use of Extraterritorial Laws to Combat Transplant Tourism

Since transplant tourism is a group of practices defined by transnationality, the only way national laws can be relevant and effective in its eradication is if the laws have extraterritorial reach. There is a need for national extraterritorial criminal laws which prohibit three broad activities involved in transplant tourism practices. First, the laws should prohibit contracts and other arrangements for the sale of organs abroad. Secondly, the laws should prohibit organ trafficking, organ harvesting and organ commercialization. Thirdly, the laws should prohibit the use of organs acquired illegally for organ transplants abroad where the parties involved in the transplants are aware of the illegal source of the organ.

Of the various principles of jurisdiction used by States in their exercise of extraterritorial criminal jurisdiction, the territorial, nationality and passive personality principles are best suited for the prohibition of transplant tourism. It goes without saying that States have control over activities which occur within their territories. It has also been shown that using tests like the "real and substantial link" test used in Canada, States also exercise jurisdiction over offences which occur partially within their territories, which were initiated in their territories, or which are otherwise linked to their territories.[212] As was noted in the case of *Libman v The Queen*, an offence carried out in another State can be prosecuted in Canada if preparatory activities for that offence were carried out in Canada.[213] What is important is that a sufficient link is established between that offence and Canada.[214] Extending this principle to other States, where a contract for the sale of an organ in a transplant State was concluded in a tourist State, that tourist State in question should be able to exercise jurisdiction over that transaction under the territoriality principle so defined.

Applying the nationality and passive personality principles, States can exercise jurisdiction over extraterritorial offences in which their nationals are respectively offenders or victims. This is because a State is always linked to its nationals irrespective of their location.[215] Under the nationality principle, tourist States should be able to exercise jurisdiction over their nationals who travel abroad to buy organs for transplantation or who act as intermediaries or brokers for such transactions. For this to happen, however, there needs to

212 *Libman v The Queen, supra* note 40 at 213.

213 *Ibid* at para. 72.

214 *Ibid.*

215 Bledsoe & Boczek, *supra* note 6 at 103.

be laws which make it illegal for nationals of tourist States to travel abroad to acquire organs through illegal means as is currently the case in Israel and Spain.[216] The nationality and passive personality principles could be relevant in the prosecution of intermediaries by transplant States where nationals act as organ brokers and facilitators for the transfer of other nationals abroad for transplant tourism purposes. This would be especially beneficial where both the tourist, and where applicable, the third State have no laws against transplant tourism. The basis for the application of the nationality principle would be that their nationals are engaging in an act in another State which if performed in the transplant State would be an offence. The basis for the application of the passive personality principle would be to address the harm done to a State's nationals who are transported to other States to sell their organs.

The method via which extraterritorial criminal legislation is applied to transplant tourism could make the difference between its eradication or perpetuation. The CST model, which began with soft law which crystalized into a treaty resulting in many national criminal laws with extraterritorial application, is a relevant and attractive model to adopt to combat transplant tourism. Recent developments in international law in the fight against transplant tourism as evidenced by the *Declaration of Istanbul*, a soft law instrument, and the 2014 *Convention against Trafficking in Human Organs* (*Trafficking in Human Organs Convention*), a regional treaty which requires States to exercise extraterritorial criminal jurisdiction over offences under the Convention, support this position.[217] At the State level, as we have seen, Israel and Spain already have laws which operate extraterritorially to prosecute their nationals who travel abroad to engage in transplant tourism.

The ability of States to extend the exercise of their jurisdiction outside their territories on the nationality jurisdiction basis is especially significant in the prohibition of transplant tourism for two major reasons. The first reason is that the exercise of such powers by States ensures that organ commercialization is no longer a prosecution-free offence when it occurs transnationally. Aside from a few transplant and tourist States which now have laws prohibiting transplant tourism,

216 See section 3, *Organ Transplant Law 5768-2008*, Israeli Book of Laws; article 156 bis, *Penal Code of Spain* (Organic Law No. 10/1995 of November 23, 1995, as amended up to Law No. 4/2015 of April 27, 2015).

217 See article 10(1) & (2), *Council of Europe Convention against Trafficking in Human Organs*, CETS No. 216; "The Declaration of Istanbul on Organ Trafficking and Transplant Tourism" (2008) 3:5 Clin J Am Soc Nephrol 1227–1231, online: <http://cjasn.asnjournals.org/content/3/5/1227.full.pdf+html>.

transplant tourism remains legal around the world. A major reason why States exercise extraterritorial jurisdiction is to prosecute perpetrators of transnational crimes and ensure that there are no safe havens for criminals when they are their nationals.[218] Extending extraterritorial criminal jurisdiction to transplant tourism activities will help ensure that everyone involved in transplant tourism activities can be charged and prosecuted by at least the laws of one connected legal system. Such a law will ensure that organ brokers in tourist States who negotiate organ sale deals will not avoid being charged for their actions. It will also ensure that persons returning to their States after traveling abroad to buy organs or undergo transplant operations using organs acquired illegally will be charged and prosecuted under the laws of their States of origin. Under the Spanish *Penal Code,* for instance, nationals who travel abroad and use organs acquired through illegal sources for transplant purposes can be prosecuted when they return home.[219]

The second reason why the use of extraterritorial criminal legislation is relevant in the prohibition of transplant tourism is that, as I have shown in previous Chapters, it is impossible for transplant States to combat transplant tourism on their own. Stiffer regulations in one State will only lead to forum shopping, with tourists travelling for organ transplants to other States with no laws or weak laws against transplant tourism. There is a need to tackle transplant tourism from both the supply (transplant States) and demand (tourist States) sides of the equation. The failure of transplant States to tackle transplant tourism on their own is a testament to this fact. There is a need for tourist States to extend the application of their national laws prohibiting organ trafficking and commercialization to cover those practices which occur abroad when committed by their nationals.

Following the CST model, the prohibition of transplant tourism should occur in stages:

### 1 *Soft Law*

A good place to start in the regulation of offences at international law is through use of soft law. As noted in Chapter 5, although not binding, soft laws offer more flexibility to States, they are cheaper to create and execute, and allow States to test the waters before deciding whether to become bound by treaty law.[220] Soft laws have immediate persuasive authority. They can also

218 *Arrest Warrant Case, supra* note 16 at paras. 73 & 74; Inazumi*, supra* note 77 at 42.

219 See article 156 bis, *Penal Code of Spain, supra* note 216.

220 Kenneth Abbott & Duncan Snidal, "Hard and Soft Law in International Governance" (2000) 54:3 Int'l Org 445; Malgosia Fitzmaurice & Olufemi Elias*, Contemporary Issues in the Law of Treaties* (Netherlands: Eleven Int'l. Pub., 2005) at 43.

provide evidence of state practice in the determination of the existence of a rule of CIL, and can lead to the development of hard international and domestic law on the subject matter which they regulate.[221] In the CST area, the OP2-CRC was based on two soft laws, the *Programme of Action* and the *Declaration and Agenda for Action*. Further, many States passed extraterritorial CST legislation after the *Declaration and Agenda for Action* was adopted. As noted above, soft law is already developing to combat transplant tourism. Starting in 1987, the WHO through the WHA began drafting resolutions and guiding principles on organ donation, organ commercialization and, in more recent years, transplant tourism.[222] These soft law instruments in part influenced the development of the *Declaration of Istanbul* which is currently the most comprehensive and effective international soft law instrument on transplant tourism.[223]

The impact of the *Declaration of Istanbul* has been discussed throughout this publication. It has led to domestic legal reforms in key transplant States and has been adopted by transplant organizations and societies in both transplant and tourist States. It was also one of the instruments which led to the drafting of the *Trafficking in Human Organs Convention.*[224] The *Declaration of Istanbul* is a soft law instrument which should serve as the foundation for a soft law which is more focused on transplant tourism. While the *Declaration of Istanbul* has brought about global reforms in the way States currently approach transplant tourism-related issues and contains useful recommendations on the attainment of self-sufficiency of organs by States, prevention of organ failure, organ allocation, post-transplant care and reimbursements for expenses connected to organ donations, its principles and proposals for the most part do not address legal reforms. Legislation is recommended only as a tool to increase organ supply.[225] In contrast, the CST *Declaration and Agenda for Action* has provisions which promote legal reforms. The *Declaration and Agenda for Action* is rights-based and provided a concrete foundation for the OP2-CRC.[226] A similar soft law instrument focusing on transplant tourism would help usher

221 Alan Boyle, "Some Reflections on the Relationship of Treaties and Soft Law" (1999) 48:4 Int'l Comp L Q 903.

222 See Chapter 4, footnotes 7–35.

223 See preamble, *Declaration of Istanbul, supra* note 217.

224 See European Committee on Crime Problems (CDPC), *Committee of Experts on Trafficking in Human Organs, Tissues and Cells* (*PC-TO*) (Council of Europe, 2012), online: <http://www.coe.int/t/dghl/standardsetting/cdpc/pc_to_en.asp>.

225 See Principle 2, *Declaration of Istanbul, supra* note 217.

226 Articles 4 & 5, The Challenge, *Declaration and Agenda for Action„ supra* note 145; Cullen, *supra* note 149 at 55.

States into creating a new regime to combat transplant tourism. The proposed soft law could be an instrument created under the auspices of the UN or more specifically, the WHO, or, like the *Declaration and Agenda for Action* and the *Declaration of Istanbul*, the product of collaborative efforts between private and State actors.

### 2 *Transplant Tourism Treaty*

Soft law can give rise to treaty law on transplant tourism. As noted earlier, the *Declaration of Istanbul* was one of the instruments which led to the development of the *Trafficking in Human Organs Convention*. Although not yet in force and regional in nature, the *Trafficking in Human Organs Convention* contains provisions which require the use of extraterritorial criminal laws by States in cases involving organ trafficking or commercialization in foreign jurisdictions.[227] An advantage a treaty will have over soft law is that it will place a binding legal obligation on States to act in combatting transplant tourism. The response of States to OP2-CRC lends credence to this point. Although a number of States already had extraterritorial national laws against CST, prosecutions of nationals did not begin until after OP2-CRC was ratified by States. With recent developments in Europe and the widespread acceptance of the *Declaration of Istanbul*, the creation of a global treaty on transplant tourism, or additional regional treaties, are real possibilities.

The treaty on transplant tourism could take one of two different approaches: it could be a UN transnational criminal law treaty or human rights treaty. Of these two options, a UN human rights treaty on transplant tourism would be the most preferred alternative as transplant tourism prohibition would be able to benefit from established regulatory and monitoring mechanisms which already exist under the UN human rights system. Another benefit of the UN human rights treaty is that these treaties do have requirements that States create domestic criminal laws with extraterritorial scope for their enforcement.[228] Taking a cue from the CST model where the CRC-OP2 is created as an optional protocol to the CRC, the treaty on transplant tourism could be an optional protocol to the ICCPR since it already contains provisions which relate to aspects of transplant tourism such as the right to life and the right to be free from torture, inhuman and degrading treatment.

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227 See articles 2, 10 and 17, *Trafficking in Human Organs Convention, supra* note 217.

228 See for e.g., articles 3(1) & 4(2)(a) OP2-CRC, *supra* note 150; article 5, *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,* GA Res. 39/46, annex, 39 UN GAOR Supp. (No. 51) at 197, UN Doc. A/39/51 (1984); 1465 UNTS 85.

### 3 *National Criminal Laws*

The success the proposed model will depend largely on national laws. Before a State can exercise extraterritorial criminal jurisdiction over any matter, there must be a national law to that effect. The nature and format of domestic criminal law on transplant tourism will ultimately depend on the principles, policies, legal rules and division of powers of the implementing State. Using Canada as a test ground for the implementation of such a law, Canada has a federal system of government with powers divided between the federal and provincial/territorial governments by the Canadian *Constitution Act* (the *Constitution*).[229] As noted earlier, section 91 of the Constitution lists the subjects over which the federal Parliament has legislative jurisdiction and Section 92 grants exclusive powers to the provinces/territories over certain matters.[230] There are established rules used to settle disputes where there is an overlap between the federal and provincial governments' powers.[231] In Canada, the legislation of criminal law matters falls under section 91, the exclusive legislative jurisdiction of the Canadian federal Parliament.[232] The federal Parliament also has exclusive powers to exercise extraterritorial powers outside of Canada.[233] Any future Canadian law prohibiting transplant tourism by Canadian nationals would have to involve a *Criminal Code* amendment or separate federal criminal law legislation. A troubling principle which States should avoid in their drafting of extraterritorial criminal legislation against transplant tourism is the principle of double criminality which requires that the offence also be an offence in the destination State. Not all States have transplant laws or laws against organ commercialization. The inclusion of the double criminality principle will limit the effectiveness of a law prohibiting transplant tourism.

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229 *The Constitution Act*, *supra* note 108.

230 Supra note 109. See ss 91 & 92, *Constitution Act*, *ibid.*

231 See *A.G. Canada v A.G. Ontario & Others* [1931] UKPC 93; *A.G. Canada v A.G. British Columbia & Others* [1930] AC 111.

232 See section 91(27), *Constitution Act, supra* note 108; Provinces also have the right to impose punishment by "fine, penalty, or imprisonment" on any of the matters which fall within their exclusive jurisdiction. This is why provincial laws such as the *Human Tissue and Organ Donation Act* of Alberta can impose fines for offences under the Act. See section 92(15), *Constitution Act*; ss 3(2) & 13 (3), the *Human Tissue and Organ Donation Act, supra* note 46.

233 The words used in section 92 of the *Constitution* are: "In each province the Legislature may exclusively make law …" This presupposes that the powers of the Legislature to make laws in each province is exclusive to that province. See the cases of *The Queen* (*Man.*) *v Air Canada* [1980] 2 SCR 303; *Unifund Assurance Co. v Insurance Corp. of British Columbia* [2003] 2 SCR 63.

## Conclusion

In this Chapter, I examined the role of extraterritorial criminal legislation in the global prohibition of transplant tourism. In doing this, I looked at the various principles of jurisdiction that States use in their extraterritorial extension of criminal laws. These principles can be traced back to the decision of the PCIJ in the *Lotus Case*. Of the various principles considered, the territorial, nationality and passive personality principles were proposed as the principles which would be most relevant in the prohibition of transplant tourism by States via extraterritorial criminal legislation. The territorial principle is based on the right of States to control activities which occur within their territories. In instances where only certain elements of an activity occur within a State, various rules have been developed to guide the application of criminal jurisdiction by States. Under Canadian law, the real and substantial connection test is used to determine whether a criminal act falls within the prescriptive jurisdiction of Canada. The nationality and passive personality principles are based on the right of States to control their nationals and protect them from harm.

In establishing support for the application of these principles to transplant tourism cases, the CST model was examined. This examination was carried out for two major purposes. The first was to show the similarities between the practices of CST and transplant tourism. The second examined the success of the model used to prohibit CST and how that model can be used to prohibit transplant tourism. It was shown that the prevention of CST using extraterritorial criminal laws has a few shortcomings which can be linked in part to the secretive nature of CST practices. Due to the reliance of transplant tourism on the healthcare sector of both transplant and tourist States, transplant tourism practices cannot be kept secret. This in turn should lead to a more successful implementation of the CST model when it is applied to transplant tourism.

This Chapter ended with arguing for the application of the CST model to transplant tourism in three stages. The first stage will involve the adoption of a soft law instrument focused on transplant tourism which will focus on legal reforms in the prohibition of transplant tourism practices. Current soft law instruments on transplant tourism such as the *Declaration of Istanbul* and the various WHO resolutions and guiding principles on organ donation, organ commercialization and transplant tourism could serve as a foundation for a soft law on transplant tourism. The second stage will involve the adoption of a treaty on transplant tourism. Recent developments in the prohibition of transplant tourism such as the 2014 *Trafficking in Human Organs Convention* makes the drafting of a future treaty on transplant tourism visible. The final stage will involve the passing of national extraterritorial criminal laws by States which

will enable them charge and prosecute their nationals who get involved in transplant tourism. Two States, Israel and Spain, are already doing this.

The implementation of the various stages by States and the international community to the prohibition of transplant tourism will not be without its challenges. There are limits, restrictions and difficulties to the prosecution of transnational crimes in general. These include the implementation of laws with extraterritorial elements in promulgating States, acquiring evidence of crimes committed in another jurisdiction and securing the presence of accused persons within the jurisdiction of the State exercising prescriptive extraterritorial jurisdiction. The enforcement and monitoring of extraterritorial criminal laws is crucial to their success. Possible solutions to these challenges will be the focus of the next Chapter.

CHAPTER 7

# Enforcement of Transplant Tourism Criminal Law Model

## A Introduction

In the last Chapter, I discussed the concept of prescriptive jurisdiction and the rules that govern its exercise by States. In particular, I examined the various international law principles used by States to extend their national criminal laws to offences which occur abroad. Starting from its modest beginnings in the *Case of the S.S. Lotus* (*France v Turkey*) (*Lotus Case*), the application of these principles has since expanded to cover various instances where States can exercise extraterritorial criminal jurisdiction.[1] Of all the principles examined, the territoriality, nationality and passive personality principles were recognized as being the most relevant to the prohibition of transplant tourism by States. The territorial and nationality principles have been used by some tourist States to prosecute nationals who travel abroad to engage in child sex tourism (CST) activities. Under various national laws, nationals of tourist States who travel to destination States to engage in CST can be prosecuted in their States of origin on their return.

The same principles which apply to CST are relevant and applicable in the prohibition of transplant tourism. This is especially so as there are many similarities between transplant tourism and CST. These similarities were outlined in the previous Chapter.[2] However, the CST model has not led to the same results in all the States which currently implement the model. While the model has led to numerous prosecutions in States like the US and Australia, in contrast, Canada has not recorded the same amount of success due to several factors.[3] Experiences of States which currently implement the CST model can be used

1 See the *Case of the S.S. Lotus* (*France v Turkey*) (1927), PCIJ Series A, No. 10 at 45.

2 These similarities include the fact that the national variations of both offences are illegal in most States, both offences have transnational elements, they are sustained by similar factors and have similar impacts on their victims. See Chapter 6, footnotes 198–210.

3 These factors include the difficulty in securing evidence of the offence in transplant/destination States and the principle of double criminality. See Benjamin Perrin, "Taking a Vacation from the Law? Extraterritorial Criminal Jurisdiction and Section 7(4.1) of the Criminal Code" (2009) 13:2 Can Cri L Rev 204–205.

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to build an improved model for the prohibition of transplant tourism. A couple of States already implement models like the CST model in the prohibition of transplant tourism with positive results.[4] The disparities between the effect of the CST model in implementing States point to the fact that for any legal model to be successful in combating transnational crimes, States must develop ways of combating the challenges inherent in the adopted model.

In the prohibition of transplant tourism using extraterritorial criminal legislation, there are certain difficulties which must be addressed by States if the model is going to be successful. These difficulties can be found in both tourist and transplant States. In tourist States, there are local factors such as inadequate laws and poor enforcement of available laws which could limit the effects of transplant laws. In addition, there are procedural challenges unique to the prosecution of extraterritorial offences by tourist States which those States would have to surmount. These challenges include an elaborate network of rules and principles which govern the admissibility of evidence obtained in other jurisdictions, the difficulties of proving the commission of an offence and securing the attendance of witnesses and victims based in foreign States in court during trial. Other difficulties faced by tourist States include the inability of tourist States to prosecute their nationals for offences committed in other States if those offenders are out of jurisdiction and there is no extradition agreement between the tourist State and the State where the offenders are residing. In other cases, tourist States are just not willing to prosecute their nationals for the commission of certain extraterritorial offences. The unwillingness of tourist States to prosecute their nationals is usually reflected in the policies of those States on extraterritorial offences and the steps taken to legislate against those offences.

There are also difficulties in transplant States which could limit the success of transplant laws. Like tourist States, there are local factors prevalent in transplant States which sustain transplant tourism and make its eradication difficult. These factors include poverty, corruption, poor regulation, weak enforcement procedures, inadequate local laws and cultural practices. Transplant States also have to contend with procedural challenges which make it difficult to prove the commission of an offence or get the necessary evidence needed to prosecute the offender in a different jurisdiction. Due to the illegal nature of the activities involved in transplant tourism, the secrecy under which some of these activities are carried out, corrupt members of enforcement and regulatory bodies and the powers which organ brokers

4 See discussions on Spain and Israel in Chapter 3, footnotes 140–166.

wield, it might be difficult to acquire evidence needed to prosecute offenders who reside in transplant States.

In this Chapter, I will discuss all the above difficulties inherent in the exercise of extraterritorial criminal jurisdiction by States. I will also discuss possible solutions to some of them. Some of these solutions, such as the use of mutual legal assistance treaties, are already available in international law and are used by States in the enforcement of various laws. Other challenges such as poverty and corruption are troublesome issues with no easy remedies. Transplant States have to tackle these issues as part of their general social and legal reforms. I will be suggesting the introduction of new solutions such as the use of transplant certificates for the verification of legally acquired organs and the creation of an obligation for medical practitioners to report cases of foreign organ transplants as measures which could aid in the prosecution of individuals who take part in transplant tourism. An obvious concern which jumps out immediately from the latter recommendation, and which will be addressed, is the right to privacy of medical records and the breach of the doctor-patient confidentiality obligation. Finally, I will look at the importance of monitoring by various bodies and the roles these bodies must play in ensuring that the prohibition of transplant tourism by States using extraterritorial criminal legislation is a success.

