Coalition for Organ-Failure Solutions

Human Trafficking for Organ Removal in India

An Evidence-Based, Victim-Centered Report

February 2014

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K. R. Raja, Debra A. Budiani-Saberi and Katie Findley wrote this report with the assistance of Ponsian Kerketta, Vijay Anand, and Sean Columb. Debra A. Budiani-Saberi and K. R. Raja developed the research. K. R. Raja, Sundaravadivelu "Sundar" Thirunavukkarasu, Ponsian Kerketta and Vijay Anand conducted field research. Their tireless efforts and dedication across many miles via train, car, motorbike, bicycle and foot to remote and inaccessible sites yielded the data supporting the findings presented here. K. R. Raja also serves as the India Country Program Manager and Kabir Karim assisted to develop the initial outreach programs in India. In Chennai, we are especially grateful for our allies and friends in this mission in India, Drs. Sunil Shroff, Sumana Navin and Mr. Raghuram Kuppuswamy of the MOHAN Foundation. We thank community organizer Mr. Maria Selvam for his assistance with coordinating victims to receive services. In Erode, we thank Mr. Ashokan and members of the labor union who aided us in both identifying and assisting victims targeted after widespread factory closures. We thank Father Herman Kindo, Director of Social Welfare Institute of CARITAS and all of the staff of CARITAS in West Bengal, for their dedication and labor-intensive foot/fieldwork alongside our team. We thank Vikasana Trust in Karnataka for assisting us in building the informal networks that helped COFS identify victims in the region. Furthermore, we thank the many doctors and medical centers who collaborated with COFS to provide low-cost medical follow-up services to victims of HTOR where we could arrange this in Erode, Chennai, and West Bengal.

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About the Coalition for Organ Failure Solutions (COFS)

COFS is a non-profit international health and human rights organization with a mission to end HTOR as well as promote altruistic and deceased organ donation within standardized, transparent, and accountable channels based on social justice and equity. COFS combines prevention, policy advocacy, and survivor support to combat HTOR.

COFS relies entirely on individual financial donations and received two small grants from the International Transplantation Society (ITS) to develop our prevention and outreach programs. To date, COFS has not received funds from any government.

www.cofs.org

SUMMARY

Socio-economic conditions should not be determinants for an organ "donation."[1]

- Debra Budiani-Saberi and Sean Columb

COFS-India has gathered evidence that offenders of human trafficking for an organ removal (HTOR)[2] in India continue the organ trade in private hospitals in the country, victims,' consequences are long lasting and service to foreign patients is ongoing. Victims' testimonies of abuses indicate that they were recruited, transported, transferred, harbored or receivedprimarily by means of fraud, deception, the abuse of power on positions of vulnerability (particularly for individuals engulfed by debt)(?) and more rarely, by means of coercion for the purpose of exploitation for a kidney removal for a commercial transplant. Victims include both men and women in destitute conditions. Web based evidence reveals that the internet is a key tool for coordinating patients with victims of HTOR, especially in India.

The total number of victims of organtrafficking in India is estimated to be in the thousands. Based on its ongoing fieldwork, COFS-India field researchers estimate that there are approximately 2,000 victims of HTOR in Erode and 2,000 victims in Chennai. These field researchers identified approximately 1,000 individuals who said they were victims of HTOR in India and each case involved the removal of a kidney. The COFS-India team conducted in-depth interviews with 153 of these individuals who described their experiences in compelling detail. COFS also arranged medical follow-up services for 133 of the victims as part of its follow-up care outreach services. Doctors who provided medical follow-up services also confirmed the nephrectomies of these cases. This fieldwork was conducted in Tamil Nadu (Erode and Chennai) and villages in West Bengal and Karnataka where COFS-India field researchers identified residential concentrations of victims. Victims' social status and conditions, rather than altruism, were the major determinants for the commercial organ removals. Debt was the leading determinant (87.7 percent) of their vulnerability for being recruited, transported, transferred, harbored or received HTOR.

Of the 153 victims interviewed, 56 are from Erode; 47 are from Chennai; 30 are from villages in West Bengal; 20 are from villages in Karnataka. Of the victims interviewed in this sample, a kidney was removed between the years of 1981 to 2012. Thirty-four cases (22 percent) occurred since 2009 (until summer 2012, the end date of data collection for this report). These recent cases include five from Erode, nine from Chennai, 14 from West Bengal and six from Karnataka. Victims reported that they knew of additional cases of commercial organ removals in recent months in each site and recent media coverage confirms

[1] Debra Budiani-Saberi and Sean Columb. "A Human Rights Approach to Human Trafficking for an Organ Removal" *Medicine, Health Careand Philosophy,*16.4 (2013): 897-914.

[2] Use of the term "HTOR" is based on the definition of human trafficking in the *United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children* (2000). Available at: http://www.uncjin.org/Documents/Conventions/dcatoc/final_documents_2/convention_%20traff_eng.pdf. Accessed October 12, 2012. This concept is further elaborated in the section, *Terminology and Key Concepts*, of this Report.

ongoing cases.[3][4][5] Eighty (52 percent) are female ranging in age between 23 to 64 years with an average age of 41 years. Five percent of victims were single, 83 percent were married, and 91 percent were parents with an average of two children. The largest percentages (49 percent) of these victims were entirely uneducated, 18 percent had some primary schooling, 17 percent had some secondary schooling and only one percent had schooling above high school.

All of the victims interviewed said they had experienced a deterioration of their health in addition to negative social, economic, and psychological consequences as a result of the experience. Additionally, all of the victims regretted the experience and would advise others against it.

The findings presented in this report include only living victims who had a kidney removed and survived the organ trade that COFS was able to identify. This report does not speak to victims of HTOR who had a partial liver or other organ commercially removed or to victims in which death was the result of a commercial organ removal.

In light of the findings presented here, COFS calls upon the international community, the Government of India, the medical professional community in India, relevant human rights organizations, and internet facilitators to recognize the findings and recommendations in this report to bring an end to HTOR in India and elsewhere.[6]

[3] "Exploitation persists, say Holalu residents". January 4, 2013. Available at: http://www.thehindu.com/todays-paper/tp-national/tp-karnataka/exploitation-persists-say-holalu-residents/article4271321.ece?textsize=small&test=2 Accessed January 4, 2013.

[4] "More Detentions Made in Kidney Racket" January 4, 2013. Available at: http://www.thehindu.com/todays-paper/more-detentions-made-in-kidney-racket/article4271300.ece. Accessed January 4, 2013.

[5] "Police Bust Kidney Racket". January 3, 2013. Available at: http://www.thehindu.com/news/states/karnataka/police-bust-kidney-racket/article4266263.ece?textsize=small&test=2. Accessed January 4, 2013.

[6] Key findings of this report were published in the following: Coalition for Organ Failure Solutions,"Human Trafficking for Organ Removal in India: A Victim-Centered, Evidence-Based Report" Debra A. Budiani-Saberi, KallakurichiRajendiran Raja, Katie C. Findley, PonsianKerkettaand Vijay Anand. *Transplantation* February 14, 2014.

RECOMMENDATIONS

To the International Community and United Nations related bodies (OHCHR, UNODC, WHO)

HTOR must be fully recognized as an egregious human rights abuse and a form of human trafficking as recognized in the UN Trafficking Protocol. As such, HTOR demands a human-rights based approach in analysis and response as paralleled by and adopted within initiatives that address the other key forms of human trafficking (i.e. for sex and labor).[7] Thus focus should be placed on the trafficked person, with commitments to protection mechanisms, support services, and remedies for victims of HTOR. The report on this issue by the UN Special Rapporteur on Human Trafficking that she presented to the UN General Assembly in October 2013 squarely recognizes these points as does the recent report on HTOR by the Organization for Security and Co-operation in Europe (OSCE).[8][9]

Accordingly, relevant UN agencies and domestic parties should work in close collaboration to share lessons learned and best practices developed for addressing other human rights abuses (especially other forms of human trafficking) that can assist with advancing advocacy towards abuses of HTOR. For example, human trafficking experts have recently refined various concepts with the UN Trafficking Protocol (i.e. protection, abuse of a position of vulnerability and other means.)[10] As advocates of anti-HTOR efforts rely further upon human rights instruments and the UN Trafficking Protocol, it is important to learn from these experiences and incorporate refinements to the specific concerns around HTOR. Such changes will also enable anti-HTOR advocates to assure that measures do not adversely affect the human rights or dignity of persons, in particular the rights of those who have been trafficked, or of migrants, internally displaced persons, refugees or asylum-seekers.

Further, a human rights-based approach to trafficking also demands acknowledgement of the responsibility of governments to protect and promote the rights of all persons within their jurisdiction.The international community thus must hold governments of host and

[7] Debra Budiani-Saberi and Sean Columb. "A Human Rights Approach to Human Trafficking for an Organ Removal" *Medicine, Health Care and Philosophy,*16.4 (2013): 897-914.

[8]Thematic Report of the Special Rapporteur on trafficking in persons, especially women and children to the Sixty-eighth session of the United Nations General Assembly, 2 August 2013 and presented orally on 25 October, 2013. See: http://www.ohchr.org/Documents/Issues/Trafficking/A-68-256-English.pdf

9OSCE Office of the Special Representative and Co-ordinator for Combating Trafficking in Human Beings, *Trafficking in Human Beings for the Purpose of Organ Removal: Analysis and Findings*, Occasional Paper Series no. 6 (July 2013). Accessed September 10, 2013 http://www.osce.org/cthb/103393.

[10] See Anne T. Gallagher. "Using International Human Rights Law to Better Protect Victims of Trafficking: The Prohibitions on Slavery, Servitude, Forced Labor and Debt Bondage" in L. N. Sadat and M. P. Scarf (eds) *The Theory and Practice of International Criminal Law: Essays in Honor of M. CherifBassiouni*. (Leiden: MartinusNijhoff)(2008): 397-430. Available at: http://works.bepress.com/anne_gallagher/5 accessed 16 Nov 2012. Accessed October 18, 2012; UNODC (n 4); United Nations. Commentary on the Recommended Principles and Guidelines on Human Rights and Human Trafficking.2010. HR/PUB/10/2. Available at: http://www.unhcr.org/refworld/docid/4d2eb7cf2.html. Accessed November 29, 2012.

client countries accountable to address abuses associated with HTOR.

To Governments of Host and Client Countries of HTOR and Transplant Tourism

Many countries across the globe have either been a host to HTOR or have had citizens or residents as transplant tourists abroad. With regard to host countries, under international human rights law, it is incumbent upon States to ensure, respect, and fulfill their obligations to enforce measures to protect the welfare of their citizens and residents, particularly those vulnerable to exploitation. To safeguard these rights, HTOR must be criminalized for all parties involved minus the victim. Host countries must continue to establish legal frameworks to prohibit HTOR within domestic legislation on both transplantation and human trafficking. With regard to the latter, every country should sign and ratify the UN Protocol on Trafficking in Persons and fulfill the obligation to establish domestic legislation on human trafficking, including HTOR. States are obliged to identify victims of HTOR, provide them with assistance, protection and access to justice and remedies. Further, host countries should support relevant civil society human rights organizations to train law enforcement on HTOR and to collaborate to identify victims and traffickers of HTOR.

Additionally, loopholes in domestic transplantation laws that allow for trafficked persons to be perceived as willing participants in commercial transplants via shallow consent procedures must be redressed. Article 3 (b) of the UN Trafficking Protocol states that the "consent of the victim ...shall be irrelevant" where any of the listed means are employed which include the threat or use of force or other forms of coercion, abduction, fraud, deception, the abuse of power or a position of vulnerability or of the giving or receiving of payments or benefits. Thus, apart from consent procedures (usually operated by a hospital or health Ministry committee), an advocate for potential organ donors should be added to the process that would include a psychosocial evaluation (as recommended in the WHO Guiding Principles and Istanbul Declaration on Organ Trafficking and Transplant Tourism) and an assessment of vulnerability within a trafficking lens.

Further, law enforcers in host countries should be trained to identify both potential and actual victims as well as perpetrators of HTOR. This could be organized with law enforcement's engagement with initiatives to combat other forms of human trafficking.

Client countries must also prohibit citizens/ residents from purchasing an organ abroad. While most countries have laws that prohibit the buying and selling of human organs, these laws must extend jurisdiction beyond its borders to prohibit citizens and residents from purchasing an organ in another country. Such an extension could be based on the model of laws such as the U.S. law on Child Sex Tourism in which U.S. citizens and legal residents are held accountable for engagement in illicit sex, according to the U.S. legal definition of illicit sex, even if it occurs in a foreign country. Similarly, it should be illegal for citizens or legal residents of any country (especially those now characterized as "client countries" for transplant tourism) to engage in "organ tourism". For example, it should be not be acceptable or legal for patients from the U.S. to go to India to buy an organ.

