“The Increasing Rates of Organ Trafficking in the Context of Globalization”

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Section I: Human Organ Trafficking and its Role in the Global Criminal Economy

The organ trade has quickly become a facet of globalization; an ugly paradox that undermines the beneficial effects that globalization should have on the world. It has become a “misrecognized form of human sacrifice” (Hughes 31). Organ trafficking is on the rise as the demand for organ transplants exceeds the rate of supply. While the commoditization of human organs sounds devastating on paper, in some areas of the world it is a lucrative facet of economic development. Human organs, in one way, have become a blood commodity and have thus triggered a response to increase the standards of human rights brought to bear on this issue. Although human organ trafficking does not directly fuel civil war like conflict commodities, its persistence does fuel the global criminal economy. Does the illicit organ trade serve larger ‘altruistic’ ends, or does it augment the economic bridge of inequality, further separating the poor from the rich, the Global South from the Global North? Globalization, greed, and inequality permit the vicious cycle of trafficking to permeate today’s modern culture.

The global organized crime of trafficking is on a rise due to the forces of an increasingly integrated world. Organ trafficking involves the transport of organs by means of coercion, abuse of power, deception, and vulnerability (Budiani and Delmonico 925). When societies become interconnected, events in one part of the world now have greater effects on people and other societies far away (Kelleher and Klein 23). Advocates for globalization argue that this opens up opportunities for the spread of technology and economic development to marginalized countries. However, the dark underside of the global economy spreads not just wealth, but danger. Global organized crime refers to the cycling of “drugs, people, counterfeit merchandise, and human organs” (Davis and Rogers). The market for organs was first documented by transplant surgeons in the Persian Gulf who treated patients for follow-up care after they had returned from India for
transplant tourism in the late 1980s (Hughes 44). Since then, global capitalism and advanced biotechnology have facilitated the black market in organs. This growing market prompted the World Health Organization to draft the WHO Guiding Principles on Human Organ Transplantation in 1991 (Morelli 935). Nevertheless, the illicit trade of human organs remains a mystery to the general public. The lack of awareness adds to the vicious cycle. Countries like Brazil and Egypt place a social stigma on the use of cadaver organs, which indirectly increases the black market for human organs. One kidney buyer states “that kidney was probably pinned down under the wheels of a car for several hours…it is really a disgusting idea” (Hughes 52). This privileged buyer, however, fails to realize that even more ‘disgusting’ is the infrastructure that allows the rich to receive superior healthcare at the expense of the poor. Furthermore, underdeveloped and developing countries with corrupt governments, like Uganda, lack the basic laws and enforcement capabilities to make trafficking illegal. The black market in organs is multifaceted, driven by vulnerable organ donors, physicians, organ brokers, harvesters, bribed airport officials, police mortuaries, lawyers, self-righteous insurance companies, and privileged organ recipients. In essence, the fear of death equally affects both the rich and the poor, while the desire for life, in a globalized world, spurs on the supply and demand system of illicit organ trafficking.

The scope and scale of human organ trafficking is often ignored and overlooked. Money is the root of all evil, and this proves true in the context of the global criminal economy. Anthropologist Nancy Hughes posed as a medical doctor and was able to link gangsters, clergyman, and surgeons in a trail that led from South Africa, Brazil, and other developing countries, all the way back to the best medical facilities in more developed countries (Interlandi). These deepened trails used for trafficking decreases the altruistic nature of legitimate donations
while fostering greed and self-gratification. Overall, the cost of transnational organized crime amounts to two trillion dollars (Davis and Rogers). This transnational organized crime includes all forms of trafficking, migrant smuggling, and drug cycling. Out of the two trillion, international trafficking of body parts, the fastest growing business of organized crime, is worth about seven billion dollars (Senkumba). Currently, Israel alone accounts for millions of those dollars in its international transplant sector (Hughes 47). The Declaration of Istanbul, created to combat organ trafficking, was signed by over seventy-eight countries in 2008 in order to protect human rights issues (Taylor). The objective of this declaration was to encourage countries to implement changes in order to prevent organ failure and provide organs from donors within its own populations. With 10% of all kidney transplants linked to organ trafficking, perhaps only seventy-eight countries is not nearly enough (Budiani and Delmonico 925). Kidney trafficking is so prevalent in India that the city of Madras has been renamed the “kidney district” (Harrington 2). Kidneys are sold by the poor for a small percentage of what they are actually paid for by the rich, and this reality leads to the unequal transfer of money. The significance of the trend lies in the future of it, as the years waiting for a transplant increases with time (Taylor). One way to increase the supply of human organs for transplantation is to reduce the demand. Nevertheless, the demand is increased as obesity, heart disease, and diabetes remain as intractable causes of organ failure. As a result of demographic shift, globalization, and rapid economic expansion, such chronic disorders once only common in industrial nations, are now sweeping the rest of the globe, especially in countries like India and China (Bloom 93).