## B Enforcement Challenges

### 1 *Local Factors in Transplant States*

Although legal reforms and policy changes in tourist States would weigh significantly in the eradication of transplant tourism, the duty of eradicating transplant tourism practices is a shared responsibility between both transplant and tourist States. Transplant States have an important role to play in the eradication process because they provide a conducive environment for transplant tourism to thrive. Transplant tourists choose to travel to transplant States to purchase organs because they know there are people in those States who will sell their organs and they, the transplant tourists, will be able to evade local laws and enforcement mechanisms set up to prevent transplant tourism. If it was impossible for transplant tourists to buy organs in transplant States, individuals from tourist States would be forced to source organs within their own States which, in turn, would place more pressure on their governments to seek out more ways of becoming self-sufficient through the acquisition of organs needed for transplantation locally. Sadly, this is not the case and local factors in transplant States continue to make them attractive destinations for organ

tourists and brokers. These local factors include poverty, corruption, poor regulation of health-care practitioners, the need to keep their States tourist-friendly, ineffective or the total absence of laws against transplant tourism and organ commercialization, and inadequate or weak enforcement procedures in these States. While some of these factors are easy to tackle, some of them are enshrined in the cultural practices of societies in these States, making them difficult to regulate.

The current paucity of national laws penalizing transplant tourism practices in tourist and transplant States has contributed to the global growth and expansion of transplant tourism.[5] With only three transplant States with laws against transplant tourism, other transplant States have indirectly left their nationals without any form of protection against transplant tourism practices. A possible reason for the lack of anti-transplant-tourism laws in most transplant States is the fear of endangering revenue gotten from medical tourists. Transplant tourism, a species of medical tourism, is a significant revenue generator for these States and medical tourists usually prefer destinations with less regulations.[6] Thus, there is an incentive for transplant States not to prohibit transplantation activities. Individuals from tourist States are aware of these factors and capitalize on them. Aside from Spain and Israel, individuals in need of organs in tourist States know that there will be little or no consequences in buying an organ in other States.[7] Not only that, they can always return home after successful organ transplants and still receive the same type of postoperative care as individuals who have followed the law by waiting in line for an organ or who could not afford the costs of purchasing an organ elsewhere. The lack of laws in tourist States against transplant tourism, coupled with the post-operative

5 Alireza Bagheri, "Asia in the Spotlight of the International Organ Trade: Time to Take Action" (2007) 2:1 Asian J WTO Int'l Health L Poly 15.

6 Andrea Whittaker, "Pleasure and Pain: Medical Travel in Asia" (2008) 3:3 Glo Pub Health 277; Rory Johnston *et al*, "What is Known about the Effects of Medical Tourism in Destination and Departure Countries? A Scoping Review" (2010) 9:24 Int'l J Equ Health 30; Ramya Vijaya, "Medical Tourism: Revenue Generator or International Transfer of Healthcare Problems?" (2010) 44:1 J Econ Issues 55; Kalen Fredette, "International Legislative Efforts to Combat Child Sex Tourism: Evaluating the Council of Europe Convention on Commercial Child Sexual Exploitation" (2009) 32:1 Boston Col Int'l & Com L Rev 13.

7 See section 3, *Organ Transplant Law 5768-2008*, Israeli Book of Laws (OTL); article 156 bis, *Penal Code of Spain* (Organic Law No. 10/1995 of November 23, 1995, as amended up to Law No. 4/2015 of April 27, 2015).

care nationals receive when they return to their home States, fosters transplant tourism practices.[8]

A few transplant States have, however, gone ahead to legislate against transplant tourism. Although the laws in Pakistan, India and the Philippines have not successfully eradicated transplant tourism, they have made it more difficult for foreigners to buy organs in these States. In the Philippines, for instance, the number of reported foreign organ transplant recipients fell from 531 in 2007 to just 2 in 2011.[9] This has given rise to a diverted and expanded organ market with organ buyers and brokers seeking out more favorable States where they can purchase organs with little opposition. There are still States which do not have organ transplant laws, so that the sale of organs in those States is unregulated. In recent years, following the ban of organ transplants to foreigners in India, Pakistan and the Philippines, transplant tourism practices have surged in States like Nepal, Bangladesh and Sri Lanka.[10] Recently, in January 2016, the Sri Lankan government had to place a temporary ban on all kidney transplants to foreigners in the State following the detention of three Indians who allegedly recruited at least 60 Indians to sell their kidneys in Sri Lanka.[11] It will be impossible to eradicate transplant tourism without legal reforms in not only key transplant and tourist States, but all States in general.

Even when laws against transplant tourism exist, poverty continues to remain a significant obstacle to the proper enforcement of laws against transplant tourism and organ commercialization in transplant States. Individuals who sell their organs have been shown to come from developing States, live in predominantly poor communities and do it mainly for financial reasons.[12] While the existence of extraterritorial criminal laws against transplant tourism would deter a lot of organ tourists from tourist States from seeking out

8 Linda Wright *et al,* "Kidney Transplant Tourism: Cases from Canada" (2013) 16:4 Med Health Care & Philos 923.

9 Benita Padilla *et al*, "Impact of Legal Measures Prevent Transplant Tourism: The Interrelated Experience of the Philippines and Israel" (2013) 16:4 Med Health Care & Philos 918.

10 Nishtha Chugh, "Need a Kidney? Inside the World's Biggest Organ Market" Aljazeera (08 October 2015), online: <http://www.aljazeera.com/indepth/features/2015/10/kidney-worlds-biggest-organ-market-151007074725022.html>.

11 Uditha Jayasinghe, "Sri Lanka Suspends Kidney Transplants for Foreigners after India Arrests" The Wall Street Journal (28 January 2016), online: <http://blogs.wsj.com/indiarealtime/2016/01/28/sri-lanka-suspends-kidney-transplants-for-foreigners-after-india-arrests/>.

12 Javaad Zargooshi, "Iranian Kidney Donors: Motivations and Relations with Recipients" (2001) 165:2 J Urol 387.

organs abroad, there will still be individuals who will be willing to risk travelling abroad to buy organs if they are assured of getting organs in transplant States.[13] Aside from States like China, where the government plays a major role in sourcing organs for transplantation, these tourists will ultimately still depend on getting organs from the poor. As long as there is an available market for human organs, there will always be individuals ready to take advantage of this market.

Closely related to the challenge posed by poverty in transplant States is corruption. Most transplant States score poorly on the yearly Corruption Perceptions Index compiled by Transparency International (TI).[14] In the 2015 report, key transplant States like India, Pakistan, the Philippines and Moldova all scored below 40 on a scale of 0 (highly corrupt) to 100 (very clean).[15] The enforcement of the proposed transplant tourism model will rely heavily on the generation of evidence from transplant States to prove the commission of an offence. The officials who will be responsible for providing this evidence are in most cases the same officials responsible for preventing the practices of organ sales and trafficking. These officials have been shown to be corrupt and sometimes they turn a blind eye to organ commercialization practices.[16] In India, for instance, the authority responsible for approving non-related organ transplants, the Authorization Committee (AC), has been accused in the past of permitting illegal transplants.[17] It is doubtful that these authorities will incriminate themselves in cases of suspected transplant tourism activities if relied on to provide relevant evidence of the practices. Corruption also leads to weak enforcement of laws. The enforcement of extraterritorial criminal laws by tourist States will be difficult if law enforcement agencies in transplant States cannot be relied upon to enforce local transplant laws.

The level of corruption witnessed among the enforcement agencies in transplant States can also be found in the healthcare systems of transplant States. Unlike crimes like CST which are committed in secret and untraceable in

13 Part of the use of extraterritorial criminal legislation is to deter would-be offenders from participating in the offence the government seeks to regulate. See James McNicol & Andreas Schloenhardt, "Australia's Child Sex Tourism Offences" (2012) 23:3 Curr Issues Crim Jus 378.

14 Transparency International, "Corruption Perceptions Index 2015," online: <http://www.transparency.org/cpi2015>.

15 *Ibid.*

16 Vivekanand Jha, "Paid Transplants in India: The Grim Reality" (2004) 19:3 Nephrol Dial Transplant 542.

17 *Ibid.*

most cases, the success of transplant tourism depends on the cooperation of the healthcare system and licensed medical professionals and their staff who perform the operations in transplant States. Medical professionals have been involved in the illegal sourcing of organs for transplant purposes via organ trafficking and other methods of illegal organ acquisition.[18] The acquiescence of medical practitioners in these activities is, however, not always motivated by money. Medical practitioners are sometimes sympathetic to the plight of transplant patients or are indifferent about the sources of organs used for transplants and proceed to perform suspicious transplant procedures.[19] As is the case with transplant enforcement officials, it will be difficult to get the cooperation of these medical professionals in the prosecution of persons suspected of engaging in transplant tourism. In combination, these local factors will make the prohibition of transplant tourism with the use of extraterritorial criminal laws difficult.

### 2 *Challenges in Securing Evidence in Transplant States*

Distance, language barriers, location of victims and the hidden nature of offences, etc., make gathering evidence for the prosecution of individuals charged with committing extraterritorial criminal offences a daunting task.[20] Since the acts which comprise transplant tourism are transnational in nature, evidence can spread across several States. Although most transplant tourism cases will typically involve two States (the tourist and transplant States), there are cases where transplant tourism practices are spread among three or more States especially when organ sellers have to be transported from one State to another for the transplant. There will always be the need to secure evidence of transplant tourism from the multiple States involved in each individual transaction. While it might be easier to get evidence of organ brokering, flights and postoperative care which occur in the tourist State, the opposite is the case when gathering evidence of acts which occurred in transplant States. Aside from the local factors discussed earlier which could possibly frustrate the collection of evidence of transplant tourism activities in transplant States, States are prevented by their international law obligations from exercising

18 Neeraj Rai & Sapna Rai, "Organ Transplantation in India, Governing Laws and their Analysis" (2015) 4:9 Glob J Multidiscip Stud 67; Nancy Scheper-Hughes, "Keeping an Eye on the Global Traffic in Human Organs" (2003) 361:9369 The Lancet 1646.

19 Sunil Shroff, "Organ Donation and Transplantation in India: Legal Aspects & Solutions to Help with Shortage of Organs" (2009) 2:1 J Nephrol Renal Transplant 29.

20 McNicol & Schloenhardt, *supra* note 13 at 384; Naomi Svensson, "Extraterritorial Accountability: An Assessment of the Effectiveness of Child Sex Tourism Laws" (2006) 28:3 Loy L A Int'l & Comp L Rev 659.

their enforcement jurisdiction in the territories of other States. This general rule can be found in the decisions of the PCIJ in the *Lotus Case* and has its foundation in the sovereignty of States.[21] States always need the permission or assistance of other States to execute orders or gather evidence in those States.[22] If permission is granted, executing officials must abide by the rules of the foreign State when executing orders or gathering evidence in that State. Failure to comply with these rules could result in grave consequences which include arrest, imprisonment or deportation.[23]

It is usually more convenient for States to depend on other States to gather evidence as opposed to trying to source the evidence themselves.[24] A tradition of cooperation between both relevant States might make this task easier. Even where cooperation exists, there are various other obstacles which could affect the nature, quality or relevance of the evidence secured. While there exist various forms of agreements between States on the exchange of data and information such as mutual legal assistance treaties, letters rogatory requests and other non-treaty requests, implementing or executing these agreements is not always straightforward or easy.[25] The challenges involved in securing evidence is especially difficult when the State where most or all of the elements of the offence occurred is one which does not have a reliable system or practice of storing or gathering information or where the enforcement agencies responsible for executing the task of securing this information are ill-equipped, corrupt or lax.

The hidden nature of most extraterritorial crimes makes it difficult for authorities to trace them or gather all the evidence needed to prove their commission. Apart from cases where the State is actively involved in the activity sought to be prohibited, there is always some form of secrecy involved in the activities which form the subject matter of extraterritorial criminal regulation.[26]

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21 *Lotus Case, supra* note 1 at para. 45. See Chapter 6, footnotes 7–20 for a detailed discussion on enforcement jurisdiction.

22 *US v Alvarez-Machain* [1992] 504 US 655; *A.G. Israel v Eichmann* [1961] 36 ILR. 5 (Dist. Ct. Jerusalem); Michael Bulzomi, "Investigating International Terrorism Overseas: Constitutional Considerations" (2003) 19:77 Crime & Just Int'l 29, Perrin *supra* note 3 at 187.

23 Mark Orndorf, "The Secrete World of Child Sex Tourism: Evidentiary and Procedural Hurdles of the Protect Act" (2010) 28:4 Penn St Int'l L Rev 812.

24 Svensson, *supra* note 20 at 659.

25 Perrin *supra* note 3 at 188–189.

26 For instance, a major challenge in the regulation of CST sterns from the fact that the act is hard to prove as most of the practices are hidden. See Amy Fraley, "Child Sex Tourism Legislation under the Protect Act: Does it Really Protect?" (2005) 2:79 St John's L Rev 445;

Though related to CST, transplant tourism is more traceable. Unlike most extra-territorial offences, transplant tourism relies on medical centers and doctors for transplantations and postoperative care and management.[27] Even with this connection to the health care sector, it could be difficult to trace evidence of actual contracts for organ sales between the organ seller and buyer. Aside from the fact that contracts for the sale of organs are usually informal, they sometimes involve multiple parties. These parties include the organ seller, the organ buyer (who could be a single intermediary broker or part of a string of intermediaries), the medical center where the transplant operation will be performed, the medical doctor performing the operation and the individual tourist receiving the organ.[28] Where there are intermediaries facilitating the organ sale transaction, there might not be any real link between the organ seller and the actual buyer thus making the contract and sale difficult to establish. Further making most organ sale transactions untraceable is the fact that black market transactions are usually paid for in cash with no form of documentation.[29] In transplant tourism transactions, intermediaries and medical practitioners are the ones who get the bulk of the money in the transplant tourist transaction. The actual organ sellers do not get paid a lot of money so it is easy to pay them in cash.[30] In cases where there is actual documentation of organ transplants, it might be difficult to gain access to this information due to rules governing the confidentiality of medical records.[31]

Where there is lack of evidence proving contracts to sell organs, evidence of sale can be gotten through the testimonies of the organ sellers which can be supported by evidence of their scars or missing organs and the lack of any real

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Nathalie McClain & Stacy Garrity, "Sex Trafficking and Exploitation of Adolescents" (2011) 40:2 JOGNN 243; Orndorf, *supra* note 23 at 789.

27 Transplant tourism practices in private healthcare centers which are part of a transplant tourism ring might be an exception to this broad view on the transparency of transplant tourism. In such cases, these healthcare centers might go to great lengths to hide their activities. See Mark Hanson, "A Pig in a Poke" (1992) 22:6 Hastings Cent Rep 2.

28 Madhav Goyal *et al.*, "Economic and Health Consequences of Selling a Kidney in India" (2002) 288:13 JAMA 1590; Ranee Panjabi, "The Sum of a Human's Parts: Global Trafficking in the Twenty-First Century" (2010) 28:1 Pace Envtl L Rev 25.

29 Edgar Feige, "New Estimates of U.S. Currency Abroad, the Domestic Money Supply and the Unreported Economy" (2012) 57:3 Crime L Soc Chan 241.

30 Jeremy Haken, *Transnational Crime in the Developing World* (Washington: Global Financial Integrity, 2011) at 23; Vanessa Chandis, "Addressing a dire Situation: A Multi-Faceted Approach to the Kidney Shortage" (2006) 27:1 U Pa J Int'l Econ L 205.

31 David Graham, "Revisiting Hippocrates: Does an Oath Really Matter?" (2000) 284 JAMA 2841.

relationship between the seller and the buyer. Securing the testimony of organ sellers is, however, not an easy task.[32] In communities notorious for the sale of organs, there is stigma attached to the sale of organs.[33] This stigma prevents individuals from disclosing the fact that they have sold their organs to feed the organ market. Even where this stigma is non-existent, organ sellers will most likely not report the sale because the sale of organs is an offence under the local laws of most States. Organ sellers are placed in the difficult position of being both victims of transplant tourism and offenders. It should be noted that although organ sellers are taken advantage of and are faced with a number of challenges after the sale, in most cases they were willing parties to the sale and are parties to the offence.[34] These individuals will always choose to hide the fact that they sold their organs and preserve themselves from self-incrimination and the legal repercussions of their actions.[35] Those bold enough to want to disclose the crime will in most cases not have links or contacts to the buyers. It is likely that organ buyers and intermediaries continue with their trade because they are aware of these factors.

Securing the testimonies of other witnesses to the transaction could also complicate the process of obtaining evidence of transplant tourism in transplant States.[36] Individuals who are aware of the commission of transnational offences often shy away from authorities, making it difficult to secure their testimonies. In most cases, there is a conspiracy of silence by witnesses to these offences. This is due in part to the fact that the public officials charged with the duty of enforcing transplant laws in transplant States are sometimes parties to organ sale transactions or are bribed to look the other way. This breeds mistrust among individuals as they might be reporting offences to these types of public officials. Witnesses could also be scared of the offenders as organ brokers sometimes belong to well-established gangs who have the means and connections to protect themselves and their transactions.[37] In some cases, witnesses just do not want to get involved with investigations and cases. These

32 Farhan Yousaf & Bandana Purkayastha, "'I am Only Half Alive': Organ Trafficking in Pakistan Amid Interlocking Oppressions" (2015) 30:6 Int'l Soc 644.

33 Angelo Nicolaides & Athena Smith, "The Problem of Medical Tourism and Organ Trafficking" (2012) 26:2 Med Tech SA 36; Debra Budiani-Saberi & Frances Delmonico, "Organ Trafficking and Transplant Tourism: A Commentary on the Global Realities" (2008) 8:5 Am J Transplant 927–929.

34 James Taylor, *Stakes and Kidneys: Why Markets in Human Body Parts are Morally Imperative* (Aldershot: Ashgate Press, 2005) at 1.

35 Yousaf & Purkayastha, *supra* note 32 at 644.

36 McNicol & Schloenhardt, *supra* note 13 at 385.

37 Christian Williams, "Combatting the Problems of Human Rights Abuses and Inadequate Organ Supply through Presumed Donative Consent" (1994) 26:2 Case W Res J Int'l L 323.

factors, combined with local factors in transplant States, could make the sourcing of evidence to prove transplant tourism an arduous task.

### 3 *Evidentiary and Procedural Challenges in Tourist States*

The purpose of extraterritorial criminal laws is to allow States prosecute their nationals in their own courts for offences committed abroad. This power is usually exercised after an accused has been arrested after returning to his or her State of nationality or after they have been extradited under an extradition agreement.[38] Even after apprehension, the accused is still deemed to be innocent until proven guilty.[39] In Canada, this principle of innocence is enshrined in the *Canadian Charter of Rights and Freedoms*.[40] In criminal cases, the standard of proof is high and the accused must be found guilty beyond a reasonable doubt in order for the prosecution to be successful. This standard has its foundation in common law and has been adopted and applied by Canadian courts.[41] The onus of proving the commission of any crime, including an extraterritorial crime, lies with the State, which in turn depends largely on the quality of evidence gathered on the crime and the admissibility of this evidence. Evidence can be gathered from the testimony of witnesses given under oath, documentary evidence and the examination of objects entered into evidence. All States have evidentiary rules which guide the admission of each type of evidence. While most of these rules are general, some are specific and apply only to special cases.[42]

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38 Charles Doyle, *Extraterritorial Application of American Criminal Law* (Collingdale: Diane Pub., 2010) at 23; Michael Farbiarz, "Extraterritorial Criminal Jurisdiction" (2016) 114:4 Mich L Rev 549.

39 In international human rights law, see e.g., article 11, *Universal Declaration of Human Rights*, GA Res. 217 (III), UN GAOR, 3d Sess., Supp. No. 13, UN Doc. A/810 (1948) 71; Article 14, *International Covenant on Civil and Political Rights*, GA Res. 2200A (XXI), 21 UN GAOR Supp. (No 16) at 59, UN Doc. A/6316 (1966); 999 UNTS 302.

40 See section 11(d), *Canadian Charter of Rights and Freedoms, Part I of the Constitution Act,* 1982, being Schedule B to the Canada Act 1982 (UK), 1982, c 11. It states that "Any person charged with an offence has the right to be presumed innocent until proven guilty according to law in a fair and public hearing by an independent and impartial tribunal." See also *R v Oakes* [1986] 1 SCR 103.

