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Human Rights, Epistemic Communities, and World Culture: The Diffusion of Legislation Against the Organ Trade

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An abstract of
A dissertation submitted to the Faculty of the
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in partial fulfillment of the requirements for the degree of
Doctor of Philosophy
in Sociology
2015

Abstract

Human Rights, Epistemic Communities, and World Culture: The Diffusion of Legislation Against the Organ Trade

By Fikresus Amahazion

Over the past several decades, more than 100 countries have passed legislation banning commercial transplantation. What explains this rapid, global diffusion of commercial transplantation laws, and what are the key factors influencing legislation? This project explores these questions through an analysis based on global-level, internationally focused, social science theories. First, I utilize various sources and conduct interviews to present a historical review of the global organ trade and legislation. The chapter details the important influence and role of the global medical epistemic community and international conceptions of human rights, dignity, and sacrality. Second, I conduct quantitative analyses of factors influencing legislation. Utilizing logistic regression and survival analysis models, I explore the global trend toward legislation across 1965-2012. In brief, the global trend toward legislation, with over 100 countries passing legislation between 1965 and 2012, is largely explained by the world society institution of human rights, a state's integration into such a society, the proliferation of world cultural scripts, models, and institutions delegitimizing the organ trade, and the influential global medical epistemic community. Additionally, economic development also impacts legislation. Overall, the results suggest that legislation is impacted by global, cultural, and economic factors.

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ACKNOWLEDGMENTS

This dissertation was only possible due to the help, encouragement, and support of many people. I express my deepest gratitude to the Sociology Department at Saint Bonaventure University. To Dr. Joyce and Father Blake for their advice and constant support. To the late Dr. Hughes, who was an amazing mentor and always available for help or feedback. To Dr. Zawicki, who sparked my interest in scholarly research and propelled me on a path to graduate study. I am so thankful for your support and friendship throughout these years.

To my friends, I thank you for your unwavering encouragement. Your prayers, hugs, positive vibes, words of wisdom, and moral support have been invaluable. I appreciate you more than you could ever know.

I am greatly indebted to Emory University, an amazing institution that supported me in innumerable ways. This dissertation would not have been possible without the resources provided by Emory, and I am grateful to the James T. Laney School of Graduate Studies who supported me with funds for research. I am extremely thankful to the Sociology Department and all my colleagues and friends. I thank you for scholarly engagement, help with data or revisions, and thorough, constructive feedback. I could not ask for a better group of people to have shared this journey. Maggie, Kim, Neema, and Pat, I thank you so much for your help throughout my time at Emory.

I am grateful to my amazing committee. Dr. Lechner, I thank you for your detailed, informative feedback. You challenged me as a student, and I am a better scholar because of you. To Dr. Rubinson, who taught me the finer details of scholarship and who was a wonderful role model. To Dr. Queen who provided great mentorship and unconditional support. It has been a blessing to be one of your students. Finally, Dr. Boli, thank you for your tremendous help with my classes, papers, questions, this dissertation, and throughout my years at Emory. You have been an amazing professor and mentor, and I am so appreciative of your guidance.

I dedicate this dissertation to my family, and this work is the culmination of a long journey that began far, far away. Dan, who always offers warm wishes. My late brother, Yonas, whose memory we cherish. My sisters, to whom I literally owe my life. Tighisti, who embodies what it means to be strong and independent. Zewdi, who sacrificed so much to ensure that no doors were closed and that I was always able to find or pursue opportunities. Most of all, my Mom. A single mother of five children, she risked and gave everything so that we could have a chance at decent lives. She worked several jobs, innumerable back-to-back day and night shifts so that we were always clothed and well-fed. She instilled within me the concepts of never giving up or never being satisfied, and the dignity of working hard and accepting challenges. She is far more than just my mother. She is my best friend, my critic, my coach. But most of all, she is my shining example, my role model, my teacher. In several weeks, I will walk across the stage and receive a degree with my name on it. In doing so, however, I will only be following the footsteps she set out before me.

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Chapter One: Introduction

~~Introduction~~

The latter stages of the 20th century were characterized by deterritorialization, increased socio-economic, political, and cultural interdependence, an intensified interaction of states, groups, and individuals, and far-reaching, rapid advances within technology, medicine, and science (Scholte 2000). One particular area experiencing the confluence of these processes has been the international organ trade. During the late 1970s and early 1980s, improvements in medical practices and the introduction by pharmaceutical companies of drugs to prevent organ rejection meant that organ transplantation became a viable and effective therapy for end-stage organ failure (Cho, Zhang, and Tansuhaj 2009; Kelly 2013). However, the access of patients to organ transplantation varies according to distinct national situations, costs of healthcare, national technical capacities, and of course, the actual availability of organs (Akoh 2012). To various degrees, these factors came together to facilitate the rise of the international organ trade (Cho, Zhang, and Tansuhaj 2009; Kelly 2013; Shimazono 2007).

The organ trade can take several different pathways. One involves organ recipients traveling abroad – termed as transplant tourism – to obtain organs from donors via commercial transactions. Another pathway involves the trafficking of organs obtained from individuals or donors through coercion, fraud, or exploitation of vulnerable populations.[1] Finally, the organ trade can involve the trafficking of human beings for the end-purpose of organ removal (Chan 2013; Shimazono 2007; UN GIFT 2013). While commercial transplantation has occasionally been raised as a possible solution for organ

[1]Such as migrants, especially migrant workers, refugees, children, homeless persons, illiterate persons, and the poor (Budiani-Saberi 2014; Moniruzzaman 2014; UN GIFT 2013).

donation shortages (Howard 2007; Spellman 2005), it has more often been described as "dangerous [and] divisive" (Noel 2014), a "slippery slope" (Naqvi 2014), creating unfair burdens on the poor (Moniruzzaman 2012A), an "egregious violation of human rights" (Glaser 2005: 22), undermining altruistic donation, arousing serious ethical quandaries, and involving or directly leading to profiteering, organized crime, and human trafficking (Jafar 2009; Scheper-Hughes 2000; UN GIFT 2013).[2]

With growing awareness of the global trade in organs (Shimazono 2007), the international community has responded in a variety of ways. Over the past several decades, numerous regional and global resolutions, guidelines, statements, declarations, and reports on the organ trade have been released by a number of actors, including the World Medical Authority (WMA), the World Health Organization (WHO), the World Health Assembly (WHA), the Council of Europe (CoE), the United Nations (UN), the Transplantation Society (TTS), and the International Society of Nephrology (ISN). Although the assorted initiatives were generally unanimous in objecting to the organ trade, a comprehensive description of the organ trade was still lacking,[3] and there was a long absence of a binding international document obligating states to take action.[4]

However, in 2008, *The Declaration of Istanbul* was adopted during the Summit on Organ Trafficking and Transplant Tourism, held in Turkey. Cosponsored by the TTS and the ISN, the Summit and the Declaration represent the first internationally concerted efforts to mobilize the professional transplant community toward developing practical

[2]Vividly, Dr. Anwar Naqvi, an internationally renowned urologist and transplant surgeon, has likened commercialism to a "Trojan horse" that will slowly destroy a society upon its entrance (Naqvi 2014).
[3]The lack of "internationally agreed definitions…to provide a framework for cooperation in combating the trafficking in human organs made it more difficult to understand and analyse the problem and its extent, and eventually to take appropriate countermeasures at the national, regional and international levels" (UN Yearbook 2009: 1306).
[4]Specifically, the Council of Europe (CoE) adopted the *Convention against Trafficking in Human Organs* on 9 July 2014 (CoE 2014). The convention is the only binding, global document specifically focused on combatting organ trafficking, With its adoption being so recent, the convention was not a factor in the earlier implementation of transplantation legislation by various countries, and is thus not examined here.

and ethically acceptable solutions to the organ trade (Ambagtsheer and Weimar 2011; DoI 2013). Even while the declaration is non-binding, it signals international and professional consensus regarding the problem of commercial transplantation, and its introduction was the result of significant collaboration amongst the global medical community (Chapman 2014; DoI 2013; Efrat 2014; Panjabi 2010: 116; Roberts 2009: 1336).

The Declaration's influence on states has been quite pronounced as, with its introduction, several countries have strengthened existing or created new domestic laws (Ambagtsheer and Weimar 2011).[5] Its notable effect is also exhibited by the fact that it has received innumerable endorsements, not only from national and international professional organizations, but also from government bodies (Danovitch et al. 2013). Finally, since the Declaration's formulation, the organ trade has allegedly been inhibited in some areas (Chan 2013; Danovitch et al. 2013: 3).[6]

Overall, the organ trade represents a "flourishing," multimillion dollar, black market transnational industry, affecting almost all countries and regions to some extent (Eckes 2011: 222). It is overwhelmingly categorized as a "gross violation of human rights" (Budiani-Saberi 2014; Moniruzzaman 2012A: 4), contravening numerous articles and principles from various international rights documents (Bagheri 2010; Budiani-Saberi and Columb 2013: 909 ff.; CRC 1989; Glaser 2005: 20; UDHR 1948; Williams

[5]For example, in the lead up to the Istanbul Declaration (DoI 2013), the Philippine government issued *Administrative Order (AO) 2008-0004*, strictly prohibiting transplant tourism (Gatarin 2014: 113), while after the adoption of the Declaration, India amended parts of the country's *Transplantation of Human Organs Act* (Danovitch et al. 2013: 3). In Israel, momentum in the buildup and surrounding the Declaration were important influences in the implementation of Israel's law (Efrat 2014). As well, Spain made special mention of the Istanbul Declaration when modifying its Penal Code in 2011 to provide sanctions for trafficking in organs or people for the purpose of organ removal (Danovitch et al. 2013: 3). Finally, following the publication of the Declaration of Istanbul in 2008, Qatar implemented the *Doha Donation Accord* in 2010, so as to meet the needs of local transplantation and further discourage Qataris from travelling abroad for commercial transplantation (Alkuwari et al. 2014).

[6]For example, after the Declaration "…the once-thriving kidney bazaars in Pakistan [were] closed" (Pfeffer 2011: 636).

1994: 315). As well, it poses a variety of serious health concerns, both for individuals and the general public (Budiani-Saberi 2014; Khamash and Gaston 2008; Gill 2014; McGuinness and McHale 2013: 12).

Yet, even with the acknowledged progress in understanding of and responses to the organ trade, many questions abound. According to the WHO (Fluss 1991; WHO 1991A), Chile and Italy were the first countries to pass legislation banning commercial transplantation in 1967, while the Cayman Islands became the latest to do so in 2013. Across that time period, over 100 countries have passed legislation banning commercial transplantation (see Figure 1.1). What explains this rapid, global diffusion of commercial transplantation laws, and what are the key factors influencing individual states' legislation?

~~Figure 1.1 Here~~

These questions are important, especially for their humanistic implications; for example, with legislation in place, the rights of potential victims of the organ trade may be better protected.[7] Furthermore, with the organ trade characterized by unsafe, substandard practices and conditions threatening both individual and public health, legislation may foster a safer, healthier environment for transplantation (Budiani-Saberi and Delmonico 2008; Francis and Francis 2010; Jafar 2009; Noorani 2008).

In recognition of the international complexities and global-level dimensions of the organ trade, it is fitting to proceed with an analysis based on global-level, internationally focused, social science theories. Accordingly, this project assesses global patterns of implementation of commercial transplantation legislation by looking to world

[7]For example, anthropologist Nancy Scheper-Hughes notes that national laws and international guidelines on the organ trade must outline and protect the rights of organ donors and recipients (Scheper-Hughes 2000: 210).

culture/world polity theory, rationalization/McDonaldization theory, neighboring country effects, and the concept of government effectiveness. With states' implementation of commercial transplantation legislation as the dependent variable, the longitudinal study examines data on 127 countries from 1965 until 2012. The central question of the study is what factors affect states' implementation of commercial transplantation legislation?

Although global awareness of the organ trade has increased, little data has been collected to help provide a more comprehensive understanding of the dimensions, extent, and reach of the problem (Delmonico 2009). Moreover, few scholarly analyses have been conducted – likely due to the dearth of reliable data – thus leaving numerous relevant, pressing questions unanswered (Cho, Zhang, and Tansuhaj 2009; Shimazono 2007). As one of the few academic works to delve into the increasingly significant topic – particularly from a sociological approach – this project contributes in several ways.

First, it offers a sociological perspective on an important global issue that has received little scholarly analysis (Cho, Zhang, and Tansuhaj 2009; Shimazono 2007). In this context, the project contributes to the general body of knowledge on the organ trade and expands the discussion. As well, through utilizing both traditional and newer theoretical frameworks from within the social sciences, the project broadens the scope of understanding of the respective theories.

Finally, and possibly most importantly, it focuses on an extremely meaningful humanistic issue, helping establish a platform for greater awareness and comprehension. Ultimately, it is hoped that the project can, in some way, play a positive, constructive role towards understanding and ameliorating a growing global problem.

~~Dissertation Overview~~

The project unfolds in the following manner. Chapter Two utilizes qualitative data from several in-depth interviews, historical analysis, and secondary sources to explore the organ trade and efforts to combat it in greater depth. After presenting a general framework of the organ trade, the chapter reviews the history of transplantation and the organ trade, and details the emergence and role of the global medical epistemic community, composed of transplantation doctors, surgeons, ethicists, and professionals from around the world. Positioning the global trend toward legislation within its historical context, the chapter illuminates the importance of the transplantation epistemic community, a finding that also emerges within quantitative analyses in subsequent chapters.

From inauspicious beginnings, and due to globalization, critical advances in medicine, technology, and the sciences, and a worldwide shortage in organ donations (Durst 1997; Panjabi 2010; Shimazono 2007; Smith 2009), transplantation and the organ trade globalized, eventually occurring within or affecting almost all states and regions. The global epistemic community provided guidance, strategic approaches, and best practices regarding transplantation. Importantly, it also helped position and categorize the organ trade as a significant health, rights, and ethical issue, and something that needed to be addressed. As the organ trade increasingly became delegitimized, states were advised, encouraged, and pressured to adopt legislation banning the organ trade. Overall, the chapter details an important international development, and highlights a worldwide movement that has come to exhibit a marked global influence.

Chapter Three presents a brief review of the literature on transplantation legislation, and also outlines areas requiring further understanding. The chapter then turns

to social science theories and concepts. Specifically, world culture/world polity theory, rationalization/McDonaldization theory, neighboring country effects, and the concept of government effectiveness are utilized to develop a theoretical framework and derive hypotheses concerning transplantation legislation.

Chapter Four offers a detailed methodological account of the project. The chapter describes data and sources, explains variable operationalization and measurement, and reviews descriptive statistics. Additionally, the data analysis strategies used – logistic regression and survival analysis – are discussed.

Logistic regression explores particular associations between the various independent variables examined and whether a country has implemented transplantation legislation. In contrast, survival analysis is a statistical methodology that focuses on the timing of the occurrence of one or more types of event (Aalen, Borgan, and Gjessing 2008: 2; Cole 2005: 481; Steele 2005); within this study, it is used to survey the duration of time until the implementation of transplantation legislation. Utilizing both analytical methods allows for a greater understanding of the processes influencing international implementation of transplantation legislation.

In Chapter Five, results from the quantitative analyses are presented and discussed. Implementation of transplantation legislation is shaped by several factors. Logistic regression results for 1965-2012 illustrate that world cultural factors, such as human rights, increase the likelihood of legislation implementation, while economic development decreases the likelihood. Notably, survival analysis results for 1965-2012 highly resemble those from logistic regression, with world cultural factors increasing, and economic factors decreasing, how quickly countries implement legislation. In aggregate,

the two sets of results support the world polity/world culture theoretical framework and hypotheses, and also demonstrate that economic development impacts the implementation of legislation.

Additionally, the chapter presents results for logistic regression analyses conducted after dividing the 1965-2012 time period into three segments: 1965-1979; 1980-88; 1989-2012. While individual results from the three separate time segments show slight variation, collectively they resemble the 1965-2012 results, thus underscoring support for the world polity/world culture theoretical framework and hypotheses.

Chapter Six, the final chapter, summarizes the overall project. The global trend toward legislation, with over 100 countries passing legislation between 1965 and 2012, is largely explained by the world society institution of human rights, a state's integration into such a society, the proliferation of world cultural scripts, models, and institutions delegitimizing the organ trade, and the influential global medical epistemic community. The latter helped to formulate and disseminate global blueprints and models, while advising and pressuring states in terms of policy adoption and implementation. The chapter concludes by describing the project's implications, and noting several areas for further research.

Figure 1.1

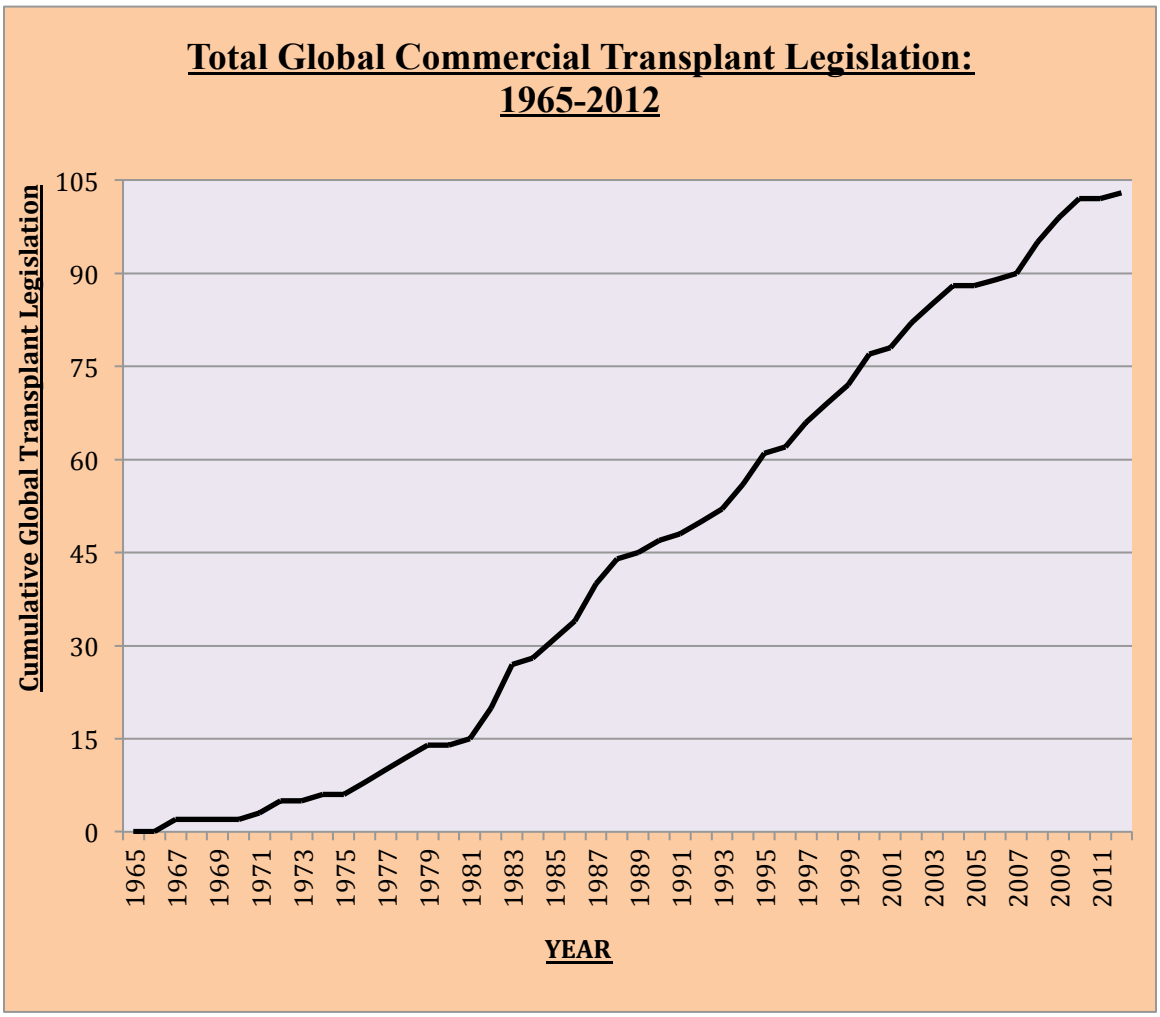

Figure 1.1 illustrates the cumulative number of countries with legislation prohibiting the organ trade. Over several decades, legislation spread to over 100 countries across the globe.

Chapter Two: Background and Historical Review

From Inauspicious Beginnings to a Global Issue

~~Background and Historical Review~~

Transplantation, the process of replacing failing organs in one individual with healthy organs from another body, is "hailed as one of the great miracles of modern science" (Sharp 2006: 9) and celebrated as "one of the major accomplishments of the last half of the twentieth century" (Munson 2002: 20). While it has saved or significantly extended innumerable lives worldwide (Miranda et al. 2003: 62; Munson 2002), transplantation has also generated several troubling consequences, including the organ trade.

The organ trade, a "flourishing," multimillion dollar, black market industry (Eckes 2011: 222), has become a transnational issue, affecting all countries and regions to some degree. Centrally involved within the global growth and spread of transplantation and the organ trade – as well as initiatives to combat the latter – has been the global medical epistemic community, comprised of transplant doctors, surgeons, practitioners, and researchers.[8] Effectively the most active global actor in promoting efforts against the organ trade, the epistemic community constitutes a network of various regional and transnational actors (individuals and organizations, such as the TTS, WHO, and the ISN).

Since arising in the 1950s and 1960s, the epistemic community has been key to many developments regarding transplantation, including recommended practices,

[8]Epistemic communities are "…a network of professionals with recognized expertise and competence in a particular domain and an authoritative claim to policy-relevant knowledge within that domain or issue-area" (Haas 1992: 3). Comprised of specialists and technical experts from different countries, disciplines, and backgrounds, epistemic communities help define state interests and legitimate goals of action (Drori 2003), set global standards, participate in communication and socialization processes, promote new ideas or policy alternatives and innovations, create international institutions, and diffuse a particular world vision based on rationality, order, and science (Adler and Haas 1992; Haas 1989: 402).

guidelines, resolutions, declarations, legislation, and model laws. However, as an important transnational actor with broad global authority, the epistemic community has not been reviewed in detail. This chapter presents a history of the organ trade, and also examines the rise, activities, and influence of the epistemic community in combating the organ trade.

Between January and December 2014, I conducted interviews with individuals affiliated with transplantation, including medical practitioners, researchers, policy makers, members of various organizations, journalists, rights activists, and lawyers.[9] Interviews were open-ended and semi-structured (Hammer and Wildavsky 1989), a particularly useful format since the study retained many exploratory features. Further, open-ended questions offered subjects an opportunity to organize responses within their own framework, thus potentially increasing the validity of responses.[10] While the interviews and questions were semi-structured, they involved many follow-up queries and creative locutions (e.g. "why" and "what else?") in order to further probe issues of merit or pursue clarity (Hammer and Wildavsky 1989).

In addition to interviews, I attended the World Transplant Congress (WTC) in July of 2014, allowing me to observe dynamics of the global transplantation community. The WTC, one of the largest, most comprehensive transplantations meetings ever assembled, focused on a variety of issues and involved representatives from over 80 countries (Cosimi 2014; TTS 2014).[11] During the WTC, I observed numerous

[9]Interviews were conducted via Skype (video), telephone, and in person, generally lasting between thirty minutes and two hours.

[10]Open-ended questions were advisable since some respondents were elites (e.g. high level doctors, lawyers, or governmental authorities on the topic) that may have reacted negatively to being put in the proverbial "straightjacket" of close-ended questions (Aberbach and Rockman 2002).

[11]The WTC 2014 was the second-ever meeting of the WTC, following up on the broad success of the first meeting, held in Boston in 2006. WTC meetings are multidisciplinary gatherings that allow participants – from around the world

presentations and panel discussions, attended a forum focusing on organ trafficking and harvesting, and conducted interviews with individuals from around the world.

Finally, this chapter incorporates information gleaned from an assortment of sources, such as NGOs, medical institutions, governmental or health ministries, and regional or global organizations (e.g. the UN or WHO). Documents examined include written laws, websites, newsletters, press releases or statements, government senate or commission hearings, summaries and reports, and countless news articles available from the Lexis-Nexis database or general online searches.

Data analysis is based on data triangulation: obtaining, comparing, and contrasting evidence from a wide range of data sources (Bieri 2010; Creswell and Miller 2000: 126; Yin 2003). Relying on multiple sources of data allows for the convergence of various lines of inquiry and strengthens validity (Creswell and Miller 2000: 126 ff.; Yin 2003), and is important in revealing the role played by epistemic communities in combatting the organ trade.

~~*Background*~~

An underground, shadowy enterprise, the international organ trade is quite complex (Sen and Ahuja 2009: 55). Furthermore, it is largely misunderstood and can, at times, be permeated by extremism and sensationalism (Meyer 2006; Surman et al. 2008). Though organ procurement and similar activities date back millennia (Hamilton 2012; Parry 2012: 215), the contemporary organ trade arose within the context of globalization,

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– to "share information, learn from a variety of perspectives, present or critique research, raise questions, receive training, collaborate on topics of mutual concern, and coordinate potential responses to various issues" (Cosimi 2014).

critical advances in medicine, technology, and the sciences, and a global shortage in organ donations (Durst 1997; Panjabi 2010; Shimazono 2007; Smith 2009).[12]

Involving a range of pertinent health, criminal, and human rights issues, the organ trade affects all regions of the world (Jafar 2009). Estimates suggest approximately ten percent of the total transplants performed worldwide involve trafficked organs (Ambagtsheer 2014; Budiani-Saberi and Delmonico 2008; Garcia-Garcia, Harden, and Chapman 2012).[13] Regardless of location, the organ trade encompasses several different activities that share the underlying trait of commercial organ transplantation or "a policy or practice in which an organ is treated as a commodity, including by being bought or sold or used for material gain" (DoI 2013).

One facet of the organ trade involves the trafficking of organs, tissues, and cells obtained through coercion, financial transaction, fraud, or consent (CoE 2014).[14] Importantly, the notion of consent is staunchly and widely rejected, since the organ trade occurs within the context of crippling inequalities, illiteracy, poverty, and vulnerability (Budiani-Saberi and Karim 2009; Chapman 2014; Noorani 2008; Scheper-Hughes 2000;

[12]Delmonico (2009) suggests the global organ trade arose "[a]s a consequence of the widespread shortage of organs and the increasing ease of Internet communication" (Delmonico 2009: 116). Several analysts also point to the influence of the worldwide web – particularly in terms of advertising – as being an instrumental factor in the growth of Pakistan's organ trade (Naqvi et al. 2007; Rizvi et al. 2010: 93).

[13]Additionally, it is estimated that trafficked kidneys represent nearly twenty percent of global kidney transplants (Mendoza 2011). However, these figures should be approached with caution; an inherent problem with estimates of any black-market, illicit activity – including the organ trade – is the inability to accurately estimate its prevalence (Ambagtsheer 2014).

[14]Budiani-Saberi and Karim (2009: 48) define organ trafficking as "the unjust practice of using a vulnerable segment of a country or population (defined by social status, ethnicity, gender or age) as a source of organs." While victims within the organ trade must not necessarily be from vulnerable populations, victims overwhelmingly tend to be the poor, vulnerable, and marginalized within society (Budiani-Saberi 2014; Moniruzzaman 2012; Moniruzzaman 2014). Vulnerable populations include migrants, especially migrant workers, refugees, children, homeless persons, illiterate persons, and the poor (Moniruzzaman 2014; UN GIFT 2013). Significantly, the trafficking of organs, tissues, and cells was the subject of the Council of Europe's Convention against Trafficking in Human Organs, adopted in July 2014. The convention, scheduled to open for signature in 2015, aims to prevent and combat the trafficking of organs, tissues, and cells, and to protect the rights of victims (CoE 2014).

Smith 2009).[15] Decades of experience have illustrated that organ sellers "are the poor or the vulnerable, whose actions reflect financial desperation and ignorance, not autonomous agency" or willful consent (Danovitch et al. 2013: 2).[16]

In various poverty-laden, debt-ridden, rural villages in Pakistan, large segments of the adult population have sold an organ,[17] while in several countries many kidneys procured from the local population are for foreign recipients (Danovitch and Al-Mousawi 2012; Jafar 2009). At times, vulnerable individuals may be "treated" for a medical ailment, which may or may not exist, and then have organs extracted without their knowledge or consent (Cohen 2003: 672). Generally, organs sold for transplant generate considerable profits for traffickers, brokers, and corrupt officials, while leaving meager (or no) returns for donors (Kelly 2013).[18]

Another facet of the international organ trade involves the trafficking of humans for the end purpose of organ removal (Kelly 2013). This facet of the organ trade received particular attention within the UN Trafficking Protocol (2000), which states that trafficking is:

> "…the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability

[15]Consent is often paralleled with liberty – in terms of the freedom to sell organs – and may be put forward as an argument for permitting organ sales. However, it is noteworthy that numerous analysts conclude that since commercialism occurs within the context of crippling inequalities, illiteracy, poverty, and vulnerability, little freedom or liberty is actually expressed (Budiani-Saberi and Karim 2009; Noorani 2008; Scheper-Hughes 2000; Smith 2009). Although not all poor individuals choose to sell organs, sellers and victims tend to be the poor, vulnerable, and marginalized within society (Budiani-Saberi 2014; Moniruzzaman 2012; Moniruzzaman 2014). Furthermore, many analyses of the organ trade have found that organ sellers frequently lament that "they would not have agreed to [sell an organ] if their economic circumstances were not so dire" (Budiani-Saberi et al. 2013: 2).

[16]For example, the recent discovery of an international organ trade network between Israel and Costa Rica – involving Israeli brokers and recipients, and Costa Rican donors and doctors – found that Costa Rican organ sellers were mainly men who had not finished high school and were either unemployed or held low-income jobs (Sack 2014).

[17]Saleem et al. (2009) note that donors in Pakistan generally live below the poverty line, are illiterate and bonded laborers, and nearly all sold their kidneys for the purpose of debt repayment. In an analysis of the organ trade in neighbouring India, one recent study found that victims live in abject poverty, with many lamenting that "they would not have agreed to [sell an organ] if their economic circumstances were not so dire" (Budiani-Saberi et al. 2013: 2).

[18]WHO estimates suggest that brokers can charge between $100,000 and $200,000 for transplants, with donors receiving as little as between $1000 and $5000 (Nullis-Kapp 2004).

> or the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude ***or the removal of organs***" (UN Protocol 2000, emphases mine).

With the UN's Trafficking Protocol (2000) primarily focused on human trafficking for the purposes of general exploitation, analysts felt it failed to give adequate attention to the organ trade, lacked specifying important aspects of the phenomenon, and only included organ removal as an addendum or afterthought (Gallagher 2011: 41; Geis and Brown 2008: 215).[19] The medical community, which has long taken the lead on the issue of the global organ trade (Efrat 2013), especially thought that a more conclusive, detailed description was required. In 2008, during an international conference in Istanbul, Turkey, a more thorough discussion of the organ trade was provided. The Declaration of Istanbul (DoI 2013), released at the conclusion of the conference, defines organ trafficking as:

> "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 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" (DoI 2013).

Part of the significance of the Declaration is that it presents clear definitions of complex, potentially vague processes, thus creating a common framework for broader understanding and cooperation (Delmonico 2009: 116). The previous lack of "internationally agreed definitions…to provide a framework for cooperation in combating the trafficking in human organs made it more difficult to understand and

[19]This is exemplified by the Philippines; while the country passed the *Anti-Trafficking in Persons Act of 2003*, organ trafficking was only tangentially included, since the law was primarily focused on sex and labor trafficking (Gatarin 2014: 112).

analyse the problem and its extent, and eventually to take appropriate countermeasures at the national, regional and international levels" (UN Yearbook 2009: 1306).

Notably, subsumed within the Declaration's definitions is a description of transplant tourism, distinguished as, "[t]he most common way to trade organs across national borders" (Shimazono 2007: 956). Transplant tourism involves potential organ recipients traveling abroad to receive organs procured from donors, and it can include commercialism, organ trafficking, and human trafficking for organ removal (Bagheri 2010). Demonstrative of the complexity of the organ trade, transplant tourism itself can occur in several ways (see Figures 2.1 through 2.4).

~~Figures 2.1 through 2.4 Here~~

One potential pathway involves recipients traveling to the donor's country of residence. Reports describe how recipients from across Southeast Asia have traveled to Taiwan and China to purchase organs procured from executed prisoners.[20] Although Taiwan eventually ceased the practice after pressure from human rights organizations (Subcommittee 2001: 58), China allegedly continues to take organs from executed prisoners (Chu 2014; Gutmann 2014; Harrison 1999: 30; Jafar 2009; Scheper-Hughes 2000).[21] This pathway is also illustrated by the "organ bazaars" of Turkey, Pakistan, and India, where foreigners arrive from far-flung locales to purchase organs from destitute locals (Scheper-Hughes 2000).

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[20]After Taiwan ended the practice in 1994, many local Taiwanese "began to travel to [mainland China] to purchase organs there" (Chu 2014).

[21]Some estimates suggest that up to ninety-nine percent of transplant organs in China came from executed prisoners (Watts 2007). In addition to Taiwan and China, early reports suggested that Singapore had also, at one time, engaged in the procurement of organs from executed prisoners (Guttmann 1992). In the Philippines, death row prisoners began donating organs in 1976 as part of a program to reduce overcrowding without resorting to widespread executions. Most inmate donors avoided execution and some were freed after spending a few more years in prison. However, after much media attention, the practice was stopped (Beelman 1989).

A second pathway sees donors travel to the country of recipients. In some cases, donors from Eastern Europe or other developing nations have been brought to the USA, while Nepalese have been taken to India (Jafar 2009; Scarpa 2006: 433; Shimazono 2007). Notably, the recent discovery of a major transplant network between Israel and Costa Rica found that some Costa Rican donors were taken to Israel to provide organs (Sack 2014).

The third type of transplant tourism occurs when both donors and recipients, as citizens of the same country, travel to another country for transplantation procedures. Often, this arrangement is made due to poor facilities and quality of care, high local costs, or stringent laws and regulations in the home country (Francis and Francis 2010; McHale 2013).[22]

In the final type of transplant tourism, recipients and donors, as citizens of separate countries, travel to a third country where transplantation is performed. This category has seen the growth of regional transplant hubs; for example, South Africa and Brazil have become favored centers for illicit transplantation activities, hosting donors from Eastern Europe and recipients from developed countries, such as Israel (Allain 2011; Shimazono 2007).[23]

Importantly, not all travel across national borders involving transplant recipients or donors is necessarily part of the illicit organ trade (Ambagtsheer 2014; Delmonico 2009: 117). Rather, some travel for transplant involves the legal travel of related donor

[22]In Kosovo, the lack of appropriate transplantation facilities led many Kosovars to purchase organs abroad (Ambagtsheer 2014). Similarly, many Azerbaijanis head to nearby Iran to receive transplants in transactions arranged by brokers in Azerbaijan (Ghods 2009: 190). One legal variation of travel for transplant sees the Tanzanian government send living related donor-recipient pairs to India to undergo transplantation, due to a lack of adequate transplantation services in Tanzania (Martin 2012: 143).

[23]Amongst the most infamous cases of this type of transplant tourism was the 2010 "Netcare" case in South Africa. Authorities discovered that 109 illegal kidney transplants had occurred between June 2001 and November 2003, in a scheme involving brokers, donors, and recipients from Israel, Romania, and Brazil (Allain 2011).

and recipient pairs from countries without transplant services to countries where transplantation is performed (Budiani-Saberi and Delmonico 2008; Delmonico 2009; Delmonico 2008).[24] Also, transplant tourism is distinguished from general medical travel[25] through the exploitation of donors who suffer coercion, threats, inducement, and fraud, and whose consent arises within the context of crippling poverty (Bagheri 2010; Budiani-Saberi and Karim 2009).[26]

Beyond solely the purchase of organs, transplant tourism affects other sectors of society. Global travel of potential recipients and donors is arranged and facilitated by intermediaries and healthcare providers (many unscrupulous) who coordinate travel and recruit donors. The Internet has also been used to attract foreign patients, with several websites offering all-inclusive transplant packages.[27] Intriguingly, Shimazono's (2007) pioneering survey of the global market notes how the price of a renal transplant package can range between US$70 000 to US$160 000 (Shimazono 2007; see *Table 2.1*),[28] while the WHO estimates that brokers can charge as much as US$100 000 to US$200 000 for transplants (Nullis-Kapp 2004).

~~Table 2.1 Here~~

Transplant tourism, through brokered, organized packages or individually arranged trips, sees recipients spend money on hotels, food, transportation, gifts or amenities, and excursions,[29] providing a potentially lucrative source of income for

[24]As illustrated by the Tanzanian government's policy (see Footnote 22).
[25]Where individuals or health practitioners travel across international borders for a variety of medical procedures or activities (Bagheri 2010).
[26]In Costa Rica, the recent discovery of transplant tourism suggests it was a malignant outgrowth of the country's long successful medical tourism industry (Sack 2014).
[27]In China, "…several hospitals have placed advertisements on the World Wide Web to attract transplant recipients from abroad" (Tibell 2007: 292).
[28]In Israel's organ trade, transplants purchased abroad can exceed $200 000 (Efrat 2013A: 85).
[29]This may often be conducted with a spouse, relative, or friend accompanying the organ recipient.

developing world economies (Bagheri 2010; Goodrich 1993; Turner 2007).[30] For example, Canadians, British, and Americans travel to countries such as India, Argentina, Cuba, and Chile (Behrmann and Smith 2010; Turner 2007). Promising "first world health care at third world prices" (Turner 2007), several Latin American, African, Southeast Asian, and Middle Eastern countries have become regional transplant tourism hubs.

Although accurate data remain elusive (Delmonico 2009: 117), meaning a fully comprehensive picture is still lacking, awareness of the organ trade's reach has undoubtedly grown (Shimazono 2007).[31] For example, at the 68th session of the United Nations General Assembly (UNGA), Joy Ezeilo, Special Rapporteur on Trafficking in Persons, Especially Women and Children, revealed that the organ trade "is a real problem that occurs oftentimes" (Ezeilo 2013: 2). Embodying the "dark side" of globalization, it has joined illicit drugs, humans, arms, diamonds, gold, and oil as an illegal multibillion-dollar industry. Recently, a report by Global Financial Integrity estimated that the organ trade generates annual profits between US$600 million and US$1.2 billion, with criminals capitalizing on globalization, new communication platforms, and improved transportation technologies (Ambagtsheer and Weimar 2011; Haken 2011; Naylor 2002).

The organ trade also represents a dramatically serious "health and human rights matter" (Budiani-Saberi 2014; Budiani-Saberi and Columb 2013; Reynolds and McKee 2010). In terms of health, rather than improvement, findings suggest the organ trade leads

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[30]In some countries experiencing transplant tourism, the phenomenon is positively viewed, since these countries "collect the substantial hospital and surgical fees that come with transplantation" (Rothman and Rothman 2004: 50). Notably, during the development of Pakistan's *Transplantation of Human Organs and Tissues Act* (2010), owners of and physicians employed within private hospitals lobbied against the enactment of prohibition laws on the grounds that transplant tourism aided the economy (Efrat 2013). As well, in the Philippines, many reacted negatively to the government prohibitions against the lucrative transplant tourism industry (Gatarin 2014: 113).

[31]Specifically, "empirical research is thin" and there are few sociological analyses of the organ trade (Healy 2006: 7). Strikingly, the WHO has reported that "there are no reliable data on organ trafficking – or indeed transplantation activity in general" (WHO 2004: 715). Of all forms of trafficking, organ trafficking is the least researched (Yea 2010: 359).

to a deterioration in health status for both recipients and donors (Khamash and Gaston 2008).[32] Significant threats stem from unsafe and substandard practices and conditions (Chugh and Jha 1996: 1183),[33] as well as inadequate testing, screening, or postoperative care (Efrat 2013A; Epstein 2009: 135; Jafar 2009; Noorani 2008). Along with maiming or death, hepatitis B, HIV, aspergillus, diabetes mellitus, fungal sepsis, cytomegalovirus, tuberculosis, donor-transmitted malignancy, wound infections, fatigue, regret, depression, and stigma are potential complications (Anker and Feeley 2012; Budiani-Saberi and Delmonico 2008; Francis and Francis 2010). These individual-level afflictions can expand into broader public health issues through the potential spread of diseases or micro-organisms,[34] as well as the need for costly provisions of healthcare and various resources for donors who have sold organs or recipients returning ill from abroad (Khamash and Gaston 2008; Gill 2014; McGuinness and McHale 2013: 12).

Overwhelmingly, the organ trade is categorized as a "gross violation of human rights" (Budiani-Saberi 2014; Moniruzzaman 2012A: 4). It violates internationally recognized rights such as rights to life, liberty, security, health and freedom from cruel or inhumane treatment, as well as various children's rights (Bagheri 2010; Budiani-Saberi and Columb 2013: 909 ff.; CRC 1989; Glaser 2005: 20; UDHR 1948; Williams 1994: 315).[35] Amongst the clearest reflections of the organ trade's challenge to internationally

[32]Goyal et al.'s (2002) oft-cited survey of over 300 donors in India found that forty-eight percent reported a three-to-four point decline of health on a five-point Likert scale. As well, the organ trade – and transplantation in general – is problematic since transplantation "…involves a medical act with no benefits accruing to the donor, breaching the old watchword 'First do no harm' (*primum non nocere*)" (Steiner 2008: 365-366).

[33]Transplants have allegedly even been performed by individuals lacking medical qualifications altogether (Nicolaides and Smith 2012).

[34]Particularly worrying is the introduction of "superbugs" and "foreign" or "tropical" diseases by recipients returning from abroad (Gill 2014).

[35]For example, coercion and exploitation of the poor or vulnerable could be considered as violating Articles 3 and 4 of the Universal Declaration of Human Rights (UDHR 1948). As well, Article 3 of the European Union's (EU) Charter of Fundamental Rights states "everyone has the right to respect for his or her physical and mental integrity" and prohibits "making the human body and its parts as such a source of financial gain" (EU 2010).

recognized human rights is China's state-organized organ trade. Servicing recipients from all over the world and predicated on the forcible extraction of organs from executed prisoners, China's organ trade illustrates contempt and blatant disregard for basic rights and principles of human dignity (Gutmann 2014; Watts 2007).