“Nature has endowed us with two kidneys including one to share…or to sell,” stated an Israeli kidney buyer (Hughes 54). There are two arguments for the occurrence of illicit organ trafficking. Proponents of the black market in organs see it as a life-giving opportunity to both
recipient and donor. Individuals who willingly sell their organs do so for quick economic gain. Even though the money given to the donor is usually swallowed up by debt, five local women in South India said that they would willingly sell their kidneys again, stating “if only there were three kidneys” (Hughes 38). Jim Cohan is a notorious organ broker whose job it is to match people in need. Newspapers in Italy accused him of being an “organs eater,” yet he stands on the grounds that even with moral dilemmas, illicit transplants will ultimately save a life (Hughes 42). Thus, if a living donor can do without an organ, why is it wrong to sell it if they can generate a profit and likely save a life? Yet, the main question to be answered is this: is the sale of organs for survival really a choice if it is just a desperate alternative available to the poor (Budiani and Delmonico 925)? The answer is no, since commercial living donors would not donate if it were not for the unfortunate circumstances, corrupt government, and poverty that forced them to do so in the first place.

The negative outcomes of such an increasing trade outweigh the monetary gain. Organs should be seen “as a human, not as a natural, resource” (Hughes 46). Those who oppose the illicit organ trade see it as an infringement upon the basic rights of human beings, particularly those of the poor donors. The United Nations is working on a local level to combat human organ trafficking through education, accountability, and a sustainable support network for countries that are in the process of forming anti-trafficking laws (United Nations 8). In 2000, the United Nations issued a protocol to prevent and punish trafficking at the Convention against Transnational Organized Crime; as of 2010, 117 countries signed the protocol (Francis 5). Currently, however, inequity still lingers. The rich are able to bribe doctors and officials into moving them up on the donor waiting list even though their condition is irrevocably life-threatening. The poor, however, are the victims of this bribery. Two prominent activists argue
that human organ trafficking, on a global scale, poses more of a threat than it does benefits. Maria Morelli sees the organ trade as the exploitation of the poor by the wealthy, stating that demand could be met if more people registered to donate their organs after death (Morelli 926). In 2009, it was reported that while 85% of British Columbians say they support organ donation, only 16% were actually registered” (Taylor). The story of the five women from South India who were actually satisfied with their transplant donation, and wished they had another to spare, is a rare tale. Of those surveyed in Egypt, 94% of commercial living donors regretted their donation (Budiani and Delmonico 928). Secondly, Robert K. Goff is a prominent lawyer and founder of Restore International and the new Prevention of Trafficking in Persons (TIP) Act, organizations that works to make a dent in social injustice. Currently, he is single-handedly creating new laws and regulations against human trafficking in Uganda, a country which lacks the infrastructure to combat this pressing issue (See Appendix, Figure 1). The average age in Uganda is 15 (CIA World Factbook). Therefore, this young country is particularly vulnerable to coerced child organ trafficking. Goff’s inspiration for involvement came after the encounter with a young boy left in the bushes to die after three witch doctors took out his organs for trafficking on the border of Congo and Uganda. The young boy, however, had hope that God would save him and thus he persevered. The three witch doctors were put on the first ever trial in Uganda against human trafficking, and were found guilty and sentenced to fifty years in prison on the morning of February 24, 2011 (Goff). Both Maria Morelli and Robert Goff recognize that there is a need for an organ market, but that need must not be met by exploiting those who are already vulnerable.