41 See *Woolmington v DPP* [1935] AC 462 at 481. For notable Canadian case, see *R v Lifchus* [1997] 3 SCR 320.

42 In Canada, the rules of evidence can be found under various statutes. The applicable rules will depend on whether the matter before the court is a federal or provincial matter and the court trying the case. The Canadian *Evidence Act*, RSC 1985, c. C-5, is the main statute which applies to criminal and civil proceedings on matters which Parliament has jurisdiction. Each province has its own evidence Act. The applicable Act in Alberta

The admission of evidence is more problematic in the prosecution of extraterritorial criminal offences. The first difficulty involves securing the presence of witnesses from other jurisdictions to testify at trials. The second challenge surrounds the admission of evidence obtained from other jurisdictions. Earlier in this Chapter, I talked about how difficult it is to find witnesses who are willing to testify about the commission of extraterritorial criminal offences. Where witnesses are found, the ideal next step is to secure their presence in trials against the accused so they can give their testimonies in court and be confronted by the accused or his or her legal representatives. However, this is not always a practical option as bringing witnesses from foreign jurisdictions to attend trials could be expensive, inconvenient and stressful for both the State and the witness.[43] One possible solution is for the evidence of the witness to be transmitted live via satellite. Technological advancements have also made it possible for witnesses' testimonies to be transmitted electronically, thus eliminating the necessity of their physical presence at trials.[44]

Another option opened to States is to acquire the deposition of witnesses and use them against the accused in trials. Where the testimonies of witnesses are documented, the question of admissibility is raised. The law generally frowns on use of hearsay evidence as every accused person has the right to confront witnesses.[45] To be admissible in court, the documented testimonies of witnesses must fall within an exception to the rules against hearsay evidence. The national criminal, evidence and procedural laws of States lay down exceptions to the rules against hearsay evidence and the deposition of a witness abroad might still be entered into evidence if it falls within one or more of these legally permitted exceptions.[46] In Canada, the deposition of witnesses

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for instance is the *Alberta Evidence Act*, RSA 2000, c. A-18. The various courts have Rules of Court which set out guidelines for proceedings which include rules of evidence. See for instance the *Rules of the Supreme Court of Canada*, SOR/2002–156. Rules of evidence can also be found under specific legislation which govern special types of proceedings. The admissibility of foreign evidence for instance is govern partly by the *Mutual Legal Assistance in Criminal Matters Act*, RSC 1985, c. 30 (4th Supp.).

43 Orndorf, *supra* note 23 at 807.

44 *Ibid.*

45 Hearsay evidence has been defined as a statement not made by the declarant while testifying at a trial and which has been offered in evidence by a party to prove the truth of a matter declared in that statement. See *Federal Rules of Evidence, Rule 801*; *R v Khelawon* [2006] SCR 787 at para. 59; *R v Baldree* [2013] SCC 35.

46 Under US law, exceptions to the hearsay rule can be found under Rule 803 of the *Federal Rules of Evidence*. See also Doyle, *supra* note 38 at 33–34; *Ohio v Roberts* [1980] 448 US 56; *Maryland v Craig* [1990] 497 US 836.

and general admissibility of evidence obtained abroad is governed by section 36 of the *Mutual Legal Assistance in Criminal Matters Act*.[47] By that provision, records of statements of persons abroad are not inadmissible in Canada because they are statements of opinion or hearsay.[48] While this provision addresses the admissibility of depositions made abroad, the real challenge still remains securing the testimonies of witnesses to crimes of this nature.

### 4 *Policies and Abilities of the Enforcing State*

Legal regimes and models are only successful when complemented with adequate enforcement mechanisms. There are several factors which lead to poor law enforcement. The roles that poverty and corruption play in the failure of extraterritorial criminal laws have already been discussed. Other factors which impede the successful implementation of legal regimes include: (1) the lack of will power and commitment of States to the prevention of the practice sought to be regulated by the regime, (2) the financial ability of States to put in place the necessary enforcement mechanisms needed to stop the practice, arrest defaulters and successfully prosecute cases, and (3) the law enforcement tradition and culture of States.

The will of a State in reference to the prohibition of a practice is often a reflection of that State's policy on the practice. Sometimes, States pass laws to fulfil their obligations under international law with no real desire to implement that law fully.[49] At other times, although States are sincere in their desire to stop a practice, they do not fully commit to their obligations. Although passing extraterritorial criminal laws against transplant tourism would be an essential step towards its eradication, States need to commit to the enforcement of that law for it to record any significant success. There are examples of laws which have had different effects in different States. While the low record of success is sometimes the effect of the nature of the laws a State chooses to adopt, at other times a holistic law suffers from poor enforcement.[50] The prohibition of CST by

47 See section 36, *Mutual Legal Assistance in Criminal Matters Act*, *supra* note 42.

48 *Ibid.*

49 George Downs & Michael Jones, "Reputation, Compliance, and International Law" (2002) 31:2 J Legal Stud S96.

50 In the regulation of CST for instance, the introduction of the "double criminality" principle into national CST Laws by some States is part of the reason why those States have not recorded a lot of success in their prosecution of the offence. The UK for instance introduced the principle in section 72(3) of the *Sexual Offences Act* of 2003, c. 42 which made it impossible for UK nationals to be prosecuted for CST activities if the act is not an offence in the country where it is performed. This provision is now contained in section 72(2) of the *Criminal Justice and Immigration Act* 2008 (c.4).

various States is a case in point. Although States like Australia and the US have both recorded successes in their prohibition of CST as reflected in the number of prosecutions they have had, the same is not the case with Canada which has had very few prosecutions under section 7(4.1) of the *Criminal Code*.[51]

Sometimes States might have the will to eradicate a practice but simply lack the ability to enforce laws which penalize it.[52] This statement is true for most transplant States as they are mostly developing States that do not have the resources needed to prevent transplant tourism. It is difficult to fight a practice where most of the beneficiaries of that practice are from rich nations that have not taken any real steps to penalize their nationals for engaging in that practice. Aside from medical tourists with the ability to pay high fees for organs, transplant States also have to contend with organ brokers who are sometimes members of established gangs equipped with the resources needed to protect their transactions and frustrate mechanisms created by the State to stop them.[53] The current regulation of organ commercialization and trafficking illustrates this point. Although most transplant States have laws against the sale of human organs, the practice still thrives in spite of these laws.

In other situations, some States are notorious for having a poor track record of human rights protection and enforcement. This is especially so in States in parts of Asia and Africa. As was shown in Chapter 4, Asia is the only continent without a regional human rights treaty system.[54] Some Asian States have not ratified key human rights treaties. China for instance is yet to ratify the *International Covenant on Civil and Political Rights* (ICCPR).[55] Some other Asian States have ratified human rights treaties but have low compliance, and, in some cases, have made serious reservations.[56] Part of the reason why there

51 See section 7(4.1), *Criminal Code* of Canada, RS 1985, c. C-46; Perrin *supra* note 3 at 204.

52 Oona Hathaway, "Do Human Treaties Make a Difference?" (2002) 111:8 Yale L J 2005–2006; Ryan Goodman & Derek Jinks, "Measuring the Effects of Human Rights Treaties" (2003) 14:1 EJIL 172.

53 Williams, *supra* note 37 at 323.

54 Note that States in the Asia-Pacific region like Australia and New Zealand are exceptions to this broad discussion on Asian States.

55 ICCPR, *supra* note 39. China signed the treaty in 1998 and thus has an obligation to act in good faith and not defeat the aim of the treaty.

56 For e.g., in its ratification of *Convention on the Elimination of all Forms of Discrimination against Women*, GA Res. 34/180, 34 UN GAOR Supp. (No. 46) at 193, UN Doc. A/34/46; 1249 UNTS 13; 19 ILM 33 (1980), Pakistan made both a declaration which made CEDAW subject to the Constitution of Pakistan. It also made a reservation to article 29(1) of the treaty which provides for an interstate enforcement procedure. Both the declaration and reservation limit the application of the treaty in Pakistan. See UN Women, "Convention on the

is a low enforcement rate of UN human rights treaties in some Asian States is that the concept of human rights is seen as Western and foreign to them.[57] Most of these States run hybrid legal systems made up of secular, religious, traditional and western laws.[58] Thus, while an act might be deemed to be heinous under international human rights law, it might be acceptable or protected by the customary law of a particular State. This could be very problematic in the prohibition of transplant tourism as most of the key transplant States where transplant tourism thrives are found in Asia. As I argue in Chapters 2 and 4, transplant tourism is a violation of international human rights law and must be seen as such by all States where transplant tourism thrives for its eradication to be successful. The importance of a regional human rights system is very important in the prohibition of transplant tourism as the most recent initiative taken to prohibit it, the *Council of Europe Convention against Trafficking in Human Organs* (*Trafficking in Human Organs Convention* or Convention) was the product of a European regional effort.[59] This treaty might influence other regions to draft similar treaties, an option that Asian States will be unlikely to exercise.

## C Possible Solutions to Enforcement Challenges: Enforcement Assistance

### 1 *Mutual Legal Assistance in Evidence Gathering*

As noted earlier, when prosecuting transnational crimes, States are precluded by international law rules from executing orders in other States without the permission of those other States.[60] There are two options open to a State that wants to execute an order or gather evidence of the commission of a transnational crime in another State. The first option is for a State to seek permission for its own enforcement agency to execute orders within the territory of the other State. The second preferred option is to rely on the enforcement

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Elimination of All Forms of Discrimination against Women: Declarations, Reservations and Objections to CEDAW" UN Women, online: <http://www.un.org/womenwatch/daw/cedaw/reservations-country.htm>.

57 Katie Zaunbrecher, "When Culture Hurts: Dispelling the Myth of Cultural Justification for Gender-Based Human Rights Violations" (2011) 33:3 Hous J Int'l L 707.

58 Mazna Hussain, " 'Take My Riches, Give Me Justice': A Contextual Analysis of Pakistan's Honor Crimes Legislation" (2006) 29:1 Harv J L & Gend 233.

59 *Council of Europe Convention against Trafficking in Human Organs*, CETS No. 216.

60 *US v Alvarez-Machain*, *supra* note 22; Perrin *supra* note 3 at 187.

agencies of the other State to help execute orders within its own territory and gather evidence. There are several alternatives open to States who want to rely on other States to execute orders and help gather evidence. The first alternative is to sign mutual legal assistance treaties (MLATs) with other States under which States undertake to offer legal assistance to law enforcement officials in contracting States. States can also make other less formal arrangements to offer legal assistance to each other. These arrangements can include the use of letters rogatory, short term administrative arrangements with other States to help execute orders, and cooperation between the police forces in various States.

i Mutual Legal Assistance Treaties

One way in which States seek legal assistance from other States is by entering into mutual legal assistance treaties (MLATs) with them. MLATs are usually bilateral agreements entered into by States to help other contracting States obtain court-ordered assistance needed to enforce criminal laws.[61] In some instances, MLATs could be multilateral like when they are provisions of multilateral treaties.[62] Unlike other forms of mutual assistance between States, which are assistance-specific and cease to exist after they have been satisfied, MLATs remain in force and binding upon the parties until terminated by either or both. They provide a continuous framework for States to seek assistance from other States whenever needed. Although used mostly in matters relating to transnational crimes, MLATs are, in limited cases, used in civil litigation.[63] Like all treaties, MLATs are binding on the States Parties, and States enter into MLATs with various States if they desire continuous cooperation and court-ordered assistance from those States in the prosecution of transnational crimes. The US, for instance, currently has MLATs with more than 60 States.[64] Canada is a bit more conservative and currently has MLATs with about 33 States.[65] Since

61 Orndorf, *supra* note 23 at 813.

62 See for e.g., article 18, *Convention against Transnational Organized Crime,* 40 ILM 335 (2001); UN Doc. A/55/383 at 25 (2000); UN Doc. A/RES/55/25 at 4 (2001).

63 Virginia Kendall & Funk Markus, "The Role of Mutual Legal Assistance Treaties in Obtaining Foreign Evidence" (2014) 40:2 Litig 59.

64 *Ibid* at 63.

65 States which currently have active MLATs with Canada are Argentina, Austria, Australia, Bahamas, Belgium, Brazil, China, Czech Republic, France, Germany, Greece, Hungary, Israel, Italy, Korea, Mexico, Netherlands, Norway, Peru, Portugal, Romania, Russian Federation, South Africa, Sweden, Switzerland, Thailand, Trinidad and Tobago, UK, Ukraine, Uruguay and USA. The list of these treaties along with their texts can be found

the purpose of a MLAT is to assist with criminal investigations, they are limited to law enforcement officials carrying out criminal investigations and cannot be used by private individuals and defence counsel.[66] Each State has its own rules which govern the general application of MLATs. In Canada, these rules can be found in the *Mutual Legal Assistance in Criminal Matters Act.*[67]

Like all treaties, parties to MLATs usually agree on their terms and undertake to provide legal assistance to each other only in reference to matters covered by the treaty. The terms of each MLAT are different and usually a reflection of the international policies of each contracting State. Canada, for instance, always leans towards the principle of double criminality when entering into MLATs with most States.[68] This avoids the undesirable effect of helping another State in the prosecution of an offence which is legal when committed in Canada. MLATs usually cover a wide range of matters such as investigations, evidence gathering, searches and seizures, extradition and freezing of assets.[69] The Canada-U.S. MLAT, for instance, covers mutual legal assistance in matters such as examining objects and sites; exchanging information and objects; locating or identifying persons; serving documents; taking the evidence of persons; providing documents and records; transferring persons in custody; and executing requests for searches and seizures.[70] Although the text of most MLATs entered into by a State are similar, the coverage of a treaty can vary depending on who the other contracting State is.

MLATs are indispensable in the prosecution of transnational crimes. The prosecution of CST offences by tourist States is a case in point.[71] Under the *Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography* (OP2-CRC), States Parties have an obligation to assist each other in investigations and in obtaining evidence of the commission of CST, through the use of mutual legal assistance

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online on the Global Affairs Canada page, online: <http://www.treaty-accord.gc.ca/section.aspx?lang=eng>.

66 Kendall & Markus, *supra* note 63 at 59.

67 *Mutual Legal Assistance in Criminal Matters Act, supra* note 42.

68 Robert Goldstein & Nancy Dennison, "Mutual Legal Assistance in Canadian Criminal Courts" (2001) 44:1&2 Crim L Q 136.

69 Kendall & Markus, *supra* note 63 at 60.

70 See Article 11(2), *Treaty Between the Government of Canada and the Government of the United States of America on Mutual Legal Assistance in Criminal Matters* (E101638–CTS 1990 No. 19).

71 Kalen Fredette, "International Legislative Efforts to Combat Child Sex Tourism: Evaluating the Council of Europe Convention on Commercial Child Sexual Exploitation" (2009) 32:1 Boston Coll Int'l & Com L Rev 38.

arrangements.[72] So far, key tourist States have MLATs with prominent CST destination States.[73] The existence of these treaties can eliminate some of the challenges prosecutors in tourist States face while gathering evidence for the prosecution of CST cases.[74]

MLATs should be made applicable to the control of transplant tourism. Tourist States will need to have MLATs with key transplant States so they can easily exchange information about transplant tourism activities and help each other carry out investigations needed to prosecute individuals suspected of engaging in transplant tourism activities. Currently, Canada does not have a MLAT with any of the key transplant States like India, the Philippines or Pakistan. The absence of such treaties could negatively impact on the prosecution of Canadian nationals for transplant tourism activities if Canada amends its criminal laws to make transplant tourism an offence. Any treaty on transplant tourism should contain provisions which require members to enter MLATs with other State members. These provisions should require mutual legal assistance in the investigation and prosecution of offences under the treaty. This would include assistance with gathering and transfer of evidence, taking statement of witnesses, searches and seizures, service of judicial documents and extradition of accused persons. In addition, all States Parties should enter MLATs with each other while implementing criminal laws on transplant tourism.

### ii Other Forms of Mutual Assistance

The rules that guide the sharing of data between States are diverse, flexible and sometimes informal.[75] Aside from requests for assistance made under MLATs, States have other methods of getting legal assistance with criminal investigations from other States and reciprocating with the same kind of assistance when needed. The other methods used by States to obtain legal assistance allow them to avoid the need of entering longer-term binding agreements and

72 See article 6(2), *Optional Protocol to the Convention on the Rights of the Child on the Sale of children, Child Prostitution and Child Pornography*, G.A. Res. 54/263, Annex II, 54 UN GAOR Supp. (No. 49) at 6, UN Doc. A/54/49 (2000).

73 See for instance the MLAT between the United States and Thailand: *Treaty Between the Government of the United States of America and the Government of the Kingdom of Thailand on Mutual Assistance in Criminal Matters*, signed on March 19, 1986.

74 Sara Andrews, "U.S. Domestic Prosecution of the American International Sex Tourist: Efforts to Protect Children from Sexual Exploitation" (2004) 94:2 J Crim L & Criminology 449.

75 Anna-Maria Osula, "Mutual Legal Assistance and Other Mechanisms for Accessing Extraterritorially Located Data" (2015) 9:1 Masaryk U J L & Tech 53.

the obligations which flow therefrom. These methods often involve a request being made by the relevant authorities in one State asking another State for legal assistance which could include carrying out investigations and gathering evidence needed to prove the commission of an offence. These agreements are usually carried out between courts in various States or by authorities charged with the responsibility of entering into foreign relations such as the ministers who oversee foreign affairs. Three such methods of obtaining legal assistance from other States are (1) letters of request or letters rogatory, (2) mutual cooperation between law enforcement bodies, and (3) obtaining assistance through administrative arrangements. All these methods of obtaining legal assistance could be useful in the prosecution of individuals charged with engaging in transplant tourism activities.

A common method used by States to obtain legal assistance from other States is the use of a letter rogatory or letter of request. A letter rogatory (or letter of request) is a formal request made through the court of one State to the court of another State asking that State for judicial assistance in the administration of justice in the former State.[76] While States are not obligated to consent to such a request, they often do so as an extension of goodwill to each other and in the hopes of reciprocation when required.[77] While there is no global standardized format which guide requests for or satisfaction of a letter rogatory, there are treaties covering civil and commercial law cases which lay down requirements which letter rogatory requests have to meet as among the States Parties.[78] These treaties can be multilateral or regional treaties like the *European Convention on Mutual Assistance in Criminal Matters*.[79] Outside these treaties, individual States have their own laws and policies which govern the use of letters rogatory. In Canada, for instance, conditions for the enforcement of letters rogatory are governed by the federal and provincial *Evidence Acts*.[80]

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76 Philip Sutherland, "The Use of the Letter of Request (or Letter Rogatory) for the Purpose of Obtaining Evidence for Proceedings in England and Abroad" (1982) 31:4 Int'l & Comp L Q 784.

77 *Ibid.*

78 See *Convention on the Service Abroad of Judicial and Extrajudicial Documents in Civil or Commercial Matters* (*Hague Service Convention*), 658 UNTS 163; 20 UST 361; *Convention on the Taking of Evidence Abroad in Civil or Commercial Matters* (*Hague Evidence Convention*), 847 UNTS 231.

79 See *European Convention on Mutual Assistance in Criminal Matters*, ETS 30; 41 ECA 283; 72 UNTS 185.

80 See e.g. section 46(2) *Canadian Evidence Act, supra* note 42; section 60, *Ontario Evidence Act*, RSO 1990, c. E.23

The courts also play a role in the enforcement of letters rogatory in Canada. The courts will not give effect to letters rogatory which are deemed to be contrary to public policy, burdensome, irrelevant, unnecessary or where the evidence is otherwise obtainable.[81]

The police of various States also work with each other directly to provide legal assistance when needed by other States.[82] This form of police cooperation is broad and covers various aspects of police work such as investigations, information exchange and the apprehension of offenders.[83] At the international level, organizations like the International Criminal Police Organization (Interpol) play a major role in facilitating international police cooperation between various States especially as it affects international organized crime.[84] Interpol has, for instance, been invested in the prevention of human trafficking which covers various aspects of CST and transplant tourism.[85] While Interpol does not get involved in actual crime enforcement such as making arrests, it provides communications and database assistance to various law enforcement agencies in various States. At the State level, various State police forces help each other in the investigation of transnational crimes. The Australian Federal Police has, for instance, in the past entered Memoranda of Understanding (MOU) with key destination and transplant States such as the Philippines, Colombia and Thailand to facilitate cooperation between all the covered States in the regulation of various transnational crimes.[86]

Another option open to States wishing to seek legal assistance from other States is to make short-term administrative arrangements with other States to provide such assistance. These arrangements are usually carried out through the ministers in charge of foreign affairs. In Canada, the Minister of Foreign Affairs may enter into administrative arrangements with States to provide

81 *Presbyterian Church of Sudan v Rybiak* [2006] 275 DLR (4th) 512 at para. 30 (Ont. C. A.); *Connecticut Retirement Plans and Trust Funds v Buchan* [2007] ONCA 462.

82 Osula, *supra* note 75 at 52.

83 Daniel Koenig & Dilip Das, *International Police Cooperation: A World Perspective* (Lanham: Lexington Books, 2001) at 231.