To the Government of India

COFS calls upon the Government of India to take steps to further investigate and halt ongoing and systematic HTOR within the country's borders. Such measures should include:

1. Ratifying the UN Trafficking Protocol that India signed in 2002 and including a component on HTOR with commitments to protection, support services, and remedies for victims of HTOR as well as criminalizing parties involved in trafficking. As the UN Special Rapporteur on Human Trafficking recommended for all states, "all states should ensure that the term 'removal of organs' is included in their national legal definition of trafficking in persons and that 'consent' to removal of organs is vitiated by any of the accepted means, including abuse of a position of vulnerability."[11] Such legislation would position India to better address loopholes regarding consent within current procedures set forth in legislation and policies on transplantation. As described in the recommendation to other host countries, employing a donor advocate to assess vulnerability would also help to address this loophole.

2. With regard to the aforementioned recommendation to governments of host and client countries of HTOR to criminalize traffickers, we also suggest the recommendation of the UN Special Rapporteur on Human Trafficking for the Government of India. Namely that the national legal framework should clearly identify criminal responsibly, ensuring that it extends to intermediaries, brokers, medical and transplant staff, and technicians who are involved in trafficking in persons for the removal of organs. This is extended to include the recommendation that national legislation should require medical personnel to notify authorities when they become aware of cases or potential cases of trafficking in persons for the removal of organs. This may involve the use of other provisions of the criminal code as suggested in the recent report on HTOR by the OSCE. Namely, provisions including corruption, organized crime, the infliction of bodily injury may be relevant, in addition to trafficking charges, to address the range of criminality involved in HTOR cases. Accordingly the report explains the importance of ensuring that criminal justice actors are sensitized to the full range of actors and abuses involved in a THB/OR network.

3. Just as the Government of India maintains a list of patients waiting for a cadaver organ donation, it should also maintain a registry of live organ donors. It could do so by granting a state agency or a non-profit civil society organization this responsibility to maintain this list and, in the case of a non-governmental organization, the Government could recognize this organization as a Nodal Agency. This process would maintain transparency on live organ donation as a measure to combat organ trafficking.

4. All transplant centers in India should be public, closely monitored and required to provide medical follow-up care for every live organ donor. Records of this care and medical outcomes should be maintained, and these services and outcomes should be monitored by the Nodal Agency.

5. With regard to prevention, and as the UN Special Rapporteur on Human Trafficking also recommend to states, the

[11] Thematic Report of the Special Rapporteur on trafficking in persons, especially women and children to the Sixty-eighth session of the United Nations General Assembly, 2 August 2013 and presented orally on October 25, 2013. See: http://www.ohchr.org/Documents/Issues/Trafficking/A-68-256-English.pdf

Government of India should support the development of civil society capacity to assist victims of HTOR, including long-term needs for employment and medical care, support projects to improve data about HTOR, and work with media and civil society organizations to raise awareness of the risks of buying or selling organs.

6. India is to be commended for initiatives to assure fully informed consent.[12]Adding an organ donor advocate, as described in the recommendation for host countries, as a key step in the organ donor approval process would also help to reduce the risk of a trafficked person being used as an organ donor. The Government of India, along with non-governmental organizations and researchers, should collaborate to examine existing organ donor assessment models and determine an appropriate model for India with an aim of enhanced protection.[13][14][15][16][17]This would also help end the use of proxy organ donors standing in for the consent process in place of an actual commercial organ donor/ victim of organ trafficking.

7. Law enforcement should engage with relevant civil society human rights organizations to gain expertise on HTOR and collaborate to work on the frontline to identify victims and traffickers of HTOR.

To medical professionals in India

HTOR requires the participation of transplant professionals and supporting staff. To this end, the medical professional community of India should:

1. enforce its responsibilities as laid out in HOTA to protect vulnerable persons from organ trafficking,

2. cease participation in transplant surgeries that involve commercial or other arrangements that exploit a vulnerable person for the purpose of removing an organ,

3. hold medical professionals accountable for involvement in surgeries with commercial organ donor victims of organ trafficking as laid out in HOTA by reporting them to appropriate state authorities.

To human rights and human trafficking non-governmental organizations (NGOs) working in India

[12] Health India. "Organ Donors Need to Be Fully Informed of Consequences: Delhi High Court". 20 August 2012. Available at: http://health.india.com/diseases-conditions/organ-donors-need-to-be-fully-informed-of-consequences-delhi-high-court/ Accessed 16 September 16, 2012.

[13]Christina Papachristou et al. "Motivation for Living-Donor Liver Transplantation from the Donors Perspective: An In-Depth Qualitative Research Study". *Transplantation* 78,10. (2004):1506-14.

[14]Mary Amanda Dew and Cassandra L. Jacobs. "Psychosocial and Socioeconomic Issues Facing Living Donors".*Adv Chronic Kidney Dis* 19,4. (2012):237-43.

[15]Mary Amanda Dew et al. "Guidelines for the Psychosocial Evaluation of Living Unrelated Kidney Donors in the United States". *Am J Transplant* 7,5. (2007):1047-54.

16 M Abecassis et al. "Live Organ Donor Consensus Group. Consensus statement on the live organ donor." JAMA (2000); 284(22):2919-26.

[17]The concept of a donor advocate has been proposed and discussed in literature and it is a common practice in settings of mostly related living donation in transplantation centers internationally. The role of the donor advocate is to focus solely on the donor's wellbeing and act towards the donor's best interest. The donor advocate shall be a third party (acting independently of the surgical team or the transplantation unit) and an expert and active in the field of human rights and human trafficking to ensure that donor's rights and well-beingare protected.

Human rights organizations must advocate HTOR as an egregious human rights abuse. Similar to victims of other forms of human trafficking, victims of HTOR must be granted rights and provided support services, protection, and remedies (medical care, counseling, legal assistance, rehabilitation, shelter, resettlement). Human rights and anti-human trafficking organizations must collaborate to call for support for these services for victims of HTOR and, when possible, extend appropriate existing services to these victims. Organizations providing outreach to vulnerable populations in areas that organ traffickers target should commit to raising awareness about the organ trade and its risks.

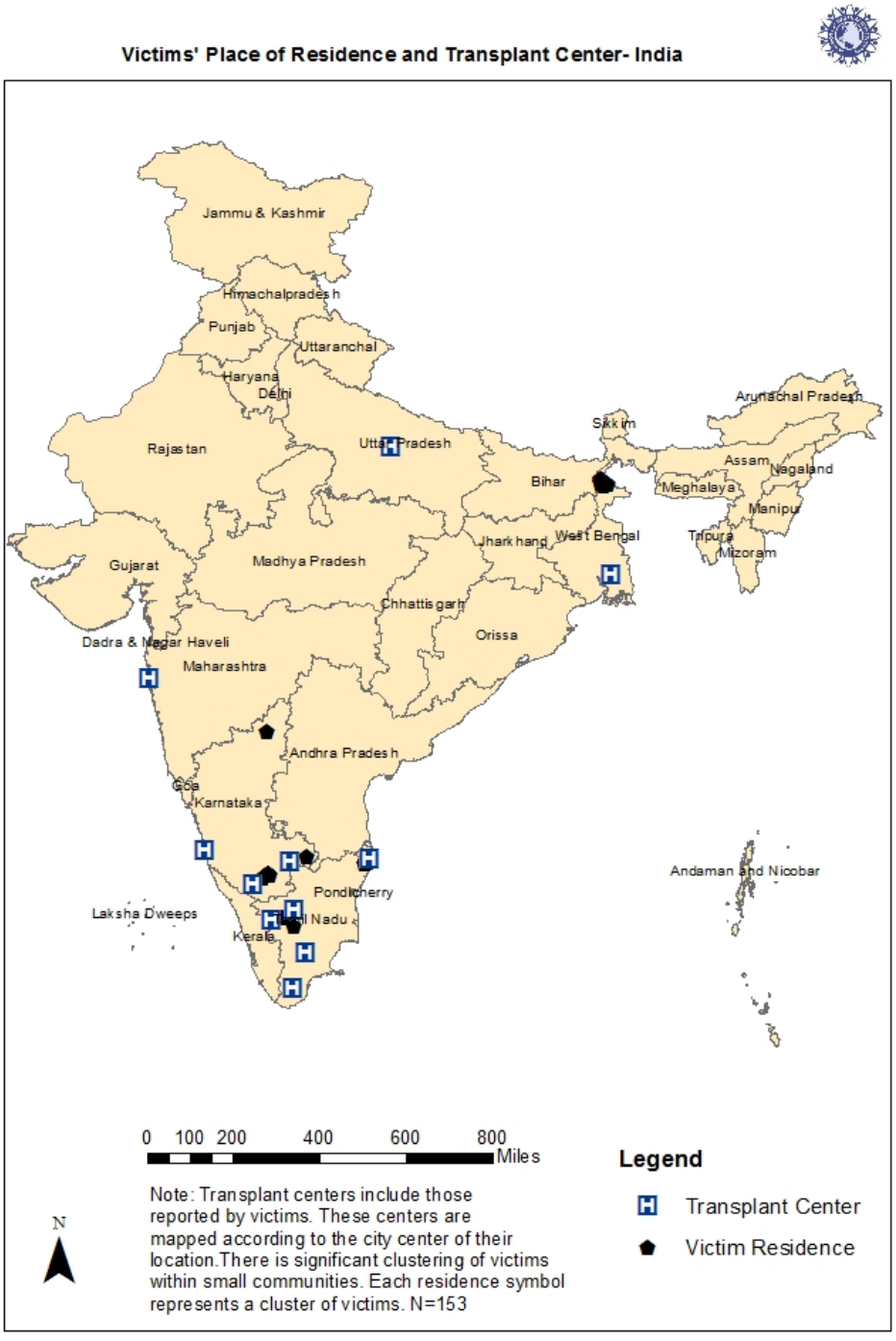
To major internet players and other internet facilitators

Victims in this study were identified via on-the-ground fieldwork and a snowball sampling technique in which each victim was asked to identify another victim they knew. As such, these findings represent certain geographic clusters of victims and do not include those who may have been recruited via the internet. Nonetheless, there are clear and present indications that internet savvy traffickers for an organ removal actively use the internet to coordinate organ-failure patients with destitute individuals who serve as the organ source.[18][19][20] In addition to small scale online social media sites, forums and blogs, major internetservices such as Facebook are actively employed to facilitate this trade. For example, several Facebook pages (i.e. Find a Donor for Kidney Transplant, Renal Transplant Coordinator, I Want to Sell My Kidney) have been created and used for these purposes. COFS has documented a transaction recorded on such a Facebook page (see Appendix) that suggeststhat an organ buyer successfully identified commercial living an organ "donor" via correspondence on the page. Although this particular documented transaction occurred in 2012, the page is still being actively used to arrange buying and selling organs.Other private independent pagessuchas http://www.kidneytransplantoverseas.com/ , http://forums.sulekha.com/forums/health/kidney-donor-urgent-36703.htm and http://dubaicity.olx.ae/kidney-donation-iid-30513108 ,easily available through Google and other search engines, function as key portals for linking organ-failure patients with "donors." These seemingly innocuous interactions are easily transformed into opportunities for exploitation, fraud and deceit, especially (although not exclusively) when an agent/ broker is involved, and would break transplant and/or trafficking laws and likely constitute cases of HTOR.