In essence, organ trafficking can be life-saving for one, but life-sacrificing for another. Human organ trafficking brings to the fore the inequalities of globalization. It becomes much easier to justify practices that only harm those who have no voice and live in a supposedly
“backward” country (Anderson 42). “Global social values lag far behind global economies,” states anthropologist Nancy Hughes (46). The need for power, control, and money takes priority over the basic rights of a human being. After all, whose needs are being privileged? It is the needs of those who already possess sufficient resources, and more resources are being handed to them in the form of human organs.

Section II: The Healthcare Profession and its Role in Human Organ Trafficking

“The chief priests picked up the coins and said, ‘it is against the law to put this into the treasury, since it is blood money’” (Matthew 27.6). In the story of the Gospel of Jesus Christ, the betrayer, Judas Iscariot, received money from the chief priests in return for revealing the identity of Jesus. Clinicians, some of whom wish it were against the law to use “blood organs,” or organs derived out of coercion and bribery, had never once thought of participating in the trade of organs. Yet, they are now being forced to participate by patients who bring in illegally-traded organs. On the other hand, healthcare professionals also willingly immerse themselves in the global organized crime of human organ trafficking and therefore become the “betrayers” to their own patients. The global organized crime of human organ trafficking has created a distrust for medical professionals. There are two sides of the coin to this dilemma, however. As the awareness of the increasing global trend of human organ trafficking increases, healthcare professionals will be challenged by new laws, regulations, and risks. Human organ trafficking affects bioethical standards, increases the corruption of medical agencies and personnel, and decreases the overall quality of healthcare across borders.

The most pressing issue that healthcare professionals deal with is the bioethical standards that affect human organ transplantation. The World Health Organization (WHO) and
International Transplant Societies have worked extensively on implementing solutions to solve the growing need for donor supplies, holding physicians to account at the highest levels of responsibility. In 1991, the WHO implemented a set of guiding principles on organ transplantation that favors voluntary, noncommercial donation and prefers cadaver donors with genetic similarity (Jafar 4). However, these guiding principles condemn the use of incentives to increase the number of organs for transplant. The incentive approach offers indirect or direct compensation for the donation of human organs. Direct incentives include cash payments to the living donor or to the deceased donor’s family, while indirect incentives include guaranteed health insurance, reimbursed funeral expenses, and payment for lost wages for living donors (Rodrigue et al. 2172). Since 1988, this strategy has been practiced in Iran and studies have shown the success of this model proven by the elimination of a kidney transplant waiting list (Jafar 7). In Iran, living unrelated donors are paid $1,200 along with health insurance and post-transplant care run by a state program (Jafar 7). This system has eliminated the need of a black market and transplant tourism, which is illegal in Iran. Professionals in Iran, however, have to be extra cautious of the long-term effects of this system, since studies of more than 5,000 participants suggest that living kidney donors have a higher risk of hypertension (Jafar 7). In a survey of international transplant surgeons, 74.6% supported indirect incentive offered to donors. Critics of this proposed plan feared the commercialization of donation and the increased exploitation of the world’s poorest population (Rodrigue et al. 2173). Ultimately, the majority of developed nations prohibit any type of monetary compensation for organ donation. Nevertheless, incentives in one’s own country for organ donation would eliminate the need for medical tourism so that transplantation procedures are generated from within one’s own country, and the need for organs from vulnerable populations would be obsolete.
While surgeons who are members of professional organizations like the International Transplant Society seek to find a solution to ending the black market of human organs, other physicians and medical agencies respond to this trend in a negative way. Location and culture influences the way that illicit organ trafficking affects patients, especially in comparison with developed versus developing nations. Often plagued by governmental corruption, developing nations lack the infrastructure to “establish a regulated, standardized, and ethical system of organ procurement” (Jafar 1). As a result, illegal organ trade is almost encouraged in developing nations as a means of income, while those in developed nations are those fortunate enough to buy these traded organs and receive the better end of the deal.