While countries from all continents and regions are involved, implicated, or afflicted in some way by the organ trade (Jafar 2009; Scheper-Hughes 2000), the international response has been lackluster (Efrat 2013; UN GIFT 2014; UN NEWS 2009).[36] In 2009, both the UN and the Council of Europe (CoE) called for a new, binding international treaty to prevent the harsh, criminal realities of the international organ trade (CoE/UN 2009; UN NEWS 2009), and the UN pronounced an urgent need for "…prohibition of financial gain from the human body or its parts as the basis of all legislation on organ transplants" (UN NEWS 2009).[37] These calls would only be heeded years later; in mid-2014, the CoE adopted the Convention against Trafficking in Human Organs (CoE 2014), the world's first binding international agreement specifically focused on the organ trade.[38]

Even with the decades-long absence of a binding international agreement, combating the organ trade has been a central feature within the world of transplantation – particularly due to the global medical epistemic community. The global medical epistemic community has broadened awareness of the global organ trade, raised concerns

[36]However, many states have implemented legislation and formulated mechanisms to combat the organ trade. Since 1967, when Chile and Italy became the first countries to pass legislation, over 100 countries have passed legislation prohibiting the organ trade (CoE 2004; Fluss 1991; GODT 2010; WHO 1991A). These responses have varied; some states passed legislation "early" while others either took longer to respond or appeared to overlook the issue altogether. Quite problematically, many countries do not recognize some aspects of the organ trade – such as trafficking for the removal of organs – as "a form of exploitation" (Budiani-Saberi and Columb 2013: 908).

[37]The European Union (EU) claimed that "…there is a need for action…" on the organ trade, and that it has a "…duty to act" (Fasting, Christensen, and Glending 1998: 521). As well, with the organ trade constituting a transnational crime, it has been suggested that a transnational criminal law approach is required (McGuinness and McHale 2013: 14).

[38]Adopted in July 2014, it was to open for signature in 2015 (CoE 2014). Significantly, the Convention is open to signature and ratification by states around the world.

and outlined problematic implications, proposed solutions, and ultimately influenced transplantation policies and global positions.

~~Epistemic Communities~~

The concept of epistemic communities dates back to Ludwik Fleck and Michel Foucault, whose respective works discuss *thought collectives* and *episteme* (Cross 2013; Fleck 1981; Foucault 1973).[39] Later, Kuhn explored the notion of a scientific community, noting that it involved individuals from a particular discipline whose work revolved around a shared paradigm (Kuhn 1962). Within sociology, Holzner (1968) was the first to use the term (in 1968), while Haas introduced the concept to international relations (IR), seeking to understand the influence of scientists (Haas, Williams, and Babai 1977).[40] In the mid-1970s, Ruggie drew upon Foucault's early understanding of episteme, and broadened the scope of Kuhn's scientific community, arguing that epistemic communities arise from "bureaucratic position, technocratic training, similarities in scientific outlook and shared disciplinary paradigms" (Ruggie 1975: 570).

Though these respective contributions were important in formulating an early, foundational framework for understanding epistemic communities, the definitive discussion of epistemic communities would emerge in the early 1990s. Specifically, Peter Haas (1992) described epistemic communities as having:

> "(1) a shared set of normative and principled beliefs, which provide a value-based rationale for the social action of community members; (2) shared causal beliefs, which are derived from their analysis of practices leading or contributing to a central set of problems in their domain and which then serve as the basis for elucidating the multiple linkages between possible policy actions and desired outcomes; (3) shared notions of validity - that is, intersubjective, internally defined criteria for weighing and validating knowledge in the domain of their expertise; and (4) a common policy enterprise - that is, a set of common practices associated with a set of problems to which their

[39]Kuhn, Holzner, and Haas also played important roles in the early advancement of the idea of an episteme (Cross 2013).

[40]Although the concept of epistemic communities has traditionally and primarily been used within IR, it is highly compatible with sociology, particularly within world culture/world polity theory (Meyer et al. 1997).

> professional competence is directed, presumably out of the conviction that human welfare can be enhanced as a consequence" (Haas 1992: 3).

A global collection of specialists, experts, scientists and professionals, and representing "significant others" for states, organizations and individuals, epistemic communities are driving forces behind the elaboration of world cultural models and principles, such as rationality and rational progress (Koenig and Dierkes 2011). Furthermore, they help define state interests and legitimate goals of action (Drori 2003), set global standards, participate in communication and socialization processes, promote new ideas and policy innovations, create international institutions, and diffuse a particular world vision based on rationality, order, and science (Adler and Haas 1992; Meyer et al. 1997: 162 ff.).

Diffusion[41] occurs via epistemic communities' interactions within international organizations, in scientific bodies, at conferences, and through publications. These transnational links allow epistemic communities to exert concurrent pressure on governments and policymakers who redefine their own expectations, reach common understanding, and coordinate their behavior accordingly (Adler and Haas 1992). With world society lacking an overarching, authoritative state, there is room for innovation (Meyer at al. 1997: 169). In this context, the role and influence of epistemic communities gains credence, and they have become significant players in the international community (Boli and Thomas 1997: 184; Haas 1992). Numerous analyses of epistemic communities have illustrated their influence in collective global responses to environmental pollution, whaling, arms control, global banking regulations, telecommunications, and international trade (Adler and Haas 1992).

[41]Within the social sciences, diffusion "connotes the socially mediated spread of some practice within a population [or some larger system]" (Strang and Meyer 1993: 487).

The following section reviews the history of the global organ trade in greater detail, while also noting the influence of the organ trade's epistemic community. The review suggests that the epistemic community arrived relatively recently, truly emerging only in the 1970s and early 1980s. The epistemic community raised awareness of the global organ trade, helped position and categorize the organ trade as a significant health, rights, and ethical issue, proposed solutions, and was ultimately influential to many international policy initiatives, resolutions, statements, and declarations (see Table 2.2 for list of declarations, statements, notable reports, etc.).

~~Table 2.2 Here~~

~~Historical Review~~

The idea of transplantation is not new, dating back to the myths of ancient civilizations and to stories found in traditional or religious texts (Hamilton 2012; Parry 2012: 215; Shayan 2001). More recently, in Europe during the 16th to 18th centuries, corpses were often sold to barbers and surgeons for training and scientific or medical purposes (Scheper-Hughes 2000).[42] However, modernized human transplant procedures only surfaced in the early-to-mid 1900s, with the first long-term successful major organ transplant – involving kidneys – occurring in 1954 (Shayan 2001). Transplantation eventually began to occur with regularity several decades later; improvements in medical practices and the introduction by pharmaceutical companies of drugs to prevent organ rejection meant transplantation was safer, more efficient, and reliable. This, alongside general societal health and medicinal advancements, a decreasing donor pool, and few voluntary post-mortem donations led to a situation where demand for organs increased at a rate greatly exceeding supply (Shimazono 2007). These factors and the lack of

[42]This was done by infamous "body snatchers" – individuals who exhumed bodies from graves.

comprehensive national or international laws[43] or systems to address organ donation would spawn the commercialization of transplantation and the lucrative international organ trade, which grew quickly and spread widely (Durst 1997; Fluss 1991; Kelly 2013; Morelli 1995; Panjabi 2010; Shimazono 2007; Smith 2009).

~~The Early Days~~

The seeds of the organ trade movement were planted in the early 1950s as small, formal meetings of researchers and clinicians interested in the new subject of transplantation convened in 1952 in Harriman, NY. Averell Harriman, former US governor, diplomat, and presidential advisor, donated a conference center to Columbia University, and a handful of clinicians, doctors, and researchers presented papers on the rapidly evolving subject (TTS 2006). This first meeting was followed by several more held biennially, ultimately leading to the establishment of the Transplantation Society (TTS), a global organization that would quickly come to be regarded as "one of the healthiest and most productive international scientific societies in existence" (Murray 1971: 426). Eventually, the TTS developed into the global leader in transplantation, the guidance of ethical practice, and activities combating the organ trade (Budiani-Saberi 2014; Chapman 2014; TTS 2015).

At the same time, in Europe, small national societies comprising scientists and clinicians and focusing on kidney diseases were emerging. These societies organized the first International Congress of Nephrology, held in France in September 1960, featuring approximately 100 participants and 75 papers covering a wide variety of topics (Epstein 2009; Robinson and Richet 2001). The meeting provided the impetus for the eventual

[43]Dr. Luc Noel of the WHO notes that "[n]on-existent or lax laws on organ donation and transplantation encourage commercialism and transplant tourism" (WHO 2007).

formation of the International Society of Nephrology (ISN) which, decades later, has grown into a prominent, active opponent of the organ trade, boasting a vast network of affiliated chapters and members from across the world (ISN 2013).

Overall, at this stage, transplantation was in its infancy and conferences allowed specialists to share research, exchange ideas, broaden knowledge within the field, and cooperate to develop the still arcane subject. As activities continued, memberships steadily expanded, and medical practices improved, general excitement permeated the field.

Despite the excitement, the reality during the early period was that transplantation was not yet effective or safe.[44] For example, by 1963, approximately two-thirds of all transplant recipients died from organ rejection (Petechuk 2006: xi). At a conference in the US in 1963, as many doctors lamented that the vast majority of their transplantation recipients continued to die, one report offered optimism. A young surgeon presented results showing high success rates, attributing them to a unique immunosuppressant that reversed organ rejection (TTS 2006). Word quickly spread and by 1967's International Congress of the Transplantation Society, held in Paris, hundreds of organs had been transplanted in chemically immunosuppressed recipients in the USA, Europe, and Australia.

Although broad success in general transplantation was still elusive, there was an emergent transplantation community. The ISN's 1966 meeting registered nearly 3000 participants from fifty-four countries (Robinson and Richet 2001), while the TTS' 1967

[44]In some areas, the poor success rates of transplantation led to a moratorium (Hakim and Papalois 2003: 8). In fact, unacceptably high mortality rates following the introduction of heart transplants in the late 1960s led to a worldwide moratorium on heart transplantation by the end of 1970 (Ritteg 1989: 196)

Paris conference saw 425 delegates attend, 200 of whom had become members of the increasingly influential TTS (TTS 2006).

Generally, these early activities were pivotal to developing professional ties amongst participants that would strengthen over decades. Regarding commercialization, although there was "little to indicate" that there was "any trafficking or commerce in organs" (Daar, Gutmann, and Land 1997: 302), anti-commercialization activities were already surfacing.[45] In 1967, Italy and Chile became the first countries to pass commercial transplantation legislation (Fluss 1991; WHO 1991A), while the first internationally framed anti-commercial article arose in 1970 under the guidance of the TTS. At a society meeting at The Hague, Netherlands, the TTS' Committee on Morals and Ethics released a brief statement asserting that, inter alia, "[t]he sale of organs by donors living or dead is indefensible under any circumstances" (Merrill 1971: 632).

The statement was somewhat of a landmark, but years would pass until further efforts were made or even required. Building upon the slow, yet tangible, progress of the 1960s, the 1970s witnessed greater societal entrenchment of transplantation (TTS 2006), even though pessimism about survival rates was still apparent (Rettig 1989:192). New information and medical innovations were features of the increasingly globalized meetings. Patient mortality continued to improve, although only incrementally,[46] and transplantation procedures were available in over 200 centers worldwide.[47] On the

[45]As well, there were early concerns that as transplantation developed, the poor and powerless would possibly be exploited as donors by the privileged and wealthy (Kass 1968).
[46]Specifically, "[w]hile survival rates improved through the 1970s, especially for kidney recipients, the eventual rejection of the gifted organ, and the death of the organ recipient, remained the norm rather than the exception" (Koch 2002: 51).
[47]For example, India's first kidney transplant occurred in 1971 and was shortly followed by the establishment of a kidney transplantation program (Chugh 2009: 756), while in neighboring Pakistan kidney transplantation took root in early 1973 (Bile et al. 2010). The Arab world's first transplant took place in Jordan in 1972 (Al Sayyari 2008: 1033). Although the world's first heart transplant was conducted in South Africa in 1967 (Hoffenberg 2001), the continent has lagged far behind the rest of the world in transplantation program development.

legislative front, by the end of the 1970s, fourteen countries had transplantation legislation in place.

~~Medical Progress, an Emerging Problem, and an Initial Response~~

Improvements in medicine and transplantation, and growth of the medical community bred optimism; the 1980 TTS global conference featured nearly 700 abstracts, and more than 1100 delegates from 37 countries (TTS 2006). Meanwhile, the ISN – which was less forthright in its anti-commercial stance than the TTS – held a 1981 Congress with nearly 2700 delegates participating, and close to 1800 abstracts submitted (Robinson and Richet 2001).

Regarding medical practice, transplantation was rapidly becoming "accepted as a routine treatment" (Chapman 2014); by now, over 50,000 total kidney transplants had been performed, and of the 6000 heart transplants performed worldwide by 1988, eighty percent occurred between 1984 and 1988 (Patrick et al. 1991; TTS 2006). These developments were augmented by the discovery of Cyclosporin A.[48] The "wonder drug" considerably improved transplantation survival rates, and ushered in a new chapter in transplantation (Harrison 1999).

Cyclosporin A's discovery, and concurrent improvements in medical practices, meant transplantation was finally a viable, effective treatment for those suffering with end-stage organ failure. At the same time, a small donor pool, and few voluntary post-mortem donations created a situation where demand for organs increased at a rate greatly exceeding supply. These factors and the conspicuous lack of comprehensive national or international laws or systems to address organ donation gave rise to the

[48]Cyclosporin A was discovered in medical trials during the late 1970s in Basel. Released for use during the 1980s, it had such a substantial, positive impact on survival for organ recipients that it quickly became the first line treatment for preventing rejection of transplanted organs (Heusler and Pletscher 2001: 299; Stahelin 1996).

commercialization of transplantation and the lucrative international organ trade (Fluss 1991). Throughout the early 1980s, newspapers in several countries regularly featured advertisements from desperate donors or recipients hoping to sell or buy organs,[49] while in India transplant tourism began to blossom (Chugh 2009: 762).

In 1983, hoping to capitalize on rising demand for organs, US physician H. Barry Jacobs attempted to establish the International Kidney Exchange. His proposal, which sought to broker organs from poor foreigners or impoverished Americans, was met with shock, dissent, and broad disapproval (Scheper-Hughes 2000; Wancata 2004: 213 ff.). Objections were adamant the scheme would "exploit or injure desperate organ sellers" (Gross 2008: 179), and that it was "immoral and unethical" (Sullivan 1983), while a former head of the American Association of Tissue Banks (AATB) derided the organ trade as "immensely damaging" (Engel 1983: A9; Gross 2008: 183).

Targeting Jacobs' proposal, future US Vice President and then Congressman Al Gore quickly introduced a national bill that would outlaw the organ trade. Subsequently, during US House of Representatives Hearings on transplantation in 1983, Dr. Robert Ettenger, president of the American Society of Transplant Physicians (ASTP), testified[50] that the organ trade "is morally offensive and ethically offensive," and that the possibility for "…coercion of the poor...is heart-rending and frightening" (House 1983A: 297). His testimony was supported by Dr. Edward N. Brandt, Jr., Assistant Secretary for Health at the US Department of Health and Human Services, who testified that the organ trade was an "immoral" activity, and that it "goes against the principles of medical ethics" (House

[49]Such as Brazil, the United States, and across Southeast Asia (Murray 1986). During US House of Representatives Hearings on transplantation in 1983, Dr. Capron testified, in regard to organs advertisements, that "[o]ne sees evidence of it from time to time – ads in newspapers offering organs, kidneys, corneas, things like this" (House 1983: 282).
[50]Dr. Ettenger's testimony was presented via written statement.

1983A: 151). As well, Dr. Bernard Towers, who at the time was co-director and Professor of Anatomy, Pediatrics and Psychiatry at the UCLA Program in Medicine, Law and Human Values, argued that the organ trade would lead to a dramatic increase in "the chances of transmission of disease" (House 1983A: 289). Dr. Towers further warned that the organ trade "would represent a major degradation for humankind," and that the organ trade should "constitute a Federal offense" (House 1983A: 289).

Testimonies from others within the epistemic community raised concerns that were similar to those brought up by Ettenger, Brandt, and Towers. Ultimately, the widespread outrage and opposition against Dr. Jacobs' proposal would contribute to the enactment of the USA's 1984 *National Organ Transplantation Act* (Joralemon 1995: 339). Amongst other stipulations, the Act made it "unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in…transplantation," and established criminal sanctions for violations (NOTA 1984: Title III).[51]

Overall, the USA's 1984 legislation and its associated hearings underscored the importance of the epistemic community. With the organ trade characterized by mystery and great uncertainty, national policy makers turned to the epistemic community,[52] delegating them with much responsibility. The epistemic community provided a wealth of "information and advice," while "illuminating the salient dimensions" of the organ trade, ultimately influencing the decisions and policies implemented by decision makers (Haas 1992: 4).

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[51]Here, "valuable consideration" refers to the buying or selling of organs (Joralemon 1995: 339; Rettig 1989: 205).
[52]Development of the bill and the subsequent Senate hearings included the participation of "all of the key people involved in the effort toward retrieving organs and transplanting organs," and had the "support of the transplant surgeons, the organ transplant coordinators, the organ procurement agencies, [and] the Kidney Foundation" (House 1984: 23).

Globally, during this juncture, the nascent organ trade was yet to be fully grasped and, at times, reports were sensationalized or difficult to verify (Scheper-Hughes 2001). Various media accounts described a variety of kidnapping and organ trafficking scenarios (Kelly 2013). In Latin America, rumors of the trafficking of children's organs, originating in colonial folklore, were especially abundant (Scheper-Hughes 1996). Honduran officials, Guatemalan authorities, and Nicaraguan sources even accused North Americans of engaging in the organ trade, while the USSR quickly disseminated the rumors internationally as part of its Cold War disinformation campaign (Morelli 1995; Raymond 1989).[53]

At about the same time, the medical community was becoming more aware of the issue, recognizing that the organ trade was flourishing and likely "increasing" (Chapman 2014; Land 1989: 175). In Egypt, disturbing reports about a thriving market in kidneys, involving medical misconduct and theft, began to circulate (Hamdy 2012), while across the Middle East, surgeons in the Gulf States began to note the prevalence of the organ trade after seeing their patients travel to India to purchase organs from indigent sellers (Panjabi 2010; Scheper-Hughes 2001). During a 3-day, TTS-sponsored international symposium on transplantation held in Alberta, Canada in 1985, author and philosopher Malcolm Muggeridge used his keynote address to warn that the "hacking out of bits of people's organs and putting them on the market is becoming an extraordinarily lucrative occupation. It's going to be a very big trade" (Marcus 1985: 314). Sir Peter Morris, TTS

[53]The USSR's rumors were disseminated via state-propaganda outlets *Pravda* and *Tess*. In 1987, responding to a request from the UN's Economic and Social Council resolution 1983/30, the UN Centre for Human Rights and the Secretary-General submitted a report on the sale of children. Notably, the report failed to uncover evidence of the sale of children for the purpose of organ transplantation. Subsequently (in both 1987 and 1988), the UN's Centre for Human Rights again invited governments, organizations, and special agencies to submit information regarding the issue; however, reports again failed to find any concrete evidence regarding the sale of children for transplantation (Kubota 1989: 17).

president in the mid-1980s, echoed Muggeridge's warnings by giving several speeches denouncing the fact that commercial transplantation was rearing its "ugly head" (TTS 2006). As rumors and reports persisted and dynamics of the organ trade remained ambiguous, angst and backlash surfaced, voluntary donations decreased further, and calls for greater understanding and a response began to rise (Fluss 1991; Morelli 1995; TTS 2006).

In 1985, the TTS built on its seminal 1970 statement, publishing a set of stringent guidelines for practice that emphatically condemned commercial transplantation (TTS 1985; WMA 1985).[54] The TTS stated that:

> "[n]o transplant surgeon or team shall be involved directly or indirectly in the buying or selling of organs or tissues, or in any transplant activity aimed at commercial gain to himself or an associated hospital or institute. Violation of these guidelines by any member of the Transplantation Society may be cause for expulsion from the society" (TTS 1985: 715).

The TTS received support from the World Medical Association (WMA), which, in addition to condemning the organ trade, also called on governments of all countries to take active steps to prevent it (Fluss 1991: 307; WMA 1985). With the international community's growing "concern" with the rise and "development" of the organ trade (WHO 1991A: 396), more initiatives soon followed. May 1987 saw the World Health Assembly (WHA) pass Resolution 40.13; the resolution asserted that the organ trade "is inconsistent with the most basic human values and contravenes the Universal Declaration of Human Rights," and called for "study" and research in order to develop appropriate guiding principles for transplantation (WHA 1987). That same year, the World Medical Assembly presented *The Declaration on Human Organ Transplantation* (WMA 1987), explicitly decrying "…the purchase and sale of human organs for transplantation" (WMA 1987). Notably, the World Medical Assembly's declaration also called on physicians to

[54]The World Medical Association's condemnation occurred at the thirty-seventh World Medical Assembly.

"protect the rights of both [donor and recipients]" (WMA 1987). Collectively, the various measures functioned to help frame transplantation and the organ trade as rights issues. Such a development was important, since representing an issue as a human rights problem can often help to "clarify" complex matters, attract broad attention, and encourage action (Keck and Sikkink 1998: 2-3; Reubi 2013: 116).[55]

Meanwhile, in the Arab world, host to many countries deeply involved within the organ trade, various initiatives were under way. In 1987, in Turkey, the Middle East Society for Organ Transplantation (MESOT) was established to "promote and encourage education, research, and cooperation in the field of organ transplantation…[and] create a scientific forum for discussion of all problems related to transplantation" (Shaheen 2009: 16). Composed of all the Arab countries, as well as Iran, Turkey, Pakistan, and the Central Asian countries,[56] MESOT organized regular meetings, symposia, and annual congresses to improve transplantation practices in the region.

The year also saw the twelfth session of the Council of Arab Ministers of Health draft *A Unified Arab Draft Law on Human Organ Transplants*.[57] The document sought to prohibit the organ trade and noted "that no specialist, knowing an organ to have been acquired by such means, may use it in a transplant operation" (Fluss 1991; WHO 1991A). Then in the following year, "the most detailed Fatwa[58] on organ transplantation" was proclaimed during the Fourth International Conference of Islamic Jurists, held in

[55]Keck and Sikkink (1998) show how a human rights frame was successful, whereas development or discrimination frames were unsuccessful, in generating attention and eliciting action regarding women's rights.
[56]Currently, MESOT has 23 member countries.
[57]The session was in Khartoum, Sudan.
[58]Generally, a Fatwa is an Islamic legal pronouncement issued by an expert or authority. A Fatwa by "a Grand Mufti is a decree and not a mere juridical opinion," as is "a Fatwa by a Conference of Jurists." However, each country's legislative parliament is responsible for endorsing or implementing it into law (Albar 2012: 819).

February (Albar 2012: 821). Inter alia, the Fatwa strongly "rejected any trading or trafficking of organs" (Albar 2012: 821).

With kidnapping and organ theft rumors swirling, in 1988 the European Parliament denounced alleged US involvement in the trade and adopted a motion "condemning the trade in organs of Third World babies" (Campion-Vincent 1997; Morelli 1995). US officials vehemently denied the charges, criticizing them as sensationalist, disinformation, unverifiable, and supported by the USSR (Beelman 1989; Raymond 1989) – yet rumors would persist well into the 1990s.

In January 1989, in a case that made headlines throughout the United Kingdom (UK), it was discovered that a British physician had been involved in selling kidneys from poor Turkish citizens. The scheme, based on fraudulent promises of employment, and involving exploitation and dishonesty (Choudry et al. 2003: 169), led to a national uproar. At a House of Commons committee that had convened to discuss the issue, then UK Health Minister Roger Freeman asserted, "the concept of organs being bought and sold for money is entirely unacceptable in a civilized society" (Barr 1989: 1). Rapidly responding to widespread alarm, "emotional outcry," societal "repugnance," and "public outrage" over the case, in July of 1989 the British Parliament enacted the *Human Organ Transplant Act*, banning the sale of human organs for transplant (Choudry et al. 2003: 169; Ghods 2009: 184; Shenfield and Steele 1995: 255; Trucco 1989).[59] Effectively, the scandal and the subsequent law, which "for the first time, [imposed restrictions] on transplant activity," had "entrenched the view that commercialization of organ

[59]Discussing the enactment of the British law, Sev Fluss, chief of health legislation for the WHO, suggested there had previously been a "gap," likely because no one thought anyone would engage in commercial transplantation activities (Trucco 1989). It is somewhat ironic that the legislation was enacted during the tenure of Prime Minister Margaret Thatcher, an ardent proponent of free market precepts.

procurement was something…unsavoury and to be avoided" (Dyer and McGuinness 2011: 129).

In 1989, the WHA would also issue Resolution 42.5, seeking to prevent the organ trade and calling for legislators to strengthen mechanisms to combat the organ trade (WHA 1989; Zielinski 1994). Dr. Ursula Lehr, then West Germany's Health Minister, ardently supported the resolution, noting that "the idea of business-minded brokers taking advantage of the financial distress of people in the Third World, buying their organs for a pittance and reselling them to wealthy patients in developed countries, is awful for me" (Beelman 1989: A6).

Overall, the 1980s saw the practice of transplantation "spread quickly," and by 1990, the practice was occurring in the Middle East, South America, and Africa – in addition to the wealthy, industrialized countries (Chapman 2014; Rothman 1998). Though clear understanding of the organ trade was yet lacking, there was recognition that countries were struggling to "…generate enough organs to meet the demand" (Beelman 1989: A6). The medical epistemic community was especially active in expanding discussion and disseminating analysis of transplantation and the organ trade, as specialists authored dozens of articles published in important journals, including The Lancet, Transplantation Proceedings, and the Journal of Health, Politics, Policy and Law (Scheper-Hughes 2000). With general awareness and discussion of the organ trade growing, there was also a mounting impetus to act.

The emerging momentum and rising stature of the epistemic community and its efforts against the organ trade were paralleled by an incremental, yet steady, growth in tangible measures undertaken by states. The decade witnessed transplantation "become

increasingly legislated and regulated, more formalized, and more organized" (Rodgers 1989: 837ff.). For example, in 1970 there were two countries with commercial legislation, a figure slowly trickling to fourteen by 1980. Yet, by the end of the 1980s – a decade of greater activity by the epistemic community – forty-six countries had passed legislation. Importantly, this progress helped lay the foundation and create impetus for efforts against the organ trade to expand and become truly globalized in the 1990s and new millennium.

~~A Spreading Issue and a Broader Response~~

In the 1990s, amidst continued technical and medical advances, sustained globalization, and rising levels of unemployment, corruption, and organized crime in the former USSR, the organ trade grew (Bilefsky 2012; Scheper-Hughes 2001; Viviano 2001). Early in the decade, the WHO observed that "the [organ trade] was reaching alarming proportions in the third world, especially as advanced medical technology proliferates" (Hedges 1991: A1), while Dr. Hugh Wood, then medical director of Singapore's National Kidney Foundation (SNKF), exclaimed that "[the organ trade] is big business" (Wallace 1992: 1). In Eastern Europe, as "[p]olitical and economic liberalization [and] internal and international militarism created new opportunity structures and daunting economic uncertainties," sex trafficking began to flourish, before shortly being joined by the trafficking of organs (Kligman and Limoncelli 2005: 119 ff.).

In response, and seeking to support implementation of World Health Assembly resolutions 40.13 (1987) and 42.5 (1989), the WHO convened a three-day international consultation in May 1990 (WHO 1990). Meetings involved presentations, updates, and reviews of progress or outstanding challenges within different countries or regions, and

were an opportunity for "a broad group of international experts to convey their views, opinions, and insights" on responses to the organ trade (WHO 1990: 2). The multidisciplinary group also discussed the possible development of a future global document featuring guiding principles. Effectively, the meeting embodied how international conferences serve as venues for policy or knowledge development for epistemic communities (Adler and Haas 1992; Haas 1992: 17). Furthermore, though a variety of complex issues were raised, a broad consensus emerged on the need to completely eliminate the global organ trade and promote "greater cooperation" between countries (WHO 1990: 8).

Following the developments of its 1990 consultation, the WHO released the *Guiding Principles on Human Organ Transplantation* in 1991. Incorporating many of the considerations raised during the three-day 1990 consultation (WHO 1990), the document reiterated the WHO's stance against the organ trade, and advised limiting organ procurement to voluntary, post-mortem donation or presumed consent systems (WHO Guide 1991). Additionally, the WHO's guiding principles were again linked to the increasingly visible and influential concepts of human rights and dignity. For example, attached commentary for guiding principle five notes that the organ trade should be prohibited since it exploits vulnerable groups and conveys the idea that some persons lack human dignity. Further, in promoting donation, states should always respect the intrinsic human dignity of donors (WHO Guide 1991).

Intriguingly, although the persistent kidnapping and "organ snatching" rumors still lacked substantiating evidence (Leventhal 1994), they elicited varying responses on both sides of the Atlantic. In Guatemala, rumors – attributed to political agitators looking

to unbalance the country's precarious socio-political position (Collinson 2007) – reached a tipping point in 1994. With a lack of appropriate understanding and no coordinated state response, there was a series of attacks on foreigners (Adams 1998).[60] By contrast, in Europe, the European Parliament passed the *Resolution on Prohibiting Trade in Transplant Organs* on September 14, 1993. The document stated:

> "…whereas there is evidence that fetuses, children and adults in some developing countries have been mutilated and others murdered with the aim of obtaining transplant organs for export to rich countries, [and]…having regard to the current existence of trafficking in fetuses, children and incapable adults who are used as organ providers…[As well] action [is] to be taken to put a stop to the mutilation and murder of fetuses, children and adults in developing countries for the purpose of providing transplant organs" (Leventhal 1994).

The resolution was partly influenced by the European "Report of the Committee on the Environment, Public Health and Consumer Protection on Prohibiting Trade in Transplant Organs" released months earlier. The report gave some credence to the rumors by paralleling doubts about the rumors to Holocaust denial (Leventhal 1994). Collectively, the European resolution and report offered some sensitive, nuanced, and informative discussion of the medical, ethical, and socio-economic factors within the organ trade (Leventhal 1994), helping to broaden understanding of the topic. Furthermore, the resolution promoted "European self-sufficiency of organs," thus targeting the important, yet frequently overlooked, "demand" side of transplant tourism (Price and Akveld 1998: 19).[61]

In September 1994, *The Resolution on Physicians' Conduct Concerning Human Organ Transplantation* was adopted at the forty-sixth WMA General Assembly. The resolution voiced "significant concern" about the continued reports of physicians engaged

[60]For example, on 4 April 1994, in the Guatemalan village of San Cristobal Verapaz, American June D. Weinstock was assaulted by a mob, suffering eight stab wounds, several broken limbs, and a fractured skull (Samper 2002: 1).
[61]Regarding organ donation and transplantation, "self-sufficiency" refers to the adequate and equitable provision of transplantation services and human organs to satisfy the transplantation needs of a given population, using resources obtained from within that population or provided through regional cooperation (Report 2011: 40).

in the organ trade, and the exploitation of vulnerable populations, including children (WMA 1994). Three years later, the CoE drafted the *Convention on Human Rights and Biomedicine*, explicitly seeking to protect the rights and dignity of humans in the application of medicine (CoE 1997). Not only was the convention a milestone in international bioethics[62] (Dommel and Alexander 1997), it also directly applied to the organ trade. Article 19 stipulates that "transplantation…may be carried out solely for…therapeutic benefit," while Article 21 outlines that "[t]he human body and its parts shall not…give rise to financial gain" (CoE 1997). Through its underlying focus on rights, and its applicability to the organ trade, the Convention helped affirm that the organ trade was an important human rights issue.

The year additionally saw the publication of the *Bellagio Task Force Report on Securing Bodily Integrity for the Socially Disadvantaged in Transplant Surgery*. The report was the culmination of a series of meetings convening in Bellagio, Italy. Attended by transplant surgeons, specialists, rights activists, and academicians, the meetings focused on a range of issues related to the organ trade. In addition to stipulating that the organ trade undermined the bodily integrity and human dignity of victims, the report asserted that there was a glaring need for an "organs watch" (i.e. an international committee) to investigate abuses by country and serve as a clearinghouse for information on transplantation practices (Scheper-Hughes 2000). Accordingly, in 1999, anthropologist Nancy Scheper-Hughes and several other researchers launched Organs Watch. The organization researches the global traffic in human organs, tracks the movements of people and organs around the globe, analyzes global inequities facilitating the organ trade, seeks to prevent rights abuses, and lobbies to change national and

[62]Representing the first binding treaty on bioethics.

international laws governing the trade (McBroom 1999; Organs Watch 1999). In tandem, the report and subsequent development of Organs Watch illustrate Haas' (1992) claim that "epistemic communities may contribute to the creation and maintenance of social institutions that guide international behavior" (Haas 1992: 4).

~~Global Hotspots: China, India, and Egypt~~

In the mid-1990s, a lurid, new dimension of the organ trade would be uncovered. Specifically, the Chinese government's use of organs procured from executed prisoners,[63] which provided important "foreign dollars," elicited international attention (Chelala 1998; Subcommittee 2001: 58; Tibell 2007).[64] While China's Ministry of Health had established the *Human Organ Transplant Ordinance* in 1995 to regulate the country's fledgling transplantation program and prohibit the organ trade (Jingwei, Yu-Hung, and Ching 2010: 6), pervasive corruption and a lack of enforcement saw the organ trade – specifically the use of executed prisoners – continue unabated. The US State Department raised the issue in bilateral discussions with China in 1996, while Human Rights Watch (HRW) and the Laogai Research Foundation documented available statistics and reports from Chinese informants (Scheper-Hughes 2000). As well, members of the Bellagio Task Force, including David Rothman and Tsuyoshi Awaya, visited China to investigate the allegations. Illustrating the rising prominence of the organ trade issue, Awaya later shared his findings at meetings with the US House Committee on International Relations in 1998

[63]Predominantly Falun Gong adherents.

[64]In addition to China and Taiwan, early reports alleged that Singapore had also, at one time, engaged in the procurement of organs from executed prisoners (Guttmann 1992; Westall et al. 2008). While the latter two countries ceased the practice, China continues to harvest organs from prisoners – and at an unprecedented rate (Gutmann 2014; Harrison 1999: 30; Jafar 2009; Scheper-Hughes 2000). In the Philippines, death row prisoners began donating organs in 1976 as part of a program to reduce overcrowding without resorting to widespread executions. Most donor inmates avoided execution and some were freed after spending a few more years in prison. However, after much negative media attention, the practice was stopped (Beelman 1989). A contemporary historical precedent for state use of organs from executed prisoners dates back to the 1940s in France, where the country's early transplantation program often used kidneys from "freshly guillotined prisoners" (Dhooper 1994: 4; Hakim and Papalois 2003: 3). Notably, at one time, the US also permitted prisoners to be organ donors (Davies 1969).

(Scheper-Hughes 2000). Nonetheless, the persistent and widespread international condemnations had little impact toward changing China's policies.

China's flagrant flouting of growing global norms and principles against the organ trade[65] contrasted starkly with how Taiwan and India respectively responded to the organ trade. Taiwan, like China, had used executed prisoners as a source for organs throughout the late 1980s and early 1990s (Chu 2014; Rothman et al. 1997). In just 1991, fourteen Taiwanese prisoners were executed, seeing a total of thirty-seven organs removed and used for transplants (Miller 1996: 220). Such practices placed the country under great international pressure, particularly from human rights and medical organizations. For example, "in the early 1990s, the British Medical Association challenged surgeons in Taiwan about [the] practice" (English et al. 2002: 54), while Amnesty International (AI) and various medical associations began to send letters to different branches of the Taiwanese government (AI 1992). Eventually, the pressure and notoriety would prove telling as Taiwan banned the practice in 1994 (Rothman et al. 1997; Subcommittee 2001: 58). In response to Taiwan's policy change, many local Taiwanese "began to travel to [mainland China] to purchase organs there" (Chu 2014).

Regarding India, during the 1980s and 1990s, it was shamefully derided as an "organs bazaar," since numerous foreigners flocked to the country in order to purchase organs from destitute locals (Chugh 2009: 762). Annually, over 1000 kidneys were allegedly sold to wealthy foreign recipients (Abouna et al. 1991: 164). Media coverage condemned the practice, often shaming doctors and featuring vivid exposés, and pressure

[65]The growing global norms against the organ trade were reflected in the fact that, by this time, nearly 100 countries had passed legislation banning the organ trade, numerous declarations, conventions, and agreements against the organ trade had been put forward, and that large, global organizations and professional societies (such as the WHO, UN, TTS, and others) held firm stances opposing the organ trade.

for a response grew (Chengappa 1990). During a 1989 global meeting on transplantation held in Canada,[66] international surgeons in attendance claimed that, "in India, the commerce in organs seems to be getting out of hand and there is need for it to be regulated immediately" (Chengappa 1990). While a few Indian surgeons were opposed to prohibitions on the organ trade,[67] many vociferously spoke out against the practice, referring to it as "immoral, ethically objectionable and socially degrading" (Wallace 1992).

Subsequently, in 1992, a bill banning the organ trade was proposed in the Indian Parliament, and the issue was referred to a select committee to investigate. Additionally, a series of conferences were conducted in multiple cities, raising awareness, sharing information, and promoting advocacy (De Cruz 2001: 591). After completing its investigation, the committee presented a detailed report that recommended banning the organ trade and – with India desperately hoping to improve its poor, flagging global reputation – the government finally took legislative action (Agarwal et al. 2012; Chengappa 1990; Kakodkar, Soin, and Nundy 2007). In June 1994, the Indian Parliament passed a bill banning the organ trade, and in the following month the *Transplantation of Human Organs Act* was officially enacted (Chugh 2009: 762).

India's law represented an important progressive step, and "[resonated] well with…international efforts" and initiatives to combat the organ trade (Agarwal et al. 2012: 113). Yet, it did not eliminate commercialism; while the "establishment

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[66]Cohosted by Health and Welfare Canada and The Transplantation Society, *The First International Congress on Ethics, Justice, and Commerce in Transplantation: A Global View* took place in Ottawa, Canada between 20-24 August 1989.

[67]Such as Dr. KC Reddy, who was an ardent advocate of commercial transplantation and had established a commercial transplant clinic. In stark contrast to the majority of reports regarding commercialism in India, Reddy's practice was allegedly "exemplary" and lacked many of the negative features traditionally associated with commercialism, such as coercion, lack of follow-up care, fraud, etc. (Cohen 2003: 664).

of…[India's law] resulted in a shift of [many] transplant tourists from India to Pakistan" (Budiani-Saberi and Karim 2009: 50; Naqvi 2014), the organ trade also continued to plague India itself (Budiani-Saberi et al. 2013; Naqvi 2014). In fact, sales allegedly continued "uninterrupted" (Singh and Singh 2008: 21), particularly to wealthy domestic and diaspora communities (Cohen 2001: 11). In the years following enactment of the law, "there were [sic] a spate of reports in the print and electronic media about illegal…transplantation in India and the possible exploitation of economically weaker sections of the society" (Agarwal et al. 2012: 111). Consequently, India later amended parts of its law, making "oversight and enforcement mechanisms more rigorous" (Epstein and Danovitch 2013: 495; Danovitch et al. 2013: 3).

Importantly, 1999 saw the beginning of research work conducted by the Coalition for Organ-Failure Solutions (COFS), an international health and human rights non-profit organization (featuring researchers and members of the medical community) that would be officially established in 2005. COFS' activities primarily focused on Egypt[68] – a notorious hotbed for organ trafficking. Egypt had long lacked legislation governing transplantation or outlawing the organ trade,[69] with the latter "evolving into an organized business [beginning] in 1987" (Hedges 1992: 1). The country soon became "the main locale for transplant tourism in the Middle East" (Epstein and Danovitch 2013: 495); up to ninety percent of transplants in Egypt were commercial[70] (Budiani-Saberi 2014; Budiani 2007: 126), and frequently involved "wealthy Persian Gulf Arabs" as recipients (Hedges 1992: 1).

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[68]COFS would later expand its work to India. As a small, non-profit organization, COFS contends with funding challenges (Budiani-Saberi 2014).
[69]This is even though Egypt's first kidney transplant took place in 1976 (Hamdy 2013).
[70]In the early 1990s, at least several hundred people per year were travelling to Egypt to participate in the organ trade (Hedges 1991: A1).

Throughout the 1980s and 1990s, vivid media reports exposed a thriving underground organ trade involving medical misconduct, organ theft, and exploitation (Hamdy 2012).[71] The UN's Office for the Coordination of Humanitarian Affairs (UNOCHA) observed that "hundreds and possibly thousands of poor Egyptians are selling their organs, mainly kidneys and liver, each year to pay off their debts and buy food, making Egypt the center for the illicit organ trade" (MESOT 2010: 8), while the WHO identified the country as one of five global organ trafficking "hot spots" (McGrath 2009).[72] As the issue festered, Dr. Hamdy Al-Sayed, head of Egypt's Doctors' Syndicate – the national authority that issues licenses for transplants in Egypt – lamented that "[i]t is very unfair that we have had no legislation regulating organ transplants so far. We are miles behind the world" (Budiani 2007: 137).

Beyond the glaring absence of legislation, other important contributing factors to Egypt's organ trade were the country's socio-religious influenced aversion to procuring organs from the dead, the large – and rising – prevalence of liver and kidney diseases,[73] the increasing privatization of healthcare, the rapidly growing gap between rich and poor, and the influx of poor, foreign migrants vulnerable to exploitation (Budiani-Saberi 2014; Hamdy 2012; Hedges 1991: A1).

Within this context, and in addition to its research work offering a greater understanding of local and regional dynamics of the organ trade, COFS provided awareness, outreach, advocacy, and victim support programs in Egypt – all of which had

[71]Later reports even suggested that vendors were selling their "organs on the street" (Pondrom 2008A: 1572).
[72]The other countries were China, Pakistan, Colombia, and the Philippines.
[73]In Egypt, "instances of cardiovascular, kidney, and liver disease have increased…in the past three decades" (Hamdy 2014: 380).

been "inadequate or wholly nonexistent" (Budiani-Saberi 2014; Budiani-Saberi and Mostafa 2010: 317 ff.).

Over the years, COFS mobilized with local civil society organizations and NGOs, engaged with the highly influential religious community (the *ulemma*), and worked with policymakers in efforts to "establish or improve national legal frameworks on transplantation" (Budiani-Saberi 2014; Budiani-Saberi and Mostafa 2010: 322). As well, COFS developed a partnership with the WHO, which had become focused on engendering change in Egypt. The combination of internal efforts (such as those through COFS) and external pressures (via COFS' global links, the WHO, and the TTS) saw Egyptian policymakers and officials begin to recognize the grave implications of the organ trade. For example, Egypt's Minister of Health, Dr. Hatem El-Gabaly, would note that the organ trade "not only [violates] the principles of equity, justice and respect for human dignity, but [it] also [causes] a general sentiment of fear and distrust in the whole conduct of organ transplantation" (TTS n.d.). In 2009, Dr. Mahmoud el-Meteini, head of one of Egypt's Liver Transplant Units, would solemnly declare, "things cannot continue like this" (McGrath 2009).