84 The International Criminal Police Organization (Interpol) is the world's largest international police organization which provides communications, database assistance, crime information and analysis, training and investigation support to police forces globally. See Interpol online: http://www.interpol.int/en. Under the European Union (EU), there is a regional body called Europol which assists States in the region investigate crimes. See Europol online: <https://www.europol.europa.eu/>.

85 See Interpol, "Trafficking in Human Beings," online: <http://www.interpol.int/Crime-areas/Trafficking-in-human-beings/Trafficking-in-human-beings>.

86 Perrin *supra* note 3 at 189.

legal assistance with respect to matters contained in the agreement.[87] Such assistance is usually provided where the offence for which the assistance is sought is also an indictable offence in Canada.[88] These various methods of mutual assistance remove some of the obstacles States encounter during the investigation and prosecution of transnational crimes and help ensure that the perpetrators of these crimes do not avoid prosecution. They enable States to acquire evidence in situations where they would previously not have been able to due to the rules governing the sovereignty of States. They are also convenient as they allow prosecuting States to rely on other States to source evidence relating to transnational crimes as the officials of the latter States will be more familiar with the terrain, people and culture, making it easier for them to gather evidence and carry out other tasks. Furthermore, they eliminate the costs associated with sending officials to another State to execute orders.

### 2 *Videoconferencing*

States can also extend technological assistance to other States in the prosecution of transnational offences. Through videoconferencing, States can ensure that witnesses are virtually present in foreign courts during trials. Videoconferencing refers to a body of audio and video technologies that allow parties in various locations to interact at the same time.[89] Advancements in technology and improvements in telecommunications now make it possible for States to access the testimonies of witnesses physically located in foreign jurisdictions through videoconferencing.[90] Videoconferencing is already being employed in the prosecution of local crimes in many States, making it possible for courts to extend or modify this service to cover the prosecution of transnational crimes.

For transplant tourism trials in tourist states, while finding witnesses in transplant States to testify at trials remains a daunting task, securing the presence of these witnesses at trials in tourist states is not without its challenges.

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87 See section 6(1), *Mutual Legal Assistance in Criminal Matters Act, supra* note 42.

88 *Ibid.* The Minister of Foreign Affairs may in exceptional cases enter administrative arrangements with States where the acts for which assistance is needed do not constitute an indictable offence. See section 6(2), *Mutual Legal Assistance in Criminal Matters Act, supra* note 42.

89 Eric Bellone, "Private Attorney-Client Communications and the Effect of Videoconferencing in the Courtroom" (2013) 8:1 J Int'l Comm L Tech 26; Michael Roth, "Laissze-Faire Videoconferencing: Remote Witness Testimony and Adversarial Truth" (2000) 48:1 UCLA L Rev 189.

90 Kendall & Markus, *supra* note 63 at 59.

As noted earlier, there is some level of expense, stress and inconvenience inherent in securing the presence of witnesses from foreign jurisdictions in local trials.[91] Videoconferencing provides a partial remedy to these challenges as audiovisuals of witnesses to transplant tourism activities can be transmitted live to courtrooms in tourist States and they can give testimony while still in a transplant State. While the physical presence of a witness in court would be the most preferred option for both the accused and prosecution during a trial, video conferencing provides a workable alternative where it is impossible, inconvenient or very stressful for the preferred option to be exercised.

Due to its benefits and convenience, a lot of States are embracing the use of videoconferencing in trials.[92] In Canada, for instance, videoconferencing is used in the trial of both civil and criminal cases.[93] The *Criminal Code* of Canada makes provision for the use of videoconferences for the testimonies of witnesses located abroad in criminal cases. Section 714.2(1) of the *Criminal Code* states that a court shall receive virtual evidence from a witness abroad unless the court is satisfied by one of the parties that the reception of such testimony will be "contrary to the principles of fundamental justice."[94] Where such evidence is permitted by the court, it must be given under oath or affirmation in accordance with Canadian law and the law of the place where the witness is physically present.[95] Canadian courtrooms across the nation have been modified to accommodate the use of presentation technology systems needed for videoconferencing.[96] With these media already in place, most Canadian courts are equipped with the technology needed to take the testimonies of witnesses abroad as long as the necessary videoconferencing apparatus is available in the relevant transplant State. Canada also extends the same assistance to courts in other States where there is a need to examine a witness situated in Canada. By section 46 of the *Canadian Evidence Act*, where a foreign court desires to obtain the testimony of a witness located in Canada, a Canadian court or judge may order the examination of such persons under oath by various means including the use of "technology that permits the virtual presence of a party or witness before the court or tribunal outside Canada …."[97]

91 Orndorf, *supra* note 23 at 807

92 Bellone, *supra* note 89 at 24.

93 Julian Borkowski, "Court Technology in Canada" (2004) 12:3 Wm & Mary Bill Rts J 681.

94 Section 714.2(1), *Criminal Code* of Canada, *supra* note 51.

95 *Ibid,* section 714.5.

96 Borkowski, *supra* note 93 at 684.

97 See section 46(2) *Canadian Evidence Act,* supra note 42.

There are several advantages of using videoconferencing in trials involving crimes with extraterritorial elements. An advantage live transmission has over a written deposition is that it affords the jury the benefit of studying the body language and mannerisms of the witness.[98] Where the witness is the organ seller who has agreed to testify, in the case of kidneys for example, the use of video conferencing will have the added advantage of allowing the court see the scars left by the organ extraction process and other physical evidence which could help prove the commission of the crime. Videoconferencing also has economic advantages as it helps saves costs which would have been incurred in the transportation of witnesses abroad for trials.[99] Canadian courts are, however, quick to note that cost saving on its own is not a good reason to resort to video conferencing.[100] The integrity of the trial, logistics and the effect of the televised testimony on the trial will always be taken into account by the Court in arriving at its decision whether or not to permit witness testimony by videoconferencing.[101] Lastly, videoconferencing also gives the accused or his or her counsel the opportunity to confront the witness through cross-examination. Granted, the process of virtual cross-examination is not as effective or efficient as face-to-face confrontation. However, it cures some of the deficiencies of video depositions where the right to confrontation is entirely absent.

In spite of its many benefits, the use of videoconferencing in the prosecution of extraterritorial offences is not without its challenges and criticisms. Most of the criticisms surrounding the use of videoconferencing arise where the defendant's testimony is the one being transmitted while being examined by his counsel or the prosecution.[102] Some of these criticisms also apply to the interrogation of witnesses.[103] One such criticism is that the use of videoconferencing

98 Orndorf, *supra* note 23 at 808.

99 Borkowski, *supra* note 93 at 681; Roth, *supra* note 89 at 190; Anne Poulin, "Criminal Justice and Videoconferencing Technology: The Remote Defendant" (2004) 78:4 Tulane L Rev 1100.

100 *R v Ross* [2007] BCPC 244 at para. 21.

101 *R v Young* [2000] SKQB 419 at para. 8.

102 The criticisms surrounding the examination of defendants through video-conferencing would rarely arise in transplant tourism trials as, in must cases, the defendants would have returned to their States of origin after successful organ transplants in transplant States. This is especially so as they would have better access to and receive better postoperative care in their tourist States.

103 The criticisms surrounding the videoconferencing of defendants include interference with the privacy rights of the defendant, the inability of the defendant to consult privately with his counsel and the reduction in levels of trust. See generally, Bellone, *supra* note 89.

interferes with the smooth flow of exchanges between the defence counsel or prosecutor and the person being interrogated.[104] This is more so where there are signal interruptions between the two locations. Other related concerns include the inability of the witness to read cues and non-verbal signals from the examining counsel or prosecutor.[105] Language could also be a barrier to the smooth operation of videoconferences, especially where an interpreter has to be used.[106] Another major challenge with video conferencing is technological limitations in transplant States. Most transplant States are developing States which may not have access to the type of technologies needed to transmit a witness' testimony to courts in tourist States. Where the technology is present, there might be the need to move witnesses from rural areas to cities where this technology is available. Time differences between transmitting and receiving States could also pose a challenge to the process of virtual testimonies. It has also been argued that the use of videoconferencing breaches the right of the accused to confront the witness.[107] Courts have, however, continued to uphold the use of videoconferencing for the examination of witnesses as its benefits outweigh its problems.[108]

### 3 *Duty to Report by Doctors in Tourist States*

A common pattern which transnational human rights offences such as CST and transplant tourism exhibit is that the perpetrators of these offences always return to their own States after the offences have been committed. This is why they are also characterized as "tourist offences." What happens after the offenders return to their home States depends on the nature of the offence. In CST cases, the offenders, if uncaught, return to their normal activities. The beneficiaries of transplant tourism, however, return to a new life of postoperative care and management. In order to avoid organ rejection, ensure the success of their operation and increase their quality and duration of life, organ transplant

104 Bellone, *supra* note 89 at 31.

105 Bellone, *ibid*; Poulin, *supra* note 88 at 1110.

106 It can, however, be argued that this challenge will also exist where the witness is present in court giving his or her testimony. Admittedly, the fact that the witness and, in some cases, the interpreter is in the foreign State would add another level of complexity to the interviewing process.

107 In the US case of *Maryland v Craig*, dissenting judges stated that the right to confront means a physical face-to-face encounter between the accused and the witnesses. See *Maryland v Craig* [1990] 497 US 836 at 861–862.

108 *Maryland v Craig, supra; Harrell v Florida* [1998] 709 So.2d. 1364; *Minnesota v Sewell* [1999] 595 N.W.2d. 207.

recipients have to rely on long-term postoperative care which includes the use of immunosuppressive drugs.[109] Beneficiaries of organ transplants are thus reliant on the care of medical practitioners in tourist States who are responsible for their care, especially in cases where health complications arise as a result of transplant tourism activities.[110] This is one major factor which distinguishes other transnational crimes such as CST and human trafficking from transplant tourism, and which could be key in eradicating transplant tourism and bringing offenders to book. Medical professionals are sometimes in a dilemma on what their response should be to patients who have bought organs abroad.[111] Withholding care from such patients would be out of the question as medical practitioners have a legal and professional duty to promote the good health of patients and are not supposed to base treatment of their patients on the patient's activities.[112] It is for this reason that medical practitioners treat persons convicted of gruesome crimes and prisoners of war.[113]

My suggestion is that medical practitioners should be legally obligated to report their knowledge of transplant tourism activities to the appropriate criminal authority which has the duty of investigating and enforcing laws against such activities. Not only will this deter people on the organ waiting lists from engaging in transplant tourism activities as a way of jumping the waiting

109 Alex Gutierrez-Dalmau & Josep Campistol, "Immunosuppressive Therapy and Malignancy in Organ Transplant Recipients" (2007) 67:8 Drugs 1169; Jacques Dantal & Jean-Paul Soulillou, "Immunosuppressive Drugs and the Risk of Cancer after Organ Transplantation" (2005) 352:13 N Engl J Med 1371; Thomas Schiano & Rosamond Rhodes, "The Dilemma and Reality of Transplant Tourism: An Ethical Perspective for Liver Transplant" (2010) 16:2 Liver Transplant 113.

110 James Onwubalili *et al*, "Outcome of Bought Living Non Related Donor Kidneys Followed up at a Single Center" (1994) 7:1 Transplant Int'l 27 & 29; Sean Kennedy *et al*, "Outcome of overseas commercial kidney transplantation: An Australian perspective" (2005) 182:5 Med J Aust 224; Gill Jagbir *et al*, "Transplant Tourism in the United States: A Single Center Experience" (2008) 3:6 Clin J Am Soc Nephrol 1820–8.

111 Frederike Ambagtsheer *et al*, "The Battle for Human Organs: Organ Trafficking and Transplant Tourism in a Global Context" (2013) 14:1 Global Crim 19.

112 Frederike Ambagtsheer *et al*, *ibid*; Schiano & Rhodes, *supra* note 109 at 116; Sally Satel & Andrew Aronson, "Transplant Tourism: Treating Patients when They Return to the US" (2008) 10:5 Virtual Ment 271; Frederike Ambagtsheer *et al*, "Cross-Border Quest: The Reality and Legality of Transplant Tourism" (2012) J Transplant 5; Timothy Caulfield *et al*, "Trafficking in Human Beings for the Purpose of Organ Removal and the Ethical and Legal Obligations of Healthcare Providers" (2006) 2:2 Transplant Direct e60.

113 Muna Canales *et al.,* "Transplant tourism: outcomes of United States residents who undergo kidney transplantation overseas" (2006) 82:12 Transplantation at 1658.

queue, it will also increase the possibility of prosecuting individuals who take advantage of poor and vulnerable persons in transplant States by buying their organs. However, this suggestion is not without its concerns, most of which surround the privacy rights of patients and doctor-patient confidentiality.[114] Medical practitioners have a duty to maintain the confidentiality of their patients' medical records.[115] This duty forms the foundation of the patient-doctor relationship and its breach is often treated as a serious infringement which attracts penalties.[116] These penalties include being sued by the patient for breach of medical confidentiality and discipline by the professional regulatory body for professional misconduct.[117] The duty of medical practitioners to respect the confidentiality of patients can be traced to the duty of care that doctors owe to patients which is most times contained in the employment contract of the doctor and can only be waived with the express consent of the patient. The legal duty of confidentiality also has its foundation in the fiduciary nature of the doctor-patient relationship.[118] This duty is also sometimes found in legislation that governs aspects of the medical profession.[119] Finally, the duty can be found in professional codes of conduct which set out ethical standards for healthcare professionals.[120]

The existence of the duty to respect the confidentiality of patients means that medical doctors are *prima facie* prevented from disclosing that a patient

114 Other concerns around mandatory reporting such as the discouragement of patients from seeking medical treatment would in most cases not apply to transplant tourism as patients would always need to rely on the healthcare system for postoperative care and immunosuppressive drugs. This concern is however relevant in other cases like the duty to report HIV infections. See Judith Ensor, "Doctor-Patient Confidentiality Versus Duty to Warn in the Context of AIDS Patients and Their Partners" (1988) 47:3 Md L Rev 694.

115 Graham, *supra* note 31 at 2841.

116 Ellen Picard & Gerald Robertson, Legal Liability of Doctors and Hospitals in Canada, 4th ed (Toronto: Carswell, 2007) at 40.

117 *Ibid;* Valarie Blake, "When Doctors Pick up the Pen: Patient-Doctor Confidentiality Breaches in Publishing" (2011) 13:7 Virtual Ment 485.

118 See *McInerney v MacDonald* [1992] 93 DLR (4th) 415; Picard & Robertson, *supra* note 116 at 17.

119 For examples of legislation which contain the duty of medical confidentiality, see *the Health Professions Act of Alberta*, RSA 2000, c. H-7 and the *Health Information Act of Alberta*, RSA 2000, c H-5; See also Timothy Caulfield & Nola Ries, "Consent, Privacy and Confidentiality in Longitudinal Population Health Research: The Canadian Legal Context (2004) Health L J 1.

120 See for example paras. 31–37, Canadian Medical Association Code of Ethics, online: <http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf>.

might have acquired an organ through illegal means if the doctor becomes aware of this fact. The only way in which medical doctors can make such disclosures without breaching this duty is if it falls under one of the permissible exceptions to this duty. The duty of non-disclosure by medical doctors is not an absolute one but one which lends itself to a few exceptions. The first exception to this duty can be found in laws which permit or require medical doctors to report confidential patient information.[121] Under Canadian law, this duty to report can be found under various statutes. Section 22(1) of the *Public Health Act of Alberta*, for instance, provides that a health practitioner who knows that a person is infected with a communicable disease has a duty to report this within 24 hours.[122] This duty is in place to ensure that public health authorities are able to track and fight infectious diseases. Also, the duty not to disclose confidential information of patients can be overruled by a court order like a search order. If a search warrant orders a physician to release certain information, s/he is bound by law to do so.[123] Finally, the Supreme Court of Canada has held that there is a duty to disclose the personal information of a client where there is a risk to an identifiable person or group of persons, where there is a risk of serious bodily harm or death, and where danger is imminent.[124]

From the above, it can be concluded that the law is willing to permit certain exceptions to the duty to disclose in two broad situations. The first situation deals with cases which involve public safety, health, wellbeing or security.[125] Exceptions under this group include those involving the disclosure of communicable diseases and the duty to report impaired or unfit drivers.[126] The second group covers disclosures permitted to protect individuals from harm and abuse

121 There is a difference between permissive and mandatory reporting. While doctors can exercise discretion in the first case, they are obligated to report in the latter. Where a right (as opposed to a duty) to report exists and a doctor chooses not to exercise it, he/she cannot be disciplined for a breach of that duty. See College of Physicians and Surgeons of Ontario, "Mandatory and Permissive Reporting," online: <http://www.cpso.on.ca/policies-publications/policy/mandatory-and-permissive-reporting>.

122 See section 22(1), *Public Health Act of Alberta,* RSA 2000, c. P-37; Picard & Robertson, *supra* note 116 at 55

123 See College of Physicians and Surgeons of British Columbia, Professional Standards and Guidelines, "Disclosure of Patient Information to Law Enforcement Authorities" (September 2014), online: <https://www.cpsbc.ca/files/pdf/PSG-Disclosure-of-Patient-Information.pdf>.

124 See *Smith v Jones* [1999] 1 SCR 455 at paras. 82 & 84.

125 *Ibid* at para. 58

126 Some provinces in Canada place a duty on medical doctors to report unfit or impaired drivers. See for instance section 203, *Highway Traffic Act of Ontario*, RSO 1990, c. H.8.

and to arrest possible perpetrators of certain crimes. Under this group are exceptions such as those aimed at protecting infants from harm,[127] preventing elder abuse and abuse of persons in long-term care homes,[128] reporting sexual abuse of patients by physicians,[129] reporting suspicious deaths[130] and arresting individuals who might be linked to crimes involving gunshots and stabbings.[131] What makes an offence or act one which attracts the duty to disclose or report is often a matter of public policy.

It would be in the public's interest and a matter of public safety for medical practitioners to report cases of transplant tourism because of the risk of transplant tourism to the health and wellbeing of patients who receive organs because of transplant tourism practices. As was noted in Chapter 2, these risks include surgical complications, poor graft outcomes and infections.[132] Addressing these issues adds additional strain on the public healthcare system. Aside from leading to the arrest of nationals who travel abroad to buy organs for transplants, reporting transplant tourism activities would also help prevent cases of organ trafficking and lead to arrests in cases where arrangements for organ trafficking are made by nationals of tourist States or concluded within those States.[133] In addition, transplant tourism brings about harm to individuals abroad who are the victims of the practices. Medical practitioners could be mandated by laws criminalizing transplant tourism to report suspicious transplant tourism activities. It is understandable that this could interfere with the doctor-patient relationship and lead to mistrust on the part of patients, as patients expect that their personal information will not be shared with a third party without their express or implied permission. The justifications for the duty to report however outweigh the importance of protecting the confidentiality of patients who have engaged in transplant tourism practices. With other measures in place, such as the introduction of transplant certificates,

127 Section 4 of the *Child, Youth and Family Enhancement Act*, RSA 2000, c. C-12, places a duty on persons who believe that a child needs intervention to report such to a director.

128 See section 23, *Long-Term Care Homes Act of Ontario*, OS 2007, c. 8.

129 See Schedule 2, *Regulated Health Professions Act of Ontario*, SO 1991, c. 18.

130 See section 10 (1) *Coroners Act*, RSO 1990, c. C-37.

131 Section 3 of the *Gunshot and Stab Wound Mandatory Disclosure Act*, SA 2009, c. G-12, places a duty on health care facilities or emergency medical technicians who treat a gunshot or stab wound to disclose certain information to the police.

132 Jennifer Babik & Peter Chin-Hong, "Transplant Tourism: Understanding the Risks" (2015) 17:18 Curr Infect Dis Rep 17. See generally Chapter 2, footnotes 202–213.

133 Sheri Glaser, "Formula to Stop the Illegal Organ Trade: Presumed Consent Laws and Mandatory Reporting Requirements for Doctors" (2005) 12:2 Hum Rts Brief 22.

the inclusion of a duty to report transplant tourism activities by medical practitioners into the regulatory framework of transplant tourism prevention is bound to yield positive results.

### 4 *Organ Verification Process* (*Transplant Certificates*)

If medical practitioners in tourist States are going to have the duty of reporting all organ transplant cases which occurred outside their State via medical tourism, there must be a standard system for verifying the sources of the organs used for organ transplants and the legality of the transplant procedure which took place in the transplant State. Verification of the legality of the procedure is important because even though an organ might have been legally sourced, its transplantation might still be transplant tourism if the rules of the transplant State concerning organ donation, registration, distribution or transplantation were not adhered to.[134] A method of organ transplant verification which could be introduced by a future treaty on transplant tourism is the use of transplant certificates which would verify the legality of a transplanted organ. It would also show that the transplant process was in line with the organ transplant laws and rules of the transplant State. Aside from aiding with the organ verification process, the introduction of transplant certificates will also serve as an additional measure to help ensure that organs used for transplant purposes in transplant States are legally acquired. The failure of a person who has received an organ abroad to have a valid organ transplant certificate would mean that he or she did not acquire an organ through the appropriate channels and could give rise to legal sanctions in line with national transplant tourism laws.