Poor people have no one to contend for them and money cannot buy their way through life’s problems, yet they still deserve the same amount of dignity in regards to healthcare. The media has uncovered the series of networks of brokers, physicians, and hospitals engaged in the illegal organ trade. The story of Liliana Goffi, reveals the truth behind this reality. In Buenos Aires, Argentina, Goffi fell victim to kidney theft after a routine operation to remove an ovarian cyst in June 1997 (Hughes 36). Cases such as Liliana’s occur in countries or regions like Bangladesh, India, and South America. Dr. K.C. Reddy is one of India’s most outspoken advocates of the individual right to sell a kidney and “prides himself on running an exemplary clinic” (Hughes 38). While Dr. Reddy informs patients of the risks and also offers follow-up care, two events that are rare in developing countries, the underlying motivation for the medical service screams “unethical” not “exemplary.” Dr. Reddy’s patients are typically low-paid domestic women workers who seek to get out of debt. Statistics, however, show that individuals remain in significant debt after organ donation and experience a decrease in median household income (Jafar 7). Moreover, healthcare professionals in China also actively participate in
transplant tourism where 99% of organs come from executed prisoners (Jafar 9). It was not until 2007 that publicity forced the Chinese government to introduce regulations to deter physicians from participating in the organ trade (Jafar 9). Health insurance companies are not exempt from the corruption that pervades the medical field. Insurances companies, like Bramstedt and Xu, pay for transplant tourism masked as “medical value travel” while physicians in developed countries actively provide the referrals (Budiani-Saberi and Delmonico 927). It is clear that, for some, compassion and altruism are no longer strong motivations for choosing the healthcare profession.

“Absence defines success in the public health realm” (Bloom 2). When there is absence of disease, public health is not threatened. However, with globalization on the rise, chronic disorders and infectious diseases are equalizing their toll on both developed and developing nations. Diabetes and hypertension are the two main causes of kidney failure. With an aging population, these conditions are even more threatening to the healthcare profession. This fact has prompted international agencies to focus on preventative measures to solve the problem of human organ trafficking. Without preventative measures, the health implications resulting from human organ trafficking can be fatal. Human organ trafficking results in the spread of infectious diseases as well as the spread of depression and psychosomatic reactions among vendors who often have limited access to medical care (Jafar 7). The Coalition for Organ Failure Solutions (COFS) partners with the People’s Health Movement to provide outreach services for survivors of the organ trade to individuals in eleven different countries, mainly located in the Middle East (Cofs.org). The COFS, founded by Dr. Deborah Budiani-Saberi, combines prevention, policy advocacy, and survivor support through a holistic approach to combat organ trafficking and end the exploitation of the poor as a source of organ supplies. The efforts of COFS, the WHO, and
international medical associations lack direct enforcement mechanisms and are still not as effective as they need to be in order to combat this global health issue (Francis 6).

Overall, the patient’s health and autonomy should be the main concern for all healthcare professionals. Healthcare professionals and insurance companies have a duty to clearly define their code of conduct and, more importantly, a duty to remain transparent as they are held accountable for their practices. Bioethical standards, however, should be qualified by region, due to religious and cultural differences. Prevention is a significant means of combating the illicit organ trade and is more efficient than reactive medicine. Yet, when organ transplants are needed, healthcare professionals should be mindful of the origin of human organs and the health of both parties involved. Indirect incentives must be implemented for organ donation in order to supply the needs of the masses. Government-regulated trials in both developing and developed nations should be conducted to assess the benefit and harm to such incentives for organ donation (Rodrigue et al. 2175). Indirect incentives, such as free post-transplant care, would eliminate the need for medical tourism and would foster self-reliance within a country, thereby greatly decreasing the need to look to the poor to meet the needs of the rich. Organ donation should remain an act of altruism in the medical field; a donation that is freely given for both regulated and unregulated markets. Without programs that foster national self-sufficiency, the rise in human organ trafficking can pose a serious threat to international public health.