By 2010, Egypt finally implemented legislation which, according to Dr. Hussein Gezairy, the WHO's regional director for the Eastern Mediterranean, was "a significant step towards ending illegal organ trafficking" (Al Arabiya 2010). While the decisive factor in the law's enactment was the WHO – which had consistently offered "critical support" and exerted pressure – COFS' long-term advocacy and engagement work inside the country were also vital and not inconsequential (Budiani-Saberi 2014). Importantly, COFS served as a bridge – helping to introduce and diffuse global norms and approaches

towards the organ trade into Egyptian society and transplantation. This encouraged an "expansion and shift in the national approach and perspective towards commercialism," helping to broaden discussions and frameworks of the organ trade to consider the organ trade's range of harmful implications and human rights dynamics (Budiani-Saberi 2014). COFS, along with the WHO and TTS, also reflect how organizations – despite lacking the power to enforce laws and having generally limited economic resources – can "lobby, criticize, and convince" states to act on global norms and principles (Boli and Thomas 1997). Furthermore, as a collection of like-minded experts, doctors, and professionals, COFS, the WHO, and the TTS helped provide the Egyptian state with much-needed information and were able to influence (if not shape) the country's response and law (Haas 1992; Schofer 1999: 264).

Overall, the 1990s fed off momentum generated during the 1980s. The organ trade was capturing international attention and an array of organizations continued to actively seek ways to address the issue.[74] Importantly, these developments were mirrored by state responses, and the decade witnessed thirty countries pass legislation. The organ trade, and efforts to stem it, it appeared, were truly becoming globalized.

~~The New Millennium, and Refocusing on China~~

The new millennium, a period of much advocacy activity, mirrored past decades as the medical epistemic community remained central to the global community's awareness of and stance towards the organ trade. To begin, in 2000, the World Medical Association issued its *Statement on Human Organ Donation and Transplantation*,

[74]As well, 1997's ISN Congress would see the ISN also begin to come to terms with commercialism. After the presentation of a report detailing the use of executed prisoners and paid donors in kidney transplantation, the ISN concluded that commercialism was "complex," needed more understanding, and that it would be best to avoid an official position "at this time" (Robinson and Richet 2001).

reaffirming the outright rejection of the organ trade and claiming commercialization "…can be coercive and should be prohibited" (WMA 2000).[75]Additionally, the statement advised that states developing national strategies on transplantation should give due consideration to human rights (WMA 2000).

In 2000, the organ trade issue was also included in two important international documents. Specifically, the world's first truly international human trafficking agreement, *The Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children*, was adopted – prohibiting the trafficking of people for exploitation, including for the "the removal of organs" (UN Protocol 2000). Moreover, the *United Nation's Optional Protocol on the Rights of the Child on the Sale of Children, Child Prostitution, and Child Pornography* encouraged states to, inter alia, criminalize "the transfer of organs of the child for profit" (CRC Protocol 2000). That the organ trade was included in two highly publicized, much heralded global agreements – even somewhat indirectly – was an important forward step and reflected the international community's ongoing recognition of and concern toward the organ trade.[76]

In 2001, Dr. Wang Guoqi, a Chinese transplant doctor who had operated on "over 100 executed prisoners," added to Tsuyoshi Awaya's earlier analysis and further exposed the brutality of China's state-organized organ trade (Subcommittee 2001: 114). Testifying at the American Congressional Committee on Human Rights, Dr. Wang expressed "deep regret and remorse," before vividly detailing how prisoners were

[75]The document was later revised in 2006 to offer physicians a clearer blueprint for appropriate conduct and practice.
[76]Although important developments, a key shortcoming of the agreements was that they were not wholly targeted at the organ trade. For example, with the UN's Trafficking Protocol primarily focused on human trafficking for the purposes of general exploitation, analysts felt it failed to provide adequate attention to the organ trade, lacked specifying important aspects of the phenomenon, and only included organ removal as an addendum or afterthought (Gallagher 2011: 41; Geis and Brown 2008: 215). The medical community, which has long taken the lead on the issue of the global organ trade (Efrat 2013), especially thought that a more conclusive, detailed description was required. Consequently, in 2008, the Declaration of Istanbul was presented at the conclusion of the Summit on Organ Trafficking and Transplant Tourism, held in Istanbul, Turkey.

executed so their organs could be sold to wealthy recipients (Subcommittee 2001: 114). As "huge profits" rolled in, other military-run prisons and hospitals began "to design similar [execution and organ procurement] programs" (Subcommittee 2001: 121). These revelations caused incredulity and reignited widespread global condemnation. The British Transplantation Society (BTS) unreservedly denounced the practice, describing it as "lamentable," and Dr. Stephen Wigmore, chairman of the BTS' ethics committee stated that the practice was "a breach of human rights and…unacceptable" (Boseley 2006). The WHO, the World Medical Association, and the TTS – who had all unequivocally decried the practice on ethical and rights grounds – attempted to engage with Chinese doctors in order to end the practice (Nathanson 2001; Tibell 2007: 294). After years of vehement denial, China eventually "acknowledged" the existence of the program, but firmly reiterated that prisoners were "willing donors" (Gutmann 2014).

Subsequently, the WHO and TTS would work directly with China's Vice Minister of Health to support "positive developments" within Chinese transplantation while also "[maintaining] international pressure towards a change [in legislation]" (Tibell 2007: 294). During the inaugural World Transplant Congress (held in Boston in July 2006), the TTS developed special guidelines for its interactions with China. The guidelines stressed that China's "policies were considered unacceptable," that doctors "transplanting organs and tissues from executed prisoners cannot become members of TTS," and that "scientific presentations [using] data or samples from recipients of organs from executed prisoners cannot be accepted for presentation at TTS meetings" (Tibell 2007: 294).

At approximately the same time as the World Transplant Congress, a detailed report on organs harvesting in China garnered major international attention (Tibell 2007:

294). David Matas, an international human rights lawyer and David Kilgour, a former Member of Parliament (MP) and a former Secretary of State for the Asia Pacific region, investigated China's organ trade via interviews and examination of an array of secondary sources (DAFOH 2014; Tibell 2007). Amongst numerous charges, the report thoroughly detailed how organs were taken from unwilling prisoners, many of whom were Falun Gong practitioners. Though Chinese authorities denied the report outright,[77] the TTS formally requested that the UN's Commission for Human Rights investigate the charges further (Tibell 2007). To a certain extent, the report authored by Matas and Kilgour exemplifies how "information generated by an epistemic community may in fact create a [societal] shock," that can lead to pressure for action (Haas 1992: 14).

Eventually, in 2007, China passed the *Human Transplantation Act* banning the organ trade (Budiani-Saberi and Delmonico 2008). While it is difficult to estimate the exact influence exerted by the epistemic community – particularly the TTS – and the Matas and Kilgour report on the enactment of China's law, the legislation was widely heralded as an "important step forward" (Surman, Saidi, and Burke 2008: 197). In effect, however, the law was little more than a paper tiger, thus mirroring the country's 1995 ordinance. China continued to execute prisoners and procure organs at an unprecedented rate (DAFOH 2014; Gutmann 2014; Pondrom 2008),[78] and the global transplantation community returned to a policy of cooperative engagement with Chinese officials.

In 2013, Dr. Francis Delmonico[79] and other TTS representatives collaborated with Chinese officials to develop the *Hangzhou Resolution* – a legal framework for donation

[77]The fact the report was denied outright, rather than considered and then rebutted was, according to investigator Ethan Gutmann, a clear sign that much of it was true (Gutmann 2014).
[78]Estimates suggest that between 2000 and 2008, up to 65,000 Falun Gong practitioners were victims of China's state-organized organ harvesting program (Gutmann 2014).
[79]The president of the TTS.

and transplantation that also seeks to eliminate the organ trade (DAFOH 2014; Delmonico et al. 2014: 796). The resolution expresses that China's "dependence upon organs from executed prisoners must be terminated," and that China "[affirms] its commitment to prohibit transplant tourism and to shut down organ trafficking and transplant commercialism" (Jie-Fu et al. 2014: 123). Indicative of the global community's rapprochement policy toward China, Delmonico also used his presentation during the 2013 Chinese Transplant Congress to reiterate the TTS' desire for global cooperation and academic collaboration with Chinese professionals and transplant centers abiding by the *Hangzhou Resolution* (Edit 2013).

Notably, the role played by the TTS in the development of China's 2007 legislation and 2013 resolution exemplifies how global civil society actors not only function as global "watchdogs," but can also shape, encourage, and strengthen states' enactment and implementation of policies and laws (Bieri 2010: 189). Crucially, "these organizations usually have greater leeway than states to speak out and take action, and are, therefore, more able to push specific agendas" (Axworthy 2001: 5).

Yet, although China's 2007 legislation and 2013 resolution appear to indicate advancement, the country remains severely troubled by the organ trade, and it still "attracts transplant tourists…from [inter alia] the Gulf countries and Malaysia" (Epstein and Danovtich 2013: 495). In 2013, amidst China's ongoing state-organized organ trade, Doctors Against Forced Organ Harvesting (DAFOH) – a collection of doctors and researchers committed to fighting the organ trade – initiated an international petition that would later be presented to the United Nations High Commissioner for Human Rights, Navi Pillay. The petition, registering over 1.5 million signatures over a period of only

several months, called for an immediate end to forced organ harvesting from prisoners, particularly Falun Gong practitioners (DAFOH 2014; Sharif 2014). Subsequently, during an open forum held in San Francisco in July 2014, DAFOH presented evidence and testimony from researchers, advocates, and former prisoners detailing the structure and extent of China's organ trade, which it describes as "a crime against humanity" (DAFOH 2014; Sharif 2014).[80] Overall, DAFOH illustrates how epistemic communities can also function as sources of issue advocacy and promote a human rights agenda (Brysk 2013: 58; Haas 1989).

~~Sustaining International Attention~~

In 2002, the CoE built upon its 1997 convention by drafting the *Optional Protocol Concerning Transplantation of Organs and Tissues of Human Origin* (CoE 2002). Not only does the protocol "[stipulate] a minimum international standard of protection [within]…transplantation," it also "constitutes an important transnational instrument for preventing the trade in organs" (Buchler and Gachter 2011: 131). For example, the protocol's recommendations advocate specific actions to eliminate commercial transplantation practices (CoE 2002). In the following year, the WHO conducted the first *Global Consultation on Human Transplantation*, an international meeting bringing together thirty-seven clinicians, ethicists, social scientists, and government officials from twenty-three countries to discuss ethical, access, and safety issues in transplantation (Chapman 2014; WHO 2003). Held in Madrid, Spain, part of the framework for the

[80]The forum was convened parallel, although officially separate, from the WTC 2014; however, many doctors and professionals who attended the WTC also participated at the forum. During the forum, it was also alleged that in the lead up to the WTC 2014, dozens of research abstracts and articles from China were rejected due to inadequate assurances that results were not obtained through the use of organs from executed prisoners (DAFOH 2014).

In addition to DAFOH's efforts, civil society and activist groups attended the forum and the WTC, picketing and handing out information packets to raise awareness and condemn China's state-organized organ trade. This picketing mirrored that which occurred during the 2006 WTC in Boston (Surman, Saedi, and Burke 2008).

meetings involved reaffirming existing principles surrounding transplantation and also proposing possible additions. Regarding the latter, discussions noted the need for protecting privacy, improving transparency, and refocusing on "vigilance and safety" (Chapman 2014). These proposals would lead to 2004's WHA Resolution 57.18, which not only urged member states to undertake measures to protect vulnerable groups but, recognizing the global complexity of the organ trade, also called for international cooperation and coordination to eradicate it (Kelly 2013; WHA 2004A).

Meanwhile, at the UN, the General Assembly (UNGA) issued a resolution on *Preventing, Combatting, and Punishing Trafficking in Human Organs*, calling on states to outlaw and combat the organ trade (UN 2004). Further, it mandated the Secretary General to report on the extent of the organ trade and states' responses. Two years later, in 2006, the Secretary General presented an eagerly awaited report, the *Commission on Crime Prevention and Criminal Justice on Preventing, Combating and Punishing Trafficking in Human Organs* (ESC 2006). The report, based on a survey of forty UN member states, noted a continued increase in the organ trade, a dramatic failure by states to prioritize it, and an urgent need for more understanding. Notably, the report also linked the organ trade to socio-economic factors, such as unemployment, the lack of education, and poverty (ESC 2006; Kelly 2013; UN-Workshop 2008: 3). Collectively, the UN's resolution and report, combined with the global trafficking and children's rights agreements of 2000, served to broaden awareness of the organ trade, while again (re)affirming and "legitimizing" the organ trade as a global and rights issue.

With the organ trade increasingly recognized as global in nature, conversations and advocacy were also extending to more regions of the world. MESOT, founded in

Turkey in 1987, remained a strong, active, thriving organization well into the new millennium; it organized regular congresses and meetings, and regional members engaged in various cooperative, productive initiatives. In Latin America, the Punta Cana Group, established in 2001, was active in seeking to improve the system of donation and procurement throughout the region. A key feature of the group's work involved training coordinators across the region and promoting the elimination of commercial transplantation (Mizraji et al. 2007).

In 2004, the TTS also expanded its geographical regional affiliations to include six global regions (TTS 2006), while the following year saw the WHO's Pan American Health Organization emphasize the importance of legal prohibitions against the organ trade and recommend physicians not perform transplants with commercially procured organs (Panjabi 2010). Afterward, in July 2007 and January 2008, an Asian Task Force on Organ Trafficking, composed of medical experts retaining ties forged during prior global meetings, convened in Taiwan. The Task Force examined the parameters of the problem within Asia, brainstormed possible solutions, and presented a series of recommendations – especially aimed at regional governments – for prohibiting, preventing, and ending the organ trade in Asia (ATF 2008). In aggregate, the various international initiatives were illustrative of how efforts to combat the organ trade had assumed a globalized nature, and involved international coordination and cooperation.

In 2006, the inaugural World Transplant Congress was held in Boston, MA; described as the "largest international conference in the field of organ transplantation," the meeting featured over 6000 attendees and saw 4000 articles submitted (TTS 2014). The multidisciplinary gathering allowed participants – representing numerous countries

and organizations – to "share information, learn from a variety of perspectives, present or critique research, raise questions, receive training, collaborate on topics of mutual concern, and coordinate potential responses to issues" (Cosimi 2014). Importantly, the broad success of the WTC would be an important factor in the establishment of a future, second global congress, occurring in San Francisco in 2014 (Cosimi 2014).

An important development during the 2006 WTC was the revision of the TTS' membership statement, which underlined the importance that all donations and transplantations be performed within legal, ethical frameworks.[81] As well, the meeting established an official collaboration between the TTS and the WHO; the two groups had traditionally focused on working with states to create legal frameworks complying with TTS ethical standards and WHO guiding principles.

~~Important Recent Developments~~

While several guidelines, resolutions, and statements regarding the organ trade had previously been released by various organizations (e.g. UN, WHO, WMA, etc.), the epistemic community felt more was required to "put an end" to the "crime[s] against humanity and [the] abrogation of basic human rights" characterizing the organ trade (Danovitch 2008: 1089). A weakness of many existing agreements was that they did not specifically target the organ trade. For example, since the UN's Trafficking Protocol (2000) focused on human trafficking for the purposes of general exploitation, analysts felt it neglected to adequately address the organ trade, lacked specifying important aspects of the phenomenon, and only included "organ removal" in the definition as an addendum or afterthought (Gallagher 2011: 41; Geis and Brown 2008: 215).

As a result, members of the epistemic community proposed a guiding, regulatory

[81] The TTS would also develop special guidelines for China, stressing an ethical approach (Tibell 2007).

framework for the global transplantation profession, modeled on the World Medical Association's highly successful Declaration of Helsinki (Chapman 2014; Danovitch and Al-Mousawi 2012: 358; Efrat 2015: 23). Developed in June 1964, the Declaration of Helsinki is a statement of ethical principles that provides guidance to investigators and physicians involved in human research (Danovitch 2008: 1089), and it has become a central component of clinical research (Danovitch and Al-Mousawi 2012: 358).

After a period of planning, discussions, and preparation, the Summit on Organ Trafficking and Transplant Tourism took place in 2008. Held in Istanbul, Turkey – as a symbolic coming together of "East and West" – the Summit led to the Declaration of Istanbul (Chapman 2014).[82] The TTS, a longtime opponent of the organ trade, was joined by the ISN in sponsoring the event, while participants included members of scientific and medical bodies, government officials, social scientists, and ethicists from around the world (Chapman 2014; DoI 2013).

Crucially, the Declaration became the first document to define transplant tourism, trafficking, and commercialism (Morris and Knechtle 2014: 722). With clear definitions of complex, potentially vague processes, the Declaration thus helped create a common framework for broader understanding and cooperation (Delmonico 2009: 116), and it would receive over 100 endorsements from national and international professional organizations, and also government bodies (Danovitch et al. 2013). Additionally, it was directly linked to globally resonant human rights principles, thus providing further legitimacy (Baquero and Alberu 2011). For example, its preamble notes that the Declaration "builds on the principles of the Universal Declaration of Human Rights,"

[82]Several aspects of the Istanbul Declaration built on 2004's World Health Assembly resolution that sought protection for vulnerable groups.

while principle six of the Declaration notes that the organ trade violates principles of equity, justice and respect for human dignity (DoI 2013).

Although non-binding, the Declaration draws authority from the degree to which it is codified in or influences national or regional legislation and regulations (Danovitch and Al-Mousawi 2012: 358). Quite notably then, its effect has been fairly pronounced as, since its release, several countries have strengthened existing or created new laws (Ambagtsheer and Weimar 2011). For example, in the lead up to the Istanbul Declaration (DoI 2013), the Philippine government issued *Administrative Order (AO) 2008-0004*, strictly prohibiting transplant tourism (Gatarin 2014: 113),[83] while after the adoption of the Declaration, India amended parts of its *Transplantation of Human Organs Act*, making "oversight and enforcement mechanisms more rigorous" (Epstein and Danovitch 2013: 495; Danovitch et al. 2013: 3).

In Israel, "momentum in the buildup to and surrounding the Declaration was an important influence" in the implementation of the country's law banning the organ trade (Efrat 2014). As well, the Declaration served to exert "…large external pressures…" and encourage "radical reforms" in Japan (Fujita, Slingsby, and Akabayashi 2010: 25), while Spain made special mention of the Declaration when modifying its Penal Code in 2011 to stiffen sanctions for trafficking in organs or people for the purpose of organ removal (Danovitch et al. 2013: 3). Last, the Declaration and its "custodian group"[84] were "instrumental" in Qatar's 2010 implementation of the *Doha Donation Accord*, which

[83]Specifically, the order banned transplant tourism for the purposes of kidney transplantation, an issue which saw the WHO brand the Philippines "as one of the top five hotspots for organ trafficking in 2008" (Gatarin 2014: 113).
[84]The Declaration of Istanbul Custodian Group (DICG) was formed in 2010 under the joint sponsorship of the TTS and the ISN, and seeks to "maintain the Declaration as a current and effective document" (Danovitch and Al-Mousawi 2012: 358). The DICG carries out its mission through several task forces, which are overseen by an Executive Committee led by two elected Council co-Chairs (from the TTS and the ISN) and an appointed Executive Secretary (Danovitch and Al-Mousawi 2012).

sought to meet local transplantation needs while discouraging citizens from travelling abroad for commercial transplantation (Alkuwari et al. 2014; Qatar Health n.d.: 15).

In addition to influencing legislation, the Declaration may have decreased parts of the organ trade (Chan 2013; Danovitch et al. 2013: 3). For example, in the Philippines, regulations and government initiatives combating the organ trade, arising out of cooperation between the Declaration of Istanbul Custodian Group (DICG) and local organizations, led to "a dramatic fall in transplant tourism" (Danovtich and Al-Mousawi 2012: 360; Martin 2014: 6), while the establishment of new regulations in Qatar, directly supported by the DICG, saw "the number of [Qatari] patients travelling abroad…[decrease] by about 90 percent" (Qatar Health n.d. 15).[85]

Overall, the Declaration helped diffuse global norms about the organ trade, and served as a model or blueprint for how to appropriately implement rules, guidelines, and legislation regarding transplantation and commercialism (Meyer et al. 1997: 145). As well, the epistemic community served to "powerfully contribute to policy" (Jones 2006: 48), since beyond formulating the Declaration, it provided advice and exhortation, and influenced states in terms of policy adoption and implementation.

Following the Declaration, in 2009, the CoE and the UN conducted a joint study of the organ trade (UN/CoE 2009). The report emphasized the need for solutions tailored to the various forms of the organ trade, since they involved different actors and dynamics. Acknowledging deficiencies within prior resolutions and conventions (e.g. the UN's 2000 Trafficking Protocol), it claimed that true solutions required stronger political will and cooperation.

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[85] Additionally, following the establishment of Israel's law, which arose within the momentum in the build-up to the Declaration, the number of Israelis travelling abroad to purchase organs "plummeted" (Efrat 2015A: 28; Lavee et al. 2013).

2009 also saw the WHO add to its past contributions by publishing an extensive glossary on various aspects of the organ trade and transplantation. A response to the "lack of a globally recognized terminology and definitions on cell, tissue and organ donation and transplantation" (WHO 2009: 3), the glossary was instrumental in "[clarifying] communication in the [areas] of donation…[and] transplantation" (WHO 2009: 3). Furthermore, it helped provide a much-needed common framework for understanding the organ trade.

The year after the glossary's release, the sixty-third session of the World Health Assembly (2010) called on states to formulate and enforce policies and legislation on the organ trade and to oppose commercial transplantation (WHA 2010). The call was issued shortly after Pakistan – one of the world's organ trafficking hotspots – finally banned the organ trade (Efrat 2013A; Naqvi 2014).

Pakistan's thriving organ trade, often referred to as an "organs bazaar" (Pfeffer 2011: 636; Rai and Afzal 2007: 11), was a direct outgrowth of the country's long "lack of regulation [as well as] the presence of a large vulnerable rural population" (Bile et al. 2010: 160).[86] Countless reports and media articles documented how wealthy foreign recipients travelled to Pakistan to purchase organs from poor vendors, with 2000 to 4000 organs purchased annually (Akhtar 2008: 128; Naqvi et al. 2007: 934).[87] The situation was further exacerbated in the early 1990s; after India passed a law banning the organ trade in 1994, many "transplant tourists" simply headed to neighboring Pakistan (Budiani-Saberi and Karim 2009: 50; Naqvi 2014; Naqvi et al. 2007; Rizvi et al. 2010: 193).

[86]Some analysts also point to the influence of the worldwide web – particularly in terms of advertising – as being an instrumental factor in the growth of Pakistan's organ trade (Naqvi et al. 2007; Rizvi et al. 2010: 193).
[87]The annual turnover of the trade was estimated at approximately US $20m (Akhtar 2008).

Although several bills banning the organ trade were proposed in Pakistan during the 1990s and early 2000s, the lack of political support and a strong opposition lobby meant proposed bills were never translated into law (Bile et al. 2010; Efrat 2013).[88] Within the opposition, a strong group of private medical institutions and physicians actively lobbied against the enactment of prohibition laws on the grounds that transplant tourism aided the economy (Efrat 2013). Additionally, other advocates of commercialism and transplant tourism petitioned the Federal Shariat Court on the grounds that prohibition against payment constituted a hurdle to saving human lives (Noel and Martin 2009: 647).

With Pakistan's absence of legislation eliciting global shame, a number of domestic organizations and professional bodies, including the Sindh Institute of Urology and Transplantation (SIUT),[89] the Transplantation Society of Pakistan (TSP), the Pakistan Society of Nephrology (PSN), and the Pakistan Association of Urological Surgeons (PAUS), began to strongly advocate for a law denouncing the organ trade (Bile et al. 2010). Their efforts would receive a strong injection of support in 2004 when the WHO offered its formidable backing. Specifically, the WHO provided extensive technical advisory support to the Ministry of Health towards implementing ethical regulations, and strongly suggested the country ban the organ trade (Bile et al. 2010).

Subsequently, the Ministry of Health and SIUT began drafting a proposed law, while physicians and civil society organizations produced and distributed information, mobilized supporters, conducted public seminars and conferences, enlisted backing from

[88]A unique perspective of the challenges faced in Pakistan during efforts to implement legislation in Pakistan is presented by Iqbal Haider, former Senator, Federal Minister for Law, Justice, and Parliamentary Affairs, and Attorney Journal (Jafar 2009: 1152).

[89]SIUT is the "premier transplant institution" in Pakistan, and was instrumental in initiating the country's campaign against organ sale and transplant tourism (Rizvi et al. 2010: 194).

the media and religious leaders, and engaged with policymakers (Efrat 2013A). As well, the TTS, WHO, and SIUT collaborated on several highly publicized seminars and symposia to highlight the extent of the organ trade, delineate its consequences, and encourage the implementation of a law (MESOT 2010: 3; Rizvi et al. 2010: 194). The broad campaign efforts were combined with the development of a strong alliance between the Ministry of Health and the Standing Committee for Health of the National Assembly, and together they decisively countered the opposition lobby (Bile et al. 2010).

Ultimately, the multifaceted campaign – involving physicians, various health organizations and professional bodies, the media, civil society, the Ministry of Health, and external support and pressure (involving the WHO and the TTS) – culminated in the promulgation of Pakistan's historical law in 2010 (Bile et al. 2010).[90] While the law's promulgation saw many of "…the once-thriving kidney bazaars in Pakistan closed" (Pfeffer 2011: 636), enforcement and "implementation of the law [constitute] an uphill task" (Bile et al. 2010: 165), and the organ trade continues to thrive in Pakistan (Naqvi 2014).

Overall, the new millennium witnessed efforts against the organ trade consolidate past progress and expand to involve actors from around the world (Budiani-Saberi and Mostafa 2010). The organ trade was recognized as an international issue of utmost medical and human rights concern – receiving coverage in several prominent global agreements – and notably, the global community was active within many of the organ trade's global "hotspots." Importantly, states continued to undertake legislative action (albeit in a slower fashion) and by 2013, over 100 countries had passed legislation.

[90]Pakistan's law made history as it was passed unanimously by the two houses of legislature, the National Assembly and the Senate (MESOT 2010: 3).

~~Summary~~

Over the last several decades, transplantation "transformed from an experimental procedure performed in a handful of tertiary medical centers in highly developed western countries to a therapeutic intervention carried out in hospitals and clinics worldwide" (Rothman et al. 1997: 2739). As the practice spread in availability and developed into a viable option for end-stage organ failure, dramatic imbalances between organ supply and demand arose. Such an occurrence, combined with other processes, such as globalization, led to the organ trade, which expanded quickly to affect all regions and countries to some degree. With the international community failing to coordinate a response or organize initiatives to combat the issue, the global medical epistemic community performed an especially critical role. In addition to shaping, guiding, and influencing norms and approaches to transplantation, the epistemic community was instrumental in the development of various international, policy initiatives, resolutions, and statements (Brysk 2005: 103), and it helped position the organ trade as an issue of societal and global import. Further, it doggedly encouraged states to undertake actions – particularly implement legislation – to combat the organ trade.

It is noteworthy that the epistemic community's efforts against the organ trade incorporated the concepts of human rights, integrity, and dignity, which had rapidly diffused globally and become institutionalized in the period after WW-II (Elliot 2007; Ignatieff 2001). Possessing great global authority and offering legitimacy, structuring the actions of states and individuals, and providing a common framework for global disputes, the principles were useful in the epistemic community's response to the organ trade by spreading awareness and helping frame the trade as a significant, problematic issue.

Linking the organ trade to the global rights framework also helped to effectively "communicate [the] issue in a way that [engaged] the general public" (Gready 2004 24; Keck and Sikkink 1998: 2-3; 17).

Ultimately, with global awareness of the organ trade's prevalence and negative social, rights, and health ramifications growing, and as the variegated efforts by the epistemic community persisted, states increasingly began to respond. Thus, the broad, rapid diffusion of policy arose within the context of the global growth of human rights, the construction, elaboration, diffusion, and institutionalization of world cultural models delegitimizing commercialism and the organ trade, and the persistent advocacy activities of INGOs and the medical epistemic community.

Figure 2.1

Transplant Tourism Pathways - A*

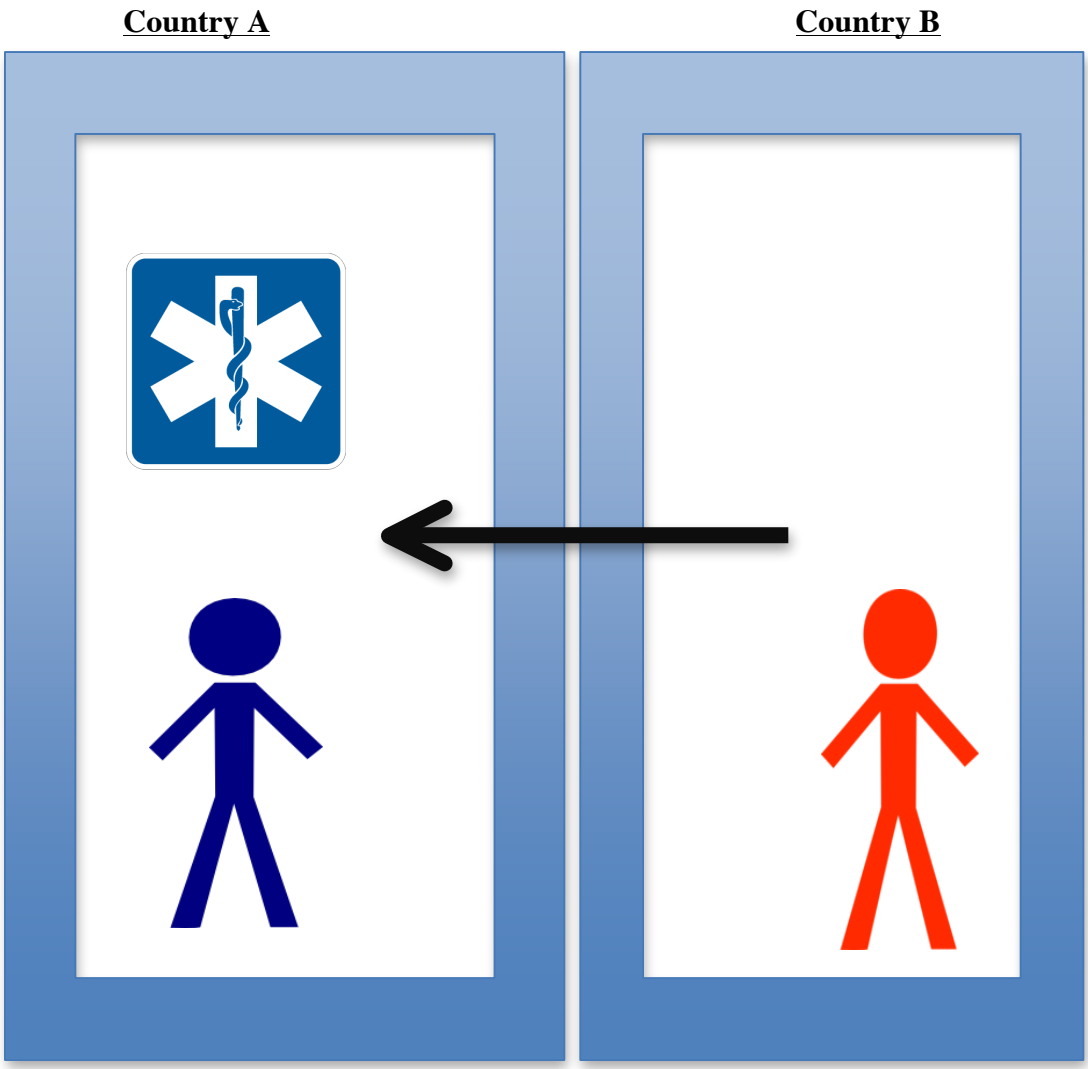

Figure 2.1 illustrates a type of transplant tourism where recipients travel to the donor's country of residence. This pathway is illustrated by the "organ bazaars" of Turkey, Pakistan, and India, where foreigners arrive from far-flung locales to purchase organs from destitute locals (Scheper-Hughes 2000).

Legend

Donor **Recipient** **Health Facility**

**Diagram is based on Budiani-Saberi and Delmonico (2003) and Shimazono (2007).*

Figure 2.2

Transplant Tourism Pathways - B*

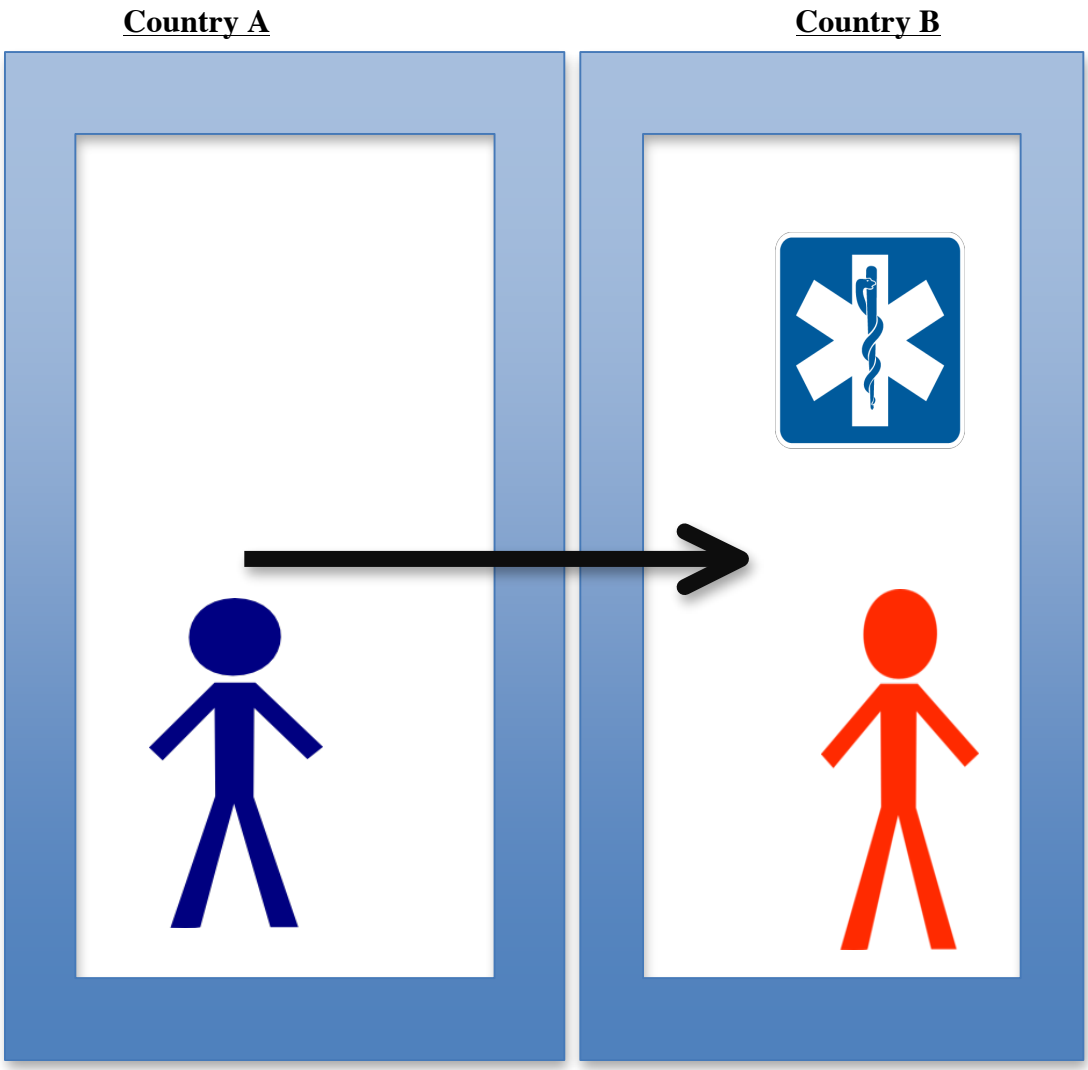

Figure 2.2 reflects the possibility that donors may travel to the country of recipients. In some cases, donors from Eastern Europe or other developing nations have been brought to the USA, while Nepalese have been taken to India (Jafar 2009; Scarpa 2006: 433; Shimazono 2007). The recent discovery of a major transplant network between Israel and Costa Rica found that some Costa Rican donors were taken to Israel to provide organs (Sack 2014).

Legend

Donor **Recipient** **Health Facility**

**Diagram is based on Budiani-Saberi and Delmonico (2003) and Shimazono (2007).*

Figure 2.3

Transplant Tourism Pathways - C*

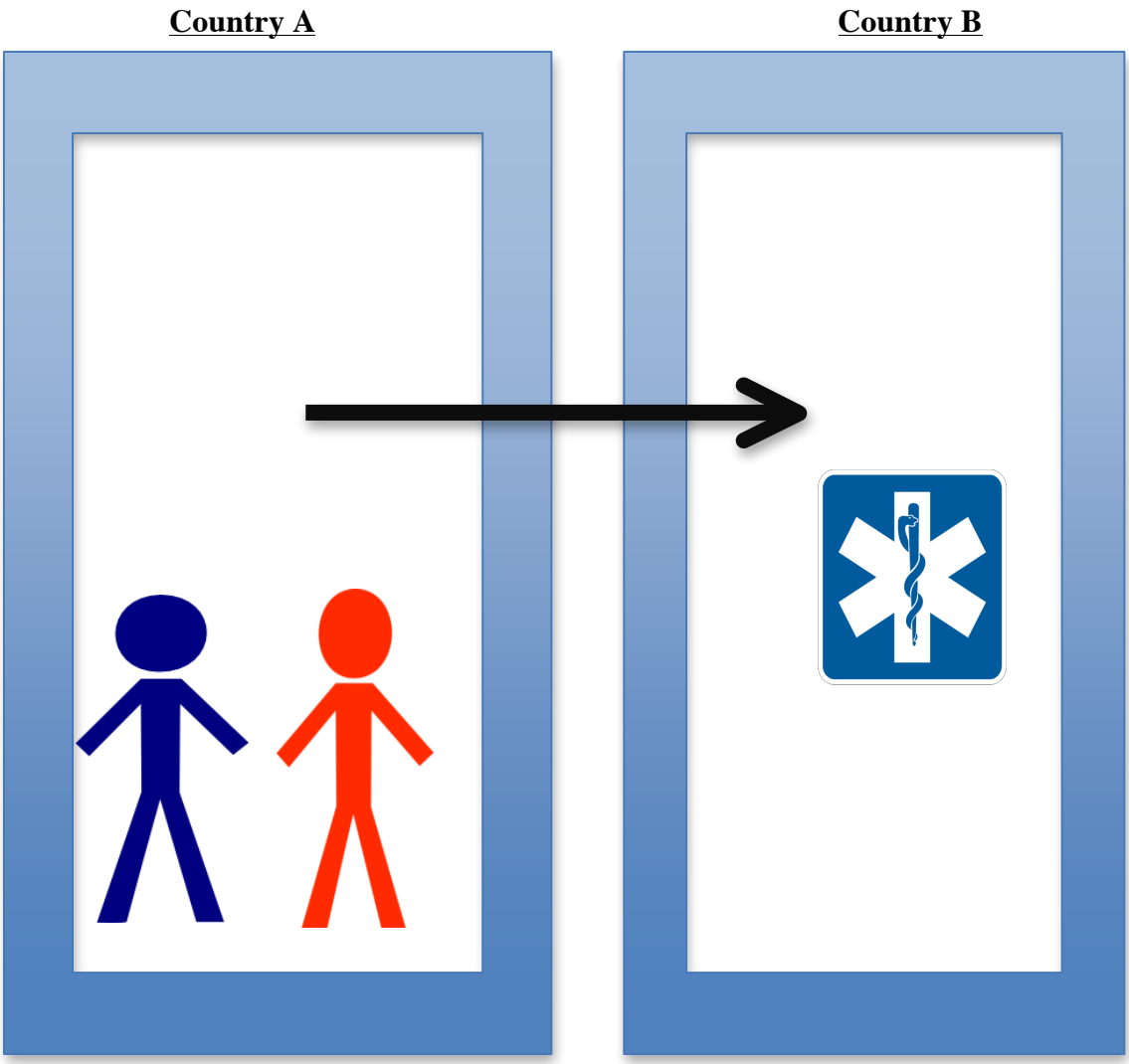

Figure 2.3 shows how both donors and recipients, as citizens of the same country, travel to another country for transplantation procedures. Often, this arrangement is made due to poor facilities and quality of care, high local costs, or stringent laws and regulations in the home country (Francis and Francis 2010; McHale 2013).

Legend

Donor **Recipient** **Health Facility**

**Diagram is based on Budiani-Saberi and Delmonico (2003) and Shimazono (2007).*

Figure 2.4

Transplant Tourism Pathways - D*

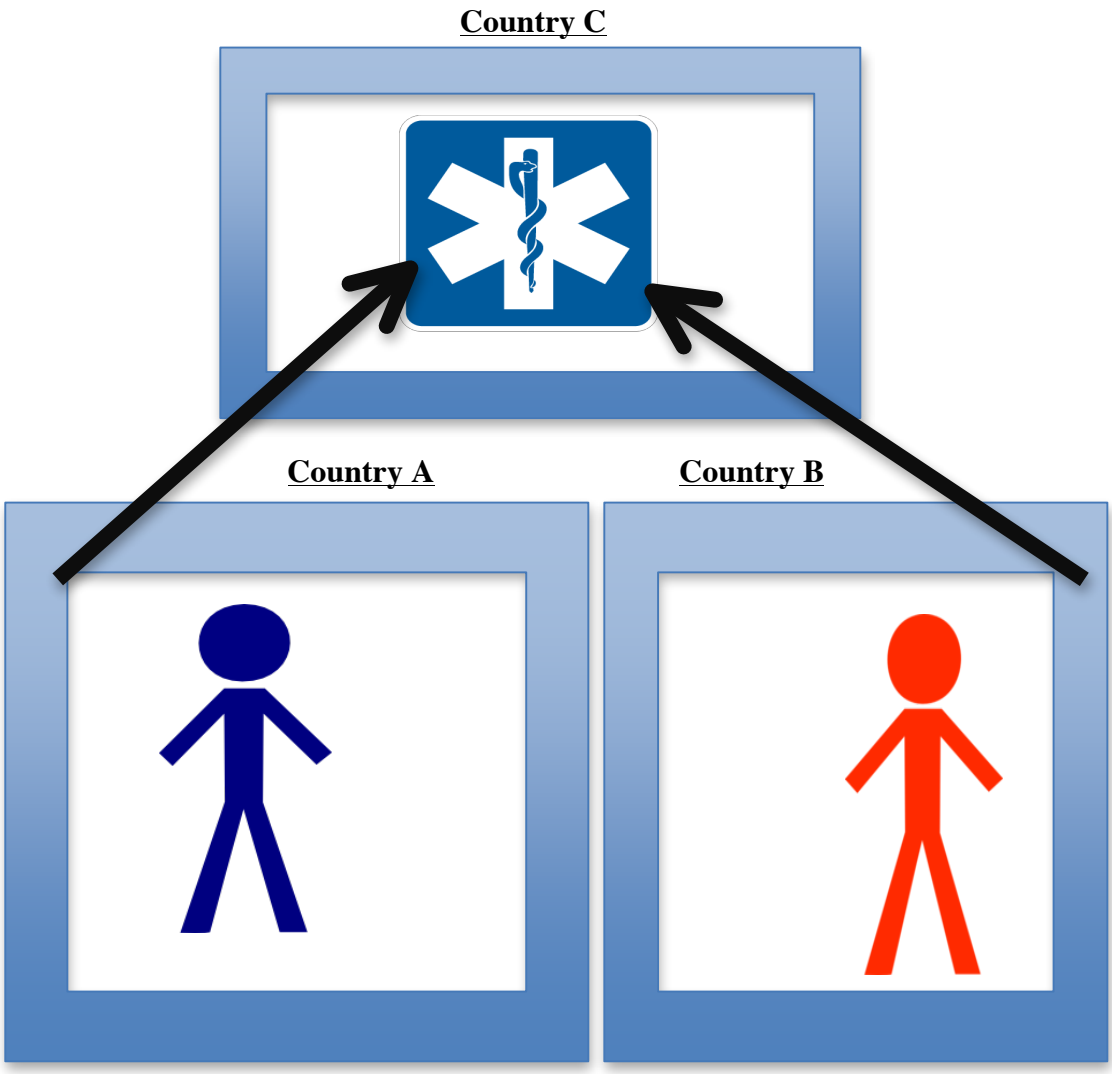

Figure 2.4 illustrates how organ recipients and donors, as citizens of separate countries, may travel to a third country where transplantation is performed. This category of transplant tourism has seen the growth of regional transplant hubs; for example, South Africa and Brazil have become favored centers for illicit transplantation activities, hosting donors from Eastern Europe and recipients from developed countries, such as Israel (Allain 2011; Shimazono 2007).