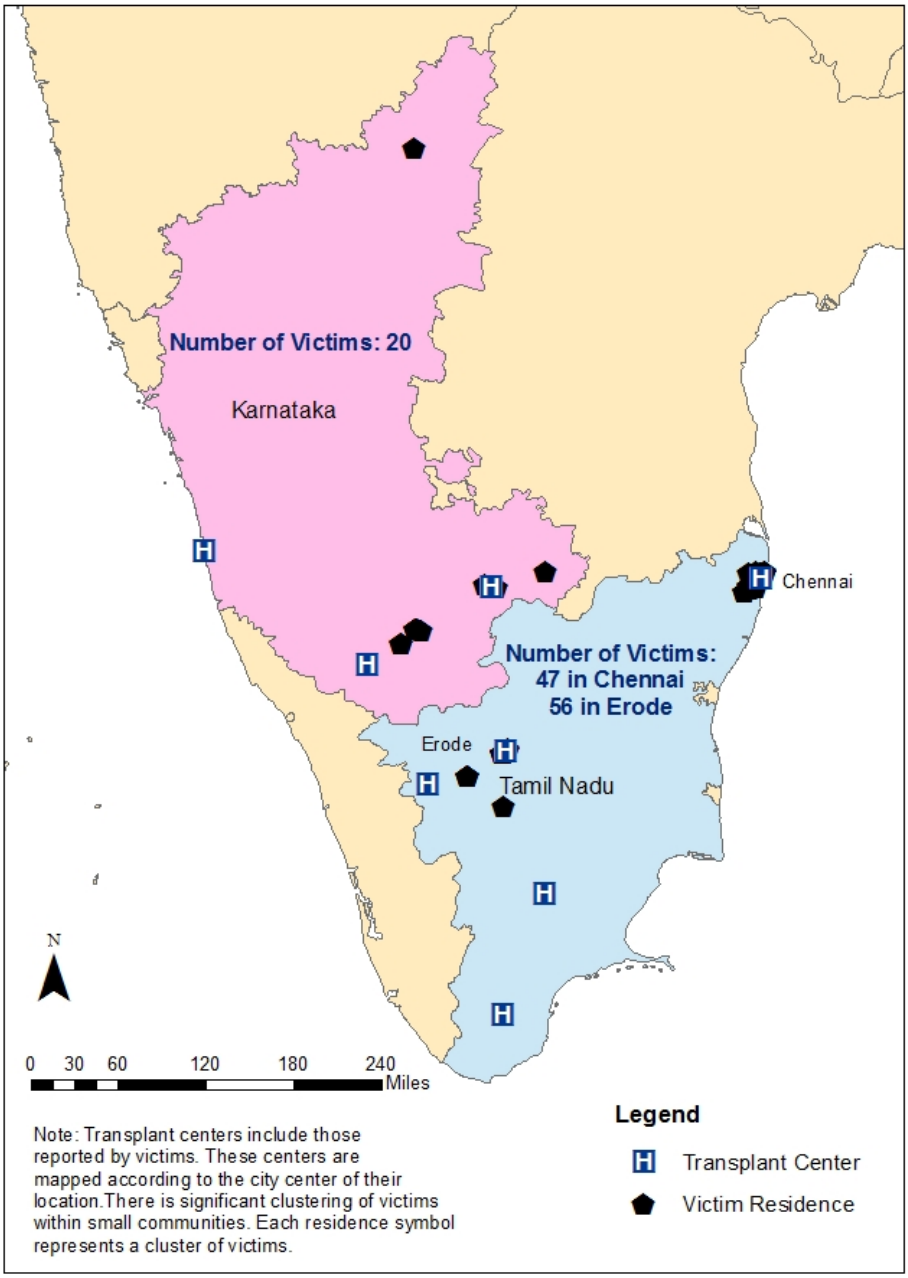
Internet players should collaborate with anti-HTOR initiatives to assess how HTOR activities can be identified, how safeguards can be developed, and how monitoring web activity can enhance law enforcement efforts to combat it. Private websites that conduct this illicit activity should be prohibited and removed.

18 Susanne Lundin. "Organ Economy: Organ Trafficking in Moldova and Israel". *Public Understanding of Science.* 21 (2012):22-221.
19Ranee KL Panjabi. "The Sum of a Human's Parts: Global Organ Trafficking in the Twenty-First Century". *Pace Environmental Law Review.* 28 (2010): 1- 144.
20 Yosuke Shimazono. "Global Situation: Mapping Transplant Tourism". Available at http://www.who.int/transplantation/publications/ReportGlobalTxConsultation_March_2007.pdf. Accessed December 12, 2012.

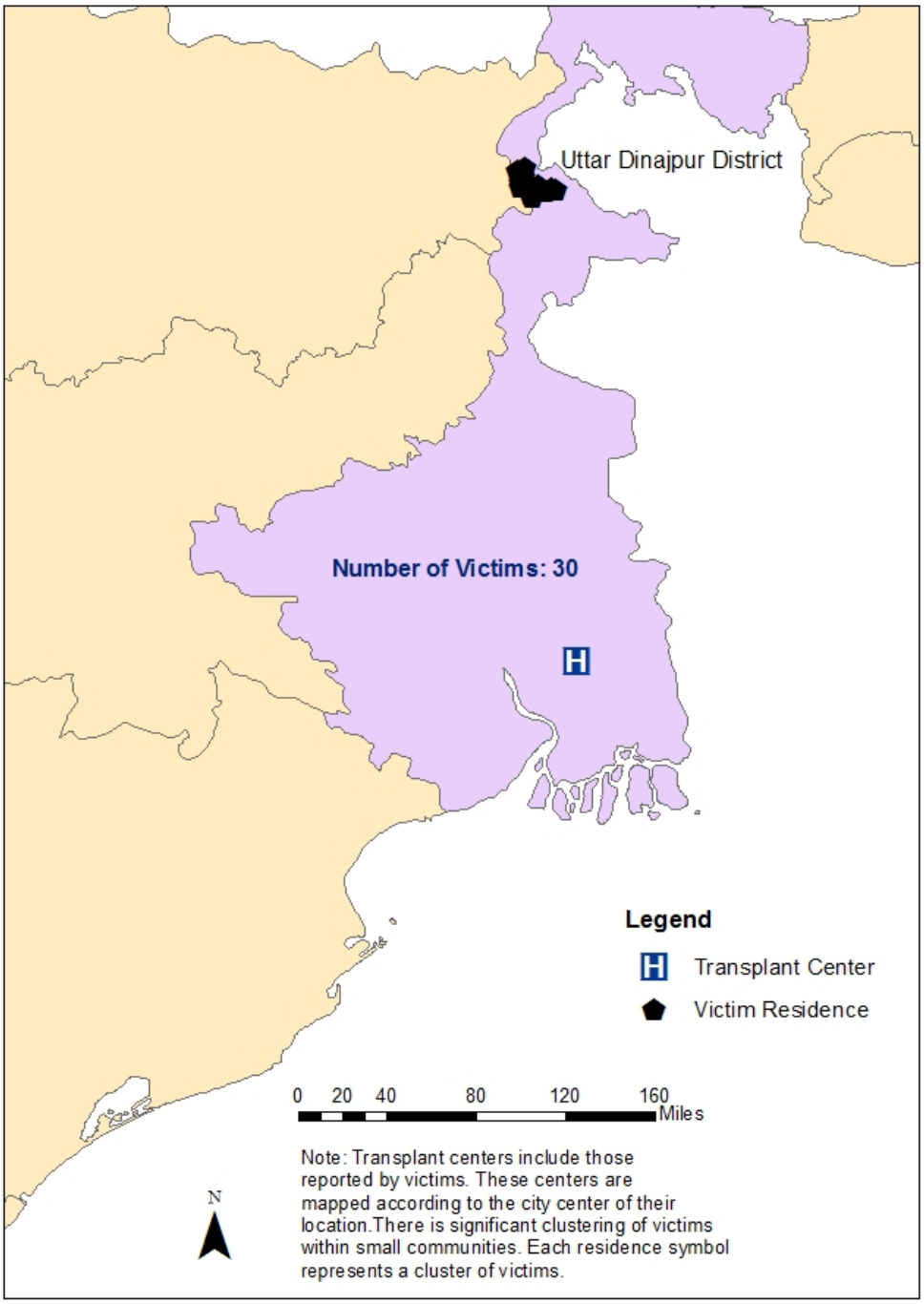
MAPS OF VICTIMS' PLACE OF RESIDENCE AND LOCATION OF TRANSPLANT CENTER WHERE KIDNEY WAS REMOVED



Victims' Place of Residence and Transplant Center- Karnataka and Tamil Nadu



Victims' Place of Residence and Transplant Center- West Bengal



TERMINOLOGY AND KEY CONCEPTS

Scholars and activists with expertise on the issue of "organ trafficking"/ "human trafficking for an organ removal" (HTOR) grapple with terms and concepts around these practices. A brief explanation of COFS' use of relevant terms serves to clarify how this report understands this phenomenon as a human rights abuse and a form of human trafficking.

COFS uses the term "victim" for several reasons. First, this term is used not from intention to diminish the sense of agency of these individuals but rather emphasize the enormous disparities in power, resources, and access to information at play in the crime of HTOR. Second, we choose to employ the term commonly used in the discourse on other forms of human trafficking.

Since its inception, COFS has used the term "organ trafficking" as developed in the definition in the *Istanbul Declaration on Organ Trafficking and Transplant Tourism*[21] which was derived from the *United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children* (elsewhere also referred to as the Palermo Protocol, here within referred to as the Trafficking Protocol).

In Article 3(a) of the UN Trafficking Protocol, trafficking in persons is defined 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 a 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.[22]

This was the first major international agreement to address abuses of the "removal of organs."

As a result of the Istanbul Declaration on Organ Trafficking and Transplant Tourism, experts on this issue established a specific definition of "organ trafficking" in 2008. The definition, as derived from Article 3(a) of the Trafficking Protocol, reads as follows:

> Organ trafficking is the recruitment, transport, transfer, harboring, or receipt of living or deceased persons or their organs by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability, or of the giving to, or the receiving by, a third party of payments or benefits to achieve the transfer of control over the potential donor, for the purpose of exploitation by the removal of organs for transplantation.[23]

The Istanbul Declaration's definition of 'organ trafficking' is thus largely harmonious with the definition of trafficking for the purpose of 'the removal

[21]International Summit on Transplant Tourism and Organ Trafficking.The Declaration of Istanbul on Organ Trafficking and Transplant Tourism.*Clinical Journal of the AmericanSociety of Nephrology.*3 (2008):1227-1231.

[22]UNODC (n 1) Art 3.

[23]International Summit on Transplant Tourism and Organ Trafficking (n 2).

of organs' as articulated in the UN Trafficking Protocol. The cases that are generally considered in discussions on "organ trafficking," and in the many cases that COFS has addressed, are within the definition of the UN Protocol on human trafficking for the purpose of an organ removal.

After engaging this issue with human rights and human trafficking legal experts, COFS began to also employ the term HTOR (what some experts also refer to as trafficking in persons for the removal of organs, TPRO) to express that the cases the organization has handled arguably fit within the UN Trafficking Protocol definition and should subsequently be recognized as a human trafficking and human rights abuse.[24] In October 2014, the UN Special Rapporteur on Human Trafficking formally recognized HTOR to be a form of human trafficking in her thematic report on this issue to the UN General Assembly.[25]

The Special Rapporteur also recognized the need for clarity in some of the key points within discourse on this issue that COFS has also addressed in previous forums.[26] These include misconceptions

[24]Debra Budiani-Saberi. Briefing Before the Senate Foreign Relations Committee and the Tom Lantos Human Rights Commission United States Congress 'Human Trafficking for an Organ Removal (HTOR): A Call for Prevention, Protection, Investigations and Accountability'. 2012. Available at: http://tlhrc.house.gov/docs/transcripts/2012_1_23_Organ_Trafficking_Briefing/Budiani_testimony.pdf.Accessed November 11, 2012; [i]The following section on terminology and concepts is also addressed in Budiani (n 3) and in Debra Budiani and Sean Columb. "A Human Rights Approach to Human Trafficking for an Organ Removal";[ii]The language on this issue in the Guiding Principles may have facilitated some of this understanding about how organs travel. For example, the WHO Guiding Principles state the need to "prevent trafficking in human materials" and that a shortage in supplies has "stimulated commercial traffic in human organs." The Guiding Principles also acknowledge that the commercial traffic in human organs are especially from living donors who are unrelated to recipients and that such commerce is related to the traffic in human beings. See,http://www.who.int/transplantation/Guiding_PrinciplesTransplantation_WHA63.22en.pdf [iii] Abuse of a position of vulnerability occurs when an individual's personal, situational or circumstantial vulnerability is intentionally used or otherwise taken advantage of, to recruit, transport, transfer, harbor or receive that person for the purpose of exploiting him or her, such that the person believes that submitting to the will of the abuser is the only real or acceptable option available to him or her, and that belief is reasonable in light of the victim's situation. In determining whether the victim's belief that he or she has no real or acceptable option is reasonable, the personal characteristics and circumstances of the victim should be taken into account". The Guidance Note is available from:http://www.unodc.org/documents/human-trafficking/2012/UNODC_2012_Guidance_Note_-_Abuse_of_a_Position_of_Vulnerability_E.pdf. The Issue paper on which it is based is available from:http://www.unodc.org/documents/human-trafficking/2012/UNODC_2012_Issue_Paper_-_Abuse_of_a_Position_of_Vulnerability.pdf

25 Thematic Report of the Special Rapporteur on trafficking in persons, especially women and children to the Sixty-eighth session of the United Nations General Assembly, 2 August 2013 and presented orally on 25 October, 2013. See: http://www.ohchr.org/Documents/Issues/Trafficking/A-68-256-English.pdf

[26]Budiani-Saberi.. Briefing Before the Senate Foreign Relations Committee and the Tom Lantos Human Rights Commission United States Congress 'Human Trafficking for an Organ

around (1) HTOR vs. trafficking in human organs (2) consent and (3) the payments for an organ.

Trafficking in Organs vs. HTOR

Although preservation techniques make the independent transporting of organs possible, there is no evidence that organs are transported independent of persons in commercial transplants. Upon removal, they are transplanted. Thus most abuses occur when an organ is removed from a victim within a location where the recipient awaits and the transplant is performed. The independent transport of organs may increase across the globe in the future. Nevertheless, even if organs are transported independently in countries where there is insufficient regulation on organ donation and commercial transplants are being commonly practiced, a person was most likely a subject of trafficking in order to remove that organ. Therefore such instances should still be considered HTOR, whether or not that organ was transported independently after the removal.