Section III: Human Organ Trafficking in Egypt and its Impact on Healthcare Professionals

Egypt was declared one of the five hot spots for human organ trafficking by the World Health Organization, making human organ trafficking one of the major bioethical issues in this country (Fischer 168). Before recently, Egypt had no transplantation law in place and was one of
the few countries that prohibited organ donation from deceased donors, due to governmental
laws and a long held belief in the sanctity of the dead. Therefore, commercial living donors
suffered under the expense of the wealthy. According to Dr. Hamdy Al-Sayed, director of the
Egyptian Medical Syndicate, one-third of transplants in Egypt take place unlicensed, and
commercial living donation constitutes at least 90% of organ donation for transplants (Budiani
126). One may ask: how can doctors, who vow to do no harm, commodify the body? In a
country in which 40% of the population lives on less than two dollars a day, $2000 for a liver or
kidney is quite enticing and is more than one could make in several years (May). At the same
time, Egypt’s rate of liver failure is one of the highest in the world and its private healthcare
sector provides the majority of care, making the out-of-pocket expense for medical care one of
the greatest burdens (Budiani 128). In essence, religion, biomedicine, and the economy have
drastic effects on the discourse of doctors and their involvement in human organ trafficking and
transplantation in Egypt.

“Does Allah give us two kidneys so that one should be like a spare tire? Taking one
deprives half of their renal function. How can we play that role?” states Dr. Safwat Lufti, head
of Egypt’s Society on Medical Ethics (Budiani 135). Ninety percent of Egyptians are Sunni
Muslims, and it follows that 90% of doctors said that their opinions and practices are shaped by
Islam (CIA World Factbook). This quite clearly represents why Egypt was one of the few
countries that prohibited deceased or cadaver organ donation (See Appendix, Figure 2). Before
his death in 1998, the Grand Sheikh Mohamed Sayed Tantawi condemned the transplant of
human organs as a “misuse of our bodies, which belong to God” (McGrath). Nevertheless, he
consented to the use of his own organs for transplant in the event of his death. Dr. Hamdy Al-
Sayed, a proponent of legal organ transplants and the use of deceased donors, states that “Egypt
is miles behind the world… with no legislation regulating organ transplants so far” (Budiani 137). Some Islamic doctors in Egypt are even against the practice of autopsies, since this practice does not preserve nor respect the wholeness of the body. Such religious barriers and lack of legislation make it difficult for doctors to practice transplantation in a country where its prominent leaders condemn legalized organ transplants. Therefore, underground human organ trafficking remains a prominent issue, due to the lack of organs to be transplanted on a legal basis.

Egyptian doctors also wrestle over the question of life versus death. Should a doctor value the sanctity of the dead over the quality of life for the living? One doctor states the practice of honoring the dead has stemmed all the way back to ancient Egyptian legacy where the pharaohs built better tombs for the dead than homes for the living (Budiani 142). This is in stark contrast to registered donors in the Western world who say, “If I am dead or in a vegetative state, what good am I?” (Budiani 142). Moreover, the question still remains amongst Egyptian doctors over the definition of death. The majority of countries today believe that brain death means the end of life even if the heart is still beating. However, Islamic doctors strongly urge that the heart must stop beating in order to declare clinical death. Yet, organs are in proper condition for transplantation when the heart is still beating. The definition of death has left some doctors feeling very disheartened: “Even a pregnant woman with brain-stem injury can give birth to a child. If someone can give life, are they really dead?” (Budiani 138). Dr. Lufti thus believes that doctors should not be the ones to make this decision, but rather it should be left up to the will of God. As a result of such unanswered dilemmas, biomedicine and religion are two interconnected facets that have the potential to decrease the donor organ supply and allow for an increase in illicit human organ trafficking.
Doctors are also faced with the question of which treatment is best, as opposed to which treatment is the most affordable. The patient is at the mercy of healthcare professionals and the high occurrence of illicit human organ trafficking is symptomatic of Egypt’s poverty. Currently, commercial living donors are predominantly middle-aged males living under the poverty line who confessed a general deterioration in their health after donation (Budiani-Saberi and Karim 49). Since Egypt is a poor, developing country, the economic advantages and disadvantages to transplantation must be studied. Doctors who are for legal transplantation suggest that one large sum cost of transplants is cheaper than many years of dialysis treatment. Dialysis treatment, they argue is inconvenient for the renal-failure patients, since dialysis treatment requires an ongoing expense, and more time during which they could be working. “A transplant gives them back their lives,” states a young Egyptian nephrologist (Budiani 144). Yet, a transplant surgery in a country with no legislation can do more harm than good. Doctors admitted that the trafficking dilemma is so pervasive that they do not inquire anymore about whether the donor is a relative or whether or not the donor was paid.