Legend

Donor **Recipient** **Health Facility**

**Diagram is based on Budiani-Saberi and Delmonico (2003) and Shimazono (2007).*

Table 2.1

Transplant Tourism Organizations and the Global Market in Organs*

Name of Organization	Country	Transplant Package
BEK-Transplant	China	Kidney (US$ 70 000) Liver (US$ 120 000) Pancreas (US$ 110 000) Kidney and Pancreas (US$ 160 000)
China International Transplantation Network Assistance Center	China	Kidney (US$ 65 000) Liver (US$ 130 000) Lung (US$ 150 000) Heart (US$ 130 000)
Yeson Healthcare Service Network	China	Kidney Liver Lung Heart
Aadil Hospital http://www.aadilhospital.com/index/html	Pakistan	Kidney
Masood Hospital	Pakistan	Kidney (US$ 14 000)
Renal Transplant Associates	Pakistan	Kidney (US$ 20 500)
Kidney Transplant Associates	Pakistan	-
Liver4You	Philippines	Kidney (US$ 85 000)
		***(Available as of March 21, 2007)**

Table 2.1 is adapted from Shimazono's (2007) analysis of the global organ trade.

Table 2.2

Significant Global Transplantation Events

Event	Location	Date
Statement of the Committee on Morals and Ethics of TTS	The Hague, Netherlands	September 10, 1970
TTS and Alberta Human Tissue Procurement Task Force International Symposium	Lake Louise, Canada	1985
TTS: Commercialization in Transplantation – The Problem and Some Guidelines for Practice		1985
World Medical Association: Statement on the Live Organ Trade	Brussels, Belgium	October 1985
World Health Assembly: Resolution 40.13 - Development of Guiding Principles for Human Organ Transplants	Geneva, Switzerland	May 4-15, 1987
World Medical Association: Declaration on Human Organ Transplantation	Madrid, Spain	October 1987
Council of Arab Ministers of Health: A Unified Arab Draft Law on Human Organ Transplants	Khartoum, Sudan	1987
World Health Assembly: Resolution 42.5 Preventing the Purchase and Sale of Human Organs	Geneva, Switzerland	8-19 May 1989
WHO: Informal Consultation Meeting on Organ Transplantation	Geneva, Switzerland	May 1990
WHO: Guiding Principles on Human Organ Transplantation	Geneva, Switzerland	May 13, 1991
European Parliament: Resolution on Prohibiting Trade in Transplant Organs		September 13, 1993
World Medical Association: Resolution on Physicians' Conduct Concerning Human Organ Transplantation	Stockholm, Sweden	September 1994
Council of Europe: Convention on Human Rights and Biomedicine	Oviedo, Spain	1997
Bellagio Task Force Report on Securing Bodily Integrity for the Socially Disadvantaged in Transplant Surgery		1997

Table 2.2 (continued)

Significant Global Transplantation Events

Event	Location	Date
Convention on the Rights of the Child: Optional Protocol on the Rights of the Child on the Sale of Children, Child Prostitution, and Child Pornography	New York, USA	May 25, 2000
World Medical Association: Statement on Human Organ Donation and Transplantation	Edinburgh, Scotland	October 2000
United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children	New York, USA	November 15, 2000
CoE Optional Protocol Concerning Transplantation of Organs and Tissues of Human Origin	Strasbourg, France	January 2002
WHO Global Consultation on Human Transplantation	Madrid, Spain	October 6-9, 2003
World Health Assembly: Resolution 57.18 – Resolution on Human Organ and Tissue Transplantation.	Geneva, Switzerland	May 22, 2004
United Nations ECOSOC Resolution 2004/22: Preventing, Combating and Punishing Trafficking in Human Organs	New York, USA	July 21, 2004
UN Report: Commission on Crime Prevention and Criminal Justice on Preventing, Combating and Punishing Trafficking in Human Organs	Vienna, Austria	2006
World Transplant Congress	Boston, USA	July 22-27, 2006
Declaration of Istanbul	Istanbul, Turkey	April 30, 2008
Joint Council of Europe/United Nations Study: Trafficking in Organs, Tissues and Cells and Trafficking in Human Beings for the Purpose of the Removal of Organs	Strasbourg, France	October 13, 2009
WHO: Global Glossary of Terms and Definitions on Donation and Transplantation.	Geneva, Switzerland	2009
Council of Europe: Convention against Trafficking in Human Organs	Strasbourg, France	July 9, 2014
World Transplant Congress	San Francisco, USA	July 26-31, 2014

Chapter Three: Literature Review & Theoretical Framework

Exploring Possible Factors Influencing Implementation of Legislation

~~Literature Review~~

The previous chapter presented a detailed history of the organ trade, and also examined the rise, activities, and influence of the global epistemic community. The epistemic community has been integral to responses to the global organ trade, particularly through guiding, developing, and encouraging an array of international policy initiatives, guidelines, resolutions, statements, and national regulations or laws. However, while the international organ trade has garnered increased attention and become an issue with broad global implications, few empirical analyses have been conducted, consequently leaving critical gaps in understanding of the phenomena (Shimazono 2007).[91] One topic requiring closer examination is legislation; since 1967, over 100 countries have passed legislation prohibiting commercialism within transplantation. What explains this rapid, global diffusion of legislation? What factors lead states to implement legislation? This chapter addresses these questions by considering international, comparative, social science theories. After briefly summarizing the general literature on transplantation legislation[92] – and noting areas requiring more understanding – the chapter utilizes rationalization/McDonaldization theory, world culture/world polity theory, neighboring country effects, and the concept of government effectiveness to develop hypotheses

[91]Organ trafficking is the least researched of all forms of human trafficking (Yea 2010: 359). Dr. David Rothman, part of the Bellagio Task Force that investigates the global organ trade, notes that while "we know a good deal about trafficking in women and children for sex[,] [we] are just beginning to learn about the trafficking in organs for transplantation" (Rothman 1998: 1).

[92]Most scholarly work on transplantation legislation is by lawyers, physicians, economists, and bioethicists (Efrat 2013; Howard 2007), while coverage within the social sciences has been sparse.

regarding important factors in the implementation of commercial transplantation legislation.

~~Various Dimensions of Transplantation Legislation~~

The long held standard legislative position on donation around the world has been that donors must be declared dead in order for vital organs to be removed (Potts and Evans 2005; Truog and Robinson 2003), and currently, the brain dead organ donor is the main source for solid organ transplants[93] (Weiss, Kotsch, Francuski, et al. 2007). Traditionally, medical declaration of death was a relative formality as patients could be declared dead when the heart stopped beating and individuals ceased breathing (Kerridge et al. 2002: 90).[94] However, with technological advancements – such as mechanical ventilation and modern intensive care – declaring death became more complex since it was possible to continue respiration and circulation even with the absence of detectable neurologic functioning. Although patients in this state are comatose,[95] they maintain most of the characteristics of living beings.[96] Significantly for transplantation, they also provide the possibility for procuring transplantable organs while organs are still perfused by a beating heart (Truog and Robinson 2003: 2391).[97]

While exciting many within the medical community, such developments also aroused debates about whether these types of donors were legally dead (Siminoff, Burant, and Youngner 2004: 219), and the ethicality of procuring organs from such donors (Sharp 1995: 362). Eventually, the medical community developed specific definitions of death –

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[93]Solid organs are the internal organs, and they have clearly defined anatomical boundaries; for example, the heart, liver, kidneys, and lungs (Lock 2002: 1).
[94]These functions ended over a very short period of time, yet not all at the same time; rather, the loss of one of them quickly led to the termination of the other two (Truog and Robinson 2003).
[95]That is, unreceptive and unresponsive.
[96]For example, these patients remain "warm [and] breathing…[with] a still-beating heart" (Steiner 2008: 366), and "…many of their organs still function properly" (Sharp 2000: 304).
[97]Notably, brain dead donors are "…the only source of hearts and livers and the major source of kidneys" (Youngner et al. 1989: 2205).

widely agreed as the permanent loss of integrative functions and consciousness without a chance of returning to meaningful life – that helped establish a common basis for transplantation using organs from brain dead donors (Kerridge et al. 2002: 90). These understandings of death have been widely accepted and incorporated into many transplantation guidelines and laws around the world (Lock 2002).[98]

Within the context of the global scarcity of organs (Abadie and Gay 2006; Delmonico 2009) – amongst the key factors fueling the organ trade (Shimazono 2007) – another focus within transplantation has been identifying mechanisms to increase donation. One oft-mentioned proposal is regulated monetary payment, which through "economic efficiency" could potentially increase donation rates, thus reducing dramatic shortages (Becker and Elías 2007; Spellman 2005). However, such proposals are "extremely simplistic, and ignore the ground realities" (Jha and Chugh 2006: 467), remain largely theoretically-based, lacking supporting evidence (de Castro 2003; Howard 2007: 31; Jarvis 1995), have "…not garnered widespread public or political support..," and currently there is only one instance of such a program being incorporated into a state's transplantation legislation (Harrison 1999: 31; Jarvis 1995).[99] Essentially, "disagreements concerning payments for organ donation revolve around empirical

[98]In Chapter One of Myanmar's *Body Organ Donation Law* (Myanmar 2004), death is defined as "…the condition of termination of all brain functions…" (Myanmar 2004). Similarly, Bulgaria's *Law on Transplantation of Organs, Tissues and Cells* outlines that the collection of organs, tissues, or cells from deceased human bodies can commence after "…all functions of the brain have stopped irreversibly…" (Bulgaria 2003: Chapter Three). Beyond guiding decisions for transplant centers, the concept of brain death also serves as a guide for intensive care units worldwide (Murray 1992: 1415).

[99]Iran implemented a paid transplant system in 1988 (Rizvi, Naqvi, Zafar, and Ahmed 2009), and to date remains the only country to have implemented such a system. Problematically, many paid donors in Iran have reported a lower quality of life and higher incidence of infections and disease post-transplant (Tong et al. 2014).

It is noteworthy that a 2002 study of twenty-four countries not only found that almost all had prohibitions against the organ trade, but also that none were moving *towards* a system allowing compensation or the organ trade (Pattinson 2008: 2, emphasis mine). In the US, in 1983, Dr. H. Barry Jacobs' proposal of a federal system that would "…pay for removal and transplant operations of organs…" was met with shock, dissent, and disapproval (Scheper-Hughes 2000; Wancata 2004: 213 ff.). The outrage against Dr. Jacobs' proposal, which sought to broker sales of organs from poor foreigners or impoverished Americans, contributed to the USA's 1984 *National Organ Transplantation Act* (Joralemon 1995: 339).

assumptions that need to be verified," since "sound ethical decisions require valid empirical assumptions" (de Castro 2003: 146). In the absence of evidence, "it is doubtful if economic efficiency arguments can persuade most governments to abandon legal prohibitions" (Mendoza 2010A: 264).

Quite problematically, payment for organs is described as "dangerous" and possibly "divisive" (Chapman 2014), and characterized as a "slippery slope" or a "Trojan horse" that will slowly destroy a society upon its entrance (Naqvi 2014). Furthermore, Dr. Luc Noel, a longtime WHO global transplant director, asserts that:

> "the idea that there can be a regulated market…is a myth; it will inevitably end up harming the most vulnerable. The sale and purchase of organs, even if regularized, can only lead to the increased use of brokers and even organized crime" (IOM 2008: 3).

Dr. Noel also claims that commercialism and the organ trade "violate [society's] shared humanity and basic dignity, harmfully impact [society's] sense of community and belonging, and infringe upon the rights of the poor or vulnerable" (Noel 2014).

Scholars have also closely examined donation consent policies – and their outcomes – within different countries. Importantly, with brain dead donors unable to grant consent and rates of donation from live donors remaining low – thus seeing desperate recipients turn to the organ trade – consent for donation has persisted as a prominent issue within the literature.

In determining consent for donation, states may employ opt-in (also referred to as explicit consent) or opt-out (presumed consent) systems. Opt-in systems require that individuals explicitly authorize organ removal after death by carrying a donor card or joining a national registry, whereas opt-out systems permit one's organs to be used for transplantation after death unless they formally objected during their lifetime (Rithalia et al. 2009). Opt-in systems are utilized by the United Kingdom (UK), the USA, Denmark,

and the Netherlands (amongst others), while several countries, including Spain, Austria, and Belgium, have introduced opt-out systems (Johnson and Goldstein 2003; Rithalia et al. 2009).[100]

In addition to opt-in and opt-out systems, recent years have seen the concept of mandated (prompted) choice garner interest. Mandated choice systems require "competent adults" to decide whether they wish to donate their organs after their death, and even allow individuals to specify which organs they would like to donate. Decisions are recorded at a particular point in one's life, such as the filing of a tax return or the renewal of a driver's license (Chouhan and Draper 2003: 158; Spellman 2005). Importantly, mandated choice systems are theorized as facilitating donation, since reports frequently find that though many individuals support organ donation, few follow through with formal procedures (Abadie and Gay 2006: 601; Kelly 2013: 1326 ff.; Morelli 2005: 921).[101]

Regarding outcomes, "…the medical literature [suggests] that donation rates are not markedly higher in [opt out] countries" (Abadie and Gay 2006: 607). However, studies of Europe have illustrated significantly higher donation rates in Belgium and Austria, which use opt-out systems, than in the UK, Germany, and the Netherlands, where opt-in systems persist (Davis 1999). Opt-out systems have also received support from Abadie and Gay's (2006) examination of twenty-two countries across ten years.

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[100]Although transplantation legislation is usually dichotomized as being based on either explicit consent (opt-in) or presumed consent (opt-out), in practice most countries permit some degree of involvement by relatives, allowing for, in instances, objections to or authorizations for donation (Abadie and Gay 2006: 599; English and Somerville 2003: 149).
[101]It is also proposed that mandated choice systems should involve "extensive public education [programs] so that when making their choices, people are sufficiently informed about both the need for choice and the implications of their decision" (Chouhan and Draper 2003: 158).

After controlling for a variety of potentially influential factors, they find that opt-out systems have a positive, sizeable effect on organ donation rates (Abadie and Gay 2006).

At the same time, however, while it is assumed that opt-out systems have a significantly positive impact on national organ donation rates, some studies have illustrated that differences between the systems are marginal and that opt-out systems do not necessarily guarantee higher donation rates than opt-in systems (Coppen et al. 2005). Furthermore, although acknowledging that opt-out systems improve donation rates, English (2007) points out that it "…is notoriously difficult to prove a causal relation between particular determinants and donation rates and to extrapolate from the experiences of one country to another" (English 2007: 1088).

Overall, continued attention to and analysis of organ donation policies and legislation should aid in identifying more effective organ donation systems, thus ultimately helping alleviate persistent, pervasive global organ scarcity.[102]

~~Social Sciences Perspectives~~

Within the social sciences, the organ trade has been mainly examined by anthropologists.[103] This view suggests that within the global capitalist market system, the North-South, East-West, core-periphery, socio-economic and political divide is manifested in the organ trade's routes and patterns (Moniruzzaman 2012: 70; Scheper-Hughes 2000). With core states facing chronic, drastic imbalances between local organ supply and quickly expanding demands from an aging population, commercial transplantation – witnessing organs procured from citizens of the periphery – ensures that

[102]According to Dr. Jeremy Chapman, "controlling or managing" the shortage of organs, rather than completely eliminating it, is a more realistic goal and probable outcome (Chapman 2014).
[103]Most notably, Nancy Scheper-Hughes (2000; 2001). Within sociology, there are few sociological analyses of the organ trade, and "empirical research is thin" (Healy 2006: 7).

core citizens receive organs, while periphery states are unable to meet local needs for organs (White et al. 2008: 233).

The vast polarization within the organ trade embodies: exploitation, which disproportionately strikes against the poor; violence, through coercion, fraud, or manipulation of the poor; and harm, in terms of physical, social, economic, and psychological effects on the poor (Moniruzzaman 2014; Moniruzzaman 2012: 71). Effectively, the organ trade "…both mirrors and reinforces the structural inequality embedded within capitalism…" as it disproportionately benefits Western, core citizens at the expense of poor citizens from the periphery (Gatarin 2014: 110; Harrison 1999: 22; Moniruzzaman 2012; Scheper-Hughes 2000).[104]

Within this context, anthropologists strongly oppose the organ trade. Legislation against the organ trade is deemed as "ethically and pragmatically necessary," (Moniruzzaman 2014), and to be effective it must be "carefully revised, clearly defined, and strictly enforced" (Moniruzzaman 2012A: 4). Further, for transplantation to be considered just and ethical, healthcare systems will have to be fair and equitable (Scheper-Hughes 2000: 210), while national laws and international guidelines must clearly outline and protect the rights of both organ recipients and donors, particularly those from vulnerable, marginalized populations (Budiani-Saberi 2014; Scheper-Hughes 2000: 210).[105] Crucially, such a "human-rights based approach" would "ensure that both the standards and the principles of human rights are integrated into all [transplantation] policies," and help guarantee that "[organ trade] victims would receive timely, adequate,

[104]Martin (2011) also notes that transplant tourism and the global organ trade are founded upon international socioeconomic inequities, while relying upon and exacerbating injustice (Martin 2011: 10).
[105]Notably, while many countries have implemented anti-human trafficking legislation, protectionist measures for victims of the organ trade are often lacking (Gatarin 2014: 123; Yea 2010).

and appropriate recovery and rehabilitation services" (Budiani-Saberi 2014). In addition, successfully combating the organ trade requires "…not only legal, but also political, economic and social solutions" to counteract the multidimensional, underlying, structural conditions forcing many victims into exploitation (Budiani-Saberi and Columb 2013: 904 ff.; Meyer 2006).

While the anthropological view outlines the need to protect victims, legal analysts have focused on the global dimensions of the organ trade and possible cooperative legal solutions. Specifically, since the organ trade constitutes a transnational issue, and is "difficult to control within any single jurisdiction," effective responses necessitate a "transnational criminal law approach" or an "international criminal law regime" (Francis and Francis 2010: 289; McGuinness and McHale 2013: 14).[106] As well, states must intensify their cooperation and coordination since a "better exchange of information between countries of origin and countries of destination" could help more effectively combat the organ trade (Sandor et al. 2013). Moreover, pressure and enforcement efforts should focus on both origin and destination countries (Naqvi 2014).

Finally, Efrat's (2013) investigation of recent laws passed in Pakistan and Israel presents a comparative analysis of the political dimensions of organ trade legislation. The two countries have long been global "hotspots" of organ trade activity; Pakistan has been described as an "organs bazaar" and key source of organs, while Israel, an "organ-importing"[107] country, has been "singled out for criticism by the international medical

[106]However, in searching for such a global solution, "we must [also] be cautious in imposing our beliefs and values on others, given our unique cultural and socio-political circumstances" (Evans 2008: 1091).
[107]Israel's organ donation rate has historically been one of the lowest in the Western world (Lavee et al. 2013), leading many Israelis to seek organs abroad via the global organ trade.

community" (Efrat 2013A: 82 ff.), and labeled as "…something of a pariah" (Scheper-Hughes 2001: 47).

Examining civil society's role in combating transnational issues – such as the organ trade – Efrat (2013) classifies Pakistan and Israel as "most likely" cases for civil society influence. Within both countries, physicians' persistent pressure on their respective governments resulted in the enactment of organ trade prohibitions. Physicians produced and distributed information, mobilized supporters, conducted public seminars and conferences, enlisted backing from the media, and engaged with policymakers. Ultimately, their efforts would prove crucial to the enactment of new laws by their respective governments (Efrat 2013).[108] Notably, even while enforcement has remained a challenge in Israel and Pakistan, both countries have allegedly experienced declines in organ trade activities.[109]

Overall, the existing literature on general transplantation legislation has examined the evolving approaches to and definitions of death, and scrutinized proposals to increase donation. As well, the literature – particularly anthropological perspectives – outlines global socio-economic facets of the organ trade, while additionally noting possible avenues for organ trade legislation. Last, Efrat's (2013) recent comparative work presents a useful examination of civil society's role in the implementation of commercial transplantation legislation. Although the existent literature has greatly improved understanding of the organ trade and various aspects of legislation, little attention has been devoted to examining specific legislation prohibiting the organ trade, thus leaving

[108]Efforts by the medical community in Israel fed off global momentum generated in the lead-up and surrounding the Istanbul Declaration (Efrat 2014).
[109]For example, after the Istanbul Declaration "…the once-thriving kidney bazaars in Pakistan [were] closed" (Pfeffer 2011: 636), while the number of Israelis traveling abroad for organs reduced dramatically (Efrat 2015: 19; Lavee et al. 2013).

the question of what factors account for variations in the implementation of legislation unanswered. Furthermore, previous work has neglected considering the longer term, historical trends in transplantation legislation, while analyses have often been in case study or small-N comparative format – thus overlooking potentially influential global or longitudinal factors and variance in transplantation legislation. Consequently, in addressing these areas, the next section utilizes international, comparative, social science theories to examine patterns of commercial transplantation legislation implementation in 127 countries from 1965-2012.

~~***Theoretical Framework***~~

~~*World Culture/World Polity Theory*~~

A potentially useful framework for understanding the likelihood of legislation is provided by world culture/world polity theory (WC/WPT). Arising in the 1970s, and generally attributed to John Meyer and collaborators from the Stanford school, WC/WPT challenges the accounts of global change provided by modernization theory and world systems theory. Specifically, it is a macro-phenomenological perspective that applies a "supralevel" analysis to global social change (Drori 2008; Meyer 2009). Pervasive and ever more ubiquitous (Boli 2005), world culture is evident in large-scale global spectacles, in travel, commerce, conflict, research, and even in ordinary, daily activities such as chess clubs or stamp collecting groups (Lechner and Boli 2005). Its foundational importance to global models of action, international human rights, the protection of the individual, and rational progress make it a particularly relevant applicatory tool to better understand global patterns of transplantation legislation.

WC/WPT seeks to explain global changes – especially the diffusion of Western inspired state political, economic, and structural policies or practices – as the consequence of emerging global institutions, international organizations, and an increasingly common world culture in the period following World War II (Finnemore 1996; Meyer, Boli, Thomas, and Ramirez 1997; Schofer, Hironaka, Frank, and Longhofer 2012). After first beginning to germinate in the nineteenth century, world culture's post-World War II accelerated growth was fueled by the dramatic increase in the activities of global civil society (Boli and Thomas 1999). Spreading outward from the West – in a diffusionary process via international nongovernmental organizations (INGOs), international governmental organizations (IGOs), other sub-state entities, and individuals – ideas of state sovereignty, individual rights, modernization, and rational progress became increasingly valid and universally legitimated (Boli and Thomas 1999; Reimann 2006).

Within WC/WPT analysis, the construction of the nation-state is especially relevant. Scholars utilizing this research paradigm describe nation-states as socially, historically, and culturally embedded within a global institutional framework (Meyer et al. 1997). By focusing on the global cultural construction of a variety of actors (such as states, organizations, associations, and individuals), world polity scholars account for the large degree of structural isomorphism occurring at a variety of levels throughout world society. As such, much research in this tradition emphasizes the diffusion of world cultural models that construct the legitimate forms of a number of globalizing institutions: the rationalization of science (Schofer 1999), the environmentalization of states' practices and policies (Frank, Hironaka, and Schofer 2000), the impact of post-

national citizenship on states implementation of dual citizenship legislation (Dahlin and Hironaka 2008), the global institutionalization of human rights (Elliott 2007), the impact of individualism on states' levels of professionalized psychology (Frank, Meyer, and Miyahara 1995), the development of women's suffrage (Ramirez, Soysal, and Shanahan 1997), and the global expansion of higher education (Schofer and Meyer 2005).

Rationalized world cultural models, variously institutionalized as cultural rules into the structure of international organizations, provide reality-defining scripts for actors of all kinds.[110] World culture generates norms and identities that are perceptible to various actors embedded within the global arena, and this resultantly influences their behaviors, actions, motivations, and goals.

INGOs are critical to WC/WPT processes. Carriers of world culture, INGOs provide a program for enactment at a variety of levels in the global system (e.g. transnational, international, state, organizational, etc.). They express world cultural principles and models and "employ limited resources to make rules, set standards, propagate principles, and represent 'humanity' vis-à-vis states and other actors" (Boli and Thomas 1999: 14). INGOs help describe and supply systems of meaning and purposes for action; accordingly, they hold a unique type of world cultural legitimacy and authority that warrants their global influence.

The legitimacy of INGOs inheres in the sort of authority they possess. Comprised of "responsible individuals acting collectively through rational procedures," INGOs "authorize" themselves to determine, monitor, and enforce the cultural rules deemed relevant to their organization (Boli and Thomas 1999: 37). INGOs thereby exert a "rational-voluntaristic" authority that is culturally grounded in the assumption that any

[110]That is, from individuals all the way up to states.

individual or group has the right to organize and freely exercise their rationality toward achieving some desired outcome (Boli and Thomas 1999).

Within world culture, high authority is also assigned to putatively disinterested professions and sciences, collectively noted as epistemic communities (Koenig and Dierkes 2011). Acting as "significant others" for states, organizations and individuals, epistemic communities are driving forces behind the elaboration of world cultural models and principles, particularly rationality and rational progress. Haas (1992) describes epistemic communities as "…a network of professionals with recognized expertise and competence in a particular domain and an authoritative claim to policy-relevant knowledge within that domain or issue-area" (Haas 1992: 3).

Comprised of specialists and technical experts from different countries, disciplines, and backgrounds, epistemic communities help define state interests and legitimate goals of action (Drori 2003), set global standards, participate in communication and socialization processes, promote new ideas or policy alternatives and innovations, create international institutions, and diffuse a particular world vision based on rationality, order, and science (Adler and Haas 1992; Haas 1989: 402). Diffusion occurs via epistemic communities' interactions within international organizations, scientific bodies, conferences, and publications. These transnational links allow epistemic communities to exert concurrent pressure on governments who redefine their own expectations, reach common understandings, and coordinate their behavior accordingly (Adler and Haas 1992).

Significantly, epistemic communities have helped shape state and international understanding, approaches, and policies toward a broad range of issues including, but not

limited to, disability rights (O'Brien 2003), pollution control (Haas 1989), nuclear arms control (Adler 1992), and the environment (Hjorth 1994).

For WC/WPT, the individual is a socio-cultural construction that has acquired an increasing amount of authority, sovereignty, and sacrality in recent centuries (Meyer, Boli, and Thomas 1987). Since WW-II, the expansion of international human rights has propounded a collection of norms and frames about the individual, which have evolved to now illustrate an increasing concern for, and elaboration of, the individual being regarded as sacred and inviolable (Drori 2003; Elliott 2007; Mathias 2013). In addition to becoming the locus of sacrality in modern society, the individual is seen as the fundamental social unit, endowed with inarguable legitimacy (Frank and Meyer 2002; Frank and McEneaney 1999; Frank, Meyer, and Miyahara 1995; Mathias 2013). These perspectives of the sacred, inviolable individual exhibit universalism, accruing to all individuals, regardless of citizenship, residency, background, sex, age, religion, or race (Soysal 1994). Importantly, these perspectives have become institutionalized internationally through the diffusion of international human rights (Ignatieff 2001).

Overall, the WC/WPT framework provides several propositions regarding global patterns of transplantation legislation. For WC/WPT, the world polity and the constituent world culture both generate and propagate models of and scripts for legitimacy and rationality that states enact and follow. One specific world cultural model for states – in constant evolution since the end of WW-II – involves the legitimate, humane treatment of the individual (Elliott 2007). The rapid growth and diffusion of an international human rights regime – constituting human rights based INGOs, human rights instruments, and international human rights conferences – has helped to globalize the model for respect of

the individual. The global human rights regime not only institutionalizes the individual's inherent right to life and sanctity of person, it also helps to establish individual sacrality globally, and thus delegitimizes the organ trade, which is viewed as violating human rights and basic human dignity (Cherry 2005: 129; Glaser 2005). Consequently, this understanding leads to several relatively straightforward hypotheses.

First, according to WC/WPT, international human rights instruments promote respect for and sacralization of the individual, while explicitly outlining models for how states approach and treat individuals (Elliott 2007). Various human rights treaty norms form the basis of and are "mirrored in [many states'] bills [and charters] of rights" and there are "causal links between [human rights] treaties and…constitutional human rights provisions" (Heyns and Viljoen 2001: 500). Further, there are "numerous instances" of legislation or policy development, enactment, and reform "prompted by" states' ratifications of human rights treaties (Heyns and Viljoen 2001: 501 ff.). For example, ratification of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) has led to policy changes regarding gender equality and the incorporation of gender equality clauses into the constitutions or national laws of many countries (Platiner 1995: 1260). In the US, the Senate's ratification of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) in 1994 was quickly followed by the US Congress' enactment of a federal anti-torture statute (Sikkink 2013: 147).

With the organ trade seen as violating human rights and dignity (Cherry 2005: 129; DoI 2013; Noel 2014; Rothman et al. 1997), the expectation is that states ratifying

more international human rights instruments are more likely to implement commercial transplantation legislation.

Second, INGOs diffuse world culture, expressing world society principles and establishing global models for enactment.[111] Frank, Longhofer, and Schofer (2007) show that domestic environmental policy changes in Asia are strongly predicted by ties to world society and INGOs, while Schofer and Meyer (2005) find that nations more densely linked to the world polity experienced greater and more rapid expansions in higher education enrolments, conforming to highly rationalized models of education and society.

In terms of the organ trade, as world cultural models of the respect for and sacralization of the individual diffuse globally via world society and INGOs, a state's ties to world society – understood as the number of INGOs in which residents of a country are members – should impact its likelihood of implementing commercial transplantation legislation. Simply, states with more connections to world society should be more likely to implement commercial transplantation legislation.

In addition to these human rights- and sacrality-based arguments of WC/WPT, with the lack of a state "taking the lead" or multilateral cooperation in combating the international organ trade (Efrat 2013: 768),[112] the role of non-state actors, in this case medical epistemic communities, has become magnified. Unlike the rise and consolidation of the global anti-human trafficking movement, which has been influenced by the direct leadership, support, pressure, and initiatives undertaken by the US State Department

[111]Recall that states implement global models in enactment of norms established by the world polity (Frank, Hironaka, and Schofer 2000; Meyer et al. 1997).
[112]This is in stark contrast to the global anti-human trafficking movement. US concern with the issue of human trafficking served as a catalyst for international action and agreements, and the UN Trafficking Protocol was "…clearly an American policy initiative" (DeStefano 2008: xx).

(Chuang 2006; Lloyd, Simmons, Stewart 2012), the global movement combating the organ trade was "initiated", highly influenced, and guided by doctors, surgeons, practitioners, and health researchers (Ezeilo 2013: 3).[113] Collectively, they have offered states guidance and scientific expertise regarding responses to the organ trade (Danovitch et al. 2013: 2). They have also arranged conferences, organized assemblies, helped formulate declarations and guidelines, and promoted recommendations, while retaining a firm stance against commercial transplantation.

Beyond serving as sources of information or innovation (Suarez 2007), medical epistemic communities have functioned as receptor sites – social structures with the capacity to receive, decode, and transmit information from world society to nation-states (Frank, Hironaka, Schofer 2000: 103). Doctors, surgeons, practitioners, and researchers diffuse models prohibiting commercial transplantation, provide awareness of the organ trade, and encourage ethical practices within their home states. For example, the Malaysian Society of Transplantation (MST) works to "[e]nsure and maintain ethical standards in the field of transplantation in Malaysia" (MST 2009), while the Transplantation Society of Pakistan aims to "…promote and encourage education…of transplantation…" (TSP 2009).

Significantly, epistemic communities press state authorities and policy makers to adopt or modify legislation and support activities facilitating the goals of global statements, resolutions, and guidelines. In 2012, the Coalition for Organ Failure Solutions (COFS) – a non-profit organization concerned with combating the global organ trade – encouraged "…the U.S. Congress to incorporate human trafficking for organ removal

[113]In fact, during his briefing at the Tom Lantos Human Rights Commission, Dr. Monir Moniruzzaman, an investigator of the organ trade in Southeast Asia, recommended that the US State Department play a more "active role" in combating the global organ trade (Moniruzzaman 2012: 4).

under the rubric of the Trafficking Victims Protection Act" (Danovitch et al. 2013: 3). Additionally, Pakistan's *Transplantation of Human Organs and Tissues Act* (2010) and Israel's *Organ Transplantation Law* (2008) were largely the outcome of persistent efforts by small, cohesive groups of physicians who pushed for legislation (Efrat 2013), while in Britain, the British Transplantation Society (BTS) has been "increasingly involved in national policy making" (BTS 2014).[114] As well, experts affiliated with the global TTS "played major roles" in the development of recent laws and regulations in China and India, amongst other countries (Delmonico 2009: 117).[115]

In this context, medical epistemic communities, acting as receptor sites that transmit global models and promote ethical practices and conduct,[116]are key in states' implementation of commercial transplantation legislation. Specifically, states with more physicians are more likely to implement commercial transplantation legislation.

~~Summary of WC/WPT Hypotheses~~

Hypothesis 1: *States ratifying more international human rights instruments are more likely to implement commercial transplantation legislation.*

Hypothesis 2: *States with more ties to world society are more likely to implement commercial transplantation legislation*.

Hypothesis 3: *States with more physicians – functioning as receptor sites – are more likely to implement commercial transplantation legislation.*

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[114]The most decisive influence on Israel's *Organ Transplantation Law* (2008) was the combined pressure of Israeli physicians and the global medical community. Employing ethical and rights frames and detailing the negative effects of the organ trade, these groups made a strong case for implementing trafficking legislation (Efrat 2014; Efrat 2013A: 98).

[115]One example is how, in response to China's persisting organ trade, the WHO and TTS worked closely with the country's Vice Minister of Health to promote "positive developments" while also "[maintaining] international pressure towards a change [in legislation]" (Tibell 2007: 294). Even after the State Council of China approved the *Human Organ Transplantation Regulation* in 2007, and with China's organ trade showing little cessation, the TTS continued to work with the government to develop the *Hangzhou Resolution*, which offers a legal framework for the oversight of donation and transplantation, and seeks to eliminate the organ trade (Delmonico et al. 2014: 796). Another example of the epistemic community's influence is the development of transplantation in Fiji. As the country began establishing a transplantation program, it consulted with the TTS' Dr. Jeremy Chapman. Chapman advised the Fijian government on all aspects of a possible transplantation law and outlined important factors for consideration – including the need to consider the issue of commercialism (Chapman 2014).

[116]Recall that states implement global models in enactment of norms established by the world polity (Frank, Hironaka, and Schofer 2000; Meyer et al. 1997).

~~Rationalization/McDonaldization~~

Though traditionally the source of moral objections or regarded as a violation of personal, social and community meanings for bodies (Seale, Cavers, and Dixon-Woods 2006), the organ trade has only recently become technically illegal in many countries (see Figure 1.1 on page 9). This process, which has prohibited the organ trade yet permitted non-transactional transplantation, can be analyzed through Ritzer's (1996; 1998) understanding of McDonaldization/rationalization theory.

In the social sciences, the topic of rationality is generally associated with Max Weber, who argued that the process of rationalization would lead to a transformation of social life (Gerth and Mills 1972; Lippmann and Aldrich 2003). Overcoming society's reliance on tradition, emotion, or intuition, rationalization would lead to new practices that were more efficient and technically superior.

Although Weber discussed several types of rationality,[117] formal rationality – the rational calculation of means to ends based on universally applied rules, regulations, and laws (Kalberg 1980) – was distinguished for its increasingly dominant role within the modern, Western, industrialized world (Ritzer 1998A). The epitome of formal rationality was the bureaucracy; it was the most effective way to arrange modern social organizations due to its attention to efficiency, order, and systematic practices (Lippmann and Aldrich 2003; Ritzer 1998A).

Ritzer extends Weber's discussion of rationality and bureaucracy by suggesting that rationalization has spread to become more apparent and firmly entrenched within almost all facets of contemporary life and society (Ritzer 1998A). Paralleling Weber,

[117]Weber's other types of rationality were practical, theoretical, and substantive. While these forms were apparent throughout history and across various locales, formal rationality was a unique feature of the modern, Western world. Its rise accounted for the distinctive development of the West (Ritzer 1998A).

Ritzer notes that modernity is associated with an expansion in formal rationality whereby "the search by people for the optimum means to a given end is shaped by rules, regulations, and larger social structures" (Ritzer 1993: 19). In contrast to ends-means rationality, where individuals draw on their own resources or consider their own specific circumstances to find the best means to their ends, under formal rationality a host of institutionally-produced "rules, regulations, and structures . . . either predetermine or help [individuals] discover the optimum methods" (Ritzer 1993: 19).

However, where Weber distinguished bureaucracies as the highest form of formal rationality, Ritzer suggests that they have been superseded by contemporary fast-food organizations (Ritzer 1998A). Specifically, Ritzer suggests that formal rationality is best illustrated by fast-food chains relying on bureaucratic institutions, scientific management, and assembly line processes (Ritzer 1996: 292; Ritzer 1998). Utilizing the term "McDonaldization" – since the McDonald's global fast-food network perfectly embodies this modern rationality (Ritzer 1996: 292) – Ritzer points out that McDonaldization has extended its influence into "more and more…areas of the world" (Ritzer 1996: 292).

Ritzer identified four elements that are integral to modern rationalization.[118] Efficiency refers to the optimal means to an end, for accomplishing a task, or for getting from one point to another (Ritzer 1996). In terms of McDonald's restaurants, efficiency is the fastest way to go from being hungry to being satiated. Another element, calculability, denotes the emphasis on the calculable, quantifiable aspects of products and services, rather than subjective ones (Ritzer 1996).[119] Predictability encompasses standardized and

[118]Although Ritzer actually discusses five elements – efficiency, predictability, calculability, control, and replacement of humans with technology – the latter two are often conflated into one category (Ritzer 1998A).
[119]Emphasizing quantity does not suggest that quality is unimportant or insignificant; rather, it leads to the sense that quality is equal to certain, usually large, quantities of things (Ritzer 1998A).

uniform services, providing an assurance that products and services are the same across time or location (Ritzer 1996). Regarding McDonald's and globalization, this facet is exemplified by the nearly identical nature of menu, service, and choices across the world, although slight variations occur.[120] Finally, control, which can involve the utilization of non-human technology, decreases unpredictability, errors, and uncertainty of employees, and also serves to control customers (Ritzer 1996).

Turning to the organ trade, recall that it is "violent, dangerous, ineffective, and inefficient" (Moniruzzaman 2014), with high rates of organ rejection, greater incidences of various contractible diseases, threats of maiming or death, and an array of potential public health implications (Anker and Feeley 2012; Francis and Francis 2010; Gill 2014; Jafar 2009; Scheper-Hughes 2000; Shelley 2010).

Goyal et al.'s (2002) survey of over 300 donors in India found that forty-eight percent reported a three-to-four point decline in health on a five-point Likert scale, while Khamash and Gaston (2000) suggest the organ trade leads to a deterioration of health status for both recipients and donors. Ethnographic work in Bangladesh has found that "…sellers typically experience pain, weakness, weight loss, and frequent illness after selling their kidneys" (Moniruzzaman 2014; Moniruzzamann 2012: 81). Notably, Ivanovski et al.'s (2005) consideration of long-term outcomes for recipients who travelled to India from the Balkans found a large proportion died within the first year after transplant. Beyond its considerable individual health risks, the organ trade is also a significant societal or public health issue since individuals are exposed to "diseased organs or organs that are an inappropriate match for their bodies," and donors or recipients are susceptible to "life-threatening problems such as AIDS or blood diseases

[120]For example, Watson (1997) describes how McDonald's slightly varied its practices once it entered Hong Kong.

that accompany organs that are obtained outside of regulated channels" (Shelley 2010: 75).

Adverse health outcomes are often attributable to unhygienic, unsafe, unprofessional, substandard practices and conditions, and a flagrant lack of testing, screening, anti-rejection and other drug prescriptions, or follow-up care (Ambagtsheer 2011; Chugh and Jha 1996: 1183; Gill 2014; Jafar 2009; Mendoza 2010; Noorani 2008; Shelley 2010; Turner 2008). Astonishingly, in some instances, the organ trade has even involved transplants being conducted or overseen by individuals lacking medical qualifications and training (Nicolaides and Smith 2012: 34).

The inefficiency and ineffectiveness of the organ trade is particularly illustrated by the economic outcomes for donors. Many donors enter the organ trade seeking to pay off debts or escape abject poverty (Budiani-Saberi et al. 2013; Budiani-Saberi and Karim 2009; Cohen 2003; Mendoza 2010: 379).[121] However, rather than discover economic stability, donors "…are frequently back in debt…" shortly after their procedures (Cohen 2003: 675). Ironically, many donors become mired in predicaments worse than those that led them to originally enter the organ trade (Danovitch et al. 2013: 2; Efrat 2013: 767 ff.; Epstein 2009: 135). Specifically, health complications and an inability to afford post-operative care mean donors are no longer able to perform manual labor or maintain steady occupation (Moniruzzamann 2012: 79; Shelley 2010: 75). Ultimately, few donors feel "…that the total compensation they received improved their overall economic outlook or condition" (Mendoza 2010: 379). Furthermore, after ending up as "invalids"

[121] In his ethnography of Bangladeshi donors within the organ trade, Moniruzzamann (2012: 79) refers to this pursuit as chasing an illusory "golden deer."

unable to work, many donors can become "a burden to their families and communities" (Shelley 2010: 75).