Such misconceptions have been expressed in major anti-human trafficking initiatives and this has hampered progress in efforts to combat HTOR abuses.[27] The thematic report of the UN Special Rapporteur on Human Trafficking to the UN General Assembly states:

> One of the principle reasons for the failure to leverage the trafficking in persons framework against transplantation-related exploitation is the persistent attachment of some States and intergovernmental organizations to a distinction between trafficking in organs and trafficking in persons for removal of organs. As shown above, this distinction is largely unjustified because the principle issue of focus, the exploitation of persons who are compelled by need or force to provide organs for transplantation to people within their own countries or to foreigners, falls squarely within the international legal definition of trafficking in persons (14).
>
> Most significantly, the Special Rapporteur has concluded that the distinction between trafficking in persons for removal of organs and trafficking in organs is generally unhelpful...Case-based experience confirms, however, that the trade in organs is inextricably linked to actions

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Removal (HTOR): A Call for Prevention, Protection, Investigations and Accountability. 2012. Available at: http://tlhrc.house.gov/docs/transcripts/2012_1_23_Organ_Trafficking_Briefing/Budiani_testimony.pdf.Accessed November 11, 2012; [i]The following section on terminology and concepts is also addressed in Budiani (n 3) and in Budiani- Saberi and Columb,. "A Human Rights Approach to Human Trafficking for an Organ Removal".

[27] For example, within a list of topics of special interest in the 2010 US State Department Trafficking in Persons (TIP) report, it is explained that: the trade in human organs – such as kidneys – is not in itself a form of human trafficking. The international trade in organs is substantial and demand appears to be growing. Some victims in developing countries are exploited as their kidneys are purchased for low prices. Such practices are prohibited under the Palermo Protocol, for example when traffickers use coercive means, such as force or threats of force to secure the removal of the victim's organs. US State Department. Trafficking in Persons Report. 2010. Available at: http://www.state.gov/documents/organization/142979.pdf . Accessed September 15, 2012.

> against individuals aimed at their exploitation. There lies great danger in removing the individual victim from this picture by separating out the concept of trafficking in organs from the concept of trafficking in persons for the removal of organs (19)

Consent

Rarely is such a decision as drastic as selling an organ determined by a rational singular choice. When faced with an option to sell an organ amidst destitute conditions and few other resources or options, the role that "rationality" might play in this choice becomes insignificant. The UN Trafficking Protocol makes clear that consent to sell an organ is irrelevant when the elements of trafficking have been employed. This is made clear by the Conference of the Parties to the United Nations Convention against Transnational Organized Crime:

> ...what might appear to be consent by a victim is nullified or vitiated by the application of any improper means by the trafficker. Furthermore, consent of the victim at one stage of the process cannot be taken as consent at all stages of the process and without consent at every stage of the process, trafficking has taken place.[28]

In all of the cases that COFS has encountered in which "consent" is claimed, the individual's vulnerability has been exploited. That is, individuals have agreed to something they would not have otherwise, if conditions were less pressing. As in other forms of human trafficking, consent in many cases of HTOR is a result of the purposeful manipulation of vulnerable, often desperate persons. Further, consent does not signify that the victim had a clear understanding of the consequences of the procedure. Often victims are intentionally defrauded (i.e. duped, deceived, mislead, given false information). Under most legal systems that cannot constitute consent, and may even run afoul of criminal laws.

Further, the Trafficking Protocol recognizes the variety of acts employed to exploit (i.e. the recruitment, transportation, transfer, harboring or receipt of persons) and is not limited to transporting persons through explicitly coercive means. While explicit threats, the use of force or other forms of coercion for an organ removal are employed in some cases, the majority of cases involve more implicit measures such as fraud, deception, direct payments or other material benefits and the abuse of power or vulnerability for the removal of an organ. For example, COFS work has shown how Sudanese asylum seekers in Egypt are put into situations in which smugglers who assisted them to cross the border later provide food and housing for them in Cairo and then demand exorbitant sums for this assistance.[29] Smugglers collaborate with kidney traffickers to suggest the idea of a kidney sale as a way to remedy financial problems. COFS work has also shown that debt collectors in India who suggest a kidney sale to settle a debt also often suggest that the indebted target would "want to see that their family remains safe." According to victims, COFS has interviewed in India and elsewhere, organ traffickers typically do not explain risks and often do not complete or make) the payment after the kidney removal.

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[28] United Nations Conference of the Parties to the United Nations Convention Against Transnational Organized Crime (July 29th 2011) CTOC/COP/WG.4/2011/2, para 13.

29 Coalition for Organ Failure Solutions,"Sudanese Victims of Organ Trafficking in Egypt", last modified February 2014, cofs.org/home/sudanese-victims/.

Payment

The UN Trafficking Protocol stipulates that the receipt of payments or benefits does not exclude cases from being exploitative. Just as an individual trafficked for domestic servitude may get paid and still be considered a victim of human trafficking, it is not the payment or the amount of money that is relevant, but rather an individual's position of vulnerability that is manipulated and controlled for the purpose of labor, sex, or an organ. Similarly, in situations of debt bondage/bonded labor, payment (like consent) does not deem the practice permissible. Furthermore, payment for an organ is in fact illegal in every country except for Iran, regardless of whether payments were received (or "consent" obtained). There are also regional prohibitions against payments for organs such as the Council of Europe's Oviedo Convention. This is important to recognize as it has been misconceived in the discourse and response to human trafficking. For example, one of the few statements on HTOR in a TIP Report (2009) incorrectly holds that, 'The UN TIP Protocol does not cover this voluntary sale of organs for money, which is considered lawful in most countries.'[30]

It is important to also note that an unsolicited organ sale can be considered trafficking where a person is *received* for the purpose of an organ removal by way of payment or benefits to achieve the consent of a person.[31] Further, although the removal of an organ is not in itself a form or exploitation, it is exploitive to remove an organ where a position of vulnerability is in *existence* and knowledge of that vulnerability is *abused* in order to recruit, transport, transfer, harbour or receive a person for the purpose of an organ removal.[32] Under such conditions an organ sale can be considered a trafficking offense, regardless of 'consent'.[33] Accordingly, in a recent case in Kosovo regarding HTOR the three judge panel found that:

> ...the person who had come to Kosovo to donate their organs did not do so to assist a family member or for any of the usual reasons that people in a civilized society chose freely to donate their organs. They did so because of their position of vulnerability. To suggest that a person would travel to a foreign country, endanger their health through such invasive procedure on the say so of a stranger runs (if they were not in a position of vulnerability) contrary to common sense.[34]

In India the majority of commercial transplants come from donors who invariably "agree" to sell an organ due to social determinants/ vulnerabilities of some kind. Findings presented in this Report reveal that many victims felt they had no other option but to sell a kidney because of a personal (i.e. gender, ethnicity, age), situational (i.e. migration status/administrative situation), or circumstantial (i.e. unemployment, debt bondage) vulnerability. Offenders of HTOR (brokers, criminal groups, medical professionals, corrupt officials) exploit this vulnerability to induce destitute individuals to sell their organs. Further, while many medical committees responsible for overseeing the compliance of ethical standards in transplantation assess relationships, the existence of potential

[30]Budiani-Saberi, and Columb (n 4).

[31]UNODC (n 1) Art 3, *Receipt* is listed as part of the 'means' element of trafficking.

[32]UNODC (n 4).

[33]UNODC (2000) Art 3 (b).

[34] EULEX, *Medicus Case*. April 27, 2011. KA 278/20, P 309/10, KA 309/10, P 340/10.

organ donors' vulnerability is not assessed. This is a key factor as to why the organ trade has continued unabated in key host countries and continues to operate internationally.

BACKGROUND

Organ transplant professionals began to perform kidney transplants in India in the 1970s. These surgeries soon became widely practiced across the country. The Indian Society of Organ Transplantation estimates that almost 21,000 renal transplants have been conducted in India from 1971 - 2011.[35] As transplant technology spread in India, a lively kidney trade also developed in which vulnerable Indian nationals have been made targets of commercial kidney removals for Indian and foreign kidney-failure patients ("transplant tourists") who have come to India from across the globe.

In response, the Ministry of Law, Justice and Company Affairs of the Government of India established the Human Organ Transplantation Act (HOTA) in 1994 to 'provide for the regulation of removal, storage, and transplantation of human organs for therapeutic purposes and for the prevention of commercial dealings in organs'.[36] This law and related initiatives have made advances in deceased and altruistic organ donation, and reduced the number of transplant tourists coming to India to buy a kidney and receive a transplant.

The law provides for the establishment of regulatory bodies —or Appropriate Authorities (AA)— in each of India's constituent State/Union territories, charged with governing the licensing of hospitals for transplant surgeries according to the standards set forth in the WHO Guiding Principles.[37] Hospitals performing transplant surgeries are required to register with the appropriate AA of which registration is available for five years before renewal. Furthermore, each state/union territory is to have an Authorization Committee (AC), consisting of nominees appointed by the central government who are responsible for 'preventing' commercial transactions between donors and recipients.[38] Chapter IV of the Act outlines a number of penalties to be applied in contravention of the provisions. The penalty for commercial dealings in organs is made punishable with imprisonment of no less than two years, which can be extended to seven.[39]Offenders are also liable to a fine of no less than RS. 10,000 (approximately $200), which can be extended to RS.20,000 (approximately $400).[40]

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[35]Indian Society of Organ Transplantation.Statistics for Kidney Donation. Available at: http://www.transplantindia.com/Accessed October 2, 2012.

[36] The Transplantation of Human Organs Act (1994) available at: http://india.gov.in/allimpfrms/allacts/2606.pdf accessed 11 Sept 2012

[36]The Transplantation of Human Organs Act (1994). Available at: http://india.gov.in/allimpfrms/allacts/2606.pdf. Accessed September 12, 2012.

[37]World Health Organization.Guiding Principles on Human Cell, Tissue and Organ Transplantation (2010). Available at: http://www.searo.who.int/LinkFiles/BCT_WHO_guiding_principles_organ_transplantation.pdf. Accessed November 1, 2012; The Transplantation of Human Organs Act (n 17) Chapter IV, s 15.

[38]Ibid, Chapter II, s 9, clause 4 (a).

[39] Ibid, Chapter VI ss 18 & 19; Subsequent to an amendment by Parliament on August 12, 2011, this penalty has been increased to a maximum of ten years and Rs 20,000.

[40]The Immoral Traffic Prevention Act (1956). India. Available at: http://www.ncpcr.gov.in/Acts/Immoral_Traffic_Prevention_Act_%28ITPA%29_1956.pdf. Accessed September 15, 2012.

Despite the adoption of the Act and penalties, the organ trade continues to thrive throughout much of the country in which hundreds of patients (mostly Indian and fewer foreign patients) still purchase a kidney from low-income Indians for the purpose of transplantation. By 2002, it was estimated that almost 3,000 kidney transplants were performed per year in the country and that approximately 200 were cases of HTOR.[41] The Indian Society of Nephrology now estimates that 6500 renal transplants are conducted in India annually for which it estimates 250-400 cases are commercial and approximately 25-50 per year are for foreign patients.[42]

There are several key reasons why HTOR persists. First, and perhaps the most significant reason is that HTOR is not recognized as a trafficking offense in domestic legislation. Article 23 of the Constitution of India prohibits trafficking in human beings as a fundamental right. The Immoral Traffic Prevention Act[43] passed in 1956 is the only domestic law that specifically addresses trafficking and is limited in its scope to trafficking of women and children for sexual exploitation.[44] Thus, there is no indication within legislation as to how trafficking can be defined and no recognition of the various forms of human trafficking.

The UN Trafficking Protocol functions to criminalize human trafficking, including for the removal of an organ. India signed this Convention in 2002[45] but has yet to ratify it, including the component on HTOR. Thus although the HOTA forbids organ donations via material incentives, many of the provisions pertinent to the suppression and prevention of HTOR cannot be enforced through Indian law.Article 5 (1) of the Protocol requires that the offense must be established to criminalize the

[41]See, Frontline. "Against the Organ Trade". Available at: http://www.frontlineonnet.com/fl1910/19100840.htm. Accessed November 4, 2012; Hogg C. Why not allow organ trading? *BBC News.* August 30, 2002. Available at: http://news.bbc.co.uk/1/hi/health/2224554.stm. Accessed November 1, 2012.

[42]VivekanandJha..Officer of the Indian Society of Nephrology (ISN). Personal communication. Jha also indicated that almost all of the transplant tourists who successfully purchase a kidney in India now are of Indian/South Asian origin.

[43] The Immoral Traffic Prevention Act 1956 (India) Available at: http://www.ncpcr.gov.in/Acts/Immoral_Traffic_Prevention_Act_%28ITPA%29_1956.pdf. Accessed September 17, 2012.