The use of transplant certificates as a method of verification for organ transplants in transplant States is not exactly a novel idea as various forms of organ transplant verification forms already exist. In India, for instance, various forms have to be filled by donors, organ recipients and medical practitioners before organ transplants are carried out.[135] These forms were introduced by

134 In defining transplant tourism, the *Declaration of Istanbul* notes that travel for transplant purposes could become illegal where the organ needs of the local population are ignored in favor of providing organs to medical tourists. It is thus a breach of transplantation procedures when foreigners are given preference over locals in the distribution of organs. This is usually the case where medical tourists are willing to pay huge amounts of money for organs. See the definition section of the *Declaration of Istanbul*. For the complete text of the *Declaration of Istanbul*, see: "The Declaration of Istanbul on Organ Trafficking and Transplant Tourism" (2008) 3:5 Clin J Am Soc Nephro 1227–1231.

135 These forms include: Form 1 (Prospective Living Related Donor Form), Form 2 (Prospective Living Spousal Donor Form), Form 3 (Prospective Living Unrelated Donor Form), Form 4 (Certification of Medical Fitness of Living Donor Form). See Appendix, THOTR.

the *Transplantation of Human Organs* (*Amendment*) *Rules* of 2008 (THOAR)[136] and included in *Transplantation of Human Organs and Tissues Rules* of 2014 (THOTR or Rules).[137] They were put in place to ensure that all organ donations are made by consenting spouses and near relatives and, in the case of donations made by individuals who are unrelated, that the donation has been approved by the Authorization Committee (AC). Among the requirements of the forms, everyone donating, receiving or transplanting an organ has to affix his or her passport photograph to the form, give his or her full names, permanent address, passport and driving license numbers and attest to the fact that the organ was donated without the exchange of money and with the full consent of the donor and signed before a Notary Public.[138] The same process should be adopted by all transplant States for all organ donations, including donations made to foreigners. Medical doctors in charge of postoperative care of patients who have had organ transplants abroad should be able to have access to these certificates electronically. The certificates should be supported by forms that contain the full details of the donors and recipients and signed by all the appropriate authorities. Enforcement officials in tourist States should also be able to communicate with transplant centers in transplant States if there is a need for further verification.

There are bound to be concerns about the effectiveness of this verification process if introduced and the willingness and ability of tourist and transplant States who benefit from transplant tourism to implement these measures. Key transplant States like India and the Philippines have recognized the role they play in the sustenance of transplant tourism and the impact it has on their nationals and rural communities that fall prey to the activities of organ merchants. It is for this reason that several measures have been taken through the years by these States to prevent transplant tourism. While the use of these transplant forms and certificates by transplant States might not necessarily lead to the end of transplant tourism, it could be one of several preventive measures put in place by these States. Other measures which have been introduced through the years with various levels of success include a ban on organ transplants to foreigners who are not near relatives and the registration of hospitals permitted to carry out organ transplants.[139] In India, the registration

136 The *Transplantation of Human Organs* (*Amendment*) *Rules* (GSR 571(E), dt.31-7-2008).

137 The *Transplantation of Human Organs and Tissues Rules*, The Gazette of India: Extraordinary [PART II-SEC. 3(I)]; March 27, 2014.

138 See Forms in appendix of THOTR, *ibid.*

139 See ss 3(1) & 7(1), *Transplantation of Human Organs and Tissues Act*, 2010, Act No. VI of 2010 (Pakistan); section 7, The *Transplantation of Human Organs* (*Amendment*) *Act*,

of hospitals was introduced under the *Transplantation of Human Organs Act of 1994* (THOA).[140] Under the THOA, only registered hospitals are permitted to remove, store or transplant human organs.[141] An Appropriate Authority (AA) was created by the THOA to grant, renew, suspend and cancel registrations of hospitals for the purpose of organ transplants.[142] An AC was also created under section 9(4) of the THOA and the THOAR to approve organ donations by individuals who are not near relatives.[143] Unlike the situation before the 2008 Rules came into force, the AC now considers all requests where either the donor or recipient is not an Indian citizen or national, no matter the relationship between both parties.[144] The AC also has to ensure that there is no commercial transaction between both parties and that no intermediary was involved in the donation arrangement.[145]

Another concern with the use of transplant certificates and forms for organ transplants in transplant States might be that all other measures which have been put in place by transplant States have been abused and circumvented by organ merchants. As noted in Chapter 3, members of an inter-state kidney racket were recently arrested in India for facilitating paid organ donations and transplantations at the Apollo Hospital in Delhi.[146] The Apollo hospital belongs to a large chain of private hospitals in India, Bangladesh and other States and has its own independent AC as mandated by the THOAR.[147] Cases like these

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2011, Act No. 16 of 2011 (India); section V(5), *Revised Rules and Regulations Governing Accreditation of Hospitals Engaged in Kidney Transplantation* (*Administrative Order No. 2008-0034*) (The Philippines).

140 The *Transplantation of Human Organs Act* No. 42 of 1994 (THOA).

141 *Ibid*, section 10(1).

142 *Ibid*, ss 13(3), 14, 15 & 16.

143 *Ibid*, section 9(4); See also ss 4-A(4) & 6A, THOAR, *supra* note 136.

144 *Ibid,* section 4A(3); ss 7(2) & 7(3), THOAR, *supra* note 136; Reeta Dar & Sunil Dar, "Legal Framework, Issues and Challenges of Living Organ Donation in India" (2015) 14:8 IOSR J Den Med Sci 60.

145 *Ibid*, section 7(3).

146 See Chapter 3, footnote 137; Abantika Ghosh, "Apollo Transplant Scandal: Explaining the Kidney Market Rules," The Indian Express (07 June 2016), online: <http://indianexpress.com/article/explained/delhi-kidney-racket-illegal-organ-trade-apollo-hospital-2838263/>; Pritha Chatterjee, "Delhi Kidney Trade Racket: How the Gang Managed to Get Around Organ Transplant Rules," The Indian Express (04 June 2016), online: <http://indianexpress.com/article/cities/delhi/delhi-kidney-trade-racket-how-the-gang-managed-to-get-around-organ-transplant-rules-2833502/>.

147 See section 6A(2)(II), THOAR, *supra* note 136.

expose the need for better oversight of private hospitals by transplant States to ensure that they are implementing relevant organ transplant rules. This will form part of the due diligence obligations of States to protect individuals from human rights abuses carried out by private parties.[148] Despite cases like that of the Apollo Hospital mentioned above, it is undeniable that the various measures that have been put in place have played a role in the reduction of transplant tourism in some transplant States. If more efforts are put into the implementation of these measures and appropriate checks and balances are introduced, transplant tourism could become a thing of the past in the future or, at the very least, reduced to the barest minimum.

## D Monitoring

Monitoring is the last important component of the prescribed transplant tourism model. All human rights treaties set obligations and standards by which States Parties are to conduct themselves. Most international and regional human rights instruments ultimately rely on States for their implementation as the success of these instruments is often tied to the ability of States to implement and comply with their obligations. Although the human rights treaty ratification rate of States has increased, this does not translate into the actual implementation of treaty obligations and treaty compliance by States.[149] Human rights monitoring bodies are essential to the overall success of the treaty implementation process. Human rights monitoring serves several purposes including assisting and pressurizing governments into applying international law standards, helping victims whose rights have been breached and providing warnings about possible conflicts.[150] Broadly speaking, there are two important functions to monitoring.[151] The first is to ensure that there are no gaps between international law standards as set by treaties and national standards as set by domestic laws and policies. The second function of monitoring is to ensure that States comply with their international law obligations.[152]

148 Jan Hessbruegge, "The Historical Development of the Doctrines of Attribution and Due Diligence in International Law" (2004) 36:2&3 N.Y.U.J. Int'l L & Pol 268.

149 See generally, Todd Landman, "The Political Science of Human Rights" (2005) 35:3 Brit J Pol Sci 549.

150 Manuel Guzman & Bert Verstappen, *What is Monitoring?* (Switzerland: HURIDOCS, 2003) at 14.

151 *Ibid* at 12.

152 *Ibid.*

These two broad functions of monitoring are carried out by a wide network of international and national bodies. At the international level, there are various human rights monitoring bodies whose job is to monitor States' compliance with their human rights obligations. There are also international NGOs that engage in a wide range of activities and seek to ensure that States comply with human rights standards. At the national level are various domestic NGOs and task forces that ensure that States, professional organizations and local law enforcement bodies play their roles in implementing laws and policies. Combined, the various tiers of monitoring contribute to the compliance by States with their obligations under international law.

### 1 *Monitoring by the United Nations and Regional International Organizations*

The United Nations (UN) plays a vital role in monitoring the implementation of UN human rights treaties.[153] It does this through Charter-based bodies and human rights treaty bodies created to promote and protect human rights, monitor the implementation of treaties and advise States on how to comply with their human rights obligations.[154] The main UN Charter-based human rights body is the Human Rights Council (Council) created in 2006.[155] Among its duties, the Council promotes respect for human rights and the resolution of human rights conflicts.[156] The Council also undertakes the Universal Periodic Review (UPR) that scrutinizes whether each UN Member State is complying with its human rights obligations and commitments.[157] If there is a human rights treaty on transplant tourism, the UPR mechanism of the Council would be useful in reviewing the how States implement the treaty and ensuring obligations under the treaty are applied uniformly by the contracting States. This in turn could lead to uniform and effective national laws against transplant

153 Benjamin Meier & Yuna Kim, "Human Rights Accountability Through Treaty Bodies: Examining Human Rights Treaty Monitoring for Water and Sanitation" (2015) 26:1 Duke J Comp & Int'l L 140.

154 *Ibid* at 142.

155 United Nations, Resolution Adopted by the General Assembly (A/RES/60/251) (General Assembly, 2006), online: <http://www2.ohchr.org/english/bodies/hrcouncil/docs/A.RES.60.251_En.pdf>.

156 Maximilian Spohr, "United Nations Human Rights Council: Between Institution-Building Phase and Review of Status" in Armin Bogdandy & Rudiger Wolfrum, eds, *Max Planck Yearbook of United Nations Law*, Vol. 14 (Netherlands: Brill, 2010) at 176.

157 The Universal Periodic Review (UPR) mechanism was created under GA Resolution 60/251. See paragraph 5(e), Resolution 60/251.

tourism which will in turn help with the eradication of transplant tourism practices.

Hinged to the Council are Special Procedures mandate holders who are independent human rights experts who carry out State visits, investigate specific concerns, and advise and report on the human rights issues they are responsible for.[158] They perform these functions over a wide range of mandates via Special Rapporteurs or working groups. There are currently Special Rapporteurs on transnational crimes like CST and areas which intersect with transplant tourism like torture, health and slavery.[159] The Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment for instance was appointed in 1985 with a mandate which includes undertaking fact-finding State visits and making appeals to States with regards to individuals at risk of torture.[160] A particular advantage Special Rapporteurs have over other human rights monitoring bodies is that they can act informally on complains and reports without the need for exhaustion of domestic remedies.[161] The prohibition of transplant tourism will benefit from having a Special Rapporteur on transplant tourism. This Special Rapporteur will be mandated to, among other things, receive complaints on transplant tourism practices, investigate allegations of transplant tourism in States and make appeals to States to protect individuals at risk of transplant tourism.

The UN human rights treaty bodies are the treaty committees discussed in Chapter 4.[162] These committees have various functions, including monitoring States to ensure that they fulfil their human rights treaty obligations.[163] A few of

158 The term of reference of State visits by Special Procedures mandate holders were adopted at the Fourth Annual Meeting of Special Procedures (E/CN.4/1998/45).

159 For a complete list of the various Special Rapporteurs on human rights issues, see the Office of the UN High Commission on Human Rights website, online: <http://www.ohchr.org/EN/Issues/Pages/ListOfIssues.aspx>.

160 Office of the UN High Commission on Human Rights, "Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment," online: <http://www.ohchr.org/EN/Issues/Torture/SRTorture/Pages/SRTortureIndex.aspx>; Deborah Blatt, "Recognizing Rape as a Method of Torture" (1991–1992) 19:4 N.Y.U. Rev L & Soc Change 826.

161 Office of the UN High Commission on Human Rights, *ibid*.

162 See Chapter 4, footnotes 146–174.

163 Examples include the Human Rights Committee (ICCPR); the Committee on Economic, Social and Cultural Rights (ICESCR); the Committee on the Rights of the Child (CRC Committee) and the Committee on the Elimination of Discrimination against Women (CEDAW); John Currie *et al.*, *International Law: Doctrine, Practice, and Theory*, 2nd ed (Ontario: Irwin Law, 2007) at 656.

the UN human rights treaty committees are relevant in monitoring human rights violations involved in transplant tourism activities given that their treaties have provisions partially addressing transplant tourism. They include the Human Rights Committee (HRC),[164] Committee Against Torture (CAT Committee),[165] and Committee on the Rights of the Child (CRC Committee).[166] The HRC, the treaty body for the ICCPR, for instance, has monitoring roles assigned to it by both the ICCPR and the *First Optional Protocol to the ICCPR* (OP1-ICCPR).[167] As discussed in Chapter 4, States Parties submit periodic reports to the HRC on the measures they have taken to give effect to their ICCPR obligations.[168] The HRC studies these reports and issues Concluding Observations.[169] In ensuring compliance with human rights treaty obligations under the ICCPR, the HRC is empowered to receive direct complains from individuals on human rights abuses. These enforcement mechanisms of the HRC could help monitor States' compliance with their obligations under the ICCPR. The prohibition of transplant tourism could benefit from the monitoring functions of the HRC on ICCPR human rights which relate to transplant tourism such as the right to life.[170]

Regional human rights organizations could also perform monitoring functions and ensure that States in the region take steps towards the eradication of

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164 Article 6 of the ICCPR protects the right to life of all individuals and article 7 lays down the norm against torture or cruel, inhuman or degrading treatment or punishment. The interference of transplant tourism activities with either of these rights could bring the activities under the mandate of the HRC.

165 CAT Committee was created under article 17 of the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,* GA Res. 39/46, annex, 39 UN GAOR Supp. (No. 51) at 197, UN Doc. A/39/51 (1984); 1465 UNTS 85. Under article 20 of the *Torture Convention*, where there is reliable information of systematic torture in the territory of a State, the CAT can make inquiries into these and make reports. The provision would cover cases where the State is directly involved in harvesting human organs to feed the organ demand market if the process involves torture of individuals.

166 Article 3(1)(a)(I)(b) of the OP2-CRC, *supra* note 62, places a duty on States Parties to ensure that the transfer of children organs for profit are prohibited under national criminal and penal laws. The committee may make reports on the implementation of the treaty by States on matters covered by the *Convention on the Rights of the Child*, GA Res. 44/25, annex, 44 UN GAOR Supp. (No. 49) at 167, UN Doc. A/44/49 (1989); 1577 UNTS 3; 28 ILM 1456 (1989), and its protocols.

167 See article 28, ICCPR, *supra* note 39; Preamble and article 1, *Optional Protocol to the International Covenant on Civil and Political Rights*, GA Res. 2200A (XXI), 21 UN GAOR Supp. (No. 16) at 59, UN Doc. A/6316 (1966); 999 UNTS 302.

168 See article 40 & 41, ICCPR, *ibid.*

169 *Ibid*, article 40(4).

170 *Ibid*, article 6(1).

transplant tourism in those regions. Under the European system for instance, the *Trafficking in Human Organs Convention* provides for the creation of a convention monitoring body called the Committee of the Parties.[171] Under article 25 of the Convention, part of the functions of the Committee of the Parties is to monitor the implementation of the Convention.[172] When the Convention comes into force, the Committee of the Parties will be able to play a role in monitoring the implementation of portions of the Convention which are relevant to transplant tourism activities.

In general, State monitoring by the UN will be crucial in the prohibition of transplant tourism activities. As has been shown by the few reported cases of transplant tourism and organ commercialization, aside from the measures put in place by transplant States to control transplant tourism practices, these States will also need the support of tourist States and the international community to bring an end to transplant tourism in transplant States. The current human rights treaties with provisions related to aspects of transplant tourism provide limited protection to victims of transplant tourism practices. To remedy this, the treaty committees of treaties like the ICCPR could focus more on how transplant tourism violates treaty provisions and develop General Comments which are relevant to transplant tourism practices.[173] This would be more likely if a treaty on transplant tourism is structured as an optional protocol to an existing UN human rights treaty like the ICCPR.

### 2 *Monitoring by Transnational Advocacy Networks (TANs)*

Transnational Advocacy Networks (TANs) are indispensable organizations in the enforcement of laws and policies at the national and transnational levels and bring the attention of the international community to the activities which form the subject matter of their focus.[174] As discussed in Chapter 4, the different types of TANs include NGOs, international organizations, social movement organizations and a wide range of societies.[175] TANs advocate on a wide range

171 Article 23, *Trafficking in Human Organs Convention, supra* note 59.

172 *Ibid*, article 25(1).

173 For instance, the HRC could develop a new General Comment on article 6 of the ICCPR on the right to life.

174 David Trubek *et al*, "Transnationalism in the Regulation of Labor Relations: International Regimes and Transnational Advocacy Networks" (2000) 25:4 Law Soc Inq 1194; Margaret Keck & Kathryn Sikkink, "Transnational Advocacy Networks in International and Regional Politics" (1999) 51:159 Int'l Soc Sc J 92.

175 See Chapter 4, footnote 244.

of issues such as child rights, labor rights, and more relevant to discussions here, the eradication of transplant tourism. Although TANs perform a great variety of tasks such as education and advocacy, I will focus on the important role they play in monitoring the enforcement of human rights in this section. With no formal ties to States and inter-governmental organizations, TANs can work independently and monitor the activities that they focus on. Their independence also gives them the ability to pressurize governments and other stakeholders to conform to international norms and rules in a manner and at a level which does not usually occur through the UN.[176] In doing this, TANs can help governments in the development of policies that could in future give rise to new laws.[177]

One unique advantage TANs have over State governments and inter-governmental organizations in trying to combat human rights abuses is that because they work closely with the victims of abuse, they are more familiar with the: affected population, localities where the offences take place, perpetrators, national laws that prohibit the offensive behavior and the enforcement agencies charged with the duty of enforcing these laws.[178] Their closeness to the victims helps them gain the trust of victims, which is useful when their testimonies are needed at trials.[179] This advantage has been useful in the prohibition of CST and will be helpful in the prohibition of transplant tourism.[180] Much more than helping with convictions, TANs also take on the unique responsibility of educating communities about their human rights and the dangers of certain activities, thus preventing future victimizations.[181]

TANs which focus on transplant tourism have been very active so far in the prohibition and monitoring of transplant tourism activities by bringing the attention of the international community to the nature, prevalence and dangers of transplant tourism, and developing policies and soft laws against transplant tourism practices. In the fourth Chapter of this publication, I wrote extensively on two TANs, The Transplant Society (TTS) and the International

176 Anna Cody, "NGOs and Human Rights Monitoring: The 'How, When, Where, What and Why' of Effective Engagement" (2014) 39:4 Alternative L J 255; Kathrin Zippel, "Transnational Advocacy Networks and Policy Cycles in the European Union: The Case of Sexual Harassment" (2004) 11:1 Soc Pol 63.

177 Cody, *supra* note 176 at 256.

178 Jeremy Seabrook, *No Hiding Place: Child Sex Tourism and the Role of ExtraTerritorial Legislation* (London: Zed Books, 2000) at 131–132.

179 *Ibid.*

180 Seabrook, *supra* note 178 at 106.

181 Cody, *supra* note 176 at 255.

Society of Nephrology (ISN), and the roles they have played in raising awareness about transplant tourism. Both societies been very vocal in their crusade to bring an end to transplant tourism. Notable among their many accomplishments is the role they played in the drafting and adoption of the *Declaration of Istanbul* which has singlehandedly led to more global reforms in the eradication of transplant tourism than any other instrument.[182] Aside from these two societies, other NGOs interested in transplant tourism include Organs Watch,[183] DAFOH,[184] and the MOHAN Foundation.[185] Together, these organizations help create awareness about transplant tourism, help in the creation of policy documents and soft laws against transplant tourism, monitor transplant tourism in various States, report news about transplant tourism practices and initiatives to stop them on their media platforms, and bring the attention of the international community and policy makers to the harms of transplant tourism. With the creation of international and national laws prohibiting transplant tourism, these organizations are bound to be more effective in their advocacy and monitoring as they will have domestic legal instruments and international law norms on which to base their activities.