Compounding the above, the organ trade is unpredictable and plagued by a wide range of criminal elements (Pattinson 2008). Overrun by unscrupulous agents or nefarious criminals – many who work hand-in-hand with intricate networks of corrupt officials, authorities, or medical personnel (Allain 2011; Mendoza 2011) – the organ trade has led to numerous donors falling victim to coercion, exploitation, fraud or the withholding of payments, organ theft, and trafficking (Mendoza 2010).

In stark contrast, legislation rationalizes transplantation processes, leading to far different outcomes.[122] First, legislation aims to protect donors and recipients (Fuenzalida-Puelma 1990: 425), and ensure that transplantation is safer and reasonably predictable.[123] For example, US legislation "…afford[s] children substantial protection…" (Morelli 1995: 942), while Bulgaria's *Law on Transplantation of Organs, Tissues and Cells* states that transplant specialists "…shall be obliged to ensure conditions for quality and safety" (Bulgaria 2003). Predictability is apparent, since legislation restricts transplantation to specific clinics or hospitals, and mandates that transplantation follow certain guidelines and procedures that are often quite similar regardless of location.[124] In the United Arab Emirates (UAE) for example, *Article 8 of Federal Law No. (15) of 1993 – Regulating the Transfer and Transplant of Human Organs* stipulates that,

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[122]Many countries have legislation that is similar in scope (e.g. US, UAE, Montenegro, amongst many others). Generally, legislation frequently involves both positive and negative aspects, thus not only banning the organ trade but also outlining proper procedures for the transplant process (see Appendices 1.1 – 1.3 for excerpts from the US, UAE, and Montenegro.

[123]The World Health Organization's (WHO) fifty-seventh World Health Assembly encouraged states to implement legislative safeguards to *protect* the poor and vulnerable from victimization by transplant tourism (WHA 2004, emphasis mine).

[124]For example, within Montenegro's *Removal and Transplantation of Human Body Parts for the Purposes of Medical Treatment Act* (Montenegro 2009), Articles 31 through 36 outline requirements of health institutions to perform transplants, while numerous other articles describe specific guidelines that must be followed in transplantation. These characteristics are apparent in the legislation of many other countries.

> "…transplantation of human organs shall be performed in the medical centres designated by the Ministry of Health for that purpose, in accordance with the conditions and measures specified by decision of the Minister of Health" (UAE 1993).

Legislation also promotes efficiency. In the early 1980s, during national subcommittee hearings on potential transplantation legislation in the US, then-Congressional Representative Al Gore noted that legislation would establish an efficient, "cohesive…rational…[and] effective," national transplantation system that would "…insure equitable and timely access" to transplantation (Gore 1983: 9). In the Philippines, *Administrative Order 2010-0018*[125] created a national organ sharing organization (PHILNOS) that would allocate the country's organs based on need and the probability of success (Philippines 2010).

Legislation further illustrates efficiency since legislation involves protocols (frequently supported by research) mandating standard hygienic practices, utilization of sterilized tools and precautionary measures, evaluations that assign matched organs with appropriate recipients, and provisions of anti-rejection drugs that drastically reduce rates of rejection (Ainley 2011: 431). Patients remain under the close supervision of certified practitioners or surgeons and receive care from qualified nursing personnel. Standardized preoperative testing and postoperative, follow-up care also help ensure adequate preparation, rest, and recuperation for patients (whereas within the organ trade, donors and recipients often receive minimal to no follow-up care [Shelley 2010]).[126] For example, Bulgaria's *Law on Transplantation of Organs, Tissues and Cells* outlines that

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[125]The Philippines'' *Administrative Order 2010-0018*, passed in 2010, makes several amendments to *Administrative Order 2008-0004-A*, which the country passed in 2008.

[126]While organ trade donors and recipients often receive minimal to no follow-up care (Shelley 2010), the international consortium of kidney guideline developers, *Kidney Disease: Improving Global Outcomes (KDIGO)* offers a clinical practice guideline on the monitoring, management, and treatment of kidney transplant recipients. Used in many countries around the world, the guidelines help ensure proper care for donors and recipients after legal transplantation (Kasiske et al. 2010).

medical institutions performing transplants are responsible for the "…selection and preparation of the potential recipient, as well as the continuous observation [and] control of the medical condition and the supporting care of the recipient" (Bulgaria 2003).

Moreover, legislation places restrictions on who can perform transplants – licensed, accredited surgeons – and where transplants can be conducted – certain clinics or hospitals – thus reducing the likelihood of malpractice, maiming, death, or various health complications. For example, Nepal's *Human Body Organ Transplantation (Regulation and Prohibition) Act* (Nepal 1998) stipulates that transplantation can only be performed by individuals who have obtained permits from a special governmental-medical committee. In Myanmar, the *Body Organ Donation Law* authorizes only "experts" and "technicians" prescribed by the Ministry of Health to perform transplantation (Myanmar 2004).

Calculability is evident with legislation, since legislation calls for data collection, record keeping, and attentive monitoring throughout the transplantation process (e.g. donations, blood type testing for matches, patient health conditions, etc.). For example, in the US, the United Network for Organ Sharing (UNOS) maintains a national database containing data on all transplant-related activities occurring in the country (Pritsker et al. 1995), while Nepal's *Human Body Organ Transplantation (Regulation and Prohibition) Act* (Nepal 1998) requires that health institutions compose annual reports on all transplantation activities. Furthermore, Malaysia's *National Organ, Tissue and Cell Transplantation Policy* calls for the "…proper documentation and maintenance of registries" (MOHM 2007: 5), and Lithuania's *Law on Donation and Transplantation of Human Tissues, Cells, and Organs* mandates that "…cases of transplantations and the

data about the donors and recipients shall be recorded, in separate lists…" within a national registry (Lithuania 1996).

Generally, calculability aids in learning from possible patterns in data, developing "best practices," increasing understanding of various aspects of transplantation, and improving overall efficiency and effectiveness (Matesanz et al. 2009).

Legislation also exemplifies McDonaldization through the concept of control. Prior to legislation, although technically not illegal, commercialism and the organ trade were seen as violating personal, social and community meanings for bodies (Seale, Cavers, and Dixon-Woods 2006), and few controls, oversights, protocols, or rationalized processes existed. However, with the development of legislation, the organ trade is prohibited and essentially all stages of the transplantation process are controlled. Rather than organs being acquired through commercialism or trafficking, involving fraud or coercion – as prevails within the organ trade – legislation helps ensure that transplantation and distribution occur in adherence to strict federal or hospital-controlled procedures, criteria, and rules (Aita 2011; Geis and Brown 2008). For example, in the US, the *Uniform Anatomical Gift Act* (UAGA) "…defines who may receive human [organ] donations and for what purposes" (Cate 1995: 72), while the *National Organ Transplant Act* (NOTA) coordinates procurement activities and specifies the donation process (Cate 1995). Bulgaria's *Law on Transplantation of Organs, Tissues and Cells* outlines that medical institutions performing transplants are responsible for the "…selection and preparation of the potential recipient, as well as the continuous observation [and] control of the medical condition and the supporting care of the recipient" (Bulgaria 2003). In Hungary, section 215 of the country's *Act No. CLIV of*

1997 on Health – Organ and Tissue Transplantation stipulates that "recipients shall be selected from the waiting list exclusively on the basis of professional rules" (Hungary 1997).

Control is also apparent in the roles played by doctors, hospitals, and the medical community. These actors have come to control nearly all facets of transplantation; they influence policy, establish guidelines, disseminate "best practices," and develop the vast assortment of standardized and rationalized procedures for all stages of transplantation. For example, Moldova's Transplant Agency, in close collaboration with the Ministry of Health, "…evaluate[s].., authorize[s].., organize[s], and supervise[s]" all transplantation activities within the country (Codreanu et al. 2012: 198).[127] Furthermore, in Pakistan and Israel, physicians' persistent pressure on their respective governments resulted in the enactment of specific organ trade prohibitions (Efrat 2013).

Overall, legislation reflects a rationalized transplantation process, and serves as a useful application for the further rationalization/McDonaldization of society. Simply, with legislation, transplantation is safer (both for individuals and society), and more effective, predictable, and efficient. Consequently, utilizing this framework, the hypothesis is that countries with higher levels of rationalization will be more likely to pass legislation.

> **Hypothesis 4***: The higher a country's level of rationalization/McDonaldization, the higher its likelihood of passing commercial transplantation legislation.*

~~Alternative Mechanisms~~

A third framework that may prove useful to explaining global trends in commercial transplantation legislation builds on Lloyd, Simmons, and Stewart's (2012)

[127]Likewise, in Lebanon, the National Organization of Organ Donation and Transplantation (NOODT) "supervise[s] all organ donation and transplantation" activities in the country (MESOT 2010: 4).

consideration of laws criminalizing human trafficking and the potential diversion of criminal activities.

Frequently, a state's policies are influenced by its neighbors, with governments likely to make policy commitments if their neighbors do so (Simmons 2000: 832). Policy decisions within a country are not always "independent choices reflecting…domestic circumstances," but instead may be interdependent with decisions made by neighboring states (Sharman 2008: 649). One important factor for consideration is crime and its spillover.

Often coordinated by criminal networks (Geis and Brown 2008), trafficking and the organ trade can exude a range of negative externalities for states including, but not limited to, violence, the spread of disease, physical and psychological harm to victims, broader issues of public health, and socio-political instability (Shelley 2009). Serious challenges to the domestic rule of law also arise, since trafficking rings engage in crimes related to small arms, illicit drugs and other contraband, extortion, and money laundering (Morawska 2007: 103; Schloenhardt 1999: 215; Surtees 2008).[128] Significantly, corruption also becomes pervasive, especially as criminal trafficking networks infiltrate and "[integrate] in [states'] legal structures and institutions" (Ambagtsheer and Weimar 2011: 572). For example, trafficking along the Nepal-India border involves mass corruption and bribery of immigration officials and border control authorities (Kara 2009; Lloyd, Simmons, and Stewart 2012: 166), while Schloenhardt (1999: 210) points out that corruption and bribery are problematic in departure, transit, and destination countries for trafficking. As well, the organ trade involves the "active collusion of transplant surgeons,

[128]Often, criminal trafficking networks, involved in drugs or other illicit activities, "branch out" or "diversify" into the organ trade (Ambagtsheer 2011: 75).

nephrologists and members of the regulatory bodies in facilitating commercial transplantations, often with the help of forged documents" (Jha and Chugh 2006).[129]

Due to this broad assortment of negative implications, states have justifiable reason to implement legislation to prevent or deter the organ trade. However, when implementing legislation states not only raise the costs of illegal activity within their own jurisdiction, they potentially divert criminal activity to neighboring states since criminal networks may turn to jurisdictions with lax laws (Bronars and Lott Jr. 1998; Keenan 2006: 507; Kelly 2013; Lloyd, Simmons, and Stewart 2012).[130] At the domestic level, a similar mechanism is apparent; the development of laws and enforcement initiatives in one location often shifts criminal activities to other jurisdictions (Naranjo 2010; Teichman 2005). As well, in Broude and Teichman's (2009) examination of states' responses to transnational crime, the authors argue that states' crime reduction policies are not developed or implemented within a vacuum; instead, policies implemented by one country may affect the policies developed by a neighbor. Specifically, the "harshness" of a policy often dictates whether criminals will shift their activities to another locale with more lenient laws.

Regarding trafficking, strict prosecution of sex trafficking in the US allegedly led to greater levels of sex tourism in nearby locales, while the US administration's strict approach to drugs in Puerto Rico saw traffickers transfer operations to nearby Haiti (Gros 2003; Keenan 2006; Lloyd, Simmons, and Stewart 2012). As well, traffickers frequently utilize routes that "…avoid policed roads, border checkpoints and jurisdictions where

[129]According to the United Nations Regional Information Centre for Western Europe (UNRIC), this aspect distinguishes the organ trade from other forms of trafficking; many of those involved in the organ trade are often individuals "from decent and respected industry sectors," including [d]octors and other health-care practitioners, ambulance drivers and mortuary workers" (UNRIC 2014).

[130]In discussing spillover, Bronars and Lott Jr. (1998) use the illustrative example of "The Club", which sees car thieves respond by moving on to other cars not protected by such a protective device.

there is efficient and honest law enforcement" (Shelley 2007: 125). Analyzing Eastern European trafficking networks, Surtees (2008) notes that they have modified their structure, trafficking routes, and operating strategies to adapt to anti-trafficking activities conducted by law enforcement agencies and legislators.[131]

For the organ trade, globalized markets and communications allow traffickers to "move their operations fluidly," and "enforcement [against the organ trade] in one country merely prompts traffickers to seek other countries with more favorable legal environments" (Kelly 2013: 1318; Roberts 2009). For example, "[t]he establishment of a detailed law to end organ trafficking in India resulted in a shift of transplant tourists from India to Pakistan" (Budiani-Saberi and Karim 2009: 50; Naqvi 2014), while after Taiwan's policy change eliminating aspects of the organ trade, many local Taiwanese simply "began to travel to [mainland] China to purchase organs there" (Chu 2014).

With neighboring states wary of criminal activities spilling over into their own jurisdictions, states will likely implement legislation when a neighbor has done so.

> **Hypothesis 5:** *A state is more likely to pass commercial transplantation legislation if its neighbors have passed legislation.*

~~Government Effectiveness~~

Increasingly, the concept of government effectiveness has gained significance in international comparative analyses (Rothstein and Teorell 2008: 165); here, it may be useful for understanding the global variance in implementing transplantation legislation. While it is universally recognized that states are responsible for establishing authority, order, laws, and regulations within their jurisdiction, it is obvious that not all states are effectively able to do so (Back and Hadenius 2008; Englehart 2009; Gros 1996: 456). In

[131]These trafficking networks often resemble a managerial-type model, conducting informal market surveys, and identifying costs, risks, and benefits (Surtees 2008).

terms of the organ trade, although the world polity and world culture sacralize the individual, delegitimize the organ trade, and encourage the implementation of legislation, many states are unable to translate this into action.

States differ greatly in terms of the efficiency of their state structures, effectiveness of bureaucracy, competence of social structures, proficiency of institutions, quality of policy making, and capacity of security, power, and wealth (Kaufmann, Kraay, and Mastruzzi 2012). They are also vastly dissimilar when it comes to the legitimacy or effectiveness of their internal civil, authority, and enforcement structures. Last, they vary widely in their commitments to stated policies, effective implementation of decisions, and service delivery (Kaufmann et al. 2012).[132]

These factors, representing key facets of government effectiveness (Kaufmann et al. 2012), are influential for general human development or welfare within countries (Bulte, Damania, and Deacon 2005; Sacks and Levi 2010), long-run economic growth (Kaufmann, Kraay, and Mastruzzi 2007: 560 ff.;[133]Kaufmann 2005); the happiness within a country (Ott 2009); state stability or peace (DeRouen Jr. and Goldfinch 2012); and a state's ability to offset potential insurgencies (Jones 2008). Government effectiveness is also an important consideration when focusing on implementation of transplantation legislation, since even if a country appears willing to take action it must actually possess the capability to put rhetoric into practice.[134]

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[132]In addition to this list, Weaver and Rockman (1993) add "coordinat[ing] conflicting objectives" and "mak[ing] and maintain[ing] international commitments," amongst other characteristics making up government effectiveness (Weaver and Rockman 1993: 6).

[133]Particularly, institutional quality and good governance – within which government effectiveness is a significant component – are important and have causal effects for economic growth (Kaufmann, Kraay, and Mastruzzi 2007).

[134]A similar mechanism is illustrated in Centeno and Portes' (2006) examination of Latin American states; the authors suggest that state policies will be a product of both what states seek to accomplish and what they are able to implement (effectiveness).

Beyond just political will, the design, development, and implementation of domestic legislation and regulations require sound judgment, bureaucratic capabilities, fiscal resources, and other facets of government effectiveness (Chayes and Chayes 1993: 194). For example, considering state compliance with European Union (EU) directives, Hass (1998) notes that "…not all [states] are capable..," and that "…states may…lack… capacity [or] competence" (Haas 1998: 19 ff.), while Lampinen and Uusikyla (1998) find that countries with efficient, flexible political institutions – described as ability to implement – are able to successfully implement EU policies domestically. Focusing on international agreements, VanDeveer and Dabelko (2001) note that government capacity and effectiveness is a central factor in explaining state implementation of agreements. As well, examining Central and East European countries applying for membership in the EU, Hille and Knill (2006) find that government bureaucratic strength and effectiveness positively influence the ability of EU candidate countries to implement policies that are aligned with EU requirements. In their analysis of governance in Bangladesh, Zafarullah and Rahman (2008) conclude that the government's poor capacity and ineffective structure have led to failures in formulating and implementing sound policies (Zafarullah and Rahman 2008). Additionally, in many African countries, attempts to implement policies recommended by the World Bank's Sector Investment Programmes (SIPs) have "foundered" due to weak government effectiveness, capacity, and capability (Jones 2000: 275).

In summary, for states to implement legislation, a combination of world culture and government effectiveness is required, as depicted in Figure 3.1. Specifically, the hypothesis is that states that are more embedded in world society and have higher levels

of government effectiveness are more likely to pass legislation than states that are less embedded and have lower levels of government effectiveness, while states that are weakly embedded and have low levels of government effectiveness are least likely to pass legislation.

> **Hypothesis 6:** *States that are more embedded and have higher levels of government effectiveness are more likely to pass legislation than states that are less embedded and have lower levels of government effectiveness, while states that are weakly embedded and have low levels of government effectiveness are least likely to pass legislation.*

~~Figure 3.1 Here~~

~~Conclusion~~

This chapter presents a theoretical framework for examining global variance in the implementation of transplantation legislation. Utilizing several international, comparative, socio-political theories and concepts – including world culture/world polity theory, rationalization/McDonaldization theory, neighboring country effects, and government effectiveness – hypotheses about states' implementation of transplantation legislation are developed. Table 3.1 summarizes these hypotheses.

~~Table 3.1 Here~~

Figure 3.1

Interaction of Ties to World Society and Government Effectiveness

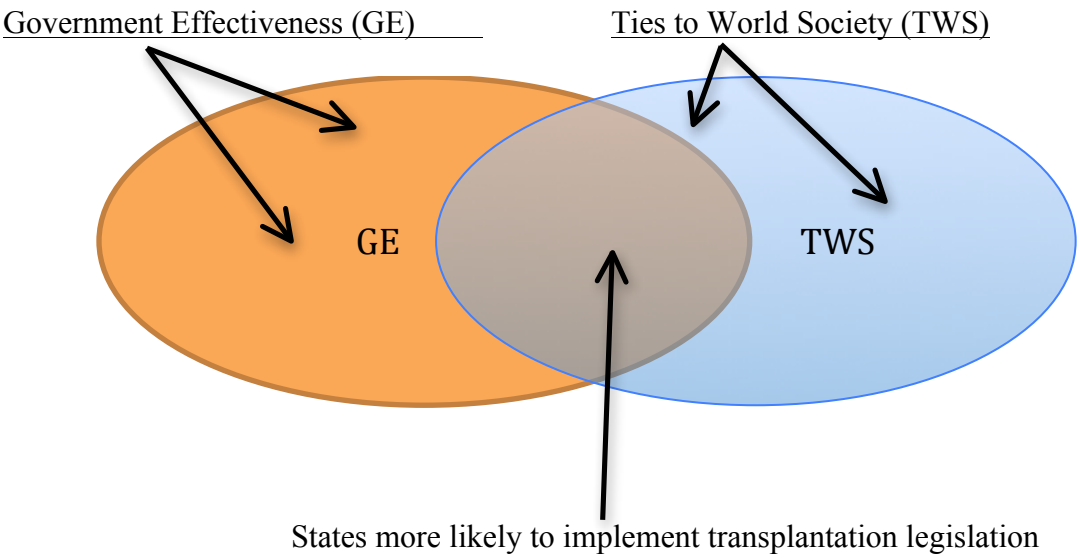

Table 3.1

Summary of Hypotheses

Theory	Hypothesis
World Polity – World Culture	***1.*** *States ratifying more international human rights instruments are more likely to implement commercial transplantation legislation.*
World Polity – World Culture	***2.*** *States with more ties to world society are more likely to implement commercial transplantation legislation.*
World Polity – World Culture	***3.*** *States with more physicians are more likely to implement commercial transplantation legislation.*
Rationalization – McDonaldization	***4.*** *The higher a state's level of rationalization/McDonaldization, the higher its likelihood of passing commercial transplantation legislation.*
Organ Trade Externalities and Spillover	***5.*** *A state is more likely to pass commercial transplantation legislation if its neighbors have passed legislation.*
Interaction: Ties to World Society and Government Effectiveness	***6.*** *States that are more embedded and have higher levels of government effectiveness are more likely to pass legislation than countries that are less embedded and have lower levels of government effectiveness, while countries that are weakly embedded and have low levels of government effectiveness are least likely to pass legislation.*

Chapter Four: Data and Methods

~~Data and Methods~~

With a paucity of empirical work on the organ trade (Shimazono 2007), I construct a time-series panel dataset that combines many significant features of previous comparative, human rights, and political economy works.[135] Overall, data covers 127 countries, spanning 1965 – 2012,[136] and includes only those countries for which relatively definitive information regarding legislative status was available.

The next section details the data and methods. Afterwards, Table 4.1 summarizes data, measurement, and sources, Table 4.2 provides further information about the dependent variable, Tables 4.3 through 4.6 review descriptive statistics, Tables 4.7 through 4.10 present Pearson correlation coefficients, and Table 4.11 presents the list of human rights documents utilized to construct the treaty ratifications variable.

~~Data~~

~~Dependent Variable~~

Legislation Banning Commercial Transplantation: This variable notes whether a country has legislation banning commercial transplantation for a given year. Since there is no single database providing the information, data was collected from a range of sources, including: *The Global Observatory on Donation and Transplantation* (GODT 2010); *The Steering Committee on Bioethics Replies to Questionnaire for Member States on Organ Trafficking* (CoE 2004); *Legal and Ethical Aspects of Transplantation* (Price

[135]Data was also collected from an array of sources, including the World Bank (WB), the United Nations (UN), the World Trade Organization (WTO), and other global organizations.

[136]Beginning the dataset at 1965 provides a two year lag period until 1967, when Italy and Chile became the first countries to pass legislation. This provides a reasonable lag period for any potential influences to take effect. Although the Cayman Islands passed legislation in 2013 (Cayman 2013), the dataset ends in 2012 since a large amount of data is generally unavailable for 2013. As well, Kosovo (which passed legislation in 2012 [Kosovo 2012]) was not included due to a lack of data, and the fact it is not a fully recognized sovereign political entity by the international community.

2000); *Kidney for Sale by Owner: Human Organs, Transplantation, and the Market* (Cherry 2005); and "Human Organ Transplantation: A Report on Developments Under the Auspices of WHO: 1987-1991" (WHO 1991A). In addition, information was gathered from various national health ministry or justice department websites.[137]

Overall, there is coverage of the legislative status of 127 total countries; to the best of my knowledge, this is amongst the broadest coverage for this variable within a single source to date. The variable is a dummy variable, where a value of 1 represents a state having legislation for a given year, and a value of 0 constitutes a lack of legislation.

~~Independent Variables~~

Rationalization/McDonaldization of Society: Acknowledging that rationalization, representing a broad socio-cultural process, is a challenging concept to "capture" or operationalize, I utilize an educational attainment variable to measure the concept in this study. Ritzer (1996; 1998) notes that McDonaldization is inseparable from modernization, involving the transition from traditional to rational systems within society, and "[s]cholars have long believed that reason forged through education would drive out myth and superstition" (Finke and Stark 2003: 160).

In addition to reflecting society's transition away from traditional, value-based systems towards rationality, education systems are prime examples of modern bureaucracies (Harper 1965: 261; Samier 2002: 32 ff.), and they exhibit many features Ritzer notes as being central to McDonaldization (Hayes and Wynyard 2002). For example, education systems have become rationalized, efficient, and predictable – clearly evident through the diffusion of standardized testing, similar textbooks or learning

[137]This list represents particularly useful sources; the entire list of sources for each respective country's legislative status is presented in Table 4.2.

materials, and an assortment of rules, regulations, and guidelines (Boli, Ramirez, and Meyer 1985: 147; Ritzer 2000). Education systems also reflect an important, interrelated element of McDonaldization – consumerism. Ritzer notes how education has transitioned to become oriented around consumerism (Ritzer 2002: 19 ff.); for example, "[s]tudents…'drop by' for a course or two…[and] parking lots will be adjacent to McUniversity's satellites (as they are to fast-food restaurants) to make access easy" (Ritzer 1998: 156). Last, the process of "corporatization and commercialization of educational institutions" is quite similar to past processes of rationalization (Samier 2002: 29).

Education is measured by Barro and Lee's (2013) and Teorell et al.'s (2013) variable of national educational attainment, which provides data on the average years of schooling of the population (both male and female) aged 25 and over, reported in five-year intervals. Using "more, improved data," figures for educational attainment "are collected from census/survey information, as compiled by UNESCO, Eurostat, national statistic agencies, and other sources" (Barro and Lee 2013: 184). An important advantage of Barro and Lee's (2013) measure is that it provides a broad amount of coverage, both across countries and time (whereas other potential measures of education or rationalization are lacking). Last, Barro and Lee's educational attainment data have been used in studies examining differences in educational attainment between countries and their evolution over time (Restuccia and Vandenbroucke 2014), and the interrelationship between education and labor mobility (Pennock 2014).

Treaty Ratifications: International human rights instruments promote respect for and sacralization of the individual, while explicitly outlining models for how states

approach and treat individuals (Elliott 2007; Wotipka and Tsutsui 2008: 725). This variable measures the degree to which a nation-state has institutionalized global human rights doctrine within its national legal structure. The variable is a cumulative variable, showing the total number of human rights treaties ratified by the given year (Elliott 2007).

Ties to World Society (Logged): Scholars identify INGOs as key carriers of world culture and discourse, and primary conduits through which world society affects nations (Boli and Thomas 1999; Cole 2005; Schofer and McEneaney 2003; Schofer and Meyer 2005: 906). Nations deeply embedded in networks of international organizations tend to conform to global norms most rapidly (Frank, Hironaka, and Schofer 2000), and embeddedness is measured by the number of INGOs in which residents of a country are members (Schofer and Meyer 2005: 906). Importantly, in measuring the number of INGOs in which residents of a state are members, this variable does *not* measure the number or proportion of the population that belong to INGOs, nor does it measure the number of INGOs headquartered in each country. Ties for each country are naturally logged (ln) to attenuate for skew, and data were collected from the *Yearbook of International Organizations,* published annually by the Union of International Associations (UIA 2011).[138]

Receptor Sites: Collectively, doctors, surgeons, practitioners, and health researchers have offered states guidance and scientific expertise regarding responses to the organ trade (Danovitch et al. 2013: 2), while acting as receptor sites – social

[138]A description of specific measurement of this variable is available in Table 4.1. A significant amount of data was generously provided by Mathias (2013), who built on the work of Hafner-Burton and Tsutsui (2005). Data for 2011-2012 are repeated; this strategy is conservative given that the global count of INGOs only slightly increases from year to year. The "UIA limits INGOs to not-for-profit, non-state organizations (TNCS and IGOs are excluded). They vary in size from a few dozen members from only three countries to millions of members from close to two hundred countries" (Boli and Thomas 1999: 20).

structures with the capacity to receive, decode, and transmit information from world society to nation-states (Frank, Hironaka, Schofer 2000: 103). Transplantation doctors, surgeons, practitioners, and health researchers also diffuse models prohibiting commercial transplantation, provide awareness of the organ trade, and encourage ethical practices within their home states (Efrat 2013). For example, in both Israel and Pakistan – two countries with long, notorious histories of involvement within the global organ trade – physicians' persistent pressure on their respective governments resulted in the enactment of organ trade prohibitions (Efrat 2013). This variable measures the physicians per 1000 people and is available from the World Bank (World Bank 2013).

Neighboring Legislation: This variable notes whether a state's neighboring countries have passed legislation. Since states' crime reduction policies are not developed or implemented within a vacuum (Broude and Teichman's 2009), and states face the potential for crime spillover (Bronars and Lott Jr. 1998; Lloyd, Simmons, and Stewart 2012), neighboring country legislation is important to consider.

Using data on contiguous land boundaries between countries, available from the *CIA World Factbook* website (CIA 2013), combined with information on states' respective legislative status for a given year, this variable is a dummy variable where, for a given year, a value of 1 indicates that at least one of a state's contiguous land neighbors had legislation, while 0 notes that no neighbors had legislation.

Interaction - Government Effectiveness and Ties to World Society: Although world cultural and societal norms may promote human rights and the sacralization of the individual, thus encouraging states to implement legislation, states must actually possess the capacity and effectiveness to do so. This variable measures the interaction between

ties to world society and government effectiveness, and is the product of a nation-state's ties to world society multiplied by that nation-state's government effectiveness score.

Government effectiveness is influential for general human development or welfare within countries (Bulte, Damania, and Deacon 2005; Sacks and Levi 2010), long-run economic growth (Kaufmann, Kraay, and Mastruzzi 2007: 560 ff.; Kaufmann 2005); the happiness within a country (Ott 2009); state stability or peace (DeRouen Jr. and Goldfinch 2012); and a state's ability to offset potential insurgencies (Jones 2008). In terms of legislation, government effectiveness is important since a state requires effectiveness and capability, in addition to will, to implement legislation.

One of the most frequently utilized measures of government effectiveness is found within the *Worldwide Governance Indicators Dataset* (Kaufman, Kraay, and Mastruzzi 2012). Specifically, the government effectiveness variable considers efficiency of state structures, effectiveness of bureaucracy, competence of social structures, proficiency of institutions, and capacity of security, power, and wealth. As well, it incorporates the legitimacy or effectiveness of states' internal civil, authority, enforcement, and military structures. However, with the variable only available since 1996, which is well after the start of the period of analysis, an unacceptable amount of coverage is lost. Consequently, I turn to the *National Material Capabilities* dataset (Singer, Bremer, and Stucky 1972), which represents a useful alternative. Traditionally, the *National Material Capabilities* dataset has been a popular resource for international, comparative analyses (Wayman, Singer, and Goertz 1983; Wohlforth 1999).

Utilizing the *National Material Capabilities* dataset (Singer, Bremer, and Stucky 1972), I first create an index of government effectiveness. Employing principal

components factor analysis, the index combines three individual, yet conceptually related, measures from the dataset: military expenditure, military personnel, and primary energy consumption. Factor analysis reduces the original number of variables to create a new, single index variable that is a linear combination of the original ones (Crown 1998; Walker and Maddan 2008).[139]

In aggregate, the three measures provide a useful, holistic account of government effectiveness, important since government effectiveness and capacity is a "multi-faceted concept that is unlikely to be fully captured by a single measure" (Sobek 2010: 270). Military personnel and spending note the degree to which a government is capable of funding, organizing, and coordinating a standing army, as well as protecting its sovereign borders – all historically key features of government effectiveness and capacity (Cardenas 2010: 3; Hendrix 2010; Tilly 1985).[140] By incorporating primary energy consumption, the index also considers a state's quality and coherence of institutions, as well as its competence in civil and public service provisions – which are also key aspects of government effectiveness and capacity (Cardenas 2010: 1; Kaufmann et al. 2012; Kirlin 1996: 161-163). An effective government, with a well-functioning bureaucracy and competent civil service can sufficiently provide for the needs of its population. Overall, combining the three measures offers a rounded interpretation and account of government effectiveness.[141]

With the *National Material Capabilities* dataset covering the period 1965-2007,

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[139]Bowman and Kearney (1988) also utilize factor analysis in identifying the multidimensional, multifaceted nature of government capacity and effectiveness.

[140]According to Tilly (1985), during the rise of the nation-state model in Europe (and eventually world) only states that effectively organized governmental institutions (bureaucracies, tax collection, organization, etc.) were able to raise standing armies, make war, and ultimately ensure security and survival. For Hendrix (2010: 274), the "…national military is the centerpiece of the state's repressive capabilities."

[141]A similar multidimensional approach to government effectiveness and capacity was utilized in Fjelde and De Soysa's (2009) examination of states and risk for civil war, while Bowman and Kearney (1988) utilize a multidimensional, multifaceted approach to understanding and measuring government capacity and effectiveness.

coverage is extended to 2012 by using World Bank (2013) data on energy consumption and military personnel, and the *SIPRI Military Expenditure Database* (SIPRI 2012) data on military expenditure.[142] Data used to extend coverage (2008-2012) are highly correlated with the original measures from the *National Material Capabilities* dataset (1965-2007),[143] helping to ensure the change of data sources does not influence results.

Regarding measurement, the *National Material Capabilities* measures military expenditures in thousands of current year US dollars, military personnel in thousands, and primary energy consumption in thousands of coal-ton equivalents. For data used to extend coverage until 2012, the *SIPRI Military Expenditure Database* measures military expenditure in millions of 2011 constant US dollars, while the World Bank (2013) presents military personnel as raw totals and energy consumption in *kt* of oil equivalent. All data are naturally logged (ln) to attenuate for skew (Singer, Bremer, and Stucky 1972).[144]

Ultimately, interacting ties to world society with government effectiveness captures the concept that in order to implement legislation, countries require both will and capability.

~~Control Variables~~

Democracy: Research has shown the influence of democracy in protecting human rights (De Mesquita, Downs, and Smith 2005; Englehart 2009: 169; Hafner-Burton and

[142]With World Bank (2013) data running only until 2011, figures are repeated for 2012.
[143]Correlation coefficients are nearly 1.0.
[144]Of note, several countries had values of zero for military personnel and primary energy consumption (within the *National Material Capabilities* data for 1965-2007) and for military spending (within both the *National Material Capabilities* data for 1965-2007 and *SIPRI Military Expenditure Database* for 2008-2012). Therefore, I add a value of 1 to these respective measures, and subsequently naturally log (ln) all measures to attenuate for skew (Singer, Bremer, and Stucky 1972).

Tsutsui 2005: 1387).[145] Accordingly, this variable controls for a state's political system, which may influence whether states take measures (i.e. enact legislation) to ban the organ trade, which is regarded as a violation of human rights (Cherry 2005: 129; DoI 2013; Rothman et al. 1997).

This variable, from *The Polity IV Project*, codes the political characteristics of states for purposes of comparative, quantitative analysis (Marshall and Gurr 2013). Widely used in international comparative analyses or works assessing governance or human rights practices (Cole 2005; Davenport and Armstrong II 2004; Hafner-Burton and Tsutsui 2005; Hathaway 2007; Mathias 2013 Melander 2005), this measure is an additive scale/index of a number of component variables dealing with executive recruitment (openness of and competition in), executive constraints, and the competitiveness of participation (Davenport and Armstrong II 2004). Scores range from 0 to 10; 0 represents less democratic states and 10 represents states with the most democratic political institutions.

Geographical Size (Logged): Potentially, geographically smaller territories may be easier to monitor or police. Consequently, organ trafficking activities may be easier to detect, thereby influencing legislation. This variable measures the total land area of a country (in sq. km., and naturally logged to minimize skew), excluding area under inland water bodies, national claims to continental shelf, and exclusive economic zones (World Bank 2013). Data was collected from the World Bank (World Bank 2013).[146]

Ethnolinguistic Fractionalization: Previous work and literature suggest that ethnolinguistic fractionalization negatively impacts political stability and the quality of

[145]For example, "democracies, almost by definition, are more willing to accept constitutional limits on governmental power and one would at least expect them to respect better the human rights of their citizens" (Neumayer 2008: 8).
[146]Data runs from 1965-2011, with 2011 data repeated for 2012.

state institutions (Alesina et. al 2003; La Porta et. al 1999). Moreover, states with higher degrees of fractionalization may have more dishonest bureaucracies (Shleifer and Vishny 1993), and be more likely to experience bouts of political violence or frequent breakdowns of law and order (Annett 2001). These factors are important to consider since they may influence the organ trade or procedural steps undertaken by governments to combat it (e.g. passing legislation).

Available from Teorell et al. (2013) and Alesina et al. (2003), this variable measures the fractionalization within a country, based upon both ethnic and linguistic lines, thus providing a more comprehensive account than traditional measures.[147] Specifically, the measure reflects the probability that two randomly selected people will not share a certain characteristic by taking the average value of five different indices of ethnolinguistic fractionalization. Values range from 0 to 1, with higher values representing a lower probability of two people sharing a characteristic.[148]

Trade Openness (Logged): A conventional variable within international, comparative analyses (Hafner-Burton and Tsutsui 2005: 1395), this variable assesses a country's openness to the movement of goods and services; specifically, it is the sum of exports and imports divided by the gross domestic product (GDP). This measure is useful not only as an indicator of global economic integration but also as a proxy for the openness of borders to the movement of people – thus tapping into the concept of the organ trade. Data are available from the World Bank (World Bank 2013), and are naturally logged (ln) to attenuate for skew.

GDP Per Capita (Logged): Quite common within international comparative

[147]As opposed to a measure that considers ethnic or linguistic fractionalization individually.
[148]Since ethnicity involves a mix of racial and linguistic characteristics, the result is a higher degree of fractionalization than the traditional ELF-index (Alesina et al. [2003]; Teorell et al. [2013]).

analyses, GDP per capita is a standard measure for economic development or affluence (Cole 2005: 480; Schofer and Meyer 2005; Tanzi and Davoodi 1998; Wotipka and Tsutsui 2008). In terms of the organ trade, poorer individuals are more vulnerable to exploitation (Budiani-Saberi and Karim 2009; Saleem et al. 2009).[149] Furthermore, while all countries have poor individuals, less economically developed countries have large proportions of them. Measured in constant 2005 US dollars, data are naturally logged (ln) to attenuate for skew, and are available from the *USDA: ERS International Macroeconomic Data Set* (USDA 2012).

Catholic Dummy: A potentially important control variable when considering states' implementation of legislation may be a state's predominant religion. While little has been written about how religion may affect the organ trade or legislation, previous analyses of similar topics offer useful insights.[150] For example, examining factors that influence a country's abolition of the death penalty, Mathias (2013) finds that predominantly Catholic nation-states are most likely to abolish the death penalty. As well, analyzing the patterns of abolition of the death penalty since 1960, McGann and Sandholtz (2012) find that being a predominantly Catholic country raises the probability of abolition very significantly. With commercial transplantation legislation sharing several underlying features with abolition of the death penalty – particularly in terms of notions of individual rights, sacrality, dignity, and protection – religion may likewise be

[149]Additionally, the level of economic development is important to consider since it has often been found to be a strong predictor of human rights conditions within a country (Englehart 2009: 170).

[150]No religion formally forbids organ donation or is against transplantation from living or deceased donors (Abouna 2003: 56; Bruzzone 2008: 1064). While it has been suggested that precepts within Orthodox Judaism may be interpreted as disallowing transplantation or donation (Nelkin and Andrews 1998: 36), researchers (e.g. Efrat 2014) conclude that Judaism does not ban organ donation or transplantation.

an important factor to control.[151]

Using data on the percentage of a population practicing Catholicism, available from Teorell et al. (2013) and La Porta et al. (1999), I create a predominant Catholic dummy variable. Specifically, when the proportion of a country's population practicing Catholicism is greater than one-half, it is coded as being predominantly Catholic. To fully investigate the influence of religion, I also create and test Islam and Protestant dummy variables.

~~Method~~

Quantitative analysis of the cross-national, longitudinal trends of implementation of legislation is most intuitive since there are enough data and observations to provide a sophisticated statistical analysis (Ragin 1987). Analysis proceeds with longitudinal models, specifically using both survival analysis and logistic regression.

Survival analysis is a longitudinal record of the timing of the occurrence of one or more types of event (Cole 2005: 481; Steele 2005). Traditionally, it has been most common in the medical sciences, being widely used to quantify survival in a population under study (e.g. examining populations receiving treatment or the testing of a new drug). In this study, it is utilized to inform about whether a country passes legislation in a given year. When a country does pass legislation, it receives a value of 1 for that year.[152] For years in which a country does not have legislation or has already passed legislation, the country receives a score of 0.

The set of states at risk of passing legislation ("the risk-set") is made up of all

[151]In addition, Fiorino and Ricciuti's (2007) examination of the determinants of direct democracy in eighty-seven countries finds that Catholicism is a positive determinant of direct democracy within a country.

[152]One possible complication that may arise is calculating parameter values for covariates, an issue stemming from "tied failures" or legislation passed at the same time by different countries. To overcome this potential problem, the Efron method for handling tied failures is utilized (Efron 1977; Mathias 2013).

countries in the world. Countries' onset of risk for legislation banning the organ trade begins when they enter the data, which is 1965 for most countries; however, countries attaining independence within the time period (1965-2012) are inserted into the risk-set the year in which they became independent (Wotipka and Tsutsui 2008: 739).[153]

In survival analysis, the model reflects the effect of several variables (i.e. "covariates") upon the time a specified event takes to happen. The quantity of interest is the instantaneous transition rate, described as the transition from no legislation to implementing legislation. Survival analysis offers a dynamic method in that it produces coefficients demonstrating the influence of explanatory variables on the rate of legislation implementation over time (Mathias 2013: 1263). Positive coefficients indicate a greater likelihood for the event (e.g. legislation) occurring, while negative coefficients indicate a decreased likelihood of occurrence.

Survival analysis also allows for the possibility that some cases will not experience an event, as in the case of countries yet to pass legislation (Gasiorowski 1995: 887). Last, the data are "right-censored" in that it is not known if or when these countries will pass legislation in the future.[154] Notably, survival analysis has been used in previous international, comparative analyses of human rights (Cole 2005), mass education (Soysal and Strang 1989), the environment (Frank, Hironaka, and Schofer 2000), and decolonization (Strang 1990).

In addition to survival analysis, logistic regression is utilized. Especially appropriate for dichotomous dependent variables, logistic regression allows researchers

[153]Beginning the dataset at 1965 provides a two year lag period until 1967, when Italy and Chile became the first countries to pass legislation. This allows a reasonable lag period for any potential influences to take effect. Although the Cayman Islands passed legislation in 2013 (Cayman 2013), the dataset ends in 2012 since a large amount of data is generally unavailable for 2013.

[154]This follows Wotipka and Tsutsui (2008: 740) who right-censor their data on state ratification of human rights treaties.

to discover whether the probability of getting a particular value of the dependent variable is associated with the independent variables or to predict the probability of getting a particular value of the dependent variable, given the independent variables (McDonald 2009). The coefficients produced by logistic regression are used to estimate log-odds and odds-ratios for the various variables in the model. So, for example, we learn how much more likely democratic countries are to pass legislation than undemocratic countries. To facilitate interpretation of the coefficients, the effect of variables can also be estimated through utilizing simulations and altering the values of particular variables of interest.

As well as being useful for learning whether the probability of legislation is associated with the different variables, logistic regression can be used to separate portions of the time period under review, thus informing which countries adopt legislation within a particular time period (such as early, middle, or late within the period of analysis).

Like survival analysis, logistic regression has been popular amongst many researchers, and has been utilized in international comparative analyses of the spread of human rights education (Suarez 2007) and the diffusion of information and communications technology (ICT) curricula (Ham and Cha 2009).