[44] Further, the Immoral Traffic Prevention Act does not define trafficking but rather conflates the phenomenon to an issue of prostitution. See also, South Asian Association for Regional Cooperation (SAARC) Convention on Preventing and Combating Trafficking in Women and Children for Prostitution. 2002. Available at: http://www.saarc-sec.org/userfiles/conv-traffiking.pdf. Accessed November 12, 2012. The SAARC Convention adopted unanimously by Bangladesh, Bhutan, Maldives, Nepal, Pakistan, Sri Lanka and India also concentrates on sex trafficking. Article 1 (3) defines trafficking as the 'moving, selling or buying of women and children for prostitution within and outside a country, for monetary or other considerations, with or without the consent of the person subjected to trafficking'.The Indian Penal Code (1860) also contains provisions dealing with trafficking offenses. Of particular relevance are ss 366, 367, 370 and 374, which penalize various activities manifest in the trafficking process, i.e. kidnapping/abducting and/or using force for the purpose of trafficking, buying and selling of human beings, and compelling to render bonded or forced labor.

[45]UNODC (n 1).

conduct set forth in Article 3. That is, 'the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs'.[46]

Important provisions of the Protocol include Article 3(b) which states that consent is irrelevant where any of the means (i.e 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) are used to achieve the consent of a person having control over another person for the purpose of exploitation. This applies where donors 'agree' to have their organ removed for payment, under circumstances that take advantage of a donor's poverty or vulnerability. Under the terms of the Protocol, a survivor of HTOR would not be held liable for selling his or her kidney, as is the case under HOTA.[47] Also, it is worth noting that for a trafficking offense to be established, the exploitation need not have occurred.[48] Exploitation is a purpose. Therefore the intention to exploit warrants liability.

Victims of trafficking for sex and labor have access to a range of rights which victims of HTOR are denied under current Indian laws. For this to change, HTOR must be codified into domestic trafficking legislation. Article 2 (b) of the Trafficking Protocol places an obligation on States to 'protect and assist the victims of such trafficking, with full respect to their human rights'. This places an obligation on States to implement measures for the prevention of trafficking and for victim protection, in recognition of 'the inherent dignity and of the equal and inalienable rights of all members of the human family' as indoctrinated under international human rights law.[49] HTOR compromises the health and freedom of human beings, and threatens basic rights to bodily integrity. Calling attention to the human rights violations manifest in this form of trafficking is critical to a comprehensive response to HTOR.

Second, the Act permits near-relatives — defined as a son, daughter, father, mother, brother, sister or spouse— to receive an organ from a live donor without any formal legal process. According to HOTA an unrelated donor is required to file an affidavit in the court of a magistrate stating that the organ is being donated by reason of 'affection or attachment'. However, the term 'affection or attachment' is not defined in the Act, nor is there any explanatory note to clarify how this term is fulfilled. It is on this point of ambiguity that the law has been repeatedly abused. Clearly, it is not difficult to conceive of a situation where a recipient would develop a sense of 'affection or attachment' for a person who had agreed to provide a much needed organ. Nevertheless, this is exactly what the Authorization Committees (AC) are tasked with determining. In practice, this determination is contingent on the donor signing a consent form attesting to the affectionate character of the donation. Consequently, the majority of applications to the AC have been approved. Out of the approximate 1,000 cases of unrelated transplants that

[46] Ibid, Article 3 (a).

[47] Supra n 2, Chapter IV s 19 (a) and (b).

[48] See, UNODC. Legislative Guides for the Implementation of the United Nations Convention on Transnational Organized Crime and the Protocol Thereto. 2004. UNODC Legislative Guides: 268-269.

[49] See, Preamble to The Universal Declaration of Human Rights (1948) available at: http://www.un.org/en/documents/udhr/index.shtmlAccessed Nov 2, 2012.

applied for approval before the State Authorization Committee between 1995 and March 2002, only 22 were rejected.[50] Moreover, there are no provisions restricting foreign nationals from undergoing transplant surgery in India.

Third, there is a lack of political will to enforce provisions which protect donors from exploitation. Since the law has been enacted various reports have documented cases of HTOR in India. Consequently, the High Court of Delhi, made a judgment on September 6th 2004 to create a committee to review the provisions and rules of HOTA. Subsequent amendments in 2008 and 2011 focus on strategies to increase deceased donation rates while also increasing the penalty for commercial transactions from a maximum term of imprisonment of seven years to ten. Although promoting deceased donation, in particular, is an important step towards controlling the organ trade, donor protection should be at the forefront of any policy pertaining to organ donation. HOTA contains no provisions to prevent or protect unrelated donors from being exploited. With growing levels of obesity and diabetes better primary care is an essential component of any strategy to combat the organ trade. Moreover, in terms of protection, survivors of HTOR should have legal recourse to follow-up care following transplantation. AC's and AA's bear the legal force of the Act. Ironically, it is these very authorities and the medical professionals who refer suspect applications to them who most often violate the rules and provisions therein. In the singular pursuit to procure an organ, transplant professionals 'shut their eyes to the illegality of what goes on; and the systems toleration of organ commerce.'[51]

COFS has thus far identified victims of HTOR in four areas of India. These include Erode, Chennai in Tamil Nadu and villages/ small town centers in West Bengal and Karnataka. Below is a brief background of victims' circumstances in these regions and how these regions have been hubs for targeting victims for HTOR.

Erode

Erode is considered the "Loom City" or "Tex Valley" of India. As such, its economy has been characterized by the textile industry that has transitioned from handloom to electric power loom over the course of the last two decades. This has created a significant employment gap and offenders of HTOR effectively played upon the vulnerabilities of handloom wage laborers' vulnerability for recruitment. COFS-India field researchers estimate there to be approximately 2,000 victims of HTOR in Erode. Every one of the over 2,000 victims that COFS identified and the 56 victims COFS-India interviewed in Erode had previously worked in the handloom industry and was unemployed thereafter and at the time of the organ removal. Each victim expressedthat they could not obtain alternative employment, none owned or had access to agricultural land, and each expressed burdens of debt that involved threats and abuse from money lenders.

Chennai

The victims of HTOR are largely part of fishing communities on the coast who lost many of their homes, belongings and livelihoods as a result of the major tsunami of December 2004. They now largely reside in an informal settlement area of the city of Chennai called Villivakkam. This area was nicknamed "kidneyvakkam"

[50] Ibid.

[51] VidyaRam, 'Karnataka's Unbaiting Kidney Trade' in L Territo and R Matteson (eds) *The International Trafficking of Human Organs: A Multidisciplinary Perspective* (Taylor and Francis, 2012), 65.

in popular media when traffickers began to target hundreds, and possibly thousands, of individuals after the tsunami.[52] Victims explained that initially full amounts were paid as promised after the kidney removal. This encouraged many vulnerable individuals to consider selling a kidney when in destitute conditions. During periods of high business, such as following the tsunami, brokers in Chennai provided a home where such organ "donors" could reside temporarily following the surgery. This also enabled brokers to attract more individuals towards a kidney sale. The victims from Chennai identified in this study include those whose kidneys were commercially removed between 1986-2011 and thus involve those who were targeted before and after the tsunami.

West Bengal

West Bengal borders Nepal and Bangladesh and attracts many migrants to the state in search of employment. The state has been a hub for human trafficking for sex and labor as well as kidneys. The COFS-India team partnered with CARITAS in rural areas of West Bengal where CARITAS and COFS' field researchers estimate that there are approximately 2,000 victims of HTOR. Field researchers identified 30 victims who were concentrated in the relatively isolated Uttar Dinajpur district. These victims mainly depend on irregular fishing and agricultural work as a daily wagers. They do not have access to public infrastructure and services such as paved roads, transportation, electricity, schools, hospitals, or government welfare schemes. Much of the population in this region is severely malnourished and field researchers received reports of some deaths of residents due to starvation.

Victims in this study reported that the city of Raiganj and villages (Bajbindol, Balia, Jalipara) of the Uttar Dinajpur province of West Bengal began to be targeted in 1990 when a renown broker returned from selling his own kidney in Mumbai where he migrated to work as a wage laborer. He collaborated with brokers in Mumbai to then recruit individuals for labor and a kidney sale in Mumbai and effectively spread his business in these areas of Uttar Dinajpur. Much of the population sought refuge in this area from Bangladesh following political conflicts in the early 1970s. This region has since been plagued by insufficient infrastructure and relief services to provide adequate food, shelter, medical care and employment. The Catholic Relief Services has been a major player in relief, rehabilitation, education and development in this region and the affiliate CARITAS assisted COFS-India extensively to identify victims and organize victim support.

Victims reported that many of them were severely malnourished and that food for themselves and their families was the motivating factor to sell a kidney. New Delhi and Lucknow became other destinations for kidney sales for villagers in Uttar Dinajpur in the 1990s until transplant practices became established in Kolkata in the last decade, fueled by HTOR. Victims of Uttar Dinajpur estimate that now at least one person per month is recruited/ resorts to a kidney sale in Kolkata. This received significant media attention starting in 2011 and due to the police response, villagers have become increasingly fearful of discussing the issue.

Karnataka

Apart from the thriving Information Technology (IT) industry that fuels

[52]See, Carney S. *The Red Market: On the Trail of the World's Organ Brokers, Bone Thieves, Blood Farmers, and Child Traffickers.* (William Morrow, 2011).

Bangalore and other areas of the state of Karnataka, much of the workforce relies on agricultural work. All victims of HTOR identified in this study worked in agriculture in Mandya District, Mysore, Mangalore, Usloor, and Udupi. All spoke of the hardship of having to take out loans when they could not yield profitable crops when they were lured to a kidney sale. These villages and the state capital of Bangalore are estimated to be increasingly targeted by offenders of HTOR as corruption is considered particularly rampant in this area and surveillance of transplant centers and practices are poorly monitored.

In sum, the National Kidney Foundation of India (NKFI) estimates that nearly 90,000 kidney transplants are required each year (2012).[53] In India and many other countries, renal failure is now reaching proportions similar to that of tuberculosis, in large part because the astounding growth in diabetes worldwide. Kidney disease in India ranks third amongst life-threatening diseases.[54] Thus, the current number of annual renal transplants conducted in India represents a fraction of the total number of patients who require transplants.[55] While deceased donation is increasing annually in India,[56][57] it supplies a small percentage of the demand. A recent study indicates that the deceased donation rate in India is 0.05 per million people.[58] Additional scholars have estimated that less than 4 percent of all renal transplants in India are the result of deceased donation.[59] With transplants as the preferred therapy for renal failure, demand for kidneys will continue to outpace supplies. Until India and other nations can build transparent, reliable systems of organ donation through altruistic donations from healthy individuals and deceased donors, poor and vulnerable individuals are at risk for being targeted to supply organs to privileged patients. Policy makers and key stakeholders in India and the global community must develop more effective responses to this human rights abuse.

[53]National Kidney Foundation of India.Kidney Diseases Rank Third Amongst Life-Threatening Diseases. Available at: http://www.nkfi.in/. Accessed January 8, 2012.

54 Ibid.

55 Ibid.

56Abraham, G., Reddy, Y., Amalorpavanathan, J., Daniel, D., Roy-Chaudhury, P., Shroff, S., Reddy, Y. "How Deceased Donor Transplantation Is Impacting a Decline in Commercial Transplantation—the Tamil Nadu Experience".*Transplantation* 93.8 (2012):757–760.

57 Sunil Shroff. Legal and Ethical Aspects of Organ Donation and Transplantation.*Indian J Urol*. 25.) (2009):348-55.

[58]Kidney Diseases Rank Third Amongst Life-Threatening Diseases. Available at: http://www.nkfi.in/. Accessed January 8, 2012.

[59]K(can't find name) R Goplani et al. "Deceased Donor Organ Transplantation with Expanded Criteria Donors: A Single-Center Experience from India". *Transplant Proceedings* 42 (2010):171–174.

METHODOLOGY

In-depth interviews with 153 survivors of organ trafficking commenced in Erode in September 2010, in Chennai in October 2010, and in the villages of Karnataka and West Bengal in May 2012. These interviews are on-going for programmatic and study purposes.

Each of COFS-India field researchers are Indian citizens and are trained in social science research methods. Three have Masters degrees in Social Work and one is a civil rights attorney. The lead researchers were certified by the Collaborative Institutional Training Initiative (CITI) and were included as research personnel on the protocol for the study. In addition to their research, COFS-India field researchers are also active social workers and victim advocates.

Considering the strict national laws against paid organ donation, transplant centers that facilitate HTOR are not transparent about their practices. Thus, field researchers identified victims via local development and human rights organizations and via a snowball technique in which victims tell COFS researchers how to reach other victims. Nearly 93 percent of the victims COFS interviewed said they know other victims of HTOR in India. About 6 percent of the victims elaborated that their own family member was also a victim.