### 3 *Creation of National Taskforces*

Taskforces are specialized groups formed to work on a subject matter or the enforcement of a particular law. The benefit of having a taskforce is that having a single mandate makes them focus all their time and resources on that subject matter and, over time, they become specialized in all aspects of the subject and can pre-empt the actions of defaulters and prevent future offences. Transplant tourism is a specialized activity with various components which could benefit from the focus of a dedicated taskforce. I am proposing two major types of national taskforces which should be adopted by all States. These taskforces could be relevant in the eradication and prevention of transplant tourism. The first type of taskforce, which I will call an Organ Procurement

182 Frederike Ambagtsheer & Williem Waimar, "A Criminology Perspective: Why Prohibition of Organ Trade in not Effective and How the Declaration of Istanbul can Move Forward" (2012) 12:3 Am J Transplant 571.

183 Founded by Nancy Schepper-Hughes, Organs Watch is an NGO that creates awareness about transplant tourism and organ trafficking.

184 For more on DAFOH, see Chapter 4, footnote 263.

185 The MOHAN Foundation is an NGO that promotes organ donations, creates public awareness about the need for organs and the prevention of commercial dealings in organs. For more about the MOHAN Foundation, visit their website, online: <http://www.mohanfoundation.org/>.

and Donation Taskforce (OPDT), is one that will focus indirectly on the prevention of transplant tourism by focusing on organ donation and procurement with an aim of increasing access to organs needed for transplantation. It is best suited for tourist States. The second type of taskforce, which I will call an Organ Trafficking and Sale Taskforce (OTST), is one which will focus directly on the prevention of organ commercialization and transplant tourism. It is best suited for transplant States.

As the name implies, an OPDT's main focus will be to ensure that there are more channels for the donation of organs for the benefit of nationals who need them. The logic here is simple: if a State becomes self-sufficient and creates more access to organs needed for transplantation, there will be no reason for its nationals to travel to other States to buy organs. This type of taskforce is more suited for tourist States because it is the scarcity of organs in these States that make their nationals travel to transplant States to buy organs. So far, some tourist States already have organ transplant taskforces which perform similar functions. In the UK, the Organ Donation Taskforce was established in 2006 to help identify barriers to organ donation and increase organ donation and procurement.[186] The Organ Donation Taskforce has so far made two major recommendations which, if implemented, could see a significant increase in the number of organs available for transplantations in the UK.[187] In the US, The Taskforce on Organ Procurement and Transplantation was established under the *National Organ Transplant Act* of 1984 to examine issues presented by human organ procurement and transplantation.[188] While these taskforces have so far not solved the organ scarcity problems in these States, they are beneficial to the overall goal of attaining organ self-sufficiency by States and eliminating the need for nationals to travel abroad to source organs.

The focus of the second type of taskforce is the enforcement of national organ transplant laws which prohibit the sale of organs and all forms of organ commercialization. If effectively composed, equipped, managed and funded, these task forces could be relevant in preventing the sale of organs in transplant States and cracking down on the activities of organ brokers. For such a taskforce to be effective though, foundational challenges such as poverty and

186 Paul Murphy & Martin Smith, "Towards a Framework for Organ Donation in the UK" (2012) 108:1 Br J Anaesth I57.

187 Amber Rithalia *et al*, "Impact of Presumed Consent for Organ Donation on Donation Rates: A Systematic Review" (2009) 338:7689 Br Med J 284; Organ Donation Taskforce, *Organs for Transplants: A Report from the Organ Donation Taskforce* (London: Department of Health, 2008).

188 See section 101, *National Organ Transplant Act* 1984, Pub. L. 98–507.

corruption need to be addressed and better checks and balances need to be put in place. There are numerous examples of regulatory mechanisms that have been put in place in transplant States that have been marred by corruption. The recent case which occurred in the Apollo hospital, discussed above, is an example of how difficult it is to regulate transplant tourism in a climate of corruption. The kidney racket in that case was still able to operate although the hospital had its own AC which was supposed to confirm the legality of all donations in the hospitals.

## Conclusion

In this Chapter, I considered various factors which could frustrate the successful implementation of a transplant tourism prohibition model that is based on the use of extraterritorial criminal laws to prosecute nationals of tourist States who travel abroad to buy organs for transplant purposes. These factors were divided into four major groups. The first group is made up of local factors in transplant States such as the lack of laws against transplant tourism, weak enforcement of available laws, corruption of law enforcement officers and poverty which make the prevention of transplant tourism and investigations of allegations of transplant tourism in these States difficult. In the second group are challenges which make it difficult for States to secure evidence of transplant tourism activities. In this group are factors such as distance, language barriers, the lack of formal agreements between organ buyers and sellers and the secretive nature of transplant tourism practices. The third group covers evidentiary and procedural challenges which make the prosecution of accused persons in tourist States more difficult like securing the presence and testimonies of witnesses. In the fourth group are factors such as the willingness and ability of States to enforce transplant laws and prosecute persons who break these laws.

I explored possible solutions to the above challenges the first of which are measures via which States offer mutual assistance to each other to execute orders, gather evidence and prosecute offenders. These measures include MLATs, letters rogatory, administrative agreements and cooperation between law enforcement bodies in various States. I pushed for the inclusion of MLATs provisions in any future treaty on transplant tourism. Key transplant and tourist States should also endeavor to enter such agreements with each other. I also recommended other possible solutions which would be useful in discouraging transplant tourism. These recommendations are: (1) the introduction of transplant certificates to verify the legality of organ transplants that occur in

transplant States; (2) the imposition of a legal duty on medical practitioners to report all cases where organs have been transplanted abroad. Although there might be valid objections to obligating medical practitioners to report suspected cases of transplant tourism, as a matter of public policy, medical practitioners should be obligated to disclose confidential patients' information where there is evidence of transplant tourism.

In the final part of this Chapter, I wrote about the importance of monitoring to the overall success of any legal model created to prevent transplant tourism. Monitoring here is to be carried out at international, regional and national levels by Charter-based bodies, UN human rights treaty bodies, medical-scientific epistemic community and TANs. The importance of having a UN human rights treaty committee dedicated to monitoring transplant tourism was recommended. Existing committees like the HRC could also perform this function as the ICCPR has provisions which relate to transplant tourism. Finally, I pointed out the advantages of having taskforces monitor the implementation of human rights standards in States. I suggested the formation of national anti-transplant tourism task forces in both transplant and tourist States to provide monitoring, enforcement and regulatory functions. Similar taskforces already exist in a few States and they have been shown to be effective.

As promising as the above recommendations are, they will not be successful where there is a culture of corruption or a general lack of will power on the part of States to see to their proper implementation and enforcement. The transnational nature of transplant tourism also makes it important for States to cooperate with each other in bringing an end to transplant tourism. These issues will form part of my concluding thoughts in the next Chapter on the role of domestic and international law in the prohibition of transplant tourism.

CHAPTER 8

# Conclusion

## A The Current State of Transplant Tourism Prohibition

This publication has been devoted to the roles which national and international legal systems should play in the prohibition of transplant tourism, which is a compound term that includes organ transplant, organ trafficking, transplant commercialism, and travel for transplantation.[1] With a view to developing a legal framework for the prohibition of transplant tourism by domestic and international law, I discussed various aspects of transplant tourism including factors that contribute to its growth, prevalence and impact on societies around the world. I also examined the laws, norms and soft laws that currently attempt to prohibit some or all aspects transplant tourism. In Chapter 1, I explored factors that have led to the development and growth of transplant tourism, such as the: global shortage of human organs, lack of laws on transplant tourism, existence of a ready market for organs in developing States, existence of intermediaries and sophisticated organ broker networks, improvements in technology, and current ease of air travel.[2] Of all these factors, the shortage of human organs needed for transplantation is the most important factor that has led to the development of and continuation of transplant tourism, as it prevents patients from receiving the benefits of organ transplantation. Faced with the possibility of dying on the wait list or possible further health deterioration, individuals are pushed to seek organs elsewhere in various States in Asia, Eastern Europe, Africa and South America that provide a ready market for organs.[3]

By its nature, transplant tourism is not without its drawbacks. The negative effects of transplant tourism were discussed in Chapters 2 and 3 of this

1 "The Declaration of Istanbul on Organ Trafficking and Transplant Tourism" (2008) 3:5 Clin J Am Soc Nephrol 1227–1231, online: <http://cjasn.asnjournals.org/content/3/5/1227.full.pdf+html>.

2 Kirpal Chugh & Jha Vivekanand, "Commerce in Transplantation in Third World Countries" (1996) 49:5 Kidney Int'l 1181; Christian Williams, "Combatting the Problems of Human Rights Abuses and Inadequate Organ Supply through Presumed Donative Consent" (1994) 26:2 Case W Res J Int'l L 323.

3 Alexis Aronowitz, *Human Trafficking, Human Misery: The Global Trade in Human Beings* (Westpoint: Praeger, 2009) at 111.

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publication. I pointed out that individuals who sell their organs are often from poor communities and slums and do so solely for financial gain and economic survival.[4] The sale does not, however, improve the financial situation of the organ sellers.[5] On the contrary, it leads to decline in income, health and social status.[6] This, along with several other negative effects of transplant tourism such as human and organ trafficking and the loss of lives, has raised ethical concerns. The three most prominent ethical concerns of transplant tourism are that it encourages organ commodification, violates the dignity of individuals and exploits vulnerable individuals in transplant States.[7] These ethical concerns are what have led to my position on the need for national and international laws which prohibit transplant tourism practices. While there are currently a few national laws which prohibit aspects of transplant tourism, transplant tourism remains one of the most under-regulated transnational crimes.

Customary international law (CIL) plays a vital role in the protection of human rights, especially in States where important international law treaties have not been ratified. Unfortunately, there are currently no CIL norms against transplant tourism practices. Luckily, we are beginning to witness the development of state practice in the evolution of CIL norms on transplant tourism. For one, treaties containing provisions dealing with aspects of transplant tourism have been signed by both transplant and tourist States. These treaties include UN human rights treaties like the *International Covenant on Economic, Social and Cultural Rights* (ICESCR),[8] and the *International Covenant*

4 Tsuyoshi Awaya *et al*, "Failure of Informed Consent in Compensated Non-Related Kidney Donation in the Philippines" (2009) 1:2 Asian Bio Rev 138.

5 Lawrence Cohen, "Where it Hurts: Indian Material for an Ethics of Organ Transplantation" (1999) 128:4 Daedalus 135; Madhav Goyal, *et al.*, "Economic and Health Consequences of Selling a Kidney in India" (2002) 288:13 JAMA 1591.

6 Cohen, *ibid.*

7 Russell Scott, "The Human Body: Belonging and Control" (1990) 22:3 Transplant Proc 1002–4; James Childress, "Ethical Criteria for Procuring and Distributing Organs for Transplantation" (1989) 14:1 J Health Polit Pol Law 110; Christine Korsgaard, "Fellow Creatures: Kantian Ethics and Our Duties to Animals" (2004) 24 Tanner Lectures on Human Values 3; Yosuke Shimazono, "The State of the International Organ Trade: A Provisional Picture Based on Integration of Available Information" (2007) 85:12 Bull World Health Organ 955; Michael Bos, *Transplant Tourism and Organ Trafficking: An Overview of Practices in Europe* (Prague: European Society of Organ Transplantation, 2007) at 8.

8 *International Covenant on Economic, Social and Cultural Rights,* GA Res. 2200A (XXI), 21 UN GAOR Supp. (No 16) at 49, UN Doc. A/6316 (1966); 993 UNTS 3; 6 ILM 368 (1967).

*on Civil and Political Rights* (ICCPR).[9] Other UN treaties with provisions relevant to transplant tourism are the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (CAT)[10] and the *Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children* (*Trafficking Protocol*) which is a protocol to the *Convention against Transnational Organized Crime*.[11] Although not yet in force, the *Council of Europe Convention against Trafficking in Human Organs* (*Trafficking in Human Organs Convention*) adds to the developing state practice against transplant tourism.[12] In addition to these treaty provisions, starting from 2008, a few transplant and tourist States have taken various steps to bring an end to transplant tourism practices. These States have passed specific transplant tourism laws or amended existing criminal and transplant laws to prohibit both transplant tourism and other related activities such as organ commercialization and trafficking.[13] Most States have also endorsed the *Declaration of Istanbul on Organ Trafficking and Transplant Tourism* (*Declaration of Istanbul*), which is currently the most comprehensive soft law instrument on transplant tourism.[14] Judging from the action of States on transplant tourism, especially those of transplant and tourist States, it can be concluded that there is a steady evolution of state practice prohibiting transplant tourism.

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9 *International Covenant on Civil and Political Rights*, GA Res. 2200A (XXI), 21 UN GAOR Supp. (No 16) at 59, UN Doc. A/6316 (1966); 999 UNTS 302.

10 *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,* GA Res. 39/46, annex, 39 UN GAOR Supp. (No. 51) at 197, UN Doc. A/39/51 (1984); 1465 UNTS 85.

11 *Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children*, supplementing the *United Nations Convention Against Transnational Organized Crime*, 40 ILM 335 (2001) / UN Doc. A/55/383 (Annex II. P. 53) / [2005] ATS 27; *Convention against Transnational Organized Crime,* 40 ILM 335 (2001); UN Doc. A/55/383 at 25 (2000); UN Doc. A/RES/55/25 at 4 (2001).

12 *Council of Europe Convention against Trafficking in Human Organs*, CETS No. 216.

13 See *Penal Code of Spain* (Organic Law No. 10/1995 of November 23, 1995, as amended up to Law No. 4/2015 of April 27, 2015) (Spain); *Organ Transplant Law 5768-2008*, Israeli Book of Laws (Israel); *Transplantation of Human Organs* (*Amendment*) *Act*, 2011, Act No. 16 of 2011 (India); *Amendment to the Administrative Order No. 2008-0004 on Revised National Policy on Living Non-Related Organ Donation and Transplantation and its Implementing Structure, Department of Health Administrative Order* No. 2008-0004-A (May 29, 2008), (*Administrative Order No. 2008-0004-A*) (The Philippines); *Transplantation of Human Organs and Tissues Act*, 2009, Act No. VI of 2010 (Pakistan).

14 *The Declaration of Istanbul*, *supra* note 1.

As noted above, there are some treaties, soft laws and national laws that apply to transplant tourism either explicitly or impliedly. These instruments are, however, very few and, in some cases, of little effect in the prevention of transplant tourism. Since the drafting of *Resolution WHA40.13* by the World Health Assembly (WHA) in 1987, various legal and quasi-legal instruments have been passed by States acting alone or together to prohibit transplant tourism.[15] These instruments fall under two major groups: international law instruments and national law instruments. International law instruments can be further categorized into treaties and soft laws. National law instruments can be categorized into tourist and transplant State laws. The prohibition of transplant tourism started with the prohibition of organ commercialization and steadily expanded to prohibit more elements of transplant tourism. In most cases, unfortunately, laws have remained at the prohibition of organ commercialization stage with transplant tourism left unattended.

Under international human rights law, treaty provisions can be interpreted to make a case for the prohibition of transplant tourism as it affects the rights of individuals. This is especially so when the violation is carried out by the State as opposed to private actors since international law treaties primarily regulate the activities of States. In most cases, these treaty provisions can also be extended to make the State liable for the conduct of private actors engaged in transplant tourism under the principle of due diligence.[16] Some of the major treaty provisions which can be interpreted to cover transplant tourism were looked at in Chapter 4 of this publication. For example, the ICESCR safeguards the right to health in article 12(1).[17] In order to fulfill their obligations under article 12(1), States Parties have to meet certain standards, including ensuring that their nationals have equal access to health care facilities and

15 *WHA40.13 Development of Guiding Principles for Human Organ Transplantation*: World Health Assembly, *Handbook of Resolutions and Decisions of the World Health Assembly and Executive Board*, Vol. 3, 3rd ed (Geneva: World Health Assembly, 1993) at 87.

16 The principle of due diligence makes States liable for the actions of private individuals within that State if the State has failed to take the necessary steps needed to prevent its nationals engaging in certain activities or where is fails to punish wrongdoers. See Jan Hessbruegge, "The Historical Development of the Doctrines of Attribution and Due Diligence in International Law" (2004) 36:2&3 N.Y.U.J. Int'l L & Pol 268; *Velasquez Rodriguez v. Honduras* (1988) Inter-Am. Ct. H. R. (Ser. C) No. 4, para. 176; article 8, *General Comment No. 31* (*Nature of the General Legal Obligation on States Parties to the Covenant*) (Article 2, ICCPR) U.N. Doc. CCPR/C/21/Rev.1/Add.13 (2004).

17 See articles 12(1), ICESCR, *supra* note 8, on right to health.

services.[18] Determining access to organs by ability to pay rather than need and directions under national organ transplant laws or policies is a clear violation of the right to health.[19] Similarly, the ICCPR protects several rights that are linked to transplant tourism. These protected rights include the right to life, freedom from torture, cruel, inhuman or degrading treatment or punishment and the right of incarcerated individuals to be treated with dignity.[20] The protection of individuals from torture, cruel, inhuman or degrading treatment or punishment can also be found under the CAT.[21] Transplant tourism activities that breach any of these rights can and should be addressed under the ICCPR and other relevant human rights treaties. Though applicable only to children and youth, the *Convention on the Rights of the Child* (CRC) also has provisions that are applicable to transplant tourism.[22] Aside from UN human rights treaties, as a transnational crime, transplant tourism is also prohibited under the *Trafficking Protocol.* The *Trafficking Protocol* offers limited rights to persons who are victims of transplant tourism through provisions which cover the recruitment, transportation, or transfer of individuals for purposes related to organ commercialization.[23]

The closest that international law has come to a treaty on transplant tourism came in 2014 when the COE adopted the *Trafficking in Human Organs Convention*.[24] The *Trafficking in Human Organs Convention* contains provisions that will help prevent aspects of transplant tourism within the 47 States who are COE member States and other non-member States of the COE.[25] For one, the Convention requires States to criminalize trafficking in human organs.[26]

18 See article 12(b), *General Comment No. 14* (*The Right to the Highest Attainable Standard of Health* (*Article 12 of the International Covenant on Economic, Social and Cultural Rights*), E/C.12/2000/4.

19 Jeremy Haken, *Transnational Crime in the Developing World* (Washington: Global Financial Integrity, 2011) at 24; see also General Comment No. 20 (Non-discrimination in Economic, Social and Cultural Rights (Article 2, Paragraph 2 of the *International Covenant on Economic, Social and Cultural Rights*)), E/C.12/GC20.

20 See articles 6(1), 7 & 10, ICCPR, *supra* note 9.

21 See articles 1 & 16, CAT, *supra* note 10.

22 See articles 6, 11, 19, 21, 22, 35, 36 & 37, *Convention on the Rights of the Child*, GA Res. 44/25, annex, 44 UN GAOR Supp. (No. 49) at 167, UN Doc. A/44/49 (1989); 1577 UNTS 3; 28 ILM 1456 (1989).

23 Article 3(a) of the *Trafficking Protocol*, *supra* note 11.

24 *Trafficking in Human Organs Convention*, *supra* note 12.

25 The *Trafficking in Human Organs Convention* is also open for signature by other non-member States of the COE: Article 28(1), *ibid.*

26 *Ibid,* articles 1 & 2.

In particular, article 4 of the Convention requires States to make it a criminal offence when organs are removed without the free and informed consent of the "donor" and where financial or other advantage has been received by a living donor, or by a third party in the case of a deceased donor.[27] This provision will definitely cover travelling for the purpose of transplantation where the procedure in question involves organ trafficking or commercialization. Lastly, the *Trafficking in Human Organs Convention* requires States to exercise extraterritorial criminal jurisdiction over offences under the Convention where the offence is committed within their territory (territorial principle), by nationals or habitual residents (nationality principle), or against their nationals or habitual residents (passive personality principle).[28] As was discussed in Chapter 6 of this publication, the use of extraterritorial criminal legislation by States is an effective way of legislating against transnational offences. When this treaty eventually comes into force, it is hoped that it will be instrumental in prohibiting transplant tourism in Europe and will serve as a model treaty against transplant tourism which could be adopted by other regions and the UN.

The most prominent way in which international law has addressed transplant tourism is by using soft laws or quasi-legal instruments which are not binding instruments. Soft laws were the first means by which the international community sought to address organ commercialization in general and transplant tourism in particular. Starting with *Resolution WHA40.13*, which was passed in 1987, the WHA has issued several resolutions and guiding principles on how States should tackle transplant tourism and organ commercialization within their territories.[29] These WHA instruments were discussed in detail in Chapters 4 and 5 of this publication. However, the most effective soft law instrument on transplant tourism, the *Declaration of Istanbul,* has not come from the WHA but from a collaboration between State representatives and the epistemic community focused on transplant tourism.[30] The positive impacts

27 *Ibid*, article 4.

28 *Ibid,* article 10(1) & (2). Article 10(1) states: "Each Party shall take such legislative or other measures as may be necessary to establish jurisdiction over any offence established in accordance with this Convention, when the offence is committed: (a) in its territory; or (b) on board a ship flying the flag of that Party; or (c) on board an aircraft registered under the laws of that Party; or (d) by one of its nationals; or (e) by a person who has his or her habitual residence in its territory." Article10(2) also states that States parties are to exercise criminal jurisdiction where the offence is committed against a national or someone who habitually resides within its territory.