In addition to analyzing legislation across 1965-2012, I explore possible variance in legislation *within* the time period by separating the 1965-2012 time period into three segments: 1965-1979, 1980-88, and 1989-2012. These time periods correspond with several key events within global transplantation. The first "cut-off" point (i.e. 1979) was selected on the basis that Cyclosporine A (an important immunosuppressant that improves rejection rates) was introduced and widely distributed in the 1980s (after having been tested in many trials during the late 1970s). The introduction of Cyclosporine A

"[ushered] in a new era of improved outcomes in transplantation," and it was crucial to the large increase and spread of transplantation (Gaston 2001: 25). Additionally, the 1980s period saw the first reports of the organ trade (Panjabi 2010; Scheper-Hughes 2001), whereas in the 1970s there was "little to indicate" that there was "any trafficking or commerce in organs" (Daar, Gutmann, and Land 1997: 302). The second "cut-off" point (i.e. 1989) represents when the World Health Assembly adopted resolution 42.5; in addition to condemning the organ trade, the resolution called on "states to take…measures to prevent the [organ trade]," and strongly urged states to "introduce legislation to prohibit trafficking in organs" (WHA 1989; Zielinski 1994).

The following tables offer more information about the data: Table 4.1 summarizes data, measurement, and sources, Table 4.2 provides further information about the dependent variable, Tables 4.3 through 4.6 review descriptive statistics, Tables 4.7 through 4.10 present Pearson correlation coefficients, and Table 4.11 presents the list of human rights documents utilized to create the treaty ratifications variable. The next chapter presents results.

Table 4.1 **Data, Measurement, and Sources**

Variable	Type	Description	Source
Legislation Status	Dependent Variable	Dummy variable noting whether country has legislation banning commercial transplantation for a given year. 1 = Legislation; 0 = Otherwise	Cherry 2005; CoE 2004; GODT 2010; Price 2000; WHO 1991A[155]
Education	Independent Variable: Rationalization – McDonaldization	Average years of schooling of population (male & female), aged 25 and over.	Barro and Lee 2013; Teorell et al. 2013
Treaty Ratifications	Independent Variable: World Polity/World Culture Theory (WP/WCT)	Total number of human rights treaty ratifications.	Elliot 2007[156]
Ties to World Society[157]	Independent Variable: World Polity/World Culture Theory (WP/WCT)	Number of INGOs in which residents of a country are members. Naturally logged.	UIA 2011
Receptor Sites	Independent Variable: World Polity/World Culture Theory (WP/WCT)	Physicians per 1000 people.	World Bank 2013
Neighboring Legislation	Independent Variable: Crime Spillover	Dummy variable. For given year, 1 indicates at least one of a state's contiguous land neighbors has legislation; 0 notes no neighbors have legislation.	Author's own calculations; CIA 2013
Government Effectiveness	Independent Variable: Government Effectiveness	Index combining yearly totals of military spending, military personnel, & energy consumption. Naturally logged.	Singer, Bremer, and Stucky 1972; SIPRI 2012; World Bank 2013
Interaction: Government Effectiveness*Ties to World Society	Independent Variable: Government Effectiveness*Ties to World Society	Interacts government effectiveness with ties to world society.	Author's own calculations; Singer, Bremer, and Stucky 1972; SIPRI 2012; UIA 2011; World Bank 2013

[155]Full list available in Table 4.2.

[156]The original variable, which runs until 2005, was generously shared by Elliott (2007). I update the measure to extend it until 2012. Although there are a total of 62 international human rights treaty documents reviewed, nation-state human rights treaty ratifications range from 0 to 46. The full list of 62 international human rights treaty documents is available in Table 4.11.

[157]The variable was shared by Mathias (2013), who built on Hafner-Burton and Tsutsui's (2005) work. Hafner-Burton and Tsutsui's (2005) INGO membership data cover the period 1968-1995, and moves in a "step-ladder" fashion; missing yearly INGO membership data is supplemented by the previous year's data. Their data for each nation-state has unique values for 1968, repeats these values for each country respectively until 1976, codes new data for 1977, which repeats until 1981, counts new data for 1982, 1983, and 1984, and then repeats for 1985. Unique INGO data are thereafter coded for each year up until 1995. Matthias (2013) interpolates data for 1995 to 2000. I then add new data for 2000-2012, repeating data for 2011-12.

Table 4.1 (*continued*)

Data, Measurement, and Sources

Variable	Type	Description	Source
Democracy	Control Variable	Additive scale/index of several component variables dealing with executive recruitment (openness of and competition in), executive constraints, and the competitiveness of participation. Scores range from 0 to 10; 0 = less democratic and 10 = most democratic.	Marshall and Gurr 2013
Geographical Size	Control Variable	Total land area, in sq. km., and naturally logged. Excludes area under inland water bodies, national claims to continental shelf, and exclusive economic zones.	World Bank 2013
Ethnolinguistic Fractionalization	Control Variable	Probability that two randomly selected people will not share a certain characteristic. Takes average value of five different indices of ethonolinguistic fractionalization. Values range from 0 to 1, with higher values representing a lower probability of two people sharing a characteristic.	Alesina et al. 2003; Teorell et al. 2013
Trade Openness	Control Variable	Sum of exports and imports divided by the gross domestic product (GDP). Naturally logged.	World Bank 2013
Gross Domestic Product (GDP) per capita	Control Variable	Gross domestic product (GDP) per capita, measured in constant 2005 US dollars. Naturally logged.	USDA 2012
Catholic Dummy	Control Variable	Dummy variable. 1= greater than one half of population practices Catholicism; 0 = less than one half of population practices Catholicism.	La Porta et al. 1999; Teorell et al. 2013

Table 4.2

Commercial Transplantation Legislation Status for Various Countries

Country	Legislation	Year	Source
Italy	Yes	1967	CoE 2004; Fluss 1991; WHO 1991A
Chile	Yes	1967	WHO 1991A
Uruguay	Yes	1971	Alvarez et al. 2009
Venezuela	Yes	1972	Venezuela 2010; WHO 1991A
Syria	Yes	1972	Cherry 2005
Costa Rica	Yes	1974	WHO 1991A
France	Yes	1976	CoE 2004
Zimbabwe	Yes	1976	WHO 1991A
Argentina	Yes	1977	WHO 1994
Jordan	Yes	1977	Jordan 2013
Romania	Yes	1978	CoE 2004
Bolivia	Yes	1978	WHO 1991A
Turkey	Yes	1979	Price 2000
Spain	Yes	1979	Price 2000
Indonesia	Yes	1981	WHO 1991A
Libya	Yes	1982	UNESCO 2011
Austria	Yes	1982	Price 2000
Luxembourg	Yes	1982	CoE 2004; WHO1991A
Honduras	Yes	1982	WHO 1991A
*Yugoslavia	Yes	1982	WHO 1991A
Australia[158]	Yes	1983	Australia 1983
Lebanon	Yes	1983	Cherry 2005; Lebanon 2010
South Africa	Yes	1983	Glaser 2005; WHO 1991A
Greece	Yes	1983	Price 2000
Panama	Yes	1983	Price 2000
Cuba	Yes	1983	WHO 1991A
Namibia	Yes	1983 (1990)	Namibia 1983
USA	Yes	1984	Jafar 2009
Algeria	Yes	1985	Price 2000
Mexico	Yes	1985	Mexico 1985
Finland	Yes	1985	Cherry 2005; CoE 2004

[158]Australia lacks a Commonwealth transplantation law; instead, each of its regions has a law. Accordingly, I use the date from when the first region passed a transplantation law (Australia 1983; Thomas and Klapdor 2008).

Belgium	Yes	1986	Price 2000
Guatemala	Yes	1986	WHO 1991A
Iraq	Yes	1986	WHO 1991A
Singapore	Yes	1987	Kaur 1998; Shum and Chern 2006
Kuwait	Yes	1987	Price 2000
Cyprus	Yes	1987	Price 2000
Ecuador	Yes	1987	WHO 1991A
Sri Lanka	Yes	1987	Cherry 2005
*Taiwan	Yes	1987	Yang n.d.
Colombia	Yes	1988	WHO 1991A
Brazil	Yes	1988	WHO 1991A
Dominican Republic	Yes	1988	WHO 1991A
El Salvador	Yes	1988	El Salvador 1988
United Kingdom	Yes	1989	Price 2000
Denmark	Yes	1990	CoE 2004; WHO 1991A
Malawi	Yes	1990	Cherry 2005
Tunisia	Yes	1991	WHO 1994
Latvia	Yes	1992	CoE 2004; Olsena 2006
Russia	Yes	1992	CoE 2004; Cherry 2005
United Arab Emirates	Yes	1993	UAE 1993
Cote d'Ivoire	Yes	1993	All-Africa 2004; Cote d'Ivoire 2013
India	Yes	1994	Glaser 2005
Oman	Yes	1994	Oman 2005; Oman 2010; UNESCO 2011
Slovakia	Yes	1994	CoE 2004
Uzbekistan	Yes	1994	Uzbekistan 1994
Poland	Yes	1995	CoE 2004
China	Yes	1995	Jingwei, Yu-Hung, and Ching 2010
F.Y. Macedonia	Yes	1995	CoE 2004
Sweden	Yes	1995	CoE 2004; De Cruz 2001
*Hong Kong	Yes	1995	Price 2000
Lithuania	Yes	1996	Lithuania 1996
Japan	Yes	1997	Bagheri 2005
Germany	Yes	1997	CoE 2004; WCO 2002
Hungary	Yes	1997	CoE 2004; Hungary 1997

Qatar	Yes	1997	Qatar 2010; Qatar News 2013
Bahrain	Yes	1998	Al-Arrayed et al. 2000
Nepal	Yes	1998	Nepal 1998
Paraguay	Yes	1998	OPS 2011; Paraguay 2010
Azerbaijan	Yes	1999	CoE 2004
Ukraine	Yes	1999	CoE 2004; Ukraine 2011
Bangladesh	Yes	1999	Moniruzzaman 2012
South Korea	Yes	2000	Bagheri 2005
Mongolia	Yes	2000	WHO 2009A
Georgia	Yes	2000	CoE 2004; Georgia 2000
Slovenia	Yes	2000	CoE 2004; Slovenia 2000
Trinidad and Tobago	Yes	2000	Trinidad 2000
Norway	Yes	2001	CoE 2004; Cherry 2005
Armenia	Yes	2002	CoE 2004
Czech Republic	Yes	2002	CCC 2013; CoE 2004
Estonia	Yes	2002	CoE 2004; Cherry 2005
Portugal	Yes	2002	Cherry 2005
Morocco	Yes	2003	UNESCO 2011
Bulgaria	Yes	2003	Bulgaria 2003
Netherlands	Yes	2003	CoE 2004
Croatia	Yes	2004	CoE 2004; Zivcic-Cosic et al. 2013
Myanmar	Yes	2004	Cherry 2005; Myanmar 2004
Peru	Yes	2004	OPS 2011
Vietnam	Yes	2006	Vietnam 2006; WHO 2009A
Switzerland	Yes	2007	Switzerland 2007
Israel	Yes	2008	Jotkowitz 2008
Moldova	Yes	2008	Moldova 2010
New Zealand	Yes	2008	New Zealand 2008
Nicaragua	Yes	2008	OPS 2011
Philippines	Yes	2008	Philippines 2008
Bosnia	Yes	2009	Bosnia 2009

Mali	Yes	2009	Mali 2009
Kazakhstan	Yes	2009	Kazakhstan 2009
Pakistan	Yes	2010	Efrat 2013
Rwanda	Yes	2010	Rwanda 2010
Egypt	Yes	2010	Hamdy 2012; IkhwanWeb 2010
*Kosovo	Yes	2012	Kosovo 2012
*Cayman Islands	Yes	2013	Cayman 2013; Fuller 2013
Brunei	No	N/A	WHO 2009A
Fiji	No	N/A	WHO 2009A
Malaysia	No	N/A	WHO 2009A
Nigeria	No	N/A	Bakari et al. 2012; Ndagi 2013
Canada	No	N/A	CBC 2008
Iceland	No	N/A	CoE 2004
Ireland	No	N/A	CoE 2004
Liechtenstein	No	N/A	WHO 1991A
Malta	No	N/A	CoE 2004
San Marino	No	N/A	CoE 2004
Laos	No	N/A	WHO 2005
Papua New Guinea	No	N/A	WHO 2005
Kenya	No	N/A	Kenya 1966
Bhutan	No	N/A	Kuensel Online 2013
Tonga	No	N/A	Tonga 1988
Mauritius	No	N/A	Mauritius 2013
Zambia	No	N/A	Zambia 1962
Botswana	No	N/A	The Voice 2006
Jamaica	No	N/A	Jamaica 2013
Tanzania	No	N/A	Tanzania 2013
Mozambique	No	N/A	Mozambique 2013; UNODC 2007
Guyana	No	N/A	Guyana 2013
I.R. Iran	No	N/A (1988)	Ghods and Savaj 2006
Tajikistan	No	N/A (1991)	Tajikistan 1991
Belarus	No	N/A (1997)	Belarus 1997
Bahamas	No	N/A	Gibson 2014
Burkina Faso	No	N/A (1994)	Burkina 1994
Uganda	No	N/A	Uganda 2014

*Yugoslavia, Taiwan, Hong Kong, Kosovo, and the Cayman Islands are included in this list, but do not factor within quantitative analyses.

Table 4.3

Descriptive Statistics of Variables
127 Countries: 1965-2012

Variable	N	Min	Max	Mean	SD	Variance	
Legislation Status	5420	0	1	0.38	0.48	0.24	
Education	998	0.15	13.27	6.21	3.14	9.86	
Treaty Ratifications	5395	0	46	16.88	10.48	109.92	
Ties to World Society	4861	0.07	8.48	6.27	1.10	1.20	
Receptor Sites	2367	0.0038	47.35	1.80	1.56	2.45	
Neighbor Legislation Dummy	5408	0	1	0.52	0.50	0.25	
Government Effectiveness	4988	-3.85	2.71	2.07e-08	0.99	0.99	
Interaction: Government Effectiveness*Ties to World Society	4528	-18.71	21.94	0.80	6.28	39.48	
Democracy	4963	0	10	5.05	4.24	17.95	
Geographic Size	5350	4.09	16.59	11.96	2.26	5.10	
Ethnolinguistic Fractionalization	5359	0.002	0.93	0.41	0.24	0.06	
Trade Openness	4821	0.269	6.333	4.142	0.626	0.391	
GDP Per Capita	4811	3.35	11.44	8.16	1.60	2.57	
Catholic Dummy	5365	0	1	0.32	0.47	0.22	

Table 4.4

Descriptive Statistics of Variables
104 Countries: 1965-1979

Variable	N	Min	Max	Mean	SD	Variance	
Legislation Status	1494	0	1	0.05	0.22	0.05	
Education	263	0.15	11.76	4.22	2.73	7.43	
Treaty Ratifications	1470	0	24	8.69	5.28	27.87	
Ties to World Society	1149	0.07	7.45	5.48	1.18	1.39	
Receptor Sites	480	0.0103	3.3042	1.071	0.671	0.45	
Neighbor Legislation Dummy	1494	0	1	0.15	0.35	0.13	
Government Effectiveness	1389	-3.45	2.52	-1.57e-09	1	1	
Interaction: Government Effectiveness*Ties to World Society	1097	-15.27	17.92	0.97	5.37	28.84	
Democracy	1358	0	10	3.84	4.32	18.70	
Geographic Size	1464	-0.42	4.07	0.01	0.93	0.87	
Ethnolinguistic Fractionalization	1456	0.002	0.93	0.41	0.24	0.06	
Trade Openness	1157	1.84	5.93	3.86	0.65	0.42	
GDP Per Capita	1060	3.65	11.44	7.90	1.60	2.56	
Catholic Dummy	1456	0	1	0.35	0.48	0.23	

Table 4.5

Descriptive Statistics of Variables
105 Countries: 1980-1988

Variable	N	Min	Max	Mean	SD	Variance	
Legislation Status	941	0	1	0.25	0.43	0.19	
Education	193	0.37	12.16	5.33	2.79	7.81	
Treaty Ratifications	941	0	29	12.61	6.49	42.08	
Ties to World Society	923	2.55	7.81	6.07	0.95	0.89	
Receptor Sites	472	0.0038	9.814	1.39	1.08	1.17	
Neighbor Legislation Dummy	941	0	1	0.45	0.50	0.25	
Government Effectiveness	870	-3.23	2.64	-5.74e-10	1	1	
Interaction: Government Effectiveness*Ties to World Society	861	-20.86	19.83	0.47	6.29	39.53	
Democracy	860	0	10	4.17	4.41	19.42	
Geographic Size	923	4.09	16.05	11.97	2.31	5.33	
Ethnolinguistic Fractionalization	941	0.002	0.93	0.41	0.24	0.06	
Trade Openness	825	2.19	6.02	4.04	0.62	0.38	
GDP Per Capita	896	3.86	11.07	8.04	1.62	2.62	
Catholic Dummy	941	0	1	0.33	0.47	0.22	

Table 4.6

Descriptive Statistics of Variables
127 Countries: 1989-2012

Variable	N	Min	Max	Mean	SD	Variance	
Legislation Status	2985	0	1	0.58	0.49	0.24	
Education	542	0.71	13.27	7.50	2.82	7.94	
Treaty Ratifications	2984	0	46	22.26	10.20	104.02	
Ties to World Society	2789	3.58	8.48	6.67	0.89	0.80	
Receptor Sites	1415	0.008	47.35	2.19	1.78	3.17	
Neighbor Legislation Dummy	2973	0	1	0.74	0.44	0.19	
Government Effectiveness	2729	-3.78	2.71	7.09e-10	0.99	0.99	
Interaction: Government Effectiveness*Ties to World Society	2570	-19.87	21.94	0.58	6.77	45.81	
Democracy	2745	0	10	5.92	3.93	15.41	
Geographic Size	2963	4.09	16.59	11.91	2.23	4.98	
Ethnolinguistic Fractionalization	2962	0.002	0.93	0.41	0.23	0.05	
Trade Openness	2839	0.27	6.33	4.29	0.57	0.32	
GDP Per Capita	2855	3.35	11.38	8.29	1.58	2.51	
Catholic Dummy	2968	0	1	0.30	0.46	0.21	

Table 4.7

Pearson Correlation Coefficients: 1965-2012 – 127 Countries

	Legislation	Education	Treaty Ratif.	Ties to World Society	Receptor Sites	Neighbor Legislation	Gov. Eff.
Legislation	**1.0**						
Education	0.3260	**1.0**					
Treaty Ratifications	0.4975	0.5538	**1.0**				
Ties to World Society	0.4494	0.6546	0.6735	**1.0**			
Receptor Sites	0.1884	0.7667	0.4193	0.3950	**1.0**		
Neighbor Legislation	0.4027	0.2624	0.4668	0.3814	0.2874	**1.0**	
Gov. Eff.	0.2545	0.2566	0.1307	0.5797	0.1688	0.1993	**1.0**
Interaction: Gov. Eff. *Ties to World Society	0.2459	0.2262	0.0879	0.5583	0.1806	0.1794	0.9836
Democracy	0.2491	0.6179	0.5003	0.6044	0.3355	0.1959	0.0968
Geographic Size	0.1218	-0.1364	0.0490	0.2847	-0.1360	0.1599	0.5461
Ethno. Fract.	-0.1104	-0.3520	-0.2437	-0.3070	-0.2535	-0.0154	-0.1582
Trade Openness	0.1028	0.3522	0.2482	0.0146	0.2669	0.1412	-0.3657
GDP per Capita	0.2006	0.6806	0.3680	0.5692	0.4564	0.0750	0.2082
Catholic Dummy	0.1451	0.0461	0.2106	0.2001	0.0958	0.2042	-0.0798

	Interaction: Gov.Eff. *Ties to World Society	Democracy	Geog. Size	Ethno. Fract.	Trade Openness	GDP per Capita	Catholic Dummy
Interaction: Government Effectiveness* Ties to World Society	**1.0**						
Democracy	0.1178	**1.0**					
Geographic Size	0.5549	-0.0751	**1.0**				
Ethno. Fract.	-0.1670	-0.3454	0.1626	**1.0**			
Trade Openness	-0.3824	0.1358	-0.5649	-0.0384	**1.0**		
GDP per Capita	0.2216	0.5627	-0.1878	-0.3702	0.2706	**1.0**	
Catholic Dummy	-0.0808	0.2344	-0.1052	-0.1815	-0.0602	0.1682	**1.0**

Table 4.8

Pearson Correlation Coefficients: 1965-1979 – 104 Countries

	Legislation	Education	Treaty Ratif.	Ties to World Society	Receptor Sites	Neighbor Legislation	Gov. Eff.
Legislation	**1.0**						
Education	0.0391	**1.0**					
Treaty Ratifications	0.1376	0.4014	**1.0**				
Ties to World Society	0.1577	0.6052	0.6229	**1.0**			
Receptor Sites	-0.0060	0.7785	0.5438	0.6046	**1.0**		
Neighbor Legislation	0.1338	0.0787	0.1446	0.2299	0.2270	**1.0**	
Gov. Eff.	0.1144	0.2926	0.2318	0.6272	0.3069	0.1402	**1.0**
Interaction: Gov. Eff.*Ties to World Society	0.1239	0.2878	0.1860	0.6075	0.2532	0.1351	**0.9773**
Democracy	0.0634	0.6524	0.3415	0.5014	0.3246	0.0454	0.1197
Geographic Size	0.0733	-0.1170	0.1103	0.3231	-0.1345	0.0247	0.4920
Ethno. Fract.	-0.1067	-0.4253	-0.3302	-0.3165	-0.3972	0.0177	-0.1740
Trade Openness	-0.0530	0.2077	0.1389	-0.1592	0.2612	-0.0102	-0.4601
GDP per Capita	0.0398	0.7116	0.4797	0.5474	0.6361	0.1144	0.2001
Catholic Dummy	0.2060	0.0776	0.1159	0.2773	0.1467	0.2852	-0.0330

	Interaction: Gov. Eff.*Ties to World Society	Democracy	Geog. Size	Ethno. Fract.	Trade Openness	GDP per Capita	Catholic Dummy
Interaction: Gov. Eff. *Ties to World Society	**1.0**						
Democracy	0.1762	**1.0**					
Geographic Size	0.5059	-0.0935	**1.0**				
Ethno. Fract.	-0.1890	-0.3272	0.1794	**1.0**			
Trade Openness	-0.4725	0.1263	-0.6394	0.0014	**1.0**		
GDP per Capita	0.2499	0.5398	-0.1588	-0.3343	0.2931	**1.0**	
Catholic Dummy	-0.0244	0.0229	-0.1178	-0.1798	-0.0692	0.1745	**1.0**

Table 4.9

Pearson Correlation Coefficients: 1980-1988 – 105 Countries

	Legislation	Education	Treaty Ratifications	Ties to World Society	Receptor Sites	Neighbor Legislation	Gov. Eff.
Legislation	**1.0**						
Education	0.0862	**1.0**					
Treaty Ratifications	0.1947	0.3905	**1.0**				
Ties to World Society	0.2664	0.5738	0.6436	**1.0**			
Receptor Sites	0.0728	0.7395	0.4511	0.4236	**1.0**		
Neighbor Legislation	0.3277	0.0043	0.2178	0.2679	0.1964	**1.0**	
Government Effectiveness	0.1997	0.2198	0.0892	0.5801	0.1986	0.1672	**1.0**
Interaction: Gov.Eff.*Ties to World Society	0.1934	0.2299	0.0963	0.5804	0.1991	0.1632	0.9937
Democracy	0.1368	0.6027	0.4800	0.6108	0.3829	0.0742	0.0932
Geog. Size	0.1943	-0.1153	0.1996	0.3803	-0.0939	0.1574	0.5264
Ethno. Fract.	-0.0573	-0.4186	-0.3180	-0.3225	-0.3583	-0.0205	-0.1451
Trade Openness	-0.1080	0.2333	0.0138	-0.1428	0.1968	-0.0278	-0.4413
GDP per Capita	0.1163	0.7246	0.4215	0.5969	0.5832	0.0936	0.1839
Catholic Dummy	0.2432	0.1161	0.3114	0.2353	0.1703	0.3545	-0.0218

	Interaction: Government Eff.*Ties to World Society	Democracy	Geographic Size	Ethno. Fract.	Trade Openness	GDP per Capita	Catholic Dummy
Interaction: Gov. Eff.*Ties to World Society	**1.0**						
Democracy	0.1291	**1.0**					
Geographic Size	0.5207	-0.0640	**1.0**				
Ethno. Fract.	-0.1542	-0.3211	0.1707	**1.0**			
Trade Openness	-0.4401	0.0653	-0.6495	-0.0834	**1.0**		
GDP per Capita	0.2009	0.6092	-0.1880	-0.3606	0.3437	**1.0**	
Catholic Dummy	-0.0211	0.2278	-0.0782	-0.1727	-0.0853	0.1651	**1.0**

Table 4.10

Pearson Correlation Coefficients: 1989-2012– 127 Countries

	Legislation	Education	Treaty Ratifications	Ties to World Society	Receptor Sites	Neighbor Legislation	Gov. Eff.
Legislation	**1.0**						
Education	0.1340	**1.0**					
Treaty Ratifications	0.3467	0.4082	**1.0**				
Ties to World Society	0.3799	0.5625	0.6035	**1.0**			
Receptor Sites	0.0631	0.7096	0.2910	0.3210	**1.0**		
Neighbor Legislation	0.1911	-0.0006	0.2932	0.1990	0.1740	**1.0**	
Gov. Eff.	0.2678	0.1438	0.0271	0.6026	0.1094	0.1384	**1.0**
Interaction: Gov. Eff.*Ties to World Society	0.2649	0.1645	0.0140	0.6012	0.1494	0.1486	0.9908
Democracy	0.2046	0.5589	0.5356	0.6274	0.3074	0.1264	0.0188
Geog. Size	0.1697	-0.1470	0.0546	0.3309	-0.1382	0.2901	0.6108
Ethno. Fract.	-0.1591	-0.3811	-0.3091	-0.3753	-0.2744	-0.0299	-0.1574
Trade Openness	-0.0201	0.2932	0.1256	-0.0664	0.1844	0.0101	-0.4049
GDP per Capita	0.2209	0.6948	0.3594	0.6123	0.4410	-0.0214	0.2092
Catholic Dummy	0.1833	0.0590	0.3531	0.2250	0.1131	0.2214	-0.1157

	Interaction: Gov. Eff.*Ties to World Society	Democracy	Geographic Size	Ethno. Fract.	Trade Openness	GDP per Capita	Catholic Dummy
Interaction: Gov.Eff.*Ties to World Society	**1.0**						
Democracy	0.0493	**1.0**					
Geographic Size	0.5941	-0.0551	**1.0**				
Ethno. Fract.	-0.1678	-0.3786	0.1515	**1.0**			
Trade Openness	-0.4046	0.0817	-0.5252	-0.0498	**1.0**		
GDP per Capita	0.2101	0.5478	-0.1957	-0.3914	0.2227	**1.0**	
Catholic Dummy	-0.1140	0.3821	-0.1101	-0.1857	-0.0181	0.1749	**1.0**

Table 4.11

List of International Human Rights Documents

Document	Year Open to Ratification
Slavery Convention	1926
Forced Labor Convention	1930
Convention on the Prevention and Punishment of the Crime of Genocide	1948
Freedom of Association and Protection of the Rights to Organize Convention	1948
Right to Organize and Collective Bargaining Convention	1949
European Convention for the Protection of Human Rights and Fundamental Freedoms	1950
Convention Relating to the Status of Refugees	1951
Equal Remuneration Convention	1951
Protocol No.1 to the European Convention for the Protection of Human Rights and Fundamental Freedom	1952
Convention on the Political Rights of Women	1953
Slavery Convention as amended by Protocol	1953
Convention Relating to the Status of Stateless Persons	1954
Supplementary Convention on the Abolition of Slavery, the Slave Trade, and Institutions and Practices Similar to Slavery	1956
Abolition of Forced Labor Convention	1957
Discrimination (Employment and Occupation) Convention	1958
Convention against Discrimination in Education	1960
Convention on the Reduction of Statelessness	1961
European Social Charter	1961
Protocol No.4 to the European Convention for the Protection of Human Rights and Fundamental Freedoms	1963
International Convention on the Elimination of All Forms of Racial Discrimination	1966
International Covenant on Economic, Social, and Cultural Rights	1966
International Covenant on Civil and Political Rights	1966
Optional Protocol to the International Covenant on Civil and Political Rights	1966
Protocol Relating to the Status of Refugees	1967
American Convention on Human Rights	1969
Convention Governing the Specific Aspects of Refugee Problems in Africa	1969
International Convention on the Suppression and Punishment of the Crime of Apartheid	1973
Minimum Age Convention	1973
European Convention on the Legal Status of Migrant Workers	1977
Convention on the Elimination of All Forms of Discrimination against Women	1979
African Charter on Human and Peoples' Rights	1981
Protocol No.6 to the European Convention for the Protection of Human Rights and Fundamental Freedoms	1983
Protocol No.7 to the European Convention for the Protection of Human Rights and Fundamental Freedoms	1984
Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	1984
Inter-American Convention to Prevent and Punish Torture	1985
European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment	1987

Additional Protocol to the European Social Charter	1988
Employment Promotion and Protection against Unemployment Convention	1988
Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights	1988
Indigenous and Tribal Peoples Convention	1989
Convention on the Rights of the Child	1989
Second Optional Protocol to the International Covenant on Civil and Political Rights, aiming at the Abolition of the Death Penalty	1989
Protocol to the American Convention on Human Rights to Abolish the Death Penalty	1990
International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families	1990
African Charter on the Rights and Welfare of the Child	1990
Protocol amending the European Social Charter	1991
European Charter for Regional or Minority Languages	1992
Protocol No.11 to the European Convention for the Protection of Human Rights and Fundamental Freedoms	1994
Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women	1994
Inter-American Convention on Forced Disappearance of Persons	1994
European Framework Convention for the Protection of National Minorities	1995
Additional Protocol to the European Social Charter Providing for a System of Collective Complaints	1995
European Convention on the Exercise of Children's Rights	1996
European Social Charter (Revised)	1996
European Convention on Nationality	1997
Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women	1999
Worst Forms of Child Labor Convention	1999
Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict	2000
Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography	2000
Protocol No.12 to the European Convention for the Protection of Human Rights and Fundamental Freedoms	2000
Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa	2003
Arab Charter on Human Rights	2004

Chapter Five: Results

Legislation Against the Organ Trade – The Key Role of Human Rights, Epistemic Communities, and World Culture

~~Introduction~~

According to the WHO (Fluss 1991; WHO 1991A), Chile and Italy were the first countries to pass legislation banning commercial transplantation in 1967. Since then, over 100 countries have passed legislation banning commercial transplantation. What explains this rapid, global diffusion of commercial transplantation laws, and what factors impact individual states' legislation?

One framework for understanding legislation is rationalization, which involves the search for the optimum means to a given end, and is often shaped by rules, regulations, and larger social structures (Ritzer 1993: 19). It is important to recall that the organ trade is "violent, dangerous, ineffective, and inefficient" (Moniruzzaman 2014), with high rates of organ rejection, greater incidences of various contractible diseases, threats of maiming or death, and an array of public health implications (Anker and Feeley 2012; Francis and Francis 2010; Gill 2014; Jafar 2009; Scheper-Hughes 2000; Shelley 2010). Within this context, legislation reflects a rationalized transplantation process, with transplantation becoming safer, more efficient, predictable, and effective. Thus, countries with higher levels of rationalization should be more likely to pass legislation.

Another potentially useful framework for examining global legislation trends is provided by world culture/world polity theory (WC/WPT). According to WC/WPT, world culture and the world polity generate and propagate models of and scripts for legitimacy and rationality that states enact and follow. One particular cultural model for

states involves the legitimate, humane treatment of the individual (Elliott 2007). The rapid growth and diffusion of the international human rights regime, constituting human rights based INGOs, instruments, and conferences, has helped globalize the model for respect of the individual. The global human rights regime institutionalizes the individual's inherent right to life and sanctity of person, helps to establish individual sacrality globally, and thus delegitimizes the organ trade, which is viewed as violating human rights and basic human dignity (Cherry 2005: 129; Ezeilo 2013; Glaser 2005).[159]

As a result, the ratification of human rights treaties, which promote respect for and sacralization of the individual and outline models for states (Elliott 2007), should positively impact legislation. Additionally, as cultural models of the respect for and sacralization of the individual diffuse globally through world society and INGOs, states with more connections to world society should be more likely to implement commercial transplantation legislation. Last, medical epistemic communities, operating as receptor sites that help develop and transmit global models, and also promote ethical practices and conduct within nation-states, should positively impact legislation.

While it is universally recognized that states are responsible for establishing authority, order, laws, and regulations within their jurisdiction, it is relatively clear that not all states are effectively able to do so (Back and Hadenius 2008; Englehart 2009; Gros 1996: 456). In terms of the organ trade, although the world polity and world culture sacralize the individual, delegitimize the organ trade, and encourage legislation, many

[159]It is important to note here that although it may be argued that legislation restricts one's ability to consent to sell organs, the notion of consent is staunchly rejected by many analysts since the organ trade occurs within the context of crippling inequalities, illiteracy, poverty, and vulnerability, meaning little freedom or liberty is actually expressed (Budiani-Saberi and Karim 2009; Chapman 2014; Noorani 2008; Scheper-Hughes 2000; Smith 2009). Decades of experience have illustrated that organ sellers "are the poor or the vulnerable, whose actions reflect financial desperation and ignorance, not autonomous agency" or willful consent (Danovitch et al. 2013: 2). Furthermore, many analyses of the organ trade have found that organ sellers frequently lament that "they would not have agreed to [sell their organ] if their economic circumstances were not so dire" (Budiani-Saberi et al. 2013: 2).

states are unable to translate this into action. Beyond political will or rhetoric, the design, development, and implementation of domestic legislation and regulations require sound judgment, bureaucratic capabilities, fiscal resources, and other facets of government effectiveness (Chayes and Chayes 1993: 194). Accordingly, countries that are both highly embedded within world society *and* have high levels of government effectiveness should be more likely to implement legislation.

Finally, states' crime reduction policies are not developed or implemented within a vacuum (Broude and Teichman 2009). Instead, a state's policies are often influenced by its neighbors, with governments likely to make policy commitments if their neighbors do so (Simmons 2000: 832). However, when implementing legislation, states not only raise the costs of illegal activity within their own jurisdiction, they may divert criminal activity to neighboring states since criminal networks frequently turn to jurisdictions with lax laws (Bronars and Lott Jr. 1998; Keenan 2006: 507; Kelly 2013; Lloyd, Simmons, and Stewart 2012). With states wary of criminal activities spilling over into their own jurisdictions, states will likely implement legislation when a neighbor has done so.

The next section presents results from the quantitative analyses testing the hypotheses summarized above. Survival analysis results are reviewed first, followed by logistic regression results. The chapter concludes by presenting results of logistic regression analyses conducted after dividing the 1965-2012 time period into three individual segments: 1965-1979; 1980-88; and 1989-2012. To facilitate interpretation, the effect of variables is estimated through utilizing simulations and "margins" [160], and altering the values of particular variables of interest.

[160] "Margins" is a command available within the *STATA* statistical analysis software package. It helps reflect the substantive and practical significance of results by estimating the probability of legislation when covariates are set to

~~*Survival Analysis Results*~~

~~*Preliminary Analyses*~~

The survival analysis examines 127 countries for 1965-2012.[161] Figures 5.1, 5.2, and 5.3 present the hazard ratio/rate, the Nelson-Aalen cumulative hazard estimate, and the Kaplan-Meier estimate, respectively. Together, Figures 5.1, 5.2, and 5.3 help clearly summarize and graphically visualize the legislation data.

The hazard rate is the probability that a country will pass legislation at time *t* while the country is "at risk" for passing legislation. The set of states at risk for passing legislation ("the risk-set") is made up of all countries in the world. Countries' onset of risk for legislation banning the organ trade begins when they enter the data, which is 1965 for most countries; however, countries attaining independence within the time period (1965-2012) are inserted into the risk-set the year in which they became independent (Mathias 2013; Wotipka and Tsutsui 2008: 739). Figure 5.1 illustrates that the hazard rate increases steadily over time. Specifically, as time passes, countries are more likely to pass legislation. However, near the end of the time period, the hazard rate decreases, suggesting that countries become less likely to pass legislation.

~~Figure 5.1 Here~~

Figure 5.2 displays the Nelson-Aalen cumulative hazard estimate, which simply sums the hazard rate estimates over time (Cleves et al. 2008: 107). Figure 5.2 illustrates a stable increase in the cumulative hazard rates over time.

~~Figure 5.2 Here~~

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different values. Specifically, marginal effects show the change in probability when a covariate increases by one unit. For continuous variables this represents the instantaneous change given that the "unit" may be very small. For binary variables, the change is from 0 to 1.

[161] The full list of countries examined is available in Table 5.6.

Last, the Kaplan-Meier estimate displays the probability of surviving (i.e. not passing legislation) during the 1965-2012 period. The Kaplan-Meier estimate is a simple, yet particularly useful method, as it allows for the estimation of survival times even when subjects (here countries) are under observation for different lengths of time (Goel, Khanna, and Kishore 2010). Figure 5.3 shows that the likelihood of not passing legislation decreases considerably over time; by the end of the time period, approximately twenty percent of the countries in the sample have "survived" or not passed transplantation legislation.

~~Figure 5.3 Here~~

In summary, Figures 5.1, 5.2, and 5.3 demonstrate that from 1965 to 2012, countries became more likely to pass legislation (or that the likelihood of not passing legislation decreased significantly). While in 1965, no countries had passed legislation, by 2012 over 100 countries implemented legislation.

~~Results~~

Table 5.1 presents the survival analysis models. Model 1 introduces the three WC/WPT variables and adds the controls. While the three WC/WPT variables are positive, only the treaty ratifications variable is significant. As a result, this model only offers support for hypothesis 1, indicating that states that ratify more international human rights treaties are quicker to implement legislation.

Examining the coefficient for treaty ratifications, which is 0.002, it is possible to obtain the percentage impact of the coefficient on the hazard for legislation by conducting the calculation: *exp*(*beta* x unit change in *X*). Therefore, *exp*(0.002 x 10) = 1.02. Interpreting this figure reveals that after holding the other covariates constant, a

yearly increase of 10 treaty ratifications leads to a 2 percent increase in the hazard of legislation. It is important to recall that during the time period examined, the global average total number of treaties ratified per country, increased (see Figure 5.4). Accordingly, treaty ratifications appear to positively impact how quickly states pass commercial legislation.

~~Figure 5.4 Here~~

Results from Model 1 fail to support hypotheses 2 and 3, which predict that ties to world society and receptor sites positively impact states' implementation of legislation. Interpreting the respective coefficients, for ties to world society, an increase of 1 in the value of the covariate leads to an increase in the estimated risk of legislation by approximately 2.4 percent, holding all other covariates constant. Performing the same procedure for receptor sites sees the estimated risk of legislation increase by 0.7 percent. While the direction of the coefficients corresponds with their respective hypotheses (both positive), the fact they fail to reach significance indicates that they do not have effects on how quickly countries pass legislation.

Of the control variables, only trade openness and GDP per capita are significant, with each being negative. This indicates that, net of the other covariates, countries with greater levels of trade openness or countries that are more economically developed have less risk of legislation. For a one-unit increase in trade openness, the risk of legislation decreases by approximately 3 percent, holding all other covariates constant, while for a one-unit increase in GDP per capita, the risk of legislation decreases by approximately 2 percent.

Model 2 maintains the same format as Model 1, but removes the democracy variable, since it may be influencing the ties to world society variable (their correlation coefficient is ~0.59). Consequently, in Model 2, ties to world society is positive and statistically significant, suggesting that the democracy variable was counteracting it in Model 1.[162] Interpreting the coefficient indicates that a one-unit increase in ties to world society increases the risk for legislation by approximately 4 percent. Recall that world society, particularly since WW-II, has developed and articulated global cultural models and norms regarding the dignity and sacrality of the individual. Moreover, these models and norms diffuse globally via INGOs (Boli and Thomas 1999A).

In Model 2, the treaty ratifications variable remains positive and significant, and it has the same coefficient as in Model 1. As well, the coefficients for the trade openness and GDP per capita variables are nearly identical to Model 1, with both variables remaining negative and statistically significant. Notably, the receptor sites variable is once again not significant, although it is positive. To examine any possible influence of receptor sites, I retest it in models without the other WC/WPT variables; however, in these retested models it is not statistically significant.[163]

In order to illustrate the effect of the variables in Model 2, Figure 5.5 displays the survival function for not passing legislation, when holding all the covariates at their means. The survival function shows clearly that the likelihood of *not* passing legislation decreases appreciably over time.

~~Figure 5.5 Here~~

[162]Alternatively, I also retest Model 2 by including democracy and removing ties to world society. In this retested model, democracy is again not significant, while the WC/WPT variables (i.e. treaty ratifications and receptor sites) are both positive and significant. This series of tests suggest that democracy does not impact legislation, whereas the WC/WPT variables are strong predictors of legislation.

[163]I also test the receptor sites concept utilizing another variable, hospital beds per 1000 people (available from the World Bank [2013]). However, this variable is also not statistically significant.

It is noteworthy that across Model 1 and 2, the treaty ratifications variable was positive and significant. Figure 5.6 demonstrates the importance of treaty ratifications to countries' risk of passing legislation. Specifically, Figure 5.6 plots a country's probability of not passing legislation for four separate levels of treaty ratifications: the minimum value (0 ratifications), the 1st quartile (9), the 3rd quartile (23), and the maximum (46). All other covariates within Model 2 are set at their means in order to capture the isolated impact of treaty ratifications on legislation. Figure 5.6 shows that as treaty ratifications increase from 1965 to 2012, a country's likelihood of *not* passing legislation greatly diminishes over time. At the beginning of the time period, countries appear relatively unlikely to pass legislation against the organ trade. If ratifications had remained at this level, then the likelihood of not passing legislation would have remained quite high. Instead, by the end of the time period, as ratifications increase, the likelihood of survival falls to nearly zero, reflecting a dramatic increase in the likelihood of passing legislation. Quite simply, the growth in human rights treaty ratifications had a strong, positive impact on the implementation of legislation.