The instrument employed to interview victims included closed-questions to collect demographic and background data and open-ended questions to elicit narratives about their experiences and how these experiences have affected their lives. Field researchers conducted interviews in victims' native language, with the assistance of a translator in some cases. In Erode, interviews were conducted with the assistance of a trade union who work as advocates for unemployed mill workers; in Chennai interviews were conducted in the home of the lead local field researcher; in the villages of West Bengal interviews were conducted with the assistance and office space of CARITAS; and in small towns around Bangalore interviews were conducted with the assistance of Vikasana Trust in the victims' place of residence. Especially with regard to West Bengal, the villages were exceptionally remote and not connected to paved roads which required a variety of public transportation means with a final journey of approximately a 38 kilometer/24 mile motorbike ride (via the courtesy arrangement of CARITAS, COFS' partner group) to travel from Raiganj to Bindole villages and an approximate 70 kilometer/ 44 mile ride round trip to reach each village.

A consent form was read to or by all victims and explained that participation was voluntary and that identities would remain confidential. Verbal consent was then obtained from each participant and additional consent was obtained for several video recordings of testimonies. No monetary compensation was provided for an interview. Because COFS' commitment is to assist victims with to address the consequences of HTOR, COFS provides outreach services, regardless of a victim's decision to participate in the interview.

Subject to the consent of its beneficiaries, COFS' also collected medical information from the follow-up services COFS provided for victims. The first aim of these services is to provide care as a basic right to victims who are otherwise abandoned by the system of medical professionals responsible for the kidney removal. Ultrasounds and physical exams also work to confirm a nephrectomy. Victim's

narratives are then corroborated and this information is then used to establish cases.

The relatively small number of participants in this study is a reflection of the following considerations:
1.*The clandestine operations and political sensitivities of HTOR that challenge data collection about this subject.* The lack of transparency of the practices in most transplant centers creates barriers to study processes and identify victims.

2. *Limited resources restricted more extensive data collection.* Although COFS-India had several supporting staff members and volunteers to help with this study, the organization could only commit four field researchers to identify victims of HTOR. The widely dispersed places of residency of victims and the intense fieldwork required to access them make it difficult to identify the many victims for which we had further leads.

Considering the clandestine nature of this activity, it is impossible to know a precise number of victims or to what extent the sample identified here represents the larger group of such victims. The findings nonetheless speak to the experience of being a victim of HTOR in India and the processes this crime entails, from victims' points of view. Individuals are being systematically exploited based, in these cases, upon their destitute conditions. Thus, this sample size of interview subjects provides an important window into the secretive operations of HTOR that targets the poor and vulnerable.

FINDINGS

Beginning in September 2010 with intervals of interview sets lasting until May 2012, COFS-India identified 153 victims of HTOR in four areas of India- Erode, Chennai, villages of West Bengal and small towns around Karnataka. Each case involved the removal of a kidney.

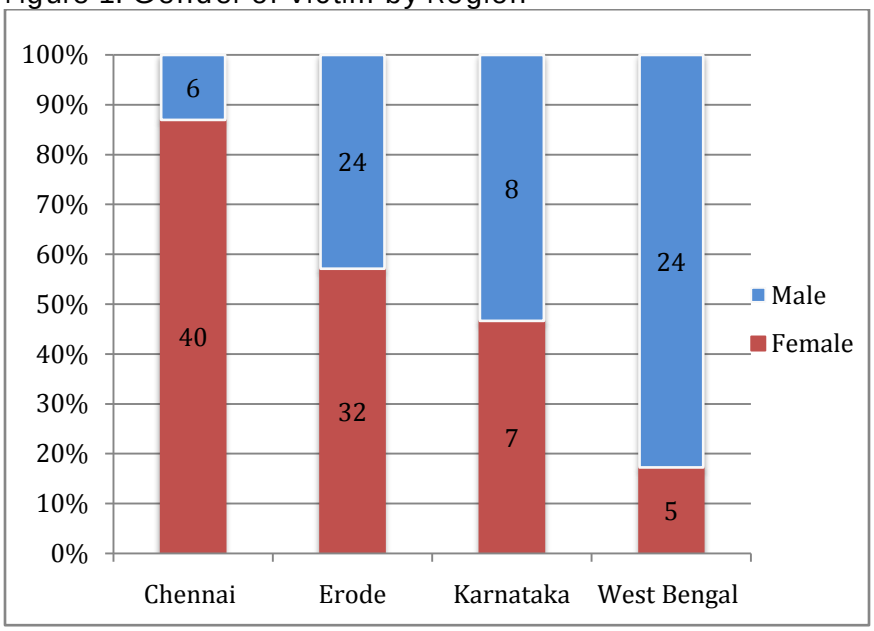
COFS-India has conducted in-depth interviews with 153 of these individuals who described their experiences in compelling detail and arranged medical follow-up services for 133 of the victims as part of its follow-up care outreach services. Social status/conditions (not altruism) is the major determinant for the organ removal as debt was the leading determinant of their vulnerability for being solicited for HTOR.

The findings presented here include information about demographics of victims interviewed, reasons for resorting to a kidney sale, awareness of how to arrange the sale, brokers, time and location of kidney removal, payment, and consequences for the victims.

Demographics of Victims Interviewed

Of the 153 victims interviewed, 56 are from Erode, 47 are from Chennai, 30 are from villages in West Bengal, 20 are from villages in Karnataka. They ranged in age from 23-64 years with an average age of 41 years at the time of the interview and eighty (52 percent) are female (see Figure 1).

Figure 1. Gender of Victim by Region



Five percent of the victims were single, 83 percent were married and 91 percent were parents with an average of 2 kids. The majority of these victims were entirely uneducated, 18 percent had some primary schooling, 17 percent had some secondary schooling and only one percent had schooling above high school (See Table 1).

Table 1. Demographics of Victims of HTOR					
	Erode	Chennai	West Bengal	Karnataka	Average
N = 153	56	47	30	20	
Age	43.2	39.3	37.8	42.7	41.0
Socio-Demographic Characteristics					
Gender					
Female	57.1	87.0	17.2	46.7	52.0
Male	42.9	13.0	82.8	53.3	48.0
Marital Status					
Single	9.0	9.0	0.0	2.0	5.0
Married	84.0	74.0	93.0	80.0	83.0
Divorced	0.0	0.0	3.0	0.0	1.0
Separated	0.0	0.0	3.0	0.0	1.0
Widowed	7.0	17.0	0.0	0.0	6.0
Education					
No Schooling	14.0	41.0	70.0	70.0	49.0
Primary (Class 1 to 5)	21.0	17.0	27.0	5.0	18.0
High School (Class 6 to 10)	21.0	22.0	3.0	20.0	17.0
Above High School	0.0	0.0	0.0	5.0	1.0
Monthly household income					
Indian Rupees	3,509	2,728	2,550	2,765	2,888
U.S. Dollars	66	51	48	52	54
Parent	87.0	95.0	96.0	85.0	91.0
Number of children (approximately)	2	2	2	2	2

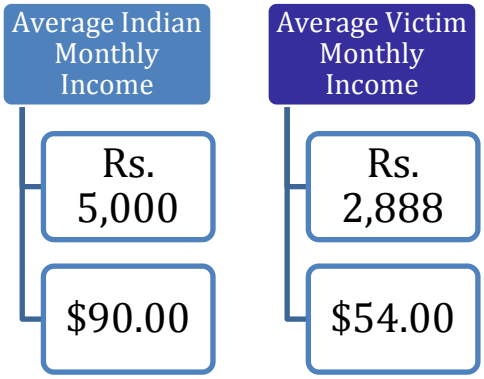
Note: Figures in tables are proportions or means.
Note: Items may not add up to 100 percent due to rounding.

Victims lived in abject poverty with monthly income levels that reach well below the national average (see Figure 2). The International Monetary Fund suggests that a third of the population in India lives below the Government's Poverty Line.[60] A recent media report suggested that the

[60]International Monetary Fund. April 2012. IMF Country Report. Available at: http://www.imf.org/external/pubs/ft/scr/2012/cr1296.pdf. Accessed November 8, 2012.

average Indian citizen's monthly income is approximately RS. 5,000 or $90(USD).61 Victims of HTOR interviewed for this study fair worse than the national average Indian with an average monthly income of Rs. 2,888 or $54 (see Figure 2).

Figure 2. Income Differential Between Indian Citizens and HTOR Victims



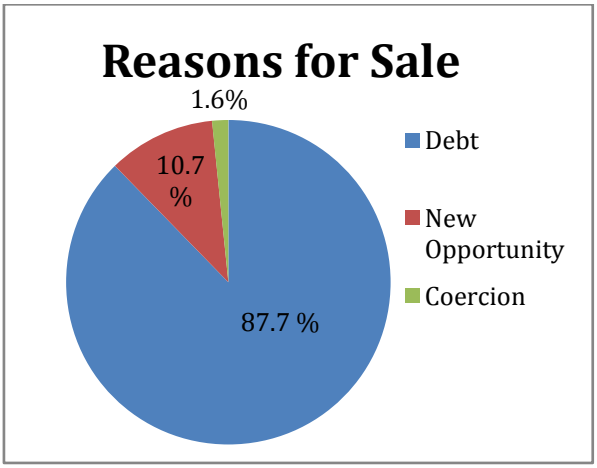
Data Source: Jargan Post (Feb 8, 2012). http://post.jagran.com/average-monthly-income-of-indians-reaches-to-rs5000-1328703863

Reasons for Resorting to an Organ Sale

Exploitative financial lending schemes have commonly resulted in insurmountable debt burdens that are especially harsh on India's poor. Victims interviewed in this study reported that debt was the primary reason to sell a kidney (87.7 percent) and they resorted to the sale with the hope of eliminating debt and transcending poverty (See Figure 2). In a report on kidney selling released in 2002, 96 percent of the 305 "kidney sellers" interviewed in Chennai sold their kidney because of debt.[62]

A small percentage of victims (10.7 percent) identified reasons of "new opportunity". These individual victims explained that the sale had represented an opportunity for personal and familial growth and stability. Purchasing a home, obtaining land, or realizing a business dream were among the noted potential opportunities for individuals. The new opportunity was an expression of a desire to break out of sustained poverty and economicstrain.

Figure 3. HTOR Victim Reason for Sale



[61] "Average Monthly Income of Indians Reaches Rs 5,000." *Jargan Post* (Feb 8, 2012). http://post.jagran.com/average-monthly-income-of-indians-reaches-to-rs5000-1328703863Accessed October 16, 2012.

[62]M Goyal et al. "Economic and Health Consequences of Selling a Kidney in India".*JAMA* 288 (2002): 1589-1593.

Marriage (costs associated with a wedding), medical, food, and household expenses were the most common source of these debts in the 2002 study in Chennai. Related reasons for debt that victims reported in this study, a decade later, include marriages (costs associated with a wedding), family illness, being abandoned or widowed, children's education, familial substance abuse, loss of job, and lack of income (see Figure 3). It is important to note that victims provided numerous reasons for sale and these categories are not mutually exclusive.

Figure 4. Cause of Debt

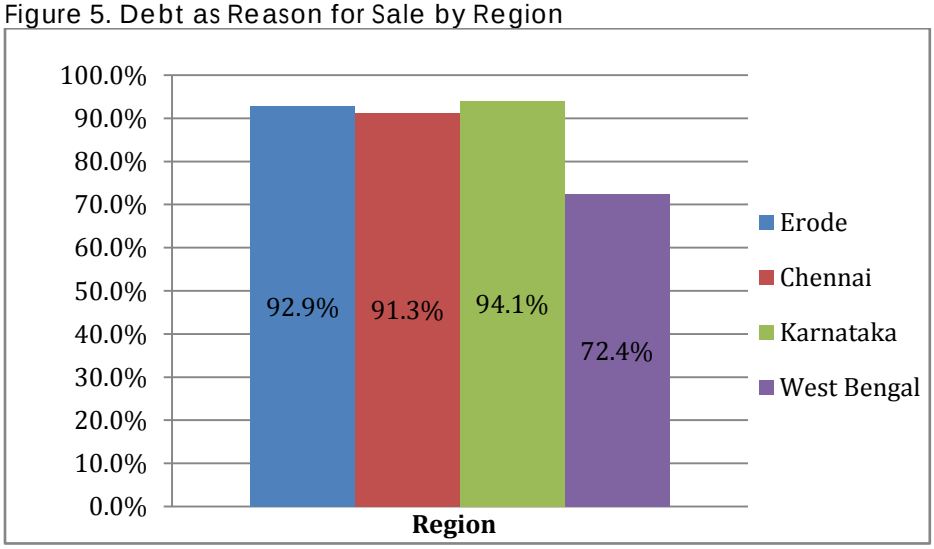
While further research is required to better understand how this abuse targets women and men distinctly in India, it is important to highlight that only women victims cited familial substance abuse (primarily alcoholism) as a reason for sale. Approximately seven percent of women victims explained that substance abuse had negatively impacted the family unit and contributed to their decision to sell. These women almost exclusively explained that their husband's substance abuse reduced their financial stability. Debt as a result of a lost relationship (abandoned or widowed) was a reason provided by nearly 10 percent of all women, where only 1.6 percent of men provided this reason. This could have been a result of unsettled debts, prior to the loss of a relationship, being posited on the women following this loss. This increased economic strain appears to have increased the instance of organ sales among women as a response.