Does a transplant enhance the quality of life? For both the donor and recipient, the answer is no. Most donors donate solely for financial reasons and ninety-four percent regretted their donation (Budiani-Saberi and Delmonico 928). Moreover, recipients must take immunosuppressant drugs for life so that their body does not reject the new transplanted organ. This requires more expense and an increased susceptibility to other diseases. How does this affect the professional doctor? Doctors involved with transplants profit from a referral system which provides them with payments at every stage (Budiani 141). In addition, doctors often dislike the donor, usually a poverty-stricken drug user. These two realities create a healthcare
system that is rigged in favor of the already-privileged individuals and is more concerned with generating profits than maintaining health.

Where does Egypt stand now in their laws and regulation on human organ trafficking? The World Health Organization estimates that there are currently 42,000 people in Egypt that need a transplant (Fisher 170). In 2007, the Egyptian Minister of Health, Hatim al-Gabaly, was finally prompted to regulate human organ transplantation by law (Fisher 168). Key figures like Dr. Delmonico, Dr. Budiani, Dr. Hamdy El-Sayed, and Roche Pharmaceuticals have since pushed for parliament to allow deceased donation in Egypt (Cofs.org). As a result, real milestones are being reached. As of 2010, Egypt prohibited the sale of organs, enacted punishment for trafficking, and established a procedure for organ donation (Francis 7). Egypt now allows the use of cadaver organs, requires the donor to be a close relative over twenty-one years old, and allows organs to be transplanted after the death of a recently deceased individual if the doctor has consent (MacGrath). Therefore, living donors are no longer the only source for organs. As Doctor El-Sayed commented, “Car accidents in Egypt claim 7,000 lives a year…and that could save an additional 20,000 lives with the consented use of their organs” (MacGrath).

Furthermore, penalties for those participating in illicit organ trafficking have been implemented. Doctors, brokers, and hospitals will be fined and individuals imprisoned for up to fifteen years. Furthermore, removal of organs without official authorization is considered first degree murder and is punishable by death (MacGrath). Most significantly, parliament has enacted an independent body to manage the national organ bank.

With each new law, there is no guarantee for immediate results. It will take time for the organ supply to increase and the gap to be bridged between the availability of proper medical care to the rich and poor. Tougher regulations have the potential to cause an unintended increase
in the illicit organ trade, posing more risks to the patient. In 2006, Egypt’s security forces went on routine raids of illegal clinics, causing guilty doctors to dump unconscious patients on the street in lieu of getting caught (May). Stricter regulations could drive the organ transplantation system further underground. Nevertheless, the raids occurred when Egypt had no real mechanism for implementing penalties or regulating the organ trade. More steps could be made to further the success of this new legislation, such as campaigning for deceased donorship and encouraging other treatment measures, like hemodiafiltration, an advanced dialysis treatment (Cofs.org). Each nation needs a self-sufficient system of organ transplantation to halt the inequity that depicts the healthcare system currently. Human beings, whether they are doctors, patients, or vendors, cannot and should not make the mistake of refusing to believe that one has the power to make a difference. Human organ trafficking, a transnational organized crime, has illuminated the flow of resources from the Global South to the Global North, from the rich to the poor; and this flow must be stopped.
Appendix:

Figure 1: Robert K. Goff with children from the Restore International School in Uganda. Robert Goff is working to create anti-trafficking legislations in Uganda (Durham).

Figure 2: Brokers work in public gathering spaces in Egypt to solicit vulnerable individuals for an organ sale (Cofs.org).


Goff, Robert K. Personal Interview. 18 February 2011.