~~Figure 5.6 Here~~

Models 3 and 4 investigate the impact of the other independent variables. Model 3 tests ties to world society, government effectiveness, and their interaction alongside the control variables, whereas Model 4 tests the neighbor legislation dummy and rationalization variables with the controls. Testing the variables in this manner helps capture their isolated impact on legislation, while also minimizing estimation problems due to correlated variables.[164] Across Models 3 and 4, the independent variables fail to

[164]For example, the correlation between ties to world society and rationalization is approximately 0.65, while the other WC/WPT variables similarly show high correlations.

exhibit a statistically significant effect. Furthermore, while the government effectiveness variable is positive, the ties to world society, interaction, rationalization, and neighbor legislation variables are each negative (contradicting their respective hypotheses).[165]

Of the control variables, across Models 3 and 4, only ethnolinguistic fractionalization is statistically significant (solely within Model 4). Examining its coefficient, which is negative, suggests that for a one-unit increase in ethnolinguistic fractionalization, the risk for legislation decreases by approximately 10 percent. This result corresponds with previous work and literature suggesting ethnolinguistic fractionalization negatively impacts political stability and quality of state institutions (Alesina et. al 2003; La Porta et. al 1999).[166] As well, although it is apparent that legislation against the organ trade involves a national, domestic legislative process, the failure of democracy, a domestic political institution, to achieve significance in any models within Table 5.1 underscores that it is a state's integration into world society, rather than its internal political dimensions, that is important to how quickly it passes legislation.

Notably, the Catholic dummy variable was not significant within any models in Table 5.1. This is slightly surprising since previous work by Mathias (2013) found that predominantly Catholic nation-states are most likely to abolish the death penalty, while

[165]I also explore the influence of government effectiveness, the interaction variable, rationalization, and neighboring country legislation simultaneously with the control variables, in a single model. However, no variables within the model are significant, indicating that they do not influence legislation. Furthermore, government effectiveness, the interaction variable, rationalization, and neighboring country dummy were also each tested individually with the control variables, yet results were generally the same. Finally, in place of the average years of schooling variable (which measures the concept of rationalization), I test a rationalization index (which is comprised of measures of a state's urbanization, secondary enrolment, and fertility rate) and also university enrolments. However, these two variables are also insignificant. For brevity, results from these various tests are not presented, but available from the author.

[166]Moreover, previous works have found that states with higher levels of ethnolinguistic fractionalization may have more dishonest bureaucracies (Shleifer and Vishny 1993), and are likely to experience bouts of political violence or breakdowns of law and order (Annett 2001).

McGann and Sandholtz (2012) found that being a predominantly Catholic country raises the probability of abolition very significantly. Since abolition of the death penalty shares traits with legislation banning commercial trafficking (e.g. sacralization of the individual and human dignity), it was expected that Catholic countries, as with abolition of the death penalty, could be more likely to implement legislation. To further explore any possible influence of religion, I also tested Protestant and Islam dummies, yet neither was significant.[167] In aggregate, these particular findings indicate that religion does not impact legislation.

In summary, results from Table 5.1 demonstrate that states more embedded into world society and with more human rights treaty ratifications have a greater risk of implementing legislation banning the organ trade. At the same time, higher levels of GDP per capita and trade openness decrease states' risk of implementing legislation. Other covariates, such as the rationalization, neighboring country legislation dummy, government effectiveness, interaction, and control variables, fail to achieve statistical significance (with only ethnolinguistic fractionalization achieving statistical significance, and in only one single model), indicating that they do not impact legislation.

~~Table 5.1 Here~~

~~Logistic Regression Results~~

Table 5.2 presents results from logistic regression for 1965-2012, with 127 countries examined.[168] While the analyses for Table 5.1 examine how quickly countries pass legislation, Table 2 presents results of analyses that explore the likelihood of ever passing legislation. Utilizing both analytical methods thus provides a fuller understanding

[167]For brevity, these results are not shown, but available from the author.
[168]The complete list of 127 countries examined is provided in Table 5.6.

of the implementation of transplantation legislation. Model 1 contains the three WC/WPT variables: treaty ratifications, ties to world society, and receptor sites. Each variable is positive and significant, indicating that treaty ratifications, ties to world society, and receptor sites have a positive effect on the likelihood that a state will implement transplantation legislation. When setting the covariates at their respective means, the probability a state will pass legislation is approximately 35 percent.

In Model 2, the WC/WPT variables are retained, while the government effectiveness and the interaction of government effectiveness and ties to world society variables are added. Although both the government effectiveness and the interaction variable have a positive effect (in accordance with hypothesis 6), neither is statistically significant. In contrast, the treaty ratifications, ties to world society, and receptor sites variables each remain positive and significant. In Model 2, if all covariates are set to their means, the probability of legislation is approximately 93 percent, reflecting a sharp increase from Model 1. As well, Model 2 indicates that government effectiveness, either individually or interacted with ties to world society, is not associated with legislation.[169]

In Model 3, the three WC/WPT variables are included, while the government effectiveness and the interaction of government effectiveness and ties to world society variables are replaced by the neighbor legislation dummy and rationalization variables. Once again, the WC/WPT framework garners support; specifically, the treaty ratifications and ties to world society variables are both positive and significant, thus each increases the likelihood of legislation. However, in this model the receptor sites variable, although positive (inline with hypothesis 3), is not statistically significant.

[169]I also test government effectiveness individually, without the interaction term; however it is not significant.

The neighboring country dummy variable has a positive effect, in alignment with hypothesis 5. This suggests that a country sharing a border with another country that has legislation is more likely to pass legislation itself; however, the effect is not statistically significant. Interestingly, in contrast to hypothesis 4, the rationalization variable is negative and not significant, indicating that rationalization does not impact legislation.[170]

Last, Model 4 retains the WC/WPT variables, and adds the control variables. Treaty ratifications, ties to world society, and receptor sites each have a significant, positive effect on the likelihood of legislation. These results underscore that the WC/WPT framework is a good predictor of legislation. Specifically, legislation is impacted by human rights treaties promoting respect for and sacralization of the individual (Elliott 2007), as well as cultural models sacralizing the individual that diffuse globally via INGOs. Additionally, receptor sites are important since they absorb, decode, and transmit global models, and encourage legitimate, ethical practices within nation-states.

Of the control variables, only GDP per capita has a statistically significant effect, which is negative.[171] This suggests that wealthier countries are less likely to pass legislation; specifically, a one-unit increase in GDP per capita decreases the odds of legislation by a factor of 0.28, holding all other covariates constant.

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[170]In addition to testing rationalization through the average schooling variable, I test rationalization via several other variables: a rationalization index (comprised of urbanization, secondary enrolment, and fertility rate) and university enrolment. However, in numerous tests the various rationalization measures do not show significance. Furthermore, I also test the model while adding government effectiveness and the interaction of government effectiveness and ties to world society; however, as with previous models, only the WC/WPT variables are significant.

[171]As with Table 5.1 (survival analysis), the Catholic dummy variable is not significant. To further investigate any possible influence of religion, I also tested Protestant and Islam dummies, yet neither illustrated a significant effect. In aggregate, these particular findings indicate that religion is not associated with legislation.

It is noteworthy that democracy is both negative and not statistically significant. One possible explanation is that its effect is mediated by the WC/WPT variables, particularly ties to world society (correlation coefficient with democracy is ~0.59). Consequently, I retest Model 4, but remove ties to world society. With only slight differences, this retested model largely mirrors Model 4, and democracy remains negative and not statistically significant, indicating that it is not associated with legislation.

In summary, Table 5.2 demonstrates that implementation of transplantation legislation is shaped by several factors. Results show that the WC/WPT variables are good, stable predictors of legislation implementation. Integration into world society (i.e. ties to world society), human rights treaty ratifications, and receptor sites (i.e. physicians per 1000 people) increase the likelihood of legislation implementation. In contrast, economic development – measured as GDP per capita – decreases the likelihood of legislation. Results also reflect that legislation is not associated with rationalization, government effectiveness or its interaction with ties to world society, legislation in a neighboring country, or a variety of control variables.

~~Table 5.2 Here~~

Overall, results from logistic regression and survival analysis present similar patterns, and offer support for the WC/WPT theoretical framework and hypotheses. Across Tables 5.1 and 5.2, the three WC/WPT variables were consistently positive and statistically significant in numerous models. Greater integration into world society positively impacts states' likelihood for legislation; as awareness and understanding of the organ trade grew, numerous regional and global policy initiatives and cultural models

emerged to combat it – often recommending legislative responses.[172] Accordingly, countries more integrated into world society were more likely to adopt such international policy frameworks, implementing them into domestic law.

Additionally, states with more human rights treaty ratifications are more likely to implement legislation prohibiting the organ trade. Individual sacrality has developed into a key feature of world society, and it is institutionalized within the global legal framework of human rights treaties and conventions (Elliott 2007; Mathias 2013). International human rights treaties and conventions establish, codify, and institutionalize the individual's inherent right to life and sanctity of person (Elliott 2007; Mathias 2013), thus delegitimizing the organ trade, which is viewed as violating basic individual rights and dignity (Budiani-Saberi 2014; Budiani-Saberi and Columb 2013; Noel 2014). Importantly, the principles of sacrality and dignity are apparent within many states' legislation. For example, El Salvador's *Law of Organ and Tissue Transplantation*; Article 128-B stipulates that "the practice of transplantation…[must adhere]…to ethical standards and [be] based on principles of equity, justice, solidarity…and without distinction of any kind" (El Salvador 1988). Additionally, Article Five of Montenegro's *Removal and Transplantation of Human Body Parts for the Purposes of Medical Treatment Act, no. 76/2009* declares that "in procedures of removal and transplantation of body parts protection of donor's and recipient's identity, personal dignity and other personal rights and freedoms shall be guaranteed" (Montenegro 2009).

Results also suggest that states with more physicians are more likely to implement commercial transplantation legislation. World society grants much authority and

[172]For example, Table 2.2 (page 68) lists many important global declarations, guidelines, conventions, and resolutions regarding transplantation and the organ trade.

legitimacy to rationalized, scientific communities (Koenig and Dierkes 2011; Meyer et al. 1997: 165), and "diffusion among nation-states is heavily mediated by scientists and professionals who define virtuous instances, formulate models, and actively support their adoption" (Meyer et al. 1997: 166). Within transplantation, such communities function as receptor sites that receive, decode, and transmit information, models, and legitimate goals for action from world society to nation-states (Frank, Hironaka, Schofer 2000: 103), while also encouraging and pressuring states to implement legislation.[173]

As well, Tables 5.1 and 5.2 illustrate that economic development, in terms of trade openness and GDP per capita, decreases the likelihood of implementation. The global organ trade involves organs flowing from poor countries to the wealthy (Delmonico and Scheper-Hughes 2003; Moniruzzaman 2012: 70; Scheper-Hughes 2000). Wealthy, developed countries regard the organ trade as an effective way to reduce glaring organ shortages,[174] and save costs on "funding an extremely expensive and indefinite dialysis treatment" (Efrat 2015: 19). Simply, for wealthy countries, "the practical effects of the [organ trade] – reduced pressure on the waiting list and keeping a back door open for the rich – are regarded as welcome" (Beard, Kaserman, and Osterkamp 2013: 68). Figure 5.7 displays the glaring gap between supply and demand of organs within wealthy countries; annually, a considerable number of individuals are added to organs waiting list, while only a small number of people receive an organ transplant.

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[173]In addition, these communities serve as general sources of expertise and innovation within world society.

[174]The large discrepancy between organ demand and supply is especially evident within transplantation waiting lists. In Western Europe, "as of 2006, nearly 40,000 people were on waiting lists," while in the US, "at the end of 2008, 100,597 people were registered on waiting lists." In this context, "desperate patients seek strategies to obtain organs from outside their home countries," and often head to the Global South (Sperling 2014: 194). It is also important to recognize that, in "poor countries, [organ shortage] problems are often masked by inadequate public health resources: countries in which dialysis is generally unavailable do not exhibit waiting lists because their end-stage renal disease patients die quickly. Patients needing transplants of organs other than kidneys receive less attention due to their smaller numbers, but in such cases no therapeutic alternatives to transplantation, such as dialysis, exists. These patients usually die quickly, and thus receive less attention than those on dialysis" (Beard, Kaserman, and Osterkamp 2013: 1).

~~Figure 5.7 Here~~

Within this context, some governments support their citizens' travel abroad (Ezeilo 2013); for example, "some governments and health insurers in rich countries…[urge] their kidney patients to obtain a transplant abroad…[and]…they often [support] this outbound tourism financially" (Epstein 2012: 133). Israel (a wealthy, developed country) has historically had low levels of donation, leading to quite significant organ shortages. Many Israelis participated in the organ trade or "roamed the globe in pursuit of organs," and their organ trade and transplant tourism activities were often encouraged, and even supported, by Israeli health and government ministries as a way to relieve domestic shortages (Efrat 2013A: 83).[175] Moreover, during the Istanbul Declaration's meeting in Turkey in 2008, a Hindu surgeon noted that while the organ trade was a "tragic turn of events," the overwhelming "demand [for it] comes from outside" (Scheper-Hughes 2014).[176]

Quantitative results also indicate that rationalization does not impact the implementation of legislation. Furthermore, the failure of government effectiveness to achieve significance shows that legislation is not impacted by capacity or effectiveness. These respective findings underscore that it is a state's integration into world society, rather than a state's particular characteristics, which is influential for legislation. All

[175]Bramstedt and Xu note how some US "insurance programs are taking steps to address the problems of organ availability, long waiting times, and high medical and surgical costs by promoting transplant tourism" (Bramstedt and Xu 2007: 1698).

[176]It should be noted that at this stage, the argument seeking to explain the counter-intuitive results for economic development is only an initial, developing hypothesis rather than a conclusive explanation. The author acknowledges that much more evidence and greater research are required to better understand (if not substantiate) this particular process (i.e. wealthy countries viewing the organ trade as a mechanism to reduce shortages). It is quite possible that other factors (as yet to be fully understood) are behind this result. While there is clear evidence that wealthy countries are generally faced with a significant shortage of organs, it is difficult to locate independent evidence that reasonably and clearly explains why or how wealthy, developed countries are less likely or slower to pass legislation. Moving forward, the collection of more data (i.e. information about more countries) may help to reveal the specific processes underlying these results. Additionally, more interviews (particularly with officials, ministry authorities, and policy-makers) would be highly beneficial towards understanding and explaining these important results.

types of states pass legislation, and embeddedness within world society is an important factor. This is a "classic" WC/WPT finding. For example, in a seminal exploration of the universal expansion of education during the 1900s (e.g. mass education and similar national curricula or systems), Meyer et al. (1977) find that the global diffusion of education was due to "characteristics of the…world system," and state ties to the system, rather than a function of the individual characteristics of nation-states (Meyer, Ramirez, Rubinson, and Boli-Bennett 1977: 255). Additionally, examining environmentalization, Frank (1999) finds that countries with dense connections to world society are most likely to embody global models of environmentalization, regardless of particular national interests, such as natural degradation, scientific capacity, or political openness.[177]

~~Subdivision of Time Period~~

Results from Table 5.1 and Table 5.2 detailed the patterns of transplantation legislation across the 1965-2012 period. To explore possible variance in legislation *within* the time period, this section separates the 1965-2012 time period into three segments: 1965-1979, 1980-88, and 1989-2012. These time periods correspond with several key events within global transplantation. The first "cut-off" point (i.e. 1979) was chosen on the basis that Cyclosporine A, an important immunosuppressant that lowers rejection rates and thereby led to a rapid expansion of transplantation medicine, was introduced and widely distributed in the 1980s.[178] The introduction of Cyclosporine A "[ushered] in a new era of improved outcomes in transplantation," and it was crucial to the large

[177]Further, examining national environmental policy reforms in Asia, Frank, Longhofer, and Schofer (2007) find that environmental policy changes are borne of the global environmental regime, and state linkages to the regime and world society, rather than domestic environmental NGOs or other state characteristics.
[178]It had been tested in many trials during the late 1970s period.

increase and spread of transplantation medicine (Gaston 2001: 25).[179] Additionally, the 1980s period saw the first reports of the organ trade (Panjabi 2010; Scheper-Hughes 2001), whereas in the 1970s there was "little to indicate" that there was "any trafficking or commerce in organs" (Daar, Gutmann, and Land 1997: 302). The second "cut-off" point (i.e. 1989) represents when the World Health Assembly adopted resolution 42.5; in addition to condemning the organ trade, the resolution called on "states to take…measures to prevent the [organ trade]," and strongly urged states to "introduce legislation to prohibit trafficking in organs" (WHA 1989; Zielinski 1994).

~~Results~~

Table 5.3 presents results for the 1965-1979 time period, with 104 countries examined.[180] Model 1, which includes the treaty ratifications, ties to world society, and receptor sites variables, offers minimal support for the WC/WPT framework. Hypothesis 2, predicting that more ties to world society leads to a greater likelihood of legislation, receives support since the ties to world society variable is positive and statistically significant. However, hypotheses 1 and 3, which predict that a greater number of treaty ratifications and more receptor sites increase the likelihood of legislation, fail to garner support, with both variables not statistically significant.

In Model 2, the three WC/WPT variables are tested alongside government effectiveness and the interaction variable. Notably, ties to world society, which was significant in Model 1, is no longer statistically significant. Additionally, the other covariates in the model fail to reach statistical significance. Results from Model 2 do not

[179]Transplantation was rapidly becoming "accepted as a routine treatment" (Chapman 2014), and as a testament of its growth, of the 6000 total heart transplants performed worldwide by 1988, eighty percent occurred between 1984 and 1988 (Patrick et al. 1991; TTS 2006).
[180]The full list of countries examined for this period is found in Table 5.7.

support the WC/WPT framework, and results also indicate that government effectiveness and its interaction with ties to world society are not associated with legislation. For Model 3, the WC/WPT variables are tested alongside the neighboring country dummy variable, while Model 4 tests the WC/WPT variables with rationalization. Across both models, the majority of covariates fail to show a statistically significant effect. Specifically, only ties to world society is statistically significant (solely within Model 3).

Last, in Model 5, the WC/WPT variables are tested alongside the control variables. The WC/WPT variables fail to achieve statistical significance, a result that is notable since they were consistently significant in other tables. Of the controls, only the Catholic dummy variable is significant,[181] indicating that predominantly Catholic countries were more likely to pass legislation during the 1965-1979 period. Specifically, the odds of legislation for a Catholic country are approximately 2.15 times larger than the odds of legislation for a non-Catholic country, holding all other variables constant.

One possible explanation for the WC/WPT variables' failure to illustrate significance is that their effects may be moderated by the democracy variable (it is strongly correlated). As a result, I retest Model 5, but remove the democracy variable. This modification slightly changes the results for the model. First, ties to world society becomes statistically significant (and is positive). This result corresponds with earlier models in Table 5.3 showing that ties to world society increases the probability of legislation, and also provides some support for the WC/WPT framework.

[181]It should be noted that the P-value for the Catholic dummy variable is 0.052, which means that it is significant at the 0.1 alpha-level, but *not* statistically significant at the traditional 0.05 alpha-level. With 14 countries passing legislation by 1979, and 9 of those 14 being predominantly Catholic, it would appear that the Catholic dummy would be significant. However, in exploring why it failed to achieve at the traditional alpha-level, recall that over 100 total countries were examined for the 1965-1979 period. Thus, with so few of the overall total passing legislation, the Catholic dummy variable's effects may have been difficult to capture.

Additionally, in the retested model, the Catholic dummy variable achieves significance, and is positive; specifically, the odds of legislation for a Catholic country are approximately 2.02 times larger than the odds of legislation for a non-Catholic country, holding all other variables constant. With the Catholic dummy variable significant in both Model 5 and the retested model, results indicate that predominantly Catholic countries were more likely than non-Catholic countries to pass legislation within the early period. Exploring the data, this result appears quite reasonable. Of 104 countries included in the analysis of the 1965-1979 period, only 14 countries passed legislation, with 9 being predominantly Catholic: Italy, Chile, Uruguay, Venezuela, Costa Rica, France, Argentina, Bolivia, and Spain. Although no formal religious statements or declarations regarding the organ trade had been made by the Roman Catholic Church until years later, the Church has long maintained a firm stance against abortion, while in 1969 it formally abolished the death penalty in Vatican City (Mathias 2013: 1254). Additionally, Pope Pius XII (tenure from 1939 to 1958) gave many addresses on fast-developing medical-moral issues, speaking out "boldly" of the "dignity of the individual and the inviolability of his personality" (Healy 1959: 462). Furthermore, Pope John Paul I, in addressing the 7th International Congress of the Organ Transplant Society meeting in 1978, underscored the importance of acting "with respect for the person" (Vatican 1978). Generally, these developments evidence the Church's "celebration and reverence for the sacrality of life" (Mathias 2013: 1254), and the results suggest that Catholic countries were impacted by these cultural models.

Overall, Table 5.3 demonstrates that few variables were influential to the implementation of legislation during the 1965-1979 period. Results reveal few noticeable

patterns, and various predictors fail to show significance in the majority of the models. Of the various hypotheses, only ties to world society received support (reaching significance in Models 1, 3, and the retested Model 5). Moreover, of the controls, only the Catholic dummy was influential, a result that meshes with previous work finding that predominantly Catholic countries were more likely to abolish the death penalty (Mathias 2013; McGann and Sandholtz 2012).

In interpreting Table 5.3, it is important to also recognize that transplantation and the organ trade were in their initial, nascent stages during the 1965-1979 period (Chapman 2014). Many countries were only beginning to develop national transplantation programs, while the global organ trade was yet to elicit broad attention (Chapman 2014; Scheper-Hughes 2001). As a result, tangible responses, such as legislation, were still in the course of development or in the process of unfolding.

~~Table 5.3 Here~~

Table 5.4 displays results for 1980-1988, with 105 countries assessed.[182] Model 1 begins with treaty ratifications, ties to world society, and receptor sites. Following the pattern of other tables, the model supports the WC/WPT framework, with each of the variables positive and statistically significant. Utilizing marginal effects, for a one-unit increase in treaty ratifications, the probability of legislation increases by slightly less than 1 percent, while setting the other covariates at their means. For ties to world society and receptor sites, the same procedure increases the probability of legislation by approximately 4 and 1 percent respectively (holding the other covariates at their means).

In Model 2, the treaty ratifications, ties to world society, and receptor sites variables are tested alongside the government effectiveness and interaction variables. The

[182]The full list of countries examined for this period is found in Table 5.8.

WC/WPT framework again garners support, as treaty ratifications and ties to world society remain positive and statistically significant. However, in contrast to Model 1, the receptor sites variable is not significant. Additionally, the government effectiveness and interaction variables fail to reach significance, indicating that they are not associated with legislation.

In Model 3, the three WC/WPT variables are tested alongside the rationalization variable, while in Model 4, rationalization is replaced with the neighboring country legislation variable. Interestingly, in Model 3, no covariates reach significance, suggesting that the influence of the WC/WPT variables (as evident in Model 1) was moderated by the inclusion of the rationalization variable.

Although no covariates were significant in Model 3, in Model 4 both the neighboring country dummy and ties to world society variables stand out as significant predictors of legislation. These results offer some support for the WC/WPT framework (particularly hypothesis 2), and also hypothesis 5, which predicts that countries are likely to pass legislation when a neighbor has done so.

Last, Model 5 retains the WC/WPT and neighboring country legislation variables, and includes the controls. The WC/WPT framework again receives support, with both ties to world society and receptor sites being positive and statistically significant. For a one-unit increase in ties to world society, the probability of legislation increases by less than 1 percent (holding all other covariates constant). Performing the same procedure for receptor sites, the probability for legislation also increases by less than 1 percent.[183]

[183]Specifically, the increases in probability for ties to world society and receptor sites are 0.2 and 0.15 percent, respectively.

As well, the neighboring country dummy variable is again positive and statistically significant; specifically, the odds of legislation for countries that have neighbors with legislation are nearly 3 times larger than the odds of legislation for countries that have no neighbors with legislation.

Turning to the control variables, only two covariates, the Catholic dummy and GDP per capita, demonstrate significant effects. The Catholic dummy variable is both positive and statistically significant. The odds of legislation for a Catholic country are approximately 1.2 times larger than the odds of legislation for a non-Catholic country, holding all other variables constant. This result is notable since in many other tables, the Catholic dummy failed to achieve significance. Additionally, the result suggests that the early momentum towards legislation by Catholic countries during the 1965-1979 period carried over into the 1980-1988 period. For example, as transplantation (and other medical technologies) continued to develop, the Catholic Church increasingly "expressed concern" about potential implications (Healy 2006: 32), and reiterated the need to protect human dignity. In 1980, Pope John Paul II cautioned that the rapid medical advancements could "[jeopardize] the survival and integrity of the human person" (Pope 1980), while in 1984 the Pope indicated that donation was "commendable" as it involved "a generous impulse of the heart, human solidarity and Christian love of neighbor"[184] (Pope 1984).

As well, GDP per capita is negative and statistically significant, indicating that wealthier countries are less likely to pass legislation. Specifically, a one-unit increase in GDP per capita decreases the odds of legislation by a factor of approximately 0.01, holding all other covariates constant. Although counter-intuitive, the result follows the

[184] As opposed to "the desire for earthly interests or ambitions" (Pope 1984).

findings in Table 5.1 and 5.2, and indicates that GDP per capita impacts legislation both across 1965-2012 and during the 1980-1988 period.

Overall, in contrast to Table 5.3, which focuses on the 1965-1979 period, Table 5.4 reflects the emergence of trends in legislation. The WC/WPT variables stand out as strong predictors of legislation, with treaty ratifications, ties to world society, and receptor sites positive and statistically significant in several models. Reports of the organ trade first surfaced in the early 1980s, and as international awareness grew, guidelines, resolutions, and legitimate models for action arose to combat it. Countries connected to world society were thus more likely to implement these models and pass legislation. At the same time, human rights treaties sacralized the individual and delegitimized the organ trade, which was increasingly characterized as a violation of human dignity and rights. Last, medical communities (functioning as receptor sites) helped to transmit cultural models and legitimate goals for action, and pressured states to implement legislation.

Interestingly, although the neighboring country dummy variable is insignificant in all the other tables, it achieves significance in Table 5.4. In interpreting this result, recall that by the 1980-1988 period, many countries had passed legislation banning the organ trade. With recognition of the organ trade and its harmful implications growing (Chapman 2014), it appears that as countries began to pass legislation, their neighbors, wary of crime spillover, tended to follow suit.[185]

Finally, the Catholic dummy variable is statistically significant in Table 5.4, whereas in many other tables it did not achieve significance. This suggests that although

[185]Recall that when states implement legislation, they not only raise the costs of illegal activity within their own jurisdiction, they may divert criminal activity to neighboring states since criminal networks frequently turn to jurisdictions with lax laws (Bronars and Lott Jr. 1998; Keenan 2006: 507; Kelly 2013; Lloyd, Simmons, and Stewart 2012).

Catholicism (or religion in general) is not associated with legislation across the entire 1965-2012 period, during 1965-1979[186] and 1980-1988 Catholic countries were more likely than non-Catholic countries to pass legislation.

~~Table 5.4 Here~~

Table 5.5 focuses on the 1989-2012 period. Model 1 includes the treaty ratifications, ties to world society, and receptor sites variables, and each of the three variables are positive and statistically significant. This mirrors the results of other tables where the WC/WPT variables are tested alone, and reflects the consistency of the WC/WPT variables as predictors of legislation.

Model 2 expands the first model by testing the three WC/WPT variables alongside the government effectiveness and interaction variables. While the treaty ratifications, ties to world society, and receptor sites variables are again positive and significant, the government effectiveness and interaction variables fail to achieve significance. This result is rather straightforward, as both the government effectiveness and the interaction variables also did not show significance in other tables, indicating they are not associated with legislation.

In Model 3, the three WC/WPT variables are retained, while the government effectiveness and interaction variables are replaced with the neighbor legislation dummy and rationalization variables. Yet again, the WC/WPT framework receives support; treaty ratifications and ties to world society are both positive and significant. However, although the receptor sites variable is positive, it is not statistically significant. As well, the neighbor legislation dummy and rationalization variables are not statistically

[186]Recall that the Catholic dummy variable was technically *not* statistically significant at the traditional 0.05 level in the original Model 5 within Table 5.3 (exploring the 1965-1979 period). After retesting Model 5, with slight modifications, the Catholic dummy variable became statistically significant.

significant. Across numerous tables, both variables largely failed to achieve significance in the majority of models, strongly suggesting that the variables are not associated with legislation.[187]

Last, in Model 4, the WC/WPT variables are tested alongside the control variables. While no control variables reach significance, the treaty ratifications, ties to world society, and receptor sites variables are each positive and significant. Specifically, a one-unit increase in treaty ratification increases the odds of legislation by a factor of approximately 1.8, holding all other covariates constant. For ties to world society and receptor sites, the same procedure increases the odds of legislation by a factor of 2.72 and 2.71, respectively.

Overall, Table 5.5 demonstrates that the WC/WPT framework is a strong, consistent predictor of legislation. Across the various models, the three variables were frequently positive and significant. World society norms, principles, and models, as well as human rights documents sacralizing the individual, and receptor sites transmitting global scripts positively impacted the implementation of legislation during the 1989-2012 period. In contrast, the rationalization, government effectiveness, interaction, neighbouring country dummy, or various control variables failed to achieve significance, indicating they are not associated with legislation.

~~Table 5.5 Here~~

In summary, results from the three individual time segments (1965-79, 1980-88, and 1989-2012) illustrate some variation. The initial time period displays few significant

[187]In addition to testing rationalization through the average schooling variable, I test rationalization via several other variables: a rationalization index (comprised of urbanization, secondary enrolment, and fertility rate) and university enrolment. However, in numerous tests the various rationalization measures do not show significance. Furthermore, I also test the model while adding government effectiveness and the interaction of government effectiveness and ties to world society; however, as with previous models, only the WC/WPT variables are significant.

effects, while the latter two time periods present results that are similar to one another. For the first period, WC/WPT receives slight support, while the Catholic dummy variable also appears to impact legislation. Notably, the Catholic dummy variable was also significant in Table 5.4, suggesting that Catholic countries were more likely to implement legislation both in 1965-1979 and 1980-1988.

Additionally, across Tables 5.4 and 5.5, ties to world society, treaty ratifications, and receptor sites are consistently positive and significant, underlining support for the WC/WPT theoretical framework and hypotheses. Simply, the WC/WPT framework is a strong predictor of legislation, both for the 1965-2012 period, as well as for these particular time segments.

Finally, as with Table 5.1 and 5.2, which each focus on the 1965-2012 period, many of the other independent or control variables fail to reach significance within Table 5.3, 5.4, and 5.5 (or only achieve significance in several models). This suggests that legislation banning the organ trade is not associated with government effectiveness, the interaction variable, rationalization, the neighbor dummy legislation, or the various controls.

~~*Conclusion*~~

Quantitative analyses of legislation banning the organ trade illustrate that the implementation of legislation is shaped by several factors. The global trend toward legislation, with over 100 countries implementing legislation between 1965 and 2012, is explained by the world society institution of human rights, a state's integration into such a society, the proliferation of world-cultural scripts, models, and institutions delegitimizing the organ trade, and the influential global medical epistemic community.

During the 20th century, but particularly since WWII, world cultural models were institutionalized globally through the human rights regime. Human rights treaties articulate and promote the dignity and sacrality of the individual, delegitimize the organ trade and encourage the implementation of legislation. Results demonstrate that states that ratify more human rights treaties are more likely to implement legislation against the organ trade.

World society norms, scripts, principles, and models champion human rights, sacralize the individual, and delegitimize the organ trade, and they are elaborated and diffused by INGOs. States with more ties to world society (i.e. memberships in INGOs) conform to highly rationalized, legitimate global models and principles, and are more likely to implement legislation. Furthermore, world society grants much authority to epistemic communities. Epistemic communities not only help develop rational models and scripts within world society but, as reflected by results, they also function as receptor sites that receive, define, and spread world cultural scripts and models within nation-states. Overall, the global growth and diffusion states' legislation against the organ trade is strongly impacted by the deepening global sacralization of the individual and its institutionalization via the global human rights regime.

In addition, economic factors are important to understanding legislation. Specifically, GDP per capita and trade openness directly impact nation-states' transplantation legislation activity, with higher levels decreasing the likelihood of legislation. The pattern of distribution within the global organ trade flows "from South to North, from Third to First World, [and] from poor to rich" (Delmonico and Scheper-Hughes 2003: 691). Furthermore, "residents of Japan, the Gulf States in the Middle East

(Kuwait, Saudi Arabia, and Oman), Israel, Western Europe, and North America,"[188] travel to "India, China, the Philippines, South America, Turkey, and Eastern Europe,"[189] to purchase organs (Delmonico and Scheper-Hughes 2003: 691-92). In this context, wealthy, developed countries view the organ trade as an effective mechanism to reduce the "unprecedented demand for a limited supply of…organs" (Delmonico and Scheper-Hughes 2003: 691).[190] In contrast, poor, underdeveloped countries ban the organ trade since it victimizes their citizens, carries a range of potential externalities, and can greatly increase domestic organ shortages (Gill 2014).[191]

[188]These represent wealthy, developed countries.
[189]These represent low-income, less developed countries.
[190]For example, "Israel was unwilling to control the illegal organ trade, due to low national donation rates," and it supported its citizens' travel abroad to purchase organs in countries such as South Africa, Turkey, Russia, and Moldova (Ambagtsheer 2011: 80). Bramstedt and Xu note how some US "insurance programs are taking steps to address the problems of organ availability, long waiting times, and high medical and surgical costs by promoting transplant tourism" (Bramstedt and Xu 2007: 1698).
[191]One of the principles of the Declaration of Istanbul is that "countries and regions should strive to achieve self-sufficiency in organ donation by providing a sufficient number of organs for residents in need" (DoI 2013). Within low-income countries, the organ trade often leads to "domestic" organs being utilized by foreigners (and illegally), rather than being potentially used by the local population. As well, the Asian Task Force on Organ Trafficking has urged "insurance companies to abstain from policies that have the effect of supporting illegal practices in organ transplantation" (ATF 2008: 8), allowing individuals from wealthy countries to travel and exploit poor citizens of the Global South.

It should be noted that at this stage, the argument seeking to explain the counter-intuitive results for economic development is only an initial, developing hypothesis rather than a conclusive explanation. The author acknowledges that much more evidence and greater research are required to better understand (if not substantiate) this particular process (i.e. wealthy countries viewing the organ trade as a mechanism to reduce shortages). It is quite possible that other factors (as yet to be fully understood) are behind this result. While there is clear evidence that wealthy countries are generally faced with a significant shortage of organs, it is difficult to locate independent evidence that reasonably and clearly explains why or how wealthy, developed countries are less likely or slower to pass legislation. Moving forward, the collection of more data (i.e. information about more countries) may help to reveal the specific processes underlying these results. Additionally, more interviews (particularly with officials, ministry authorities, and policy-makers) would be highly beneficial towards understanding and explaining these important results.

Figure 5.1

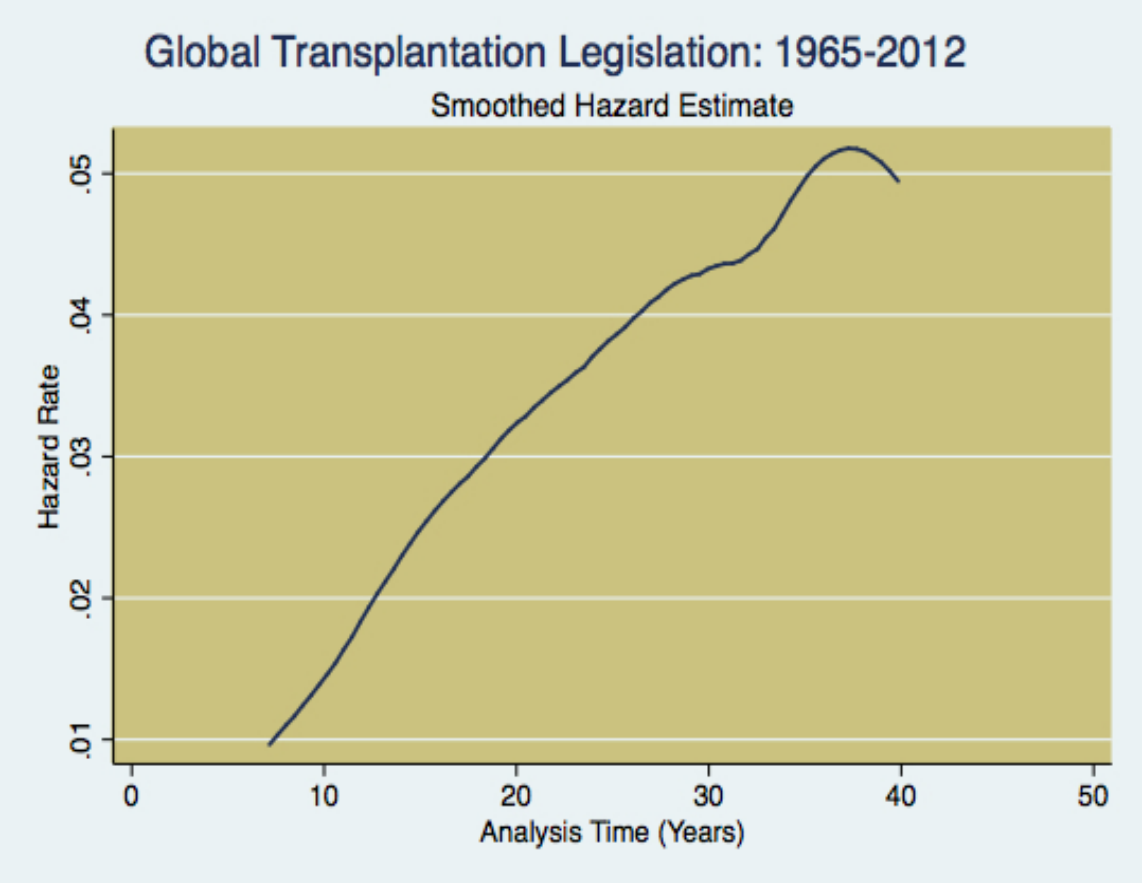


Figure 5.1: Analysis time begins at 1965 and ends at 2012.

Figure 5.2

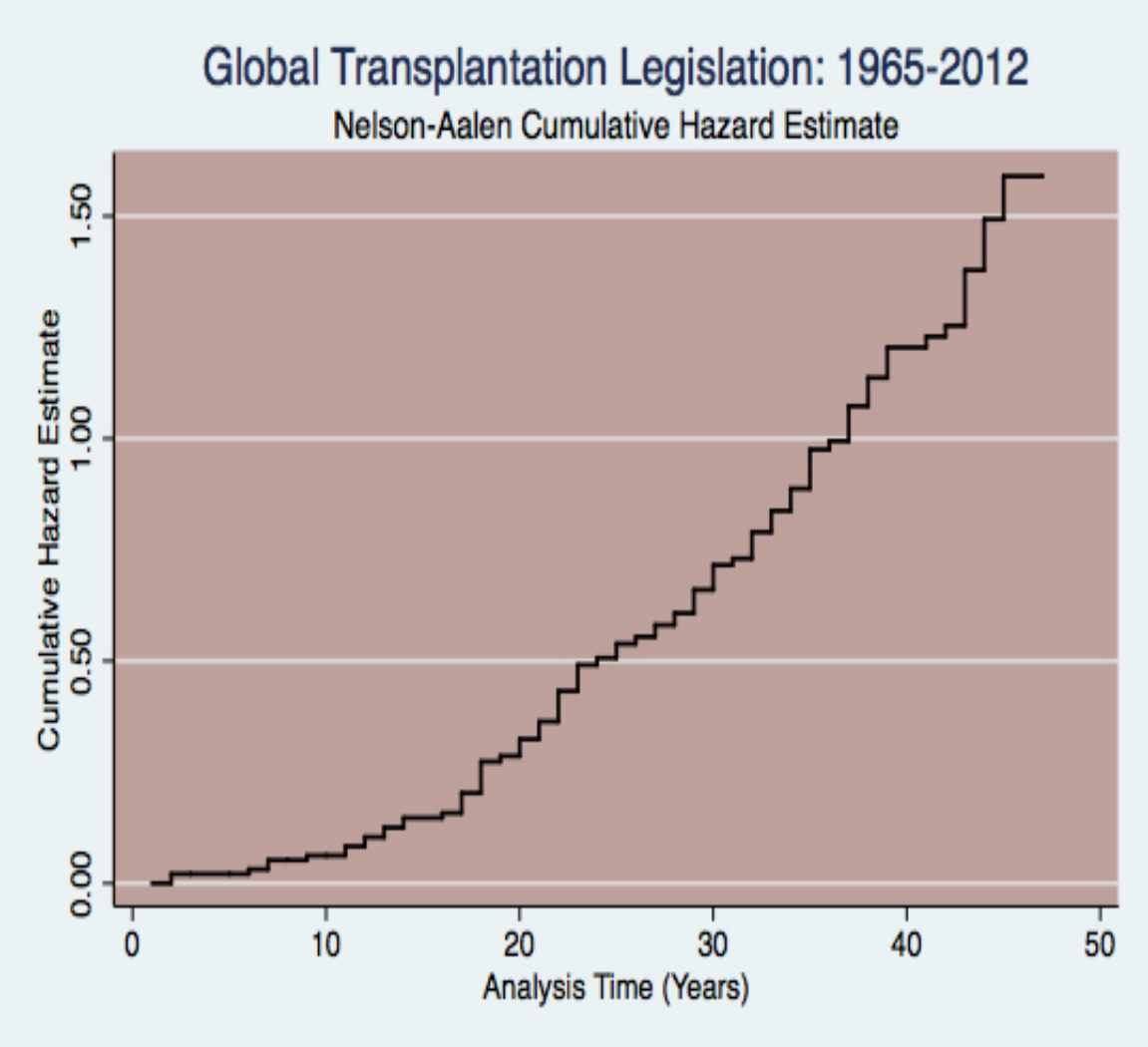


Figure 5.2: Analysis time begins at 1965 and ends at 2012.