Although reported as "debt," many women's narratives (see sample statements below) also expressed the pressures they felt from within the family, and especially from their husbands, to sell a kidney for the sake of the family. Only two individuals reported this as coercion. One case was particularly compelling in the story of a woman in West Bengal who described the pressures her husband placed on her to sell her kidney for the family's survival. She explained that once he received her kidney money, that he forced her to leave their home and threatened to take her life should she try

to return. She told COFS field researchers that she later found out that he had done this to three other wives before her.

Debt as the primary reason for sale was reported across all four regions (See Figure 4). In West Bengal, however, a lower percentage (72.4 percent) of victims noted debt, as opposed to the other three regions where over 90 percent of victims cited debt as the primary reason. This reflects that money lenders/ debt collectors are less common in the rural regions of West Bengal where the victims who participated in this study reside.

Figure 5. Debt as Reason for Sale by Region



Victims explained the circumstance that led to debt in open-ended interview questions:

I got married when I was 15 years old. Since my husband did not have permanent employment due to bad habits (alcoholism) we took a loan of RS. 60,000 to cover cost of living expenses. My husband asked me to sell and I agreed.

I was a dealer of (cooking) vessels and utensils. I used to take vessels on loan from big dealers and sell them to my customers in nearby places in a two wheeler. When I met with an accident about six years ago I was bedridden for more than three months. When I resumed my business afterwards many customers had moved to others such sellers and also did not pay the dues to me. Hence I took loan to settle the dealers from whom I purchased the vessels. Due to business loss I could not repay my loan of Rs1,00,000 hence I had to sell my kidney.

My husband had lot of health problems He could not work so I had to work to maintain the family. Slowly we borrowed RS. 10,000 on different occasions for family expenses and his treatment. When the lender started harassing me, I had to sell my kidney because of my income was not sufficient even to meet our family expenses.

We had to repay loan RS. 40,000 in 2007. My husband underwent tests

and since he does not match then I decided to sell my kidney.

My husband who took another wife and deserted me. Hence I had to settle a family loan of RS. 30,000 and this was the only way I could pay it.

I had a family loan of more than RS. 100,000. My husband donated his kidney a few years earlier since the loan could not be settled so I also sold my kidney.

When the tsunami struck Chennai, we were relocated, my husband could not go for employment for many months and his health was also not good. We thus took loan and with interest and it accumulated to RS. 70,000 in 2010. As I had no other option we both thought to sell a kidney to repay the loan. My husband volunteered to sale his kidney but did not match to any recipient. Hence I sold mine alone.

We had no funds for food after the Tsunami. We took a loan of RS. 100,000 for living expenses and to pay for the marriage of my oldest daughter. The money lender's abuse to us was intolerable.

My wife health was not good and she was living in a pathetic condition. I approached many people for help but no one could help me since they are also poor like us. So I had to sell kidney. Still my wife's check-up is going on and it is very difficult to manage the things without money.

My main problem is severe poverty not having our own land, own home and no money for my children's education. All this made me to go for this act. I never wanted my wife to donate and everyone is having money from this so [I thought,] why can't I?

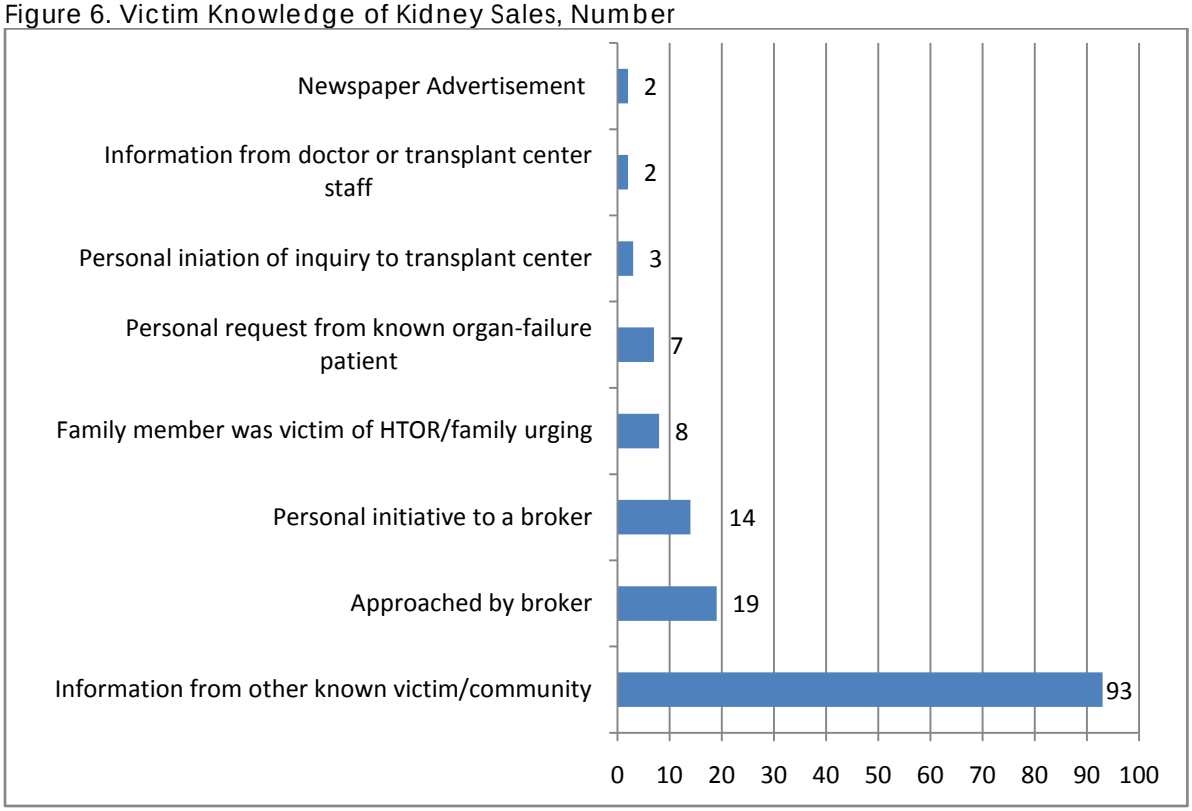
My husband convinced me that many of our problems will be solved if I do this and we could live a happy life. He said we would receive much money so that we can make separate house because we are two wives living with him. He also told me that we would get more money for my kidney than for his.

A Malayalam lady asked me to give my kidney to her husband when I was working as a maid in her home. She gave me Rs.1,000 as my salary after they took my kidney.

Awareness of How to Arrange the Sale

The majority of victims (93 / 61 percent) gained knowledge of organ sales from another known victim who was a family member or member of their community. This data points to the occurrence of targeting of victims in specific impoverished areas, particularly Chennai, where 95.3 percent of victims noted that the practice was common knowledge in their community. Brokers also played a significant role in the victim's understanding and involvement in organ sales. Nearly 13 percent of victims were approached by a broker and offered a sum of money for their involvement in the sale. Other victims (6 percent) reported that their own family members were also victims and that their decision to sell was greatly due to the urging of a family member, and in most cases, a husband. (see Figure 6).

Figure 6. Victim Knowledge of Kidney Sales, Number



Brokers

COFS does not engage in payments for interviews (as brokers requested) and avoided the risks involved in interacting with brokers. Information about brokers reported here is entirely provided by victims.

Erode

Victims collectively identified seventeen brokers (three women, fourteen men) who were active offenders of HTOR in Erode. The majority of the brokers were from Coimbatore and four brokers were from Bangalore. Several victims from Erode explained that at least three of the brokers were victims of HTOR before brokering and four brokers pressured their own wives to sell a kidney. Some brokers rented a house nearby the villages to recruit victims locally and navigate them to Coimbatore and Bangalore for the commercial kidney removal. Many brokers trained victims on scripts to present to authorization committee and make artificial documents to indicate kinship of recipient.

Chennai

Victims collectively identified eighteen brokers (thirteen women, five men) who were active offenders of HTOR in Chennai. Many of them were organized by a female broker who coordinated the broader operations of the business.

West Bengal

Victims collectively identified eighteen brokers who were led by three lead brokers (all men) who conducted HTOR in West Bengal. Each were native to the areas where they recruited victims and arranged to bring them to the various transplant centers (Mumbai, New Delhi, and Kolkata). There were eight victims who resorted to a kidney sale by going

directly to a transplant center independent of a broker's recruitment.

Karnataka

Victims collectively identified ten brokers (thirteen women, five men) who were active offenders of HTOR in Karnataka, many of them organized by a male victim who became a broker and coordinated the broader operations of the business. One of the key brokers is a transplant doctor directly involved in recruiting commercial organ "donors". There are four victims who resorted to a kidney sale by going directly to a transplant center independent of a broker's recruitment.

Time and Location of Kidney Removal

The incidents of organ trafficking occurred between 1981 and 2012. While it has been globally recognized that HTOR has occurred in India for decades, these findings confirm that cases are ongoing. Of the 56 cases interviewed in Erode, the kidney removals occurred between 1981-2010 with 6 cases occurring within the last three years; of the 47 cases interviewed in Chennai, the kidney removals occurred between 1986-2011 with 10 cases occurring within the last three years; of the 30 cases interviewed in West Bengal, the kidney removals occurred between 1987-2012 with 10 cases occurring within the last three years; and finally, of the 20 cases interviewed in villages in Karnataka, the kidney removals occurred between 1993-2011 with 3 cases occurring within the last three years.

All commercial transplants addressed in this study occurred in private, not government, transplant centers. Each of these centers however are recognized and licensed by state and federal level authorities of the Ministry of Health and Family Welfare Department. The locations marked on the maps indicate the city center, not the address, of the transplant center that victims reported as the location where they had a kidney removed. Table 2 indicates the place of residence of the victim reporting that location of her/his kidney removal.

Table 2. Region of Victims' Residence and Location of Transplant Center Where Organ was Removed

Victims' Residence	Erode	Chennai	West Bengal	Karnataka
Urban center where kidney was removed	Erode 1 Chennai 3 Kerala 3 Coimbatore 31 Bangalore 18	Coimbatore 5 Chennai 37 Tirunelveli 1 Madurai 4	Kolkata 26 Mumbai 3 Lucknow 1	Bangalore 13 Mysore 4 Udupi1 Chennai 1 Coimbatore 1

Payment

Reports on the price of a kidney in India vary, but it has been estimated that recipients pay approximately $25,000 U.S. dollars and the donors receive between $1,250 and $2,500 (Chopra, 2008). In this study, seven victims received no payment, 89 victims received between 200-1,000 USD (10-50,000 INR), 38 victims received between 1-2,000 USD (50,000-100,000 INR), 14 victims received between 2-4,000 USD (100-200,000 INR) and five victims received more than 4,000USD (200,000INR).

Knowledge about the Recipient

Most victims of HTOR in India interviewed in this study knew something about the patient who received their kidney. In Erode, victims reported that three recipients were foreign (from Malaysia)

and the remainder 53 recipients were from India and included ten patients from Kerala, one from Andhra Pradesh, two from Karnataka, one from Bihar and 39 from Tamil Nadu. In Chennai, victims reported that five recipients were foreign (three from Malaysia, one from Sri Lanka and one unknown) and 42 recipients are Indian and include one patient from Kerala, one from Andhra Pradesh and one from Maharashtra and 39 from Tamil Nadu. It is noteworthy that while one of the victims knew the recipient of their kidney was foreign but the country was unknown, there was also a news report that a transplant tourist from the U.S. had recently purchased a kidney in Chennai with few barriers.[63] In West Bengal, none of the victims had information about the recipient of their kidney. And in Karnataka, victims reported that all recipients were Indian nationals.

Consequences after the Commercial Kidney Removal

Negative health, economic, social, and psychological consequences for victims of organ trafficking have become evident from studies conducted in Egypt,[64] India,[65] Iran[66], Pakistan[67] and the Philippines.[68]Consistent with these studies, the victims in this study also reported that their lives worsened after the nephrectomy. Of the 153 victims interviewed, 90 percent expressed deterioration in their health. Half of those who did not feel their health worsened had also had their kidney removed within three months of the interview. Their negative health consequences are likely a result of factors such as insufficient donor medical screening and pre-existing compromised health conditions of this vulnerable population.

As with victims of organ trafficking elsewhere, many spoke at length about the pain and cramping they continued to experience at the site of the incision, an inability to lift heavy objects or do labor-intensive work, swelling of legs, loss of appetite, insomnia, and considerable fatigue. There were also consistent expressions of anxiety about the kidney removal including a guilt, depression and ongoing fear that death would result from it.