29 *Resolution WHA40.13, supra* note 15.

30 *The Declaration of Istanbul*, *supra* note 1.

that the *Declaration of Istanbul* has had on combatting transplant tourism have been highlighted throughout this publication. Aside from the impact it has had on national and professional organ transplant policies and laws throughout the world, its impact has also been felt in the international law system. The *Declaration of Istanbul* was one of the instruments that led to the drafting of the *Trafficking in Human Organs Convention.*[31] Based on how receptive States have been to the *Declaration of Istanbul*, it is most likely going to have a major influence on the terms contained in any future treaty on transplant tourism.

Unlike international law, where there are currently no binding instruments on transplant tourism which are in force, a few States have taken steps unilaterally to either criminalize transplant tourism practices or protect their nationals from the negative impacts of transplant tourism. While these steps are more pronounced in transplant States, a few tourist States have modified their laws to ensure that their nationals do not travel abroad to engage in transplant tourism. As noted in Chapter 3, the Israeli parliament passed the *Organ Transplantation Law* in 2008 which is aimed at eradicating transplant tourism and organ commercialization and increasing organ donation.[32] The Law makes organ trade and trafficking an offence and prohibits foreign organ transplants that are not carried out in accordance with the laws of the transplanting State.[33] The Israeli Law also bans reimbursement for organ transplantation carried out abroad if the procurement of the organ and its transplantation has been performed contrary to the law of that foreign State and if the provisions of the Israeli Law have been contravened.[34] This Law is a direct attempt by the Israeli government to discourage its nationals from engaging in transplant tourism activities in other States. The Law has already produced some positive results as the records show a significant decrease in the annual number of Israeli patients traveling abroad for transplants since it came into force.[35] Although not a major tourist State, Spain has always been in the forefront of combating

31 See Council of Europe, European Committee on Crime Problems, "Committee of Experts on Trafficking in Human Organs, Tissues and Cells (PC-TO)," online: <http://www.coe.int/t/dghl/standardsetting/cdpc/pc_to_en.asp>.

32 *The Organ Transplant Law, supra* note 13.

33 See ss 3, 5 & 36, *ibid;* Alan Jotkowitz, "Notes on the New Israeli Organ Donation Law-2008" (2008) 40:10 Transplant Proc 3297.

34 Benita Padilla *et al*, "Impact of Legal Measures Prevent Transplant Tourism: The Interrelated Experience of the Philippines and Israel" (2013) 16:4 Med Health Care & Philos 916.

35 The records show a decrease in the annual number of Israeli patients who travel abroad for kidney transplants from 155 in 2006 to 35 in 2011. See Padilla *et al, ibid* at 917.

organ trafficking and seeking self-sufficiency of organs for transplantation for its nationals.[36] It therefore comes as no surprise that in 2010 Spain amended its *Penal Code* to make it unlawful for its nationals to traffic in human organs or carry out transplants while being aware of their unlawful origin.[37] This law, which carries a maximum penalty of 12 years imprisonment, applies to organ trafficking carried out both nationally and abroad where a party is a Spanish national.[38]

Transplant States have adopted a different approach to legislating against transplant tourism. As destination States for transplants and host States for organ brokers and buyers, the governments of a few key transplant States have laws in place to regulate the donation and transplant of organs to foreigners who are not near relatives of the organ donors. As was discussed extensively in Chapter 3 of this publication, foreigners who are not near relatives of nationals in the Philippines, India and Pakistan are not allowed to receive organs for transplant in these States.[39] While this has not led to the eradication of transplant tourism there, it has reduced the prevalence of transplant tourism practices in these key States. With the whole world as a possible harvest ground for organ traffickers and brokers, one potential undesired effect that these laws could have on the general global trade in human organs is that they may lead to forum shopping, with organ merchants seeking out more favorable States for their activities.[40]

I have provided a concise picture of the current state of transplant tourism prohibition at both national and international law. It shows the current lack of laws prohibiting transplant tourism. It also shows that the current laws to combat transplant tourism practices are unsystematic and diverse. While diversity in combatting crime is not by itself problematic, it becomes so when the various forms of criminal law have not successfully led to the prevention or eradication of that crime. Aside from the *Trafficking in Human Organs Convention*

36 Spain is one of the 17 States which have signed the *Trafficking in Human Organs Convention.*

37 See article 156 bis, *Penal Code of Spain*, *supra* note 13,

38 *Ibid.*

39 See ss 3(1) & 7(1), *Transplantation of Human Organs and Tissues Act* (Pakistan), *supra* note 13; section 7, The *Transplantation of Human Organs* (*Amendment*) *Act* (India), *supra* note 13; section V(5), *Revised Rules and Regulations Governing Accreditation of Hospitals Engaged in Kidney Transplantation*, (*Administrative Order No. 2008-0034*) (The Philippines).

40 Nishtha Chugh, "Need a Kidney? Inside the World's Biggest Organ Market" Aljazeera (08 October 2015), online: <http://www.aljazeera.com/indepth/features/2015/10/kidney-worlds-biggest-organ-market-151007074725022.html>.

which will come into force next year, there is currently no binding instrument against transplant tourism at international law. Soft law instruments continue to play a major role in influencing the direction of transplant tourism laws and policies in States. Aside from Israel and Spain, which have taken steps to discourage their nationals from traveling abroad to buy organs, transplant tourism remains an undesirable activity with no penalty in other tourist States. Although transplant States like India, Pakistan and the Philippines have taken steps to protect their nationals from transplant tourism by passing laws aimed specifically at the prevention of transplant tourism, nationals in some other transplant States are protected only by local transplant and criminal laws against organ commercialization. Yet, there are transplant or neutral States devoid of any form of transplant tourism, organ trafficking and organ commercialization legislation. The law could and should play a more active role in the eradication of transplant tourism.

## B Proposals and Their Justifications

Flowing from the above, I have made certain recommendations on how transplant tourism should be prohibited by both international and national laws with the aid of the child sex tourism (CST) model which has been shown to work in the prevention of CST in a number of States. These recommendations were articulated in Chapters 5 to 7 of this publication, and consist of three major legal reforms. These reforms are:

1. The development of a comprehensive international soft law instrument on transplant tourism which sets out standards, recommendations and legal directions for States to adopt and apply locally;
2. The adoption of international treaties on transplant tourism; and
3. The creation of extraterritorial criminal laws by States based on the soft law and existing international law instruments on transplant tourism to prohibit the activities of their nationals who travel abroad to engage in transplant tourism.

### 1 *A Comprehensive Soft Law Instrument on Transplant Tourism*

My first recommendation is the development of a comprehensive international soft law instrument which has transplant tourism, including related practices such as organ commercialization and organ trafficking, as its sole focus. Like the *Declaration of Istanbul* and the *Declaration and Agenda for Action*, the soft law instrument should be the result of collaboration among representatives

of State governments, healthcare professionals, academics, non-governmental organizations and other stakeholders.[41] The inclusion of multi-stakeholders in the drafting of the instrument will increase the likelihood of including more workable, effective and relevant provisions in the instrument. This is because unlike States, interest groups like Transnational Advocacy Networks (TANs) work closely with the victims of abuse, are more familiar with the challenges brought about by transplant tourism and are independent.[42] In addition, the epistemic community of physicians, scientists and scholars focused on transplant tourism have the required expertise.

Starting the prohibition of transplant tourism at international law will help set the standards, principles and guidelines which would guide States in their prohibition of transplant tourism practices.[43] This soft law instrument will satisfy the need for a unified approach to tackling transplant tourism which should be adopted by all States. I have chosen soft law as the first vehicle for setting these global standards instead of a binding treaty as it is easier to get States to support a soft law instrument due to the various advantages of soft law as discussed in Chapter 5 of this publication.[44] These attractions include the non-binding nature of soft law, lower cost of implementation, flexibility, and the ability to test run potentially future binding obligations before committing to them. It is also evident that even though most States are so far unwilling to ratify a binding international law agreement on transplant tourism, they are more responsive to soft law instruments. For instance, States have been very receptive to the *Declaration of Istanbul* by adopting it in anti-transplant tourism policies and local and regional laws. The *Trafficking in Human Organs Convention* might however be an exception to the general observation that States are unwilling to

41 See the *Stockholm Declaration and Agenda for Action*, adopted at the First World Congress against Commercial Sexual Exploitation of Children, Stockholm, Sweden, 27–31 August 1996.

42 Anna Cody, "NGOs and Human Rights Monitoring: The 'How, When, Where, What and Why' of Effective Engagement" (2014) 39:4 Alternative L J 255; Kathrin Zippel, "Transnational Advocacy Networks and Policy Cycles in the European Union: The Case of Sexual Harassment" (2004) 11:1 Soc Pol 63; Jeremy Seabrook, *No Hiding Place: Child Sex Tourism and the Role of Extraterritorial Legislation* (London: Zed Books, 2000) at 131–132.

43 As has been show, a few States have gone ahead to create laws against transplant tourism on their own. Any future instrument on transplant tourism should take these laws into account. Provisions from successful transplant tourism laws should be transplanted into the international law instrument which in turn would help diffuse those laws, standards and procedures to other States.

44 See Chapter 5, footnotes 171–179.

ratify treaties. So far, it has been ratified by five States. There will most likely be more ratifications of this treaty within the next few years[45]

Another reason for starting with soft law is that they have proven to be useful tools in the enforcement of human rights standards. For one, they help build and serve as evidence of state practice and *opinio juris* in determining the existence of a rule of CIL.[46] They also influence the creation of binding international human rights treaties, domestic laws and policies. Starting with the codification of civil, political, economic, social and cultural rights in 1948 when the *Universal Declaration of Human Rights* (UDHR) was adopted, soft law has played a major role in the development of binding human rights norms in international law.[47] The UDHR, for instance, led to not only the ICCPR and the ICESCR, but has also inspired a wide network of human rights treaties, soft laws, national legislation and policies which safeguard various human rights standards. As we saw in Chapters 5 and 6 of this publication, the *Second Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography* (OP2-CRC) was a direct result of the *Declaration and Agenda for Action*.[48] The effect of the *Declaration and Agenda for Action* continues to snowball as national laws against CST in most tourist States can be traced back to its principles.[49] The influence of soft laws on the creation of binding legal instruments can also be

45 For updates on signatures and ratifications of the treaty, see the COE website, online: <https://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/216/signatures?p_auth=2SFgGGr3>.

46 Alan Boyle, "Some Reflections on the Relationship of Treaties and Soft Law" (1999) 48:4 Int'l Comp L Quart 903; Brian Lepard, *Customary International Law: A New Theory with Practical Applications* (New York: Cambridge University press, 2010) at 116; *Case Concerning the Military and Paramilitary Activities in and against Nicaragua* (*Nicaragua v. USA*) (1986) ICJ Rep. at 14, para. 191; *Legality of the Threat or Use of Nuclear Weapons, Advisory Opinion*, (1996) ICJ Rep. at 383, para. 100

47 *Legal Consequences for States of the Continued Presence of South Africa in Namibia* (*South West Africa*) *Notwithstanding Security Council Resolution 276* (1971) ICJ Rep. 16 at para. 52; Hilary Landorf, "The Universal Declaration of Human Rights" (2012) 76:5 Soc Edu 247.

48 *Optional Protocol to the Convention on the Rights of the Child on the Sale of children, Child Prostitution and Child Pornography*, G.A. Res. 54/263, Annex II, 54 UN GAOR Supp. (No. 49) at 6, UN Doc. A/54/49 (2000).

49 There are currently over 30 States with laws against CST. See Ronald Flowers, *Perpetrators, Predators, Prostitutes and Victims* (Springfield: Charles C. Thomas Pub., 2006) at 137; Sara Austin, "Commercial Sexual Exploitation of Children: How Extraterritorial Legislation Can Help" in Don Brandt, ed, *Violence Against Women: From Silence to Empowerment* (California: World Vision International, 2003) at 53.

found in recent attempts at the prohibition of transplant tourism. Although not yet in force, the *Trafficking in Human Organs Convention* was influenced in part by the *Declaration of Istanbul* and the 2008 *WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation*.[50]

The prohibition of transplant tourism, however, requires more than the creation of targeted soft law. For soft law to be of any real relevance, it must be robust and cover every aspect of transplant tourism. The important provisions that must be covered by soft law will be discussed in greater details in the third section of this Chapter. For one, transplant tourism must be well defined to capture every facet of transplant tourism practices. Luckily, the *Declaration of Istanbul* has already led to an all-encompassing definition of transplant tourism that should be adopted in the soft law instrument.[51] Provisions of the *Trafficking in Human Organs Convention* which make the removal of organs without the free and informed consent of the donor or where the donor is paid a criminal offence should be adopted.[52] Also of great importance is the adoption of article 10 of the *Trafficking in Human Organs Convention* which requires States to exercise extraterritorial criminal jurisdiction over organ trafficking offences.[53] This provision should be expanded to cover all transplant tourism activities. Other important provisions which the soft law should contain are those on the promotion of organ transplant laws and organ self-sufficiency, the prohibition of organ trafficking and organ commercialization and penalties for engaging in any activity related to transplant tourism. If adopted by an increasing number of tourist and transplant States and implemented domestically, a soft law on transplant tourism could be the first step to true eradication of transplant tourism and could blossom into binding international and national laws against transplant tourism.

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50 World Health Organization, "WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation" (2010) 11:4 Cell Tissue Bank 413–9.

51 The *Declaration of Istanbul* defines transplant tourism as travel for transplantation "if it involves organ trafficking and/or transplant commercialism or if the resources (organs, professionals and transplant centers) devoted to providing transplants to patients from outside a country undermine the country's ability to provide transplant services to its own population."

52 See article 4, *Trafficking in Human Organs Convention, supra* note 12.

53 *Ibid*, article 10.

### 2 *A Treaty on Transplant Tourism*

My second major recommendation involves the transformation of the soft law on transplant tourism into a treaty opened for signature and ratification by all States. While a soft law on transplant tourism could be effective in influencing change in the way States address transplant tourism as can be seen from the impact that the *Declaration of Istanbul* has had so far on transplant tourism, there is still a need for a treaty which focuses principally on transplant tourism. As noted in Chapter 6, the treaty on transplant tourism should be made under the auspices of the UN, preferably, as a protocol to an already existing human rights treaty like the ICCPR.[54] This way, the treaty can benefit from existing operational structures and treaty enforcement mechanisms and committees. Among other things, the treaty should cover comprehensive definitions of important terms, extraterritorial national criminal law application, best practices in organ transplantation, the need for States to seek out ways of becoming more self-sufficient in the donation of organs, regulation of travel for transplant purposes and prohibition of organ trafficking and organ commercialization. The major support for an adoption of a treaty on transplant tourism can be traced back to the principal advantage treaties have over soft law instruments. While soft law instruments can influence the actions of States, States are still free to act contrary to the provisions of a soft law as they do not possess any binding authority. Treaties, on the other hand, contain provisions that States agree to be bound by. In addition, a treaty on transplant tourism will have the added advantage of subjecting the enforcement of transplant tourism laws by States to the scrutiny of the international community at large. I am choosing the adoption of a soft law on transplant tourism before a treaty as the soft law would test run potentially future binding legal obligations and ease States into treaty obligations.[55]

The important provisions the treaty on transplant tourism should contain have been listed under my first recommendation and will be discussed in greater detail below. For the treaty to have its desired effect, it must have provisions which prevent States from making reservations to provisions of the treaty during ratification. Instead, States should be encouraged to include provisions in their national laws which encourage cooperation between States via the extension of mutual legal assistance when needed. States should also be discouraged from including certain limiting provisions into their treaty

54 See Chapter 6, footnote 228.

55 Brian Sheppard, "Norm Supercompliance and the Status of Soft Law" (2014) 62:4 Buff L Rev 792.

implementation laws. Of importance to the implementation of the treaty is the exclusion of provisions that introduce the principle of double criminality into provisions on the enforcement of transplant tourism criminal laws.[56] This principle is part of the reason why some States have not recorded much success in the prosecution of CST cases.[57]

Is a treaty on transplant tourism viable soon? The answer to this question is yes. Unlike the pre-2008 period when States, international NGOs, interest groups and medical associations had yet to make the prevention of transplant tourism a priority, the current interest and focus on transplant tourism makes the possibility of a treaty on transplant tourism is no longer inconceivable. As discussed in Chapter 4, the epistemic community and TANs focused on transplant tourism have been very active in their campaign for the eradication of transplant tourism practices.[58] They have championed the creation of soft laws on transplant tourism and the development of ethical standards which should guide organ transplants in States. The effect of their activities is already evident. For one, it led to the adoption of the *Declaration of Istanbul* which in turn was one of the instruments which influenced the drafting of the *Trafficking in Human Organs Convention* in the European region.[59] Aside from influencing the adoption of an international law treaty on transplant tourism, the *Trafficking in Human Organs Convention* could also influence the adoption of regional treaties on transplant tourism. With this treaty and various other transplant-tourism-focused policies, declarations and resolutions in place, the path has been paved for a treaty on transplant tourism.

Though an important step in the prohibition of transplant tourism, the adoption of treaties on transplant tourism would not be an end in and of itself. For one, States would have to ratify any treaty for it to come into

56 The principle of double criminality requires that an activity be an offence in both the enforcing State and the State here the activity takes place. See Daniel Edelson, "The Prosecution of Persons who Sexually Exploit Children in Countries Other than Their Own: A Model for Amending Existing Legislation" (2001) 25:2 Fordham Int'l L J 495.

57 See for instance section 72(2) of the *Criminal Justice and Immigration Act* 2008 (c.4), which makes it impossible for UK nationals to be prosecuted for CST activities if the act is not an offence in the State where it is performed. *Contra:* section 7(4.1), *Criminal Code* of Canada, RS 1985, c. C-46.

58 See Chapter 4, footnotes 241–254.

59 See Council of Europe, European Committee on Crime Problems, "Committee of Experts on Trafficking in Human Organs, Tissues and Cells (PC-TO)," online: <http://www.coe.int/t/dghl/standardsetting/cdpc/pc_to_en.asp>.

force.[60] After a treaty has been ratified by a State, that State will still need to commit to the implementation and enforcement of such a treaty, such as through passing and enforcing local laws on transplant tourism. No matter the number of national and international instruments put in place to outlaw transplant tourism, these laws will be of no effect if States and the international community do not commit to their enforcement. This last point will be the focus of my concluding thoughts on the path towards the eradication of transplant tourism in the last section of this Chapter.

### 3 *Extraterritorial National Criminal Laws on Transplant Tourism*

The third recommendation focuses on the creation of unified national transplant tourism laws in accordance with the principles and spirit of the international law instruments. As mentioned earlier, there are only 5 States with national transplant laws that explicitly include provisions on transplant tourism. What this means is that organ buyers and facilitators can avoid these States and shop for organs in all the other States with no transplant tourism laws or no organ transplant laws in general. Most national transplant laws in both transplant and tourist States only address organ commercialization within those States. Organ buyers from other States are thus able to escape any form of liability once they have successfully returned to their States of origin. A unified approach to national prohibition of transplant tourism would mean that there are no safe havens for organ sellers and buyers. It will also foster cooperation among States and lead to better enforcement of transplant tourism laws.

An essential component of this national organ transplant law reform is the inclusion of provisions which allow States to use extraterritorial criminal laws to prosecute their nationals who are involved in transplant tourism practices in other States as transplant tourists, organ buyers, facilitators and brokers. This recommendation flows directly from one of the recommended provisions of the soft law on transplant tourism. In Chapter 6 of this publication, I examined the use of longstanding extraterritorial criminal legislation by States in the prohibition of offences ranging from bigamy to piracy and treason.[61] Also in Chapter 6, I discussed how the use of extraterritorial criminal legislation by States has its foundation in international law.[62]

60 This is subject to any other direct stipulation on the treaty on when, how and the actions which bring it in force.

61 See Chapter 6, footnotes 112–114.

62 The *Case of the S.S. Lotus* (*France v Turkey*) (1927), PCIJ Series A, No. 10 at 45; See Chapter 6, footnote 30.

Five CIL principles emerged for the exercise of such jurisdiction by States, the: territorial, nationality, passive personality, protective, and universality principles. Of these five principles, only the territorial, nationality and passive personality principles are relevant to combat transplant tourism as they provide real and direct links between transplant tourism practices and States. The same three principles have also been used by States in their prohibition of CST. With the many similarities between transplant tourism and CST, it is foreseeable that the current model used to prohibit CST would work if applied to transplant tourism. Already, there are a couple of tourist States (Israel and Spain) that have laws prosecuting their nationals who engage in transplant tourism activities abroad using the nationality principle of jurisdiction.