Figure 5.3

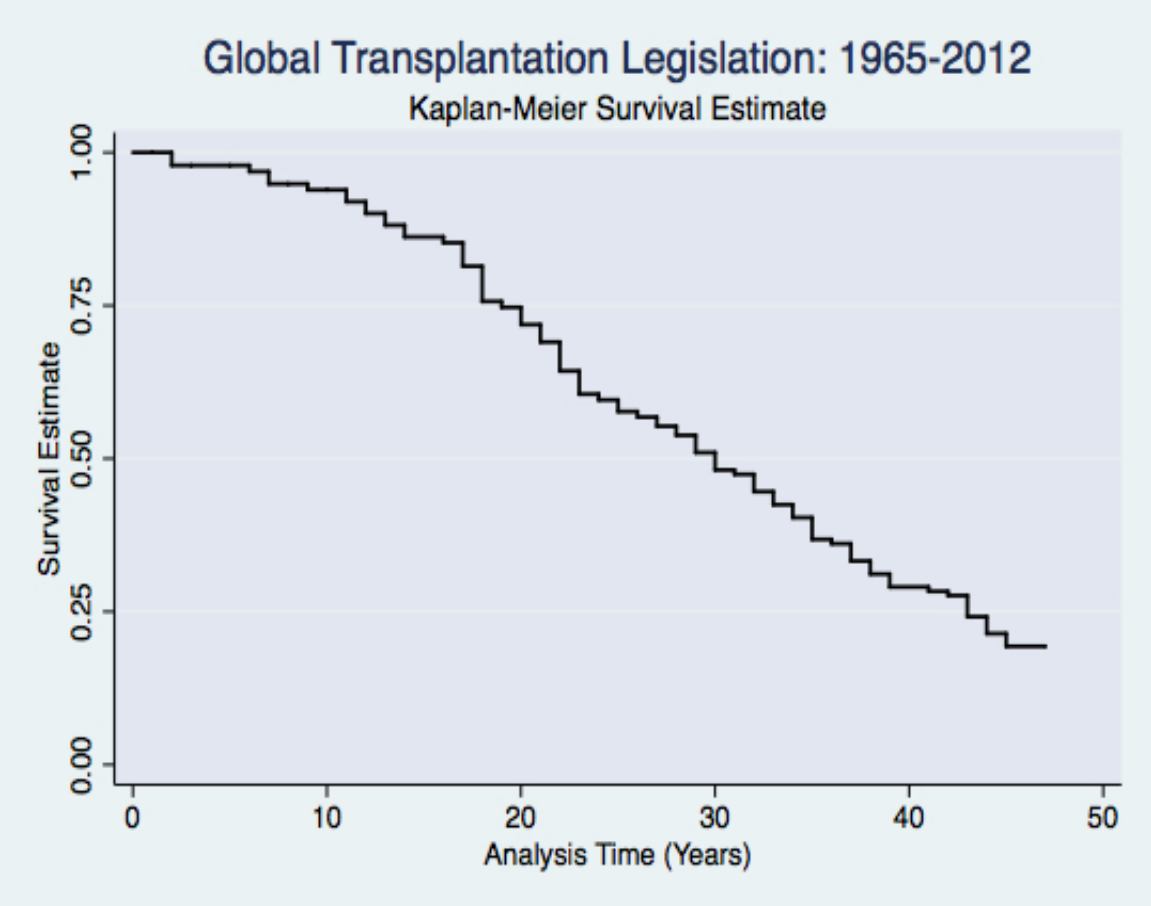


Figure 5.3: Analysis time begins at 1965 and ends at 2012. Figure 3 shows that the likelihood of not passing legislation decreases considerably over time.

Figure 5.4

Global Growth of Human Rights Documents and Ratifications: 1965-2012

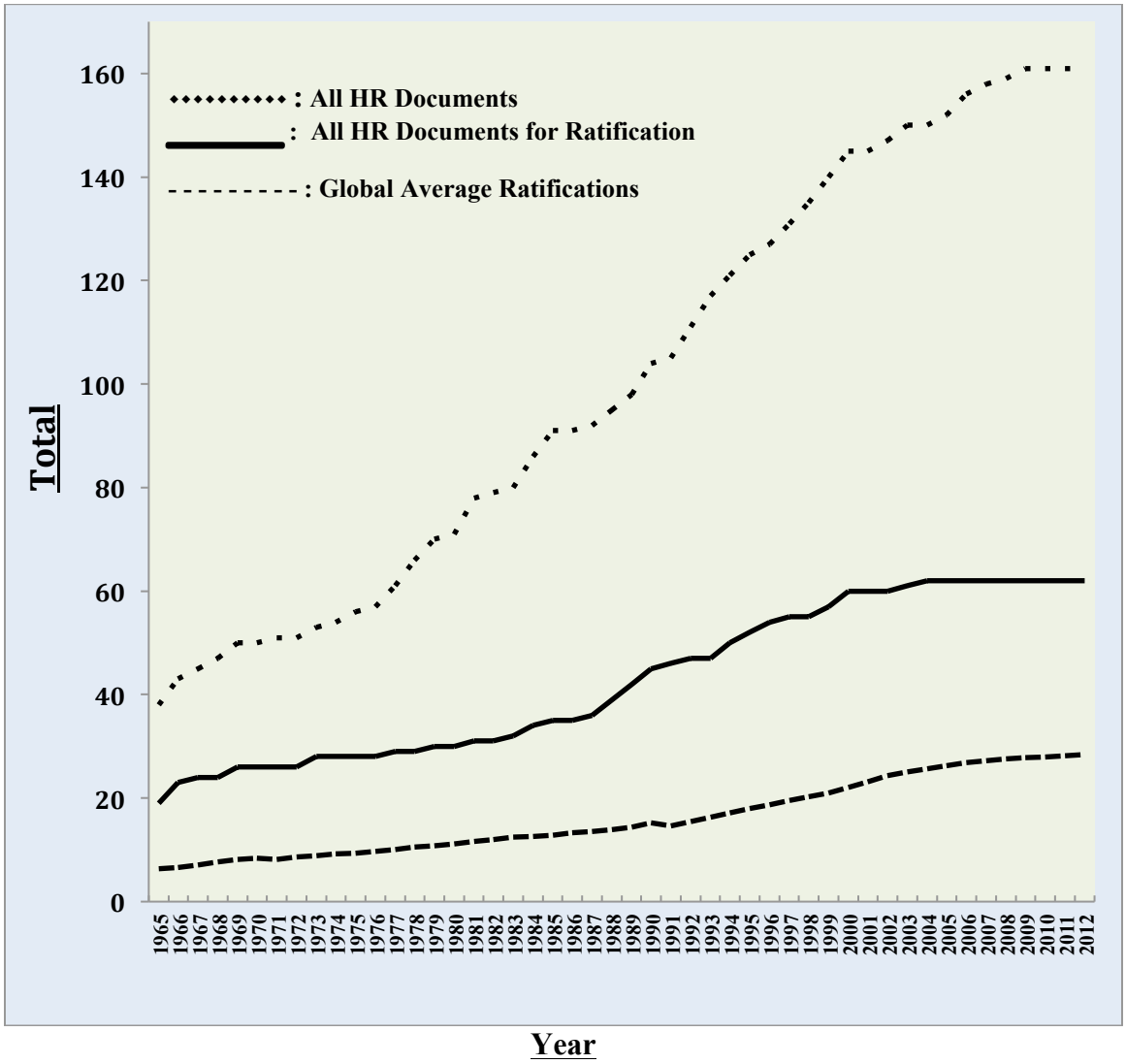


Figure 5.4 presents the global growth in total human rights documents, documents available for ratification, and the global average ratifications.

Figure 5.5

Global Transplantation Legislation, 1965-2012: Baseline Survival Function

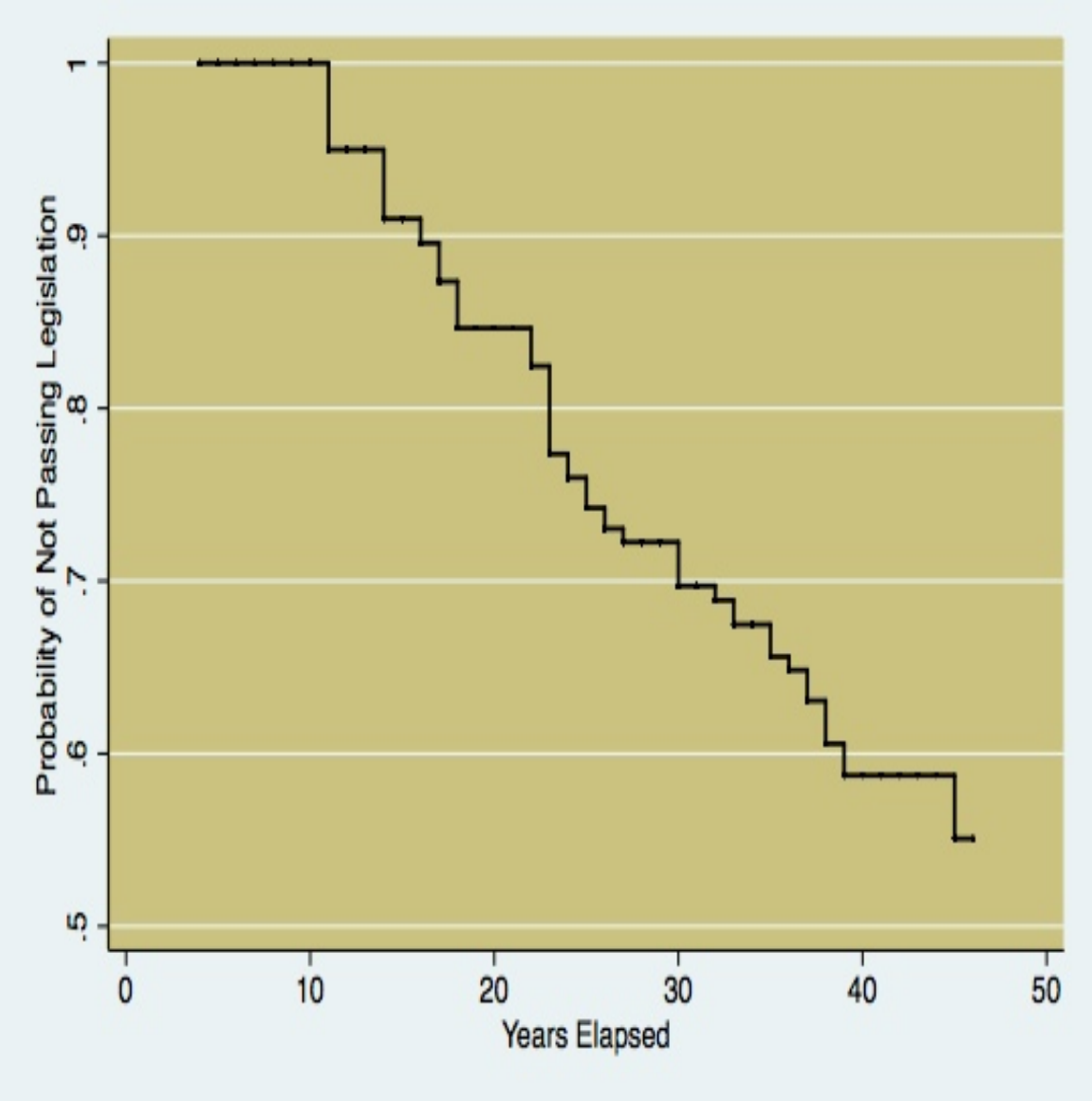


Figure 5.5 plots the survival function for Table 5.2: Model 2, when holding all covariates at their means.

Figure 5.6

Global Transplantation Legislation, 1965-2012: Impact of Treaty Ratifications

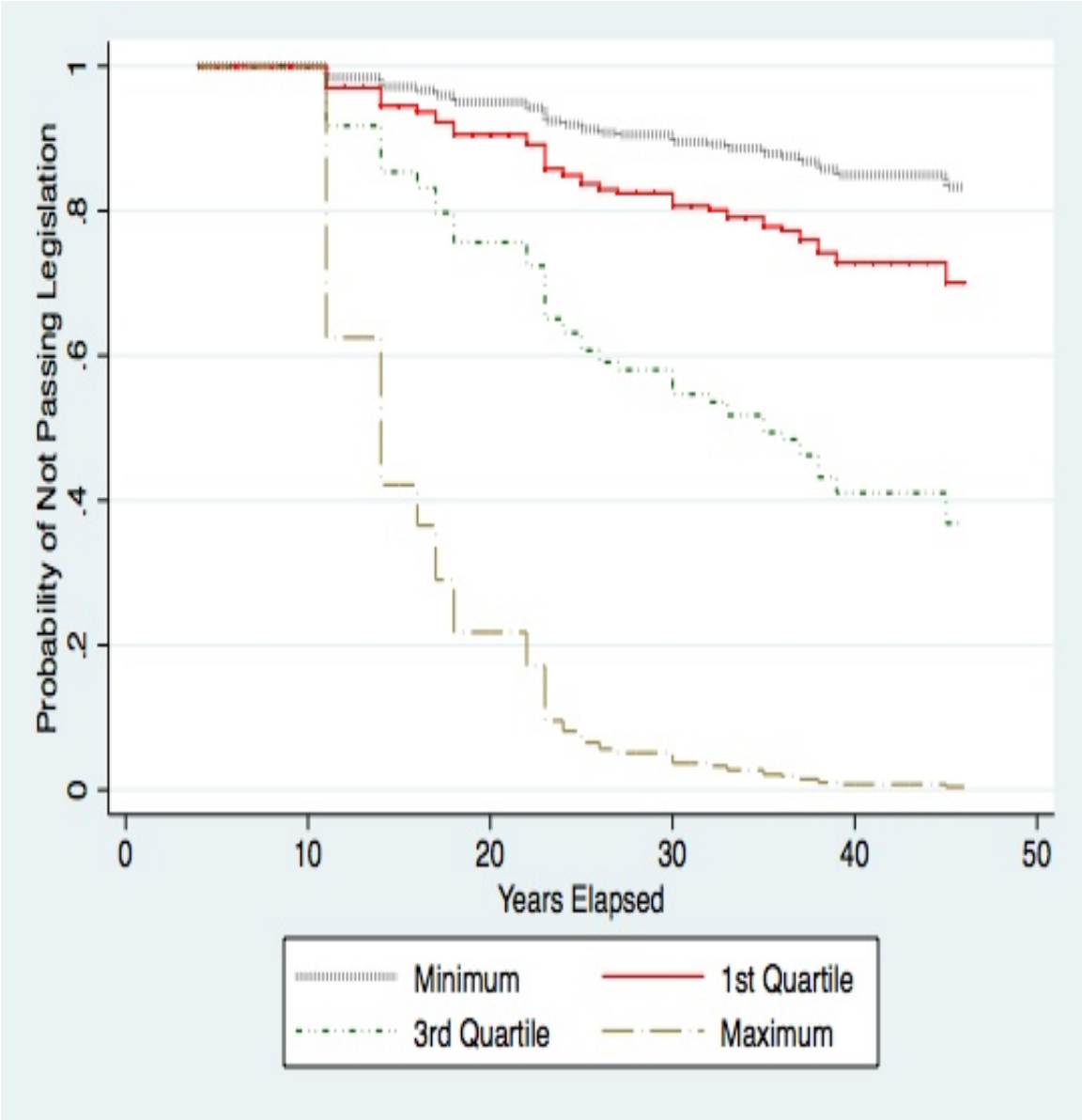
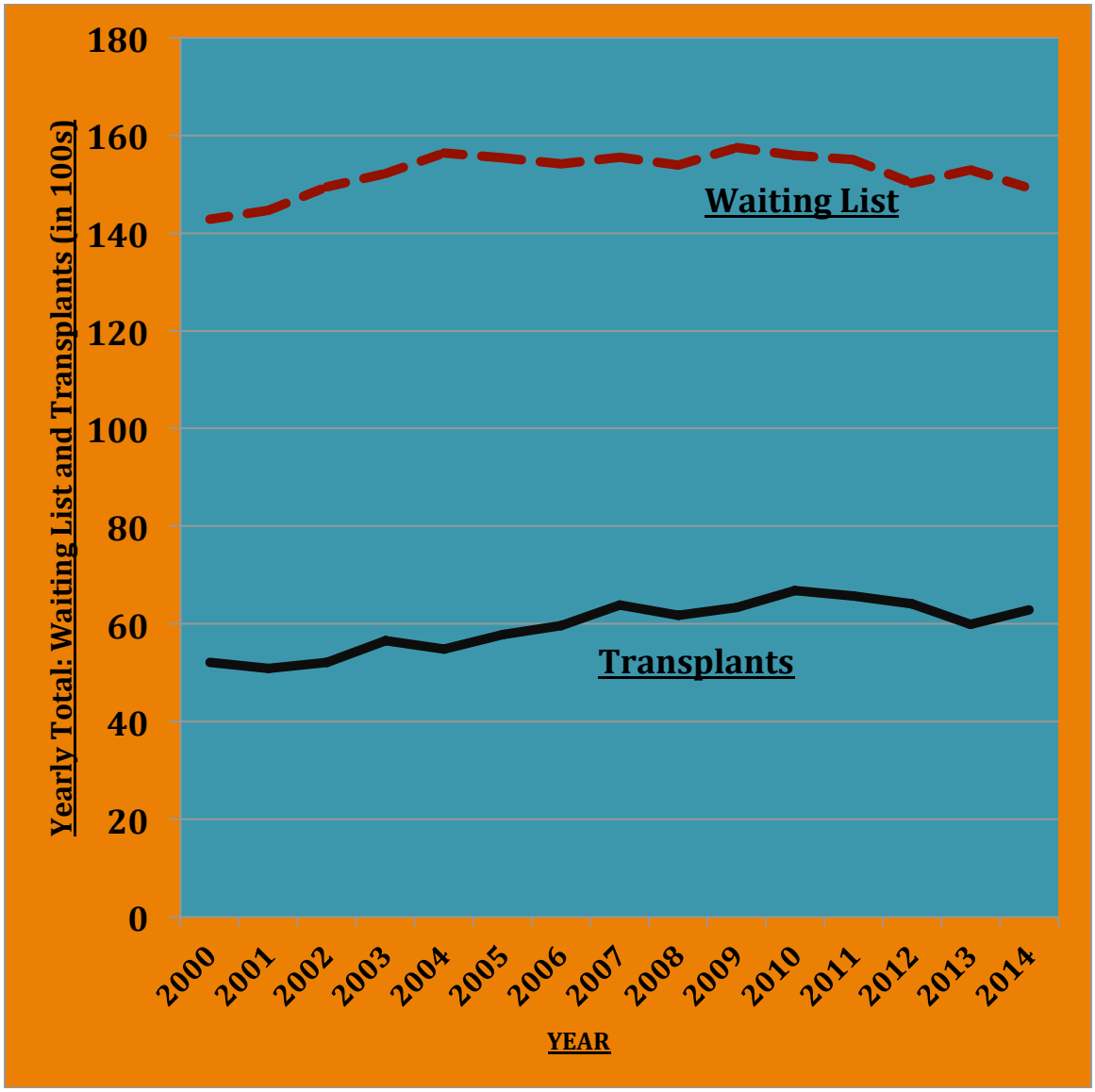


Figure 5.6 displays the impact of treaty ratifications on countries' hazard of passing legislation over time. Treaty ratifications values are given as minimum, maximum, 1st quartile, and 3rd quartile, while all other covariates are held at their means.

Figure 5.7

Annual Organ Transplants and Waiting List in Selected European Countries[192]



Source (Eurotransplant 2015)

Figure 5.7 shows the glaring gap between supply and demand of organs within wealthy countries; annually, a considerable number of individuals are added to organs waiting list, while only a small number of people receive an organ transplant. The large discrepancy between organ supply and demand is a key factor in the organ trade.

[192]Countries selected are Austria, Belgium, Croatia, Germany, Hungary, Netherlands, and Slovenia. These countries were the only ones reported by Eurotransplant. Eurotransplant is responsible for the allocation of donor organs in these countries, and it works collaboratively with transplant hospitals, tissue-typing laboratories and hospitals where organ donations take place.

Table 5.1

Survival Analysis
Estimates of Coefficients Impacting Global Transplantation Legislation: 1965-2012

	Model 1	Model 2	Model 3	Model 4
Treaty Ratifications	0.002* (0.001)	0.002* (0.001)		
Ties to World Society	0.024 (0.018)	0.037* (0.017)	-0.006 (0.012)	
Receptor Sites	0.007 (0.007)	0.006 (0.008)		
Government Effectiveness			0.026 (0.051)	
Interaction: Government Effectiveness*Ties to World Society			-0.001 (0.007)	
Neighbor Legislation Dummy				-0.026 (0.021)
Education				-0.002 (0.005)
Ethnolinguistic Fractionalization	-0.064 (0.034)	-0.052 (0.032)	-0.034 (0.021)	-0.106* (0.042)
Democracy	0.002 (0.003)		0.002 (0.002)	0.001 (0.003)
Geographic size	-0.001 (0.006)	-0.001 (0.005)	-0.003 (0.003)	0.008 (0.006)
Trade Openness	-0.028*** (0.008)	-0.028*** (0.008)	-0.007 (0.005)	-0.007 (0.013)
GDP per Capita	-0.021** (0.008)	-0.022** (0.007)	-0.0009 (0.004)	0.001 (0.011)
Catholic Dummy	0.156 (0.410)	0.243 (0.407)	0.528 (0.289)	0.129 (0.644)
LR chi2	32.05	36.30	24.65	10.77
Prob > chi2	0.0002	0.000	0.0034	0.2154
Log likelihood	-86.50	-88.48	-258.262	-49.296

NOTE: ***p≤ 0.001; **p≤ 0.01; *p≤ 0.05
Standard errors reported in parentheses.
N = 127 countries
RANDOM EFFECTS

Table 5.2

Logistic Regression Coefficients - Global Transplantation Legislation: 1965-2012

	Model 1	Model 2	Model 3	Model 4
Treaty Ratifications	0.908*** (0.042)	0.663*** (0.115)	0.801** (0.287)	0.69*** (0.21)
Ties to World Society	7.091*** (0.432)	9.214*** (0.896)	10.448*** (2.148)	9.97*** (1.61)
Receptor Sites	0.541** (0.182)	1.029* (0.488)	0.642 (1.293)	1.44** (0.54)
Government Effectiveness		0.958 (4.538)		
Interaction: Government Effectiveness*Ties to World Society		0.023 (0.711)		
Neighbor Legislation Dummy			4.445 (3.772)	
Average Years Schooling			-0.392 (0.642)	
Ethnolinguistic Fractionalization				-8.17 (9.29)
Democracy				-0.23 (0.15)
Geographic size				-0.32 (0.35)
Trade Openness				-0.26 (1.01)
GDP per Capita				-1.29** (0.504)
Catholic Dummy				-0.15 (1.73)
Constant	-66.037*** (2.731)	-73.964*** (4.236)	-86.220*** (16.787)	-62.242*** (6.869)
Wald chi2	1496.88	913.38	47.80	785.85
Prob > chi2	0.000	0.000	0.000	0.000
Log likelihood	-363.281	-343.662	-179.099	-303.247

NOTE: ***p≤ 0.001; **p≤ 0.01; *p≤ 0.05
Standard errors reported in parentheses.
N = 127 countries

Table 5.3

Logistic Regression Coefficients - Global Transplantation Legislation: 1965-1979

	Model 1	Model 2	Model 3	Model 4	Model 5
Treaty Ratifications	0.518 (0.303)	0.439 (0.260)	0.524 (0.289)	-0.124 (0.142)	0.456 (0.349)
Ties to World Society	12.399*** (3.074)	1.784 (3.201)	1.772*** (2.852)	0.879 (0.845)	9.771 (5.086)
Receptor Sites	-4.093 (3.978)	-2.055 (2.988)	-3.544 (4.021)	-0.128 (1.609)	-2.296 (3.748)
Government Effectiveness		1.158 (9.754)			
Interaction: Government Effectiveness*Ties to World Society		0.143 (1.688)			
Neighbor Legislation Dummy			-0.707 (2.523)		
Education				-0.102 (0.326)	
Ethnolinguistic Fractionalization					1.554 (8.622)
Democracy					-0.226 (0.304)
Geographic Size					-0.831 (1.916)
Trade Openness					-0.586 (2.640)
GDP per Capita					-2.639 (2.429)
Catholic Dummy					0.766*[193] (3.994)
Constant	-99.279*** (17.598)	-25.353 (20.648)	-96.922*** (15.459)	-6.881 (4.165)	-43.799 (29.089)
Wald chi2	42.87	3.71	57.71	1.52	8.22
Prob > chi2	0.000	0.5918	0.000	0.824	0.512
Log likelihood	-42.822	-39.206	-42.917	-17.133	-34.699

NOTE: ***p≤ 0.001; **p≤ 0.01; *p≤ 0.05
Standard errors reported in parentheses.
N = 104 countries for all models

[193]Strictly, the P-value for the Catholic dummy variable is 0.052, which means that it is significant at the 0.1 alpha-level, but *not* statistically significant at the traditional 0.05 alpha-level. With fourteen countries passing legislation by 1979, and nine of those fourteen being predominantly Catholic, it would appear that the Catholic dummy would be significant. However, in exploring why it failed to achieve significance at the traditional alpha-level, recall that over 100 countries were examined for the 1965-1979 period. With so few of the overall total passing legislation, the Catholic dummy variable's effects may have been difficult to capture.

Table 5.4

Logistic Regression Coefficients - Global Transplantation Legislation: 1980-1988

	Model 1	Model 2	Model 3	Model 4	Model 5
Treaty Ratifications	0.465*** (0.139)	0.569*** (0.157)	0.107 (0.166)	0.413 (0.235)	0.098 (0.210)
Ties to World Society	6.551*** (1.288)	4.514* (1.812)	1.355 (1.764)	4.831*** (1.308)	9.838*** (2.539)
Receptor Sites	2.063* (0.908)	1.237 (0.803)	1.083 (1.381)	1.439 (0.818)	3.365*** (0.828)
Government Effectiveness		11.544 (9.262)			
Interaction: Government Effectiveness*Ties to World Society		-1.503 (1.399)			
Neighbor Legislation Dummy				1.062* (1.901)	1.045** (2.259)
Education			-0.238 (0.466)		
Ethnolinguistic Fractionalization					5.794 6.715
Democracy					0.305 (0.360)
Geographic Size					-0.929 (0.774)
Trade Openness					-1.658 (2.883)
GDP per Capita					-4.876** (1.828)
Catholic Dummy					0.184* (3.515)
Constant	-57.996*** (8.356)	-46.590*** (10.925)	-15.840 (9.111)	-48.055*** (7.002)	-27.994 (23.353)
Wald chi2	79.82	57.41	4.49	98.98	86.54
Prob > chi2	0.000	0.000	0.343	0.000	0.000
Log likelihood	-127.713	-125.173	-42.048	-124.655	-88.074

NOTE: ***p≤ 0.001; **p≤ 0.01; *p≤ 0.05
Standard errors reported in parentheses.
N = 105 countries

Table 5.5

Logistic Regression Coefficients - Global Transplantation Legislation: 1989-2012

	Model 1	Model 2	Model 3	Model 4
Treaty Ratifications	0.710*** (0.058)	0.463*** (0.085)	0.814*** (0.132)	0.588*** (0.068)
Ties to World Society	6.588*** (0.688)	3.975** (1.387)	6.586*** (1.756)	1.001*** (1.122)
Receptor Sites	0.397* (0.182)	1.333** (0.489)	1.018 (1.155)	0.998* (0.504)
Government Effectiveness		-4.878 (5.167)		
Interaction: Government Effectiveness*Ties to World Society		0.851 (0.797)		
Neighbor Legislation Dummy			4.441 (2.351)	
Education			-0.888 (0.537)	
Ethnolinguistic Fractionalization				3.337 (2.893)
Democracy				-0.201 (0.168)
Geographic Size				0.344 (0.339)
Trade Openness				-0.779 (0.918)
GDP per Capita				0.709 (0.420)
Catholic Dummy				-0.359 (1.427)
Constant	-55.116*** (4.076)	-35.765*** (7.161)	-55.508*** (10.899)	-49.661*** (9.859)
Wald chi2	748.30	799.87	143.00	673.26
Prob > chi2	0.000	0.000	0.000	0.000
Log likelihood	-242.520	-242.809	-129.462	-219.336

NOTE: ***p≤ 0.001; **p≤ 0.01; *p≤ 0.05
Standard errors reported in parentheses.
N = 127 countries

Table 5.6

List of Countries Used for Analysis, 1965-2012*

Algeria	Georgia	Montenegro	Tanzania
Argentina	Germany	Morocco	Tonga
Armenia	Greece	Mozambique	Trinidad-Tobago
Australia	Guatemala	Myanmar (Burma)	Tunisia
Austria	Guyana	Namibia	Turkey
Azerbaijan	Honduras	Nepal	United Arab Emirates
Bahrain	Hungary	Netherlands	United Kingdom (UK)
Bangladesh	Iceland	New Zealand	Ukraine
Belarus	India	Nicaragua	Uruguay
Belgium	Indonesia	Nigeria	USA
Bhutan	IR Iran	Norway	Uzbekistan
Bolivia	Iraq	Oman	Venezuela
Bosnia-Herzegovina	Ireland	Pakistan	Vietnam
Botswana	Israel	Panama	Zambia
Brazil	Italy	Papua New Guinea	Kazakhstan
Brunei	Cote d'Ivoire	Paraguay	Bahamas
Bulgaria	Jamaica	Peru	Burkina Faso
Canada	Japan	Philippines	Uganda
Chile	Jordan	Poland	Zimbabwe
China	Kenya	Portugal	
Colombia	Kuwait	Qatar	
Costa Rica	Laos	Romania	
Croatia	Latvia	Russia	
Cuba	Lebanon	Rwanda	
Cyprus	Libya	San Marino	
Czech Republic	Liechtenstein	Singapore	
Denmark	Lithuania	Slovakia	
Dominican Republic	Luxembourg	Slovenia	
Ecuador	Malawi	South Africa	
Egypt	Malaysia	South Korea	
El Salvador	Mali	Spain	
Estonia	Malta	Sri Lanka	
Fiji	Mauritius	Sweden	
Finland	Mexico	Switzerland	
France	Moldova	Syria	
FYR Macedonia	Mongolia	Tajikistan	

(N = 127)

Note: These countries were also used in the 1989-2012 analysis.

Table 5.7

List of Countries Used for Analysis, 1965-1979*

Algeria	France	Malaysia	Rwanda
Argentina	Greece	Mali	San Marino
Australia	Guatemala	Malta	Singapore
Austria	Guyana	Mauritius	South Africa
Bahrain	Honduras	Mexico	South Korea
Bangladesh	Hungary	Mongolia	Spain
Belgium	Iceland	Morocco	Sri Lanka
Bhutan	India	Mozambique	Sweden
Bolivia	Indonesia	Myanmar (Burma)	Switzerland
Botswana	I.R. Iran	Nepal	Syria
Brazil	Iraq	Netherlands	Tanzania
Bulgaria	Ireland	New Zealand	Tonga
Canada	Israel	Nicaragua	Trinidad-Tobago
Chile	Italy	Nigeria	Tunisia
China	Cote d'Ivoire	Norway	Turkey
Colombia	Jamaica	Oman	United Arab Emirates
Costa Rica	Japan	Pakistan	United Kingdom
Cuba	Jordan	Panama	Uruguay
Cyprus	Kenya	Papua New Guinea	USA
Denmark	Kuwait	Paraguay	Vietnam
Dominican Republic	Laos	Peru	Zambia
Ecuador	Lebanon	Philippines	Zimbabwe
Egypt	Libya	Poland	Bahamas
El Salvador	Liechtenstein	Portugal	Burkina Faso
Fiji	Luxembourg	Qatar	Uganda
Finland	Malawi	Romania	Venezuela

(N = 104)

Table 5.8

List of Countries Used for Analysis, 1980-1988*

Algeria	Hungary	Norway
Argentina	Iceland	Oman
Australia	India	Pakistan
Austria	Indonesia	Panama
Bahamas	I.R. Iran	Papua New Guinea
Bahrain	Iraq	Paraguay
Bangladesh	Ireland	Peru
Belgium	Israel	Philippines
Bhutan	Italy	Poland
Bolivia	Jamaica	Portugal
Botswana	Japan	Qatar
Brazil	Jordan	Romania
Brunei	Kenya	Rwanda
Bulgaria	Korea, South	San Marino
Burkina Faso	Kuwait	Singapore
Canada	Laos	South Africa
Chile	Lebanon	Spain
China	Libya	Sri Lanka
Colombia	Liechtenstein	Sweden
Costa Rica	Luxembourg	Switzerland
Cuba	Malawi	Syria
Cyprus	Malaysia	Tanzania
Cote d'Ivoire	Mali	Tonga
Denmark	Malta	Trinidad and Tobago
Dominican Republic	Mauritius	Tunisia
Ecuador	Mexico	Turkey
Egypt	Mongolia	United Kingdom (UK)
El Salvador	Morocco	USA
Fiji	Mozambique	Uganda
Finland	Myanmar (Burma)	United Arab Emirates
France	Nepal	Uruguay
Greece	Netherlands	Venezuela
Guatemala	New Zealand	Vietnam
Guyana	Nicaragua	Zambia
Honduras	Nigeria	Zimbabwe

(N = 105)

Chapter Six: Conclusion

~~Conclusion~~

Transplantation is "hailed as one of the great miracles of modern science" (Sharp 2006: 9) and celebrated as "one of the major accomplishments of the last half of the twentieth century" (Munson 2002: 20). While it has saved or significantly extended innumerable lives worldwide (Efrat 2015: 11; Miranda et al. 2003: 62; Munson 2002), it has also led to several troubling consequences, such as the organ trade.

During the late 1970s and early 1980s, improvements in medical practices and the introduction by pharmaceutical companies of drugs to prevent organ rejection meant transplantation became a viable and effective therapy for end-stage organ failure (Cho, Zhang, and Tansuhaj 2009; Kelly 2013). However, the access of patients to organ transplantation varies according to distinct national situations, costs of healthcare, national technical capacities, and of course, the actual availability of organs (Akoh 2012). To various degrees, these factors coalesced to facilitate the rise of the international organ trade (Cho, Zhang, and Tansuhaj 2009; Kelly 2013; Shimazono 2007).

Today, the organ trade is a "flourishing," multimillion dollar, black market, transnational industry, and affects almost all countries and regions to some extent (Eckes 2011: 222). It is overwhelmingly viewed as a "gross violation of human rights" (Budiani-Saberi 2014; Moniruzzaman 2012A: 4), contravening numerous guidelines and principles from international rights documents (Bagheri 2010; Budiani-Saberi and Columb 2013: 909 ff.; CRC 1989; Glaser 2005: 20; UDHR 1948; Williams 1994: 315). Furthermore, the organ trade poses numerous and considerably serious health risks, both for individuals

and the broader public (Budiani-Saberi 2014; Khamash and Gaston 2008; Gill 2014; McGuinness and McHale 2013: 12).

Although there has been progress in understanding the organ trade, several questions remain unanswered. Specifically, since 1967 over 100 countries have passed legislation banning commercial transplantation (see Figure 1.1 on page 9). What explains this rapid, global diffusion of commercial transplantation laws, and what factors influence individual states' legislation?

Chapter Two utilizes qualitative data from in-depth interviews, historical analysis, and secondary sources to explore the organ trade and efforts to combat it.[194] The chapter reviews the history of transplantation and the organ trade, and details the emergence and role of the global medical epistemic community, composed of transplantation doctors, surgeons, ethicists, and professionals from around the world. Positioning the global trend toward legislation within its historical context, the chapter illuminates the importance of the epistemic community, a finding that also emerges within quantitative analyses in Chapter Five.

The historical review reveals that the global medical epistemic community has been the most active global actor in the international growth and spread of transplantation, and efforts to curb the organ trade. In the 1980s, as organ trafficking began to emerge, it was poorly understood, and governments' responses to allegations or reports were lackluster or nonexistent (Raymond 1995: 160). With states failing to

[194]Interview informants included medical practitioners, researchers, policy makers, members of various organizations, journalists, and activists. Interviews were conducted via Skype (video), telephone, and in person, generally lasting between thirty minutes and two hours. As well, the historical review is guided by insights from the World Transplant Congress (WTC) in July of 2014. Attending the WTC allowed me to observe dynamics of the global transplantation community, including numerous presentations and panel discussions, a forum focusing on organ trafficking and harvesting, and interviews with individuals from around the world. The chapter also relies on a variety of sources, including written laws, websites, newsletters, press releases or statements, government senate or commission hearings, summaries and reports, and countless news articles available from the Lexis-Nexis database or general online searches.

coordinate a response or organize effective initiatives to combat the issue, the global medical epistemic community assumed an especially critical role. In addition to shaping, guiding, and influencing norms and approaches to transplantation, the epistemic community was instrumental in the development of various international resolutions, policy initiatives, recommended practices, statements, legislation, and model laws (Brysk 2005: 103). Moreover, the epistemic community helped position the organ trade as an issue of societal and global import, and it persistently encouraged states to undertake actions – such as implementing legislation – to combat the organ trade.

The review also demonstrates that the epistemic community's efforts against the organ trade incorporated the concepts of human rights, integrity, and dignity, which had diffused globally and become institutionalized in the period after WW-II (Elliott 2007; Ignatieff 2001). Specifically, the period involved the rapid development and proliferation of numerous international human rights documents, human rights international nongovernmental organizations, and human rights conferences (Brewington 2005; Elliott 2007; Mathias 2013: 1258).[195] Possessing great global authority, central to the global moral order, structuring the actions of states and individuals, and providing a common framework for global disputes, the concepts of human rights, integrity, and dignity were useful in the epistemic community's response to the organ trade. Linking the organ trade to the global rights framework helped to effectively "communicate [the] issue in a way that [engaged] the general public," and broadly spread awareness (Gready 2004: 24; Keck and Sikkink 1998: 2-3; 17). Furthermore, framing the organ trade as an important human rights issue helped to elicit and legitimize concern regarding it; importantly,

[195]For example, Figure 5.4 (page 167) illustrates how the global total number of human rights documents increased tremendously during this period.

framing claims in terms of rights often also gives them significant "moral authority," "political force," and a "greater degree of legitimacy" (Elliott 2007: 343; Lang 2011: 101; Nyamu 1999: 304).

Ultimately, as global awareness of the organ trade's prevalence and negative social, rights, and health ramifications grew, and as the various efforts by the epistemic community continued, states increasingly began to respond. Thus, the broad, rapid diffusion of policy arose within the context of the global growth of human rights, the construction, elaboration, diffusion, and institutionalization of world cultural models delegitimizing commercialism and the organ trade, and the persistent advocacy activities of INGOs and the medical epistemic community.

The historical review's focus on the epistemic community, INGOs, and human rights resonates with the quantitative component of the project. Chapter Five investigates the factors impacting the implementation of legislation, presenting results from quantitative analyses of 127 countries from 1965-2012. The chapter utilizes rationalization/McDonaldization theory, world culture/world polity theory, neighboring country effects, and the concept of government effectiveness to develop hypotheses regarding important factors in the implementation of commercial transplantation legislation. Logistic regression was utilized to explore factors influencing the likelihood of ever passing legislation, while survival analysis was used to examine the factors affecting how quickly states adopt legislation.

Both survival analysis and logistic regression present similar results, with only minor differences, and indicate that implementation of transplantation legislation is shaped by several factors. Survival analysis results demonstrate that states more

embedded into world society and with more human rights treaty ratifications have a greater likelihood of implementing legislation banning the organ trade, while logistic regression results show that integration into world society, human rights treaty ratifications, and receptor sites increase the likelihood of legislation implementation.

As well, results from both analytical methods suggest that economic development impacts legislation. Survival analysis results show that higher levels of GDP per capita and trade openness decrease states' likelihood of implementing legislation, whereas logistic regression results illustrate that higher levels of GDP per capita decrease the likelihood of legislation

Collectively, the two sets of results support the WC/WPT framework and hypotheses. Greater integration into world society increases the likelihood of legislation; as awareness and understanding of the organ trade grew, numerous regional and global policy initiatives and cultural models emerged to combat it – often recommending legislative responses. Consequently, countries more integrated into world society would be more likely to adopt such international policy frameworks, implementing them into domestic law.

As well, as states ratify human rights treaties, they are more likely to implement legislation prohibiting the organ trade. Individual sacrality has developed into a core feature of world society, and it is institutionalized within the global legal framework of human rights treaties and conventions. International human rights treaties and conventions establish, codify, and institutionalize the individual's inherent right to life and sanctity of person, thus delegitimizing the organ trade, which is overwhelmingly

viewed as violating basic individual rights and dignity.[196]

Additionally, the results demonstrate the importance of the medical community (a finding that corresponds with the historical review in Chapter Two). Simply, a larger medical community leads to a higher likelihood of legislation. World society grants much authority and legitimacy to rationalized, scientific communities, and within transplantation, such communities have served as sources of expertise, information, and innovation, while holding a firm stance against the organ trade. These communities receive, decode, and transmit information and models from world society to nation-states, encouraging and pressuring states to implement legislation.

The quantitative results for 1965-2012 also illustrate that economic development negatively impacts the likelihood of implementation. While wealthy, developed countries view the organ trade as an effective mechanism to reduce the "unprecedented demand for a limited supply of…organs," and save costs on "funding an extremely expensive and indefinite dialysis treatment" (Delmonico and Scheper-Hughes 2003: 691; Efrat 2015: 19),[197] poor, underdeveloped countries ban the organ trade since it victimizes their citizens, carries a range of potential externalities, and can greatly increase domestic organ shortages (Gill 2014).[198]

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[196]The principles of sacrality and dignity are apparent within many states' legislation. For example, El Salvador's *Law of Organ and Tissue Transplantation*; Article 128-B stipulates that "the practice of transplantation…[must adhere]…to ethical standards and [be] based on principles of equity, justice, solidarity…and without distinction of any kind" (El Salvador 1988). Additionally, Article Five of Montenegro's *Removal and Transplantation of Human Body Parts for the Purposes of Medical Treatment Act, no. 76/2009* declares that "in procedures of removal and transplantation of body parts protection of donor's and recipient's identity, personal dignity and other personal rights and freedoms shall be guaranteed" (Montenegro 2009).

[197]In poor, less developed countries, dialysis is generally unavailable; as a result, these countries "do not exhibit waiting lists because their end-stage renal disease patients die quickly" (Beard, Kaserman, and Osterkamp 2013: 1).

[198]According to Ruth-Gaby Vermot-Mangold, Rapporteur during the Council of Europe's 2003 Parliamentary Assembly on Trafficking in Organs in Europe, the organ trade is "demand driven," with the poor, less developed countries of Eastern Europe serving as "donor countries," while wealthy, more developed Western European countries functioning as "demand countries." As well, Vermot-Mangold recommended that wealthy, European "demand countries…deny national medical insurance reimbursements for illegal transplants abroad [and] deny national insurance payments for follow up care of illicit transplants" (CoE 2003). Last, it should be noted that at this stage, the

In addition to examining implementation of legislation across 1965-2012, Chapter Five explores possible variations within the 1965-2012 period, dividing the period into three individual segments: 1965-79, 1980-88, and 1989-2012. The time periods coincide with key events within global transplantation. The first "cut-off" (i.e. 1979) corresponds with the introduction of Cyclosporine A, an immunosuppressant that lowers rejection rates and thereby led to a rapid expansion of transplantation. Furthermore, while there was "little to indicate" that there was "any trafficking or commerce in organs" in the 1970s (Daar, Gutmann, and Land 1997: 302), in the 1980s the first reports of the organ trade began to surface (Panjabi 2010; Scheper-Hughes 2001). The second "cut-off" point (i.e. 1989) coincides with World Health Assembly resolution 42.5, which strongly urged states to implement legislation prohibiting the organ trade (WHA 1989; Zielinski 1994).

While the initial time period displays few significant effects, the latter two time periods present results that are quite similar to one another. For 1965-1979, few factors appear to impact legislation; results suggest that legislation was positively impacted by connections to world society and predominantly Catholic countries were more likely to implement legislation. Results for the latter two periods (1980-1988 and 1989-2012) indicate that the WC/WPT framework – incorporating ties to world society, treaty ratifications, and receptor sites – positively impacts