> *My health condition is deteriorating after 1 year from the surgery. I had pain everyday after waking up and also if I walk for long distance and if I work for long time. The pain was in the left abdominal at the place of surgery.*
>
> *I become tired if I work more than 10 minutes. I have a feeling of breathlessness if I walk for a long time or do hard work. I also have frequent pain in the left side of my abdomen as If a ball moves in the abdomen area. I*

[63]KavitaShanmugam, "The Great Kidney Bazaar". *The Telegraph (India)*. http://www.telegraphindia.com/1111113/jsp/7days/story_14743553.jsp Accessed Dec 21, 2012.

[64] Debra Budiani-Saberi and Amr Mostafa. "Care for Commercial Living Donors: The Experience of an NGO's Outreach in Egypt. *Transplant International* 24 (2010): 317–323.

[65]M Goyal et al. "Economic and Health Consequences of Selling a Kidney in India".*JAMA* 288 (2002): 1589-1593.

66Javad Zargooshi.. "Iranian kidney donors: Motivations and relations with recipient" Journal of Urology 165 (2001): 386–392.

[67]Anwar Naqvi A. "A socio-economic survey of kidney vendors in Pakistan." Transplant International 2007; 20: 909.

[68] Yosuke Shimazono. What is Left Behind? Presentation at an Informal Consultation on Transplantations at the World Health Organization.May 2006, Geneva.

have now became diabetic and have high blood pressure.

I cannot eat or easily put food in my belly. I get headaches, have breathing problems, and cannot do my normal work. I am afraid of death now [as a result of the kidney removal].

A total of 33 victims (22 percent) have seen a doctor since the kidney removal; 15 in Erode, 15 in Chennai and 3 in Karnataka. None of the victims in West Bengal saw or even had access to a doctor following the kidney removal. Of those who did see a doctor in Erode, most consultations were a result of a single follow-up that the transplant center provided. Of those who saw a doctor in Chennai, the reverse was the case such that most of them never again saw the medical professionals who performed the kidney removal but instead they saw doctors in local low-cost clinics when they sought treatment for pain and related health consequences. Thus, the majority (78 percent) of victims interviewed for this study did not receive medical follow-up care and many reported fear of consulting a doctor and reliance upon unprescribed pain medicine from local pharmacies. Victims of HTOR unanimously regretted the commercial removal of a kidney and would advise others against it.

As with findings highlighted elsewhere, all of the victims reported that the payment for the commercial kidney "donation" did not improve their economic conditions. Only 66 victims/ 43 percent of the victims whose debt drove them to the kidney sale were able to resolve the debt from the payment. Many victims also reported that they nonetheless had to withdraw their children from school and instead have them join wage labor jobs to contribute to their household's income. Many also later incurred debt from continued impoverished circumstances.

Results from studies released in 2002[69] and 2003[70]study, as well as the findings in this Report, indicate that a sale of a kidney in India had not been associated with an improvement in economic status and is associated with a subsequent decline in family income.

Victims have predominantly worked in labor-intensive jobs in fishing and agriculture, construction, weaving mills, power loom factories and domestic servants. One hundred and fifteen victims (75 percent) of victims interviewed reported that they could not carry out the same kind of hard work after the organ removal and that this compromised their ability to generate an income.

Victims of HTOR also reported significant social consequences that have resulted from the commercial kidney removal. Many interviewed victims expressed that a loss of dignity accompanied the loss of their kidney when their family, friends and community ridiculed themfor undergoing the procedure. There were reports of marriages broken when a spouse learned that their wife/husband sold a kidney, that relatives "disowned" the victim, and that a grown child's fiancé and family cancelled a planned wedding when it was revealed that their parent sold a kidney. Many female victims told their husband that they received a hysterectomy rather than a nephrectomy to explain their time in a hospital.

---

[69]M Goyal et al. "Economic and Health Consequences of Selling a Kidney in India".*JAMA* 288 (2002): 1589-1593.

[70] Lawrence Cohen. "Where it Hurts: Indian Material for an Ethics of Organ Transplantation". *Zygon* 38(1999): 663-688.

Victims also explained that media coverage heightened the stigma and presented challenges for them to be comfortable in public spaces within their communities. Victims in each field site expressed frustration that the media paid much attention to this issue internationally, but that this coverage has not led to assistance for their hardships as a result of the experience. One hundred percent of the victims interviewed expressed that they need support to cope with these consequences.

DISCUSSION AND QUESTIONS FOR FURTHER RESEARCH

Policy makers in India have worked diligently to combat the rampant organ trade that emerged in the 1970s. Regardless of these efforts, offenders of HTORcontinue to operate in various centers throughout the country, well beyond the scope of findings presented in this report.

The findings in this report highlight the following key concerns:
1). HTOR continues in private hospitals in India
2). Victims' resort to/ are targeted largely as a play of power upon theirdestitute conditions and their consequences of HTOR procedures are long lasting
3). The majority of commercial transplants for Indian nationals, but service to foreignpatients is ongoing
4). Based on indications on various websites, the internet is a key tool for coordinating patients with victims of HTOR in India

The findings presented in this report include only identifiable living victims who have had a kidney removed and survived the organ trade. This report does not speak to victims of HTOR who had a partial liver or other organ commercially removed or to victims in which death was the result of a commercial organ removal. More attention must be paid to address these concerns to better understand the scope and additional offenses at play in these practices.

Further research is also required to better understand recruitment of certain geographic regions and vulnerabilities. This includes the need for better research and analysis on the extent to which use of the internetis facilitating/ extending HTOR and ways to disrupt this illicit activity. Research should also be conducted on household and community dynamics where debt collectors are at play to suggest an organ sale to destitute individuals. This could shed new light especially on the relatively high number of women who are made victim in India (compared to the rest of the world in which the majority of victims of HTOR are men).

Above all, this report calls for a rights-based response to HTOR. Recognizing HTOR as a human rights abuse invokes a universal commitment to prevent, protect, and suppress its continuation. State parties who have ratified the relevant human rights treaties are legally bound to ensure, respect, and fulfill their human rights obligations.

In the absence of public or private commitments to victim support services, COFS has worked to deliver such services to victims of HTOR in India and elsewhere. COFS' assessment studies have found that victims of HTOR require medical follow-up, health education (about concerns after an organ removal), counseling/ peer support, income generation assistance, legal aid,and in some cases, shelter. COFS' limited capacity has only permitted the provision of follow-up medical services in Erode, Chennaiand villages in West Bengal. In Erode and Chennai, medical follow-up has included a clinical assessment, complete urine analysis, blood tests (to assess blood urea, serum uric acid and serum creatinine), and an ultrasound. In West Bengal, the COFS-India team arranged a health camp in which doctors set up a makeshift clinic in Raiganj to run basic tests and primary care provision for all of victims COFS identified in West Bengal. Due to severe malnutrition rampant in the region, COFS also delivered food supplies (rice and lentils) to each victim during the health camp treatments (see images below).

COFS is working to extend its partnerships with other anti-trafficking, human rights, health and development organizations in an effort to extend their relevant services to victims of HTOR. This will enable COFS to share such support with victims via a mobile phone text-based resource line that is currently being developed. This line will also serve to collect reports from victims, witnesses and other informants about HTOR that will feed a data tool COFS is also currently developing to eXpose and Disrupt Organ Traffickers "XDOT."

Especially since establishing the UN Trafficking Protocol, state and civil society organizations committed to anti-human trafficking measures have maintained a victim-focus and have advanced commitments to provide victim assistance, protection, and remedies to victims of trafficking for sex and labor. Support services have addressed a range of needs and including counseling, legal aid, medical care, rehabilitation, shelter. Victims of HTOR must be understood to have similar rights and support for similar relevant services andmeasures must be committed to these individuals who are otherwise abandoned after the crime.

Health Camp Raiganj
Victims and their families gather for COFS-India medical follow-up services and food rations






APPENDIX

The following is a copy of correspondences that occurred from January 4-June 16, 2012 of a search and identification of a kidney for purchase from a live organ "donor" in India via the Facebook page "Find a Donor for Kidney Transplant."

[redacted] ▸ Find A Donor for Kidney Transplant
January 4

Hello, my name is [redacted]. My Wife has been on dialysis for 1 Month and desparately needs a kidney or We Have One Child he is Now 4 Months Old Please help save his life. Please post on [redacted] facebook.
Thanks and Jay Mataji.

Like · Comment 1 44

Transplant Organizer likes this.

[redacted] hello.. wr r u from.... and which group do you wan....
January 4 at 10:29pm · Like

[redacted] iam from hyd... o positive... willing to donate kidney
January 4 at 10:36pm · Like

[redacted] i am from gujarat
January 4 at 10:37pm · Like

[redacted] my wife's blood group is B NEGETIVE SO DOCTOR SAY I WANT B NEGETIVE B POSITIVE O NEGETIVE O POSITIVE SO PLE HELP ME.....
January 4 at 10:39pm · Like

[redacted] how can i contct you,,,,
January 4 at 10:40pm · Like

[redacted] Hi, Mine is B Positive 38 yrs good health , I am from Bangalore can u pls send me your contact details
January 5 at 12:17am · Like

[redacted] Contact me if O+ve required
January 5 at 4:53am · Like

[redacted] Hi, I want to donate my O+ve Kidney. I am 31 years old from India. Can Travel to any part of the world. Any serious enquiries do message me. Thank You...
January 5 at 4:55am · Like

[redacted] my contact no is [redacted] or [redacted]
January 5 at 12:49pm · Like

[redacted] pleas contact me very fast.....
January 5 at 12:49pm · Like

[redacted] hi,,, if you dont mind can you call my frind he will definately help you he is from hyderabad.....
January 5 at 4:52pm · Like


[redacted] thankyu very much mrs.[redacted].....
January 5 at 7:25pm · Like
[redacted] i m 19yrs old boy want to donate kidney with o+bg
January 5 at 7:40pm · Like
[redacted] I CAN HELP YOU . YU CAN CONTACT ME [redacted]@GMAIL.COM
January 5 at 8:33pm · Like
[redacted] mr [redacted] r u expecting kidney for money or what,,,,
January 5 at 8:37pm · Like
[redacted] What r u want for donat kidney ple answer me!
January 6 at 8:35am · Like
[redacted] are you interested in having transplant and if you are serious than you can call us on [redacted] we provide donor legal and transplant
January 6 at 11:41am · Like
[redacted] i want to donate for 7 lac
January 6 at 12:05pm · Like
[redacted] plz tell me.....i m from delhi...
January 6 at 12:06pm · Like
[redacted] my new contact no-[redacted]
January 8 at 12:35pm · Like
[redacted] how to contact u?
January 11 at 10:13am · Like
[redacted] my contact no see up..[redacted]
January 11 at 3:14pm · Like
[redacted] area code? and country code?
January 11 at 6:17pm · Like
[redacted] contact me at [redacted] or by email [redacted]@gmail.com
January 11 at 6:32pm · Like
[redacted] My blood group B+ iam ready to help u
January 12 at 7:34pm · Like
[redacted] i dont know how is this serious. i msg u in fb. u didnt reply. i have my medical checkup and blood test. if you are serious. do reply back. as this would save someone life and make someone happy
January 14 at 3:59am · Like
[redacted] i will arrange the kidney donors and hospitals in india with all legal procedures, if u need then contact me on [redacted]@yahoo.com
April 7 at 12:11pm · Like
[redacted] I am [redacted] ready to donate my kidney for money [redacted] or [redacted]@gmail.com
April 21 at 1:28pm · Like

[redacted] i want to be donor [redacted]@gmail.com
April 23 at 11:26am · Like

[redacted] We can arrange donor and Hospital fro Kidney and Liver transplant in Singapore, Iran, Costa-rica.We are facilitators, we arrange NOC's, transplant dates, hospital selection, consutations, negotiations, visa's,
FRRO's, post transplant follow up's, end to end of the complete treatment.
Visit our website at http://www.[redacted].com/
Or email us on [redacted]@[redacted]com or call us on +[redacted]

:: Index ::
www.[redacted].com
[redacted] the competently managed Indian enterprise special...See More

April 24 at 11:12am · Like

[redacted] I would like to donate my one kidney (O+) for some monetary benefits. I am 36 year old male from MUMBAI, India. Since I am in huge financial debts, I have decided to donate my kidney. Needy person willing to provide me Rs 5,00,000 and bare my to and from and all hospital expenses during kidney transplantation pre and post till recovery can contact me at : [redacted]@rediffmail.com
May 24 at 7:18pm · Like

[redacted] hi how ru i hve donate my kidney urgent sir
May 25 at 3:13pm · Like

[redacted] Hi This is deepa, is the problem been solved or I can be a help pls
May 27 at 6:10pm · Like · 1

[redacted] hi Deepa how can i contact you?
May 28 at 11:54am · Like

[redacted] im [redacted] 30yrs old blood type A+ healthy non drinker or smoker send me an email [redacted]@hotmail.com
June 12 at 9:35am · Like

[redacted] Hi [redacted]... have u found a donor?
June 15 at 11:03pm · Like

[redacted] yes...
June 16 at 12:34pm · Like