The importance of using a model that includes extraterritorial criminal laws to combat transplant tourism were highlighted in Chapter 6 of this publication. First, it would ensure that transplant tourism is no longer largely a prosecution-free activity. As a transnational practice that has been shown to breach the rights and endanger the lives of individuals in both tourist and transplant States, there is an urgent need to eradicate it. Secondly, the use of this model by tourist States is bound to have a greater effect on the prevention of transplant tourism than any measure currently put in place by transplant States. The nature and format of national laws implementing this model will ultimately depend on the principles, policies, legal rules and division of powers of the implementing State. Already, the two tourist States with a similar transplant tourism model have applied them in slightly different ways. While Israel has chosen to include the prohibition of transplant tourism in the provisions of its *Organ Transplantation Law*, Spain has done so by amending its *Penal Code*. Another difference between the implementation of transplant tourism laws in both States is that, unlike the Spanish law, the law in Israel targets the funding of transplant tourism by insurance companies and makes it illegal for nationals to be reimbursed for transplant tourism activities.[63] In reality, it does not matter the format the implementation of the prohibition of transplant tourism takes in States so long as the format is effective, the applicable laws are in line with the international soft law instrument and States commit to the enforcement of these laws.

63 Section 3, *Organ Transplant Law, supra* note 13; Jacob Lavee & Avraham Stoler, "Reciprocal Altruism: The Impact of Resurrecting an Old Moral Imperative on the National Organ Donation Rate in Israel" (2014) 77:3 Law Contemp Pro 323.

## C Key Provisions of an International Law Instrument on Transplant Tourism

Throughout the body of this publication, I have advocated for the creation of a legal model which prohibits transplant tourism starting with the creation of an international soft law instrument on transplant tourism which will give rise to a treaty and national laws on the practices. I have also referred to several terms which the soft law and treaty should contain. Except for the binding language and more specific provisions which the treaty would adopt, the treaty and the soft law will contain similar terms. Below, I provide a detailed explanation of the key provisions which these instruments should contain. These provisions include: preliminary matters like definition of terms and the coverage of the instrument; substantive matters like the prohibition of transplant tourism and the use of extraterritorial criminal laws by States; and penalty and enforcement provisions.

### 1 *Key Provisions*

#### i Purpose and Coverage of the Instrument

One of the early articles of the instrument should outline its purpose and coverage area. The purpose of the instrument should be the prohibition of transplant tourism by States. To this end, the instrument should provide articles which States Parties should adopt and apply in their prohibition of transplant tourism. Due to the compound nature of transplant tourism, the instrument should enumerate the several practices it seeks to prohibit. These practices should include organ trafficking, organ commercialism, travel for transplant purposes, illegal removal of organs, illegal organ transplants, and organ brokering. Where any of these practices is made up of sub-practices, these sub-practices should also be enumerated to properly cover the field of prohibition. For instance, organ brokering would include activities such as organ sourcing, recruitment of organ buyers, facilitation of organ sales, linking of the several persons involved in the organ trade and transplants, sourcing of suitable health centers for the performance of the illegal operation, arrangement of travels for organ sellers and buyers and payment of parties involved in the organ trade. Each of these practices should be enumerated.

#### ii Definition of Terms

Flowing from the above provision, the instrument should go a step further and define each of the core terms and practices involved in transplant tourism. This would set the parameters of the instrument and automatically include or exclude certain acts from the ambit of the instrument. In the prohibition

of transplant tourism, certain terms need to be accurately defined, starting with what is meant by transplant tourism. Being that transplant tourism is a complex term which involves multiple practices such as organ commercialism, organ trafficking and travel for transplantation, it is imperative that the instrument provides a broad or compound definition which covers these practices. The definition provision should also contain detailed definitions of the types of organs, tissues and body parts covered by the instrument. The *Declaration of Istanbul* has a very elaborate definition of transplant tourism which should be adopted. It clearly distinguishes transplant tourism from organ commercialization and organ trafficking and highlights the importance of travel for transplantation to the definition of transplant tourism. It also extends the coverage of its provisions to instances where the transplant needs of the national population are ignored in favor of that of foreigners.[64]

iii Provisions which Promote Self-Sufficiency in Organ Donations

The attainment of self-sufficiency in organ donations by all States is very important in the prevention of transplant tourism. The logic here is simple: if a State can meet all the organ needs of its nationals, there would be no need for its nationals to seek organs elsewhere. The instrument on transplant tourism should have provisions dedicated to the attainment of organ donation self-sufficiency by States. Measures which encourage people to willingly donate their organs should be encouraged above those which propose financial compensation for organ donation. States should be encouraged to tap into sources of organs which they are not currently taking advantage of.[65] States should also be encouraged to educate their nationals against myths and cultural practices which limit the available pool of organs for donation. In certain parts of Asia,

64 The *Declaration of Istanbul* defines transplant tourism as travel for transplantation "if it involves organ trafficking and/or transplant commercialism or if the resources (organs, professionals and transplant centers) devoted to providing transplants to patients from outside a State undermine the State's ability to provide transplant services to its own population." See *Declaration of Istanbul, supra* note 1.

65 Some Asian and Middle Eastern cultures frown against cadaveric organ donation due to cultural believes that the integrity of the body should be maintained at the time of burial. The affected States need to work at dispelling such believes so as to increase their organ donation pool. See George Abouna, "Organ Transplantation in the Middle East: Problems and Possible Solutions" in Mehmet Habera, ed, *Recent Advances in Nephrology and Transplantation* (Ankara: Pelin Group Pub Co, 1990) at 236; David Rothman *et al*, "The Bellagio Task Force Report on Transplantation, Bodily Integrity, and the International Traffic in Organs" (1997) 29:6 Transplant Proc 2739.

for instance, post mortem donation of organs is frowned upon for cultural and religious reasons.[66] There should be a way of dispelling whatever fears and biases are involved in the donation of organs. Practices which are outright illegal or deemed to be immoral should not be encouraged. Strict rules should be put in place to protect minors and other vulnerable persons in the organ acquisition process. The fifth principle of the *Declaration of Istanbul* contains provisions on the attainment of self-sufficiency in organ donation by States.[67] These provisions could serve as a guide for the instrument on transplant tourism.

iv Provisions which Promote Organ Transplant Laws

One of the key challenges facing the eradication of transplant tourism is the lack of national laws prohibiting it. Although a lot of States around the world have laws which regulate organ transplantation, there are still States where these laws are nonexistent. Most troubling is the fact that some key transplant States do not have organ transplant laws. Some developing States do not see the need to pass organ transplant laws since they do not have the facilities to carry out organ transplants nationally. What they fail to realize is that, although they lack the financial and infrastructural capacity to carry out organ transplants, their nationals are victims of the organ trade in other States to where they are transported to sell their organs. This reflects patterns of transplant tourism in which persons from a State are transported to the State of the donee or a third State for organ extraction.[68] There is a need for all States to protect their nationals from the dangers of transplant tourism whether or not the transactions take place within their territories. To this end, States should be directed to pass national transplant laws which prohibit various aspects of transplant tourism. As mentioned in Chapter 6, these laws should prohibit contracts and other arrangements for the sale of organs, organ trafficking, harvesting and commercialization, and the use of organs acquired illegally

66 Kevin Woo, "Social and Cultural Aspects of Organ Donation in Asia" (1992) 21:3 Ann Acad Med Sing 421; Christina Chung *et al*, "Attitudes, Knowledge, and Actions with Regard to Organ Donation among Hong Kong Medical Students" (2008) 14:4 Hong Kong Med J 282; Dana Alden & Alan Cheung, "Organ Donation and Culture: A Comparison of Asian American and European American Beliefs, Attitudes and Behaviors" (2000) 30:2 J App Soc Psycho 296; Kazuo Ota, "Present Status of Kidney Donation in Japan" (1991) 23 Transplant Proc 1804.

67 See *Declaration of Istanbul, supra* note 1.

68 Debra Budiani-Saberi & Frances Delmonico, "Organ Trafficking and Transplant Tourism: A Commentary on the Global Realities" (2008) 8:5 Am J Transplant 926.

for organ transplants abroad where the parties involved in the transplants are aware of the illegal source of the organ.[69]

### v Prohibition of Transplant Tourism via Extraterritorial Criminal Law Provisions

States should also be directed to prohibit transplant tourism in their national organ transplant laws. Because of the transnational nature of transplant tourism, States should be directed to exercise jurisdiction over offences under their national transplant laws based on three principles of jurisdiction, the: territorial principle, nationality principle and passive personality principle. In other words, States should be encouraged to exercise jurisdiction over transplant offences where the offence or part of the offence is committed within their territory, the offence is committed by a national or where a victim of the offence is a national. Without the existence of extraterritorial criminal laws, jurisdictional challenges will make it impossible to penalize individuals from tourist States who travel abroad to buy organs and undergo illegal transplants. Article 10 of the *Trafficking in Human Organs Convention* which requires States to pass laws with extraterritorial reach over offences, including those committed in their territories or by nationals and habitual residents in their territories should be adopted with relevant modifications.[70]

### vi Provisions which Limit People Allowed to Access Organs Nationally

Due to the different roles which transplant and tourist States play in the sustenance of transplant tourism, there is the need for special provisions which are tailored to the needs of either transplant or tourist States. One provision which transplant States should be encouraged to have in their national transplant laws are provisions which limit the people who can have access to organs in these States. Currently, three States, India, the Philippines and Pakistan, have been able to limit the cases of transplant tourism within their States by regulating not only the source of organs for transplantation but also the individuals

69 See Chapter 6, page 244.

70 Article 10(1) states: "Each Party shall take such legislative or other measures as may be necessary to establish jurisdiction over any offence established in accordance with this Convention, when the offence is committed: (a) in its territory; or (b) on board a ship flying the flag of that Party; or (c) on board an aircraft registered under the laws of that Party; or (d) by one of its nationals; or (e) by a person who has his or her habitual residence in its territory." See article 10(1), *Trafficking in Human Organs Convention, supra* note 10.

who can receive these organs. In the States listed above, organs are *prima facie* only allowed to be donated to nationals and foreigners who are close relatives of the donors.[71] Pakistan, for instance, uses the term "close blood relatives" in its transplant law which is defined as a "parent, son, daughter, sister, brother and includes spouse."[72] A treaty on transplant tourism should encourage State Parties to pass laws with provisions such as the above.

vii Penalties and Provisions which Discourage Transplant Tourism

The imposition of criminal liability remains an effective tool for encouraging compliance with laws. States with laws against organ commercialization have criminal provisions which penalize individuals who engage in the practice. These laws often cover all possible parties to the trade including the brokers, organ sellers and organ recipients. Due to the importance of having access to organs by those who need them, people are often willing to risk penalization for a shot at extending their length and quality of life. For any form of penalty to be effective, it must be severe enough to deter would-be defaulters. States should be required to have severe penalty provisions for offences under their national transplant laws. The type of penalty, whether fine, imprisonment, or both, should be left to each State Party. Aside from severe penalty provisions, States should also be required to include provisions in their national laws which discourage activities unique to them which promote transplant tourism. As mentioned above, the Israeli transplant law, for instance, prohibits insurance companies from reimbursing nationals who engage in illegal organ transplants abroad with positive results.[73]

viii Enforcement, Monitoring and Mutual Legal Assistance Provisions

The imposition of severe penalties is only one part of enforcement. For these penalties to have their desired effect, they must be backed up by appropriate enforcement mechanisms. Where this is missing, legal provisions will remain ineffective. The instrument should have provisions on two forms of enforcement: one at the State level and the other by international law treaty bodies. States should be encouraged to set up monitoring committees which will see to the implementation of national transplant laws. At the treaty stage, there should be a treaty committee with functions specific to transplant tourism. As was discussed in Chapter 4 of this publication, treaty committees have a

71 See *supra* note 39.

72 Section 3(1)(a), *Transplantation of Human Organs and Tissues Act*, *supra* note 13.

73 Section 3, *Organ Transplant Law,* supra note 13

wide range of powers.[74] With the inability of most transplant States to properly enforce local organ transplant and transplant tourism laws due to corruption and other local social factors, the activities of a treaty committee on transplant tourism would complement State enforcement efforts.[75] They could also put pressure on State governments to be more proactive in enforcing transplant tourism laws and preventing transplant tourism activities within their territories. If the treaty on transplant tourism is structured as a protocol to an existing human rights treaty, it will be able to benefit from the monitoring functions of its treaty committee.

As part of its enforcement provisions, the instrument should contain provisions which encourage mutual legal assistance among various States. As was discussed in Chapter 7, mutual legal assistance is essential to the enforcement of anti-transplant tourism laws.[76] Other enforcement provisions which should be included are those which require the documentation of organ transplant activities. An example of this is the introduction of transplant certificates as recommended in Chapter 7.[77]

ix Exclude Provisions which Limit the Application of the Instrument

The treaty should exclude provisions which limit the application of the treaty. Treaty limiting provisions include those which permit States Parties to make reservations to important provisions of the treaty. As was noted in Chapter 4, in the *Trafficking in Human Organs Convention* for instance, States can make reservations to provisions of the treaty such as provisions which criminalize the removal of organs from living donors and provisions which allow States to choose whether or not they want to prosecute their nationals or habitual

74 See for instance articles 40, 41 & 42 of the ICCPR, *supra* note 9, and the preamble & article 1 of the *Optional Protocol to the International Covenant on Civil and Political Rights,* GA Res. 2200A (XXI), 21 UN GAOR Supp. (No. 16) at 59, UN Doc. A/6316 (1966); 999 UNTS 302, for the functions of the Human Rights Committee (HRC).

75 For more on transplant tourism in India despite the amendment of the *Transplantation of Human Organs Act*, see: Abantika Ghosh, "Apollo Transplant Scandal: Explaining the Kidney Market Rules," The Indian Express (07 June 2016), online: <http://indianexpress.com/article/explained/delhi-kidney-racket-illegal-organ-trade-apollo-hospital-2838263/>; Pritha Chatterjee, "Delhi Kidney Trade Racket: How the Gang Managed to Get Around Organ Transplant Rules," The Indian Express (04 June 2016), online: <http://indianexpress.com/article/cities/delhi/delhi-kidney-trade-racket-how-the-gang-managed-to-get-around-organ-transplant-rules-2833502/>.

76 See Chapter 7, page 272.

77 See Chapter 7, footnotes 134–148.

residents for offences under the convention.[78] If States are permitted to make reservations such as these to a treaty on transplant tourism, the exercise of this right by States could impact negatively on the enforcement of the treaty. States should also be discouraged from including provisions in their national laws and MLATs made under the treaty which promote the principle of double criminality. Such provisions would limit the application of the instrument as not all States would have laws against organ commercialization and trafficking.

## D The Need for Better Commitment to the Eradication of Transplant Tourism by States and the International Community

Throughout the body of this publication, workable suggestions have been made on steps which should be taken by States and the international community to ensure that transplant tourism is eradicated. These suggestions culminated in the above noted list of provisions which an international law instrument on transplant tourism should contain. As I stated in the previous section, the standards that should guide the global regulation of transplant tourism need to have their foundation in international law. While various resolutions and declarations have been reached by the international community as a whole on the prevention and eradication of transplant tourism and the principles that should guide organ transplantation and best practices for organ acquisition and distribution, the fact that none of these instruments have so far been transformed into a treaty on transplant tourism is a solid reflection of the level of commitment of the UN and international community as a whole.[79] Although it is a regional treaty, after the *Trafficking in Human Organs Convention* comes into force next year, it might encourage similar transplant tourism-specific UN multilateral treaties in the near future.

As with the enforcement and prevention of all transnational human rights offences, whether in response to international law developments or on a unilateral basis, States must play a major role in ensuring that human rights standards prohibiting transplant tourism are transmitted into legislation that can be enforced at the State level. The commitment and compliance of States to these norms are important if eradication goals are to be achieved. It is surprising that of all of the transplant States affected by transplant tourism, only three

78 See Chapter 4, page 139; Articles 4(2) & 10(3), *Trafficking in Human Organs Convention, supra* note 10.

79 These instruments are the WHA Resolutions and the *Declaration of Istanbul*.

have take legal steps to protect their nationals from transplant tourism activities. Given the small number of transplant States taking action, States without any form of regulation have seen their territories become hot beds for organ commercialization and transplant tourism. This is especially so in States that are located in proximity to States with regulations. Already, this is happening in Sri Lanka, Nepal and Bangladesh.[80] Granted that more regulation needs to come from tourist States as their transplant tourism laws have been shown to be more effective in prohibiting transplant tourism, addressing transplant tourism practices from both ends would lead to even quicker resolutions.

The creation of national laws against transplant tourism is, however, only the first step in combatting it nationally. States must be committed to the enforcement of their national transplant tourism laws. There are ready examples of transnational crimes the prevention of which have not been successful due to non-performance by States. As discussed in Chapter 6 of this publication, State measures to enforce their anti-CST laws had varying results. Shortcomings in the enforcement of anti-CST laws in some States can be traced in part to a lack of total commitment on the part of the tourist States and destination States. Although key destination States like Thailand, Cambodia and the Philippines all have national laws which prohibit sexual offences against children and are all parties to the OP2-CRC, the practice of CST continues in these States.[81] Some tourist States, on their part, with national laws prohibiting CST have not been very successful in ensuring that their nationals do not travel abroad to engage in the practice or in investigating and prosecuting offenders. For example, unlike Australia and the US with high prosecution rates of nationals who engage in CST, Canada has not fared so well in this regard.[82]

The current enforcement of anti-transplant tourism laws in transplant States is another illustration of how the enforcement of good laws can be hampered by poor commitment on the part of States. As has been shown in several parts of this publication, a few transplant States have taken legal steps, with mixed results, to ensure that their nationals do not engage in transplant

80 Chugh, *supra* note 40.

81 See section 277, *Thailand Criminal Code*, B.E. 2499 (1956) as amended by the *Criminal Code* (No. 17), B.E. 2547 (2003) (Thailand); section 5, *Republican Act No. 7610* (*An Act Providing for Stronger Deterrence and Special Protection Against Child Abuse, Exploitation and Discrimination, and for Other Purposes*) (The Philippines); and chapter 4, *Law on Suppression of Human Trafficking and Sexual Exploitation*, 2008, NS/RKM/0208/005 (Cambodia).

82 Benjamin Perrin, "Taking a Vacation from the Law? Extraterritorial Criminal Jurisdiction and Section 7(4.1) of the Criminal Code" (2009) 13:2 Can. Cri. L. Rev. at 204, 205.

tourism. Some States have also created monitoring bodies to oversee organ donations and transplants.[83] Although these are important steps in the eradication process and have been shown to reduce the prevalence of organ sales and tourist transplants in these States, they have not guaranteed their eradication. Enduring cases of transplant tourism in these States that have been publicly reported can be traced to several factors including poverty, corruption and the general lack of commitment of the governments to oversee the enforcement of these laws.[84]

A factor which might guarantee greater commitment of States to future laws prohibiting transplant tourism is the direct involvement of States in the drafting of international law instruments to combat it. It has been shown that the likelihood of compliance with international soft law rules increases when States are involved in the formation and drafting process.[85] Another factor which might ensure better commitment on the part of States to the eradication of transplant tourism is support from other States. It is obvious that transplant States have a harder time enforcing international law obligations, but support from other States could help ensure better compliance. Technical and financial assistance from tourist States to transplant States would also lead to a reduction in transplant tourism activities in transplant States. This assistance could be built into the treaty on transplant tourism which in turn will attract more transplant States to ratify the treaty and implement its provisions. If a treaty on transplant tourism is a UN human rights treaty, it will be able to benefit from extra monitoring by the UN. Finally, TANS and the

83 In India for e.g., an Authorization Committee was created under the *Transplantation of Human Organs Act,* Act No. 42 of 1994, to oversee organ donations and transplants. See section 9(4), THOA; see also section 4 A(4), The *Transplantation of Human Organs* (*Amendment*) *Rules* (GSR 571(E), dt.31-7-2008).

84 The failure of the transplant State governments to tackle corruption especially as it relates to the enforcement of the laws against transplant tourism can also be traced back to the general lack of commitment of these States to transplant tourism eradication. As was shown in Chapter 7, State governments in transplant States sometimes turn a blind eye to the transnational crimes which attract tourists and foreign revenue. This attraction to foreign revenue could limit the attention such a State pays to corruption and enforcement of national laws against transnational crimes. See Rory Johnston *et al*, "What is Known about the Effects of Medical Tourism in Destination and Departure Countries? A Scoping Review" (2010) 9:24 Int'l J Equity Health 30; Ramya Vijaya, "Medical Tourism: Revenue Generator or International Transfer of Healthcare Problems?" (2010) 44:1 J Econ Iss 55.

85 Dinah Shelton, *Commitment and Compliance: The Role of Non-Binding Norms in the International Legal System* (Oxford: Oxford University Press, 2003) at 16.

epistemic community which include nephrologists, ethicists, policy makers, transplant organizations, NGOs and other stakeholders have so far been very active in ensuring that transplant tourism becomes a thing of the past. Their expertise will be indispensable in the development and enforcement of future laws against transplant tourism.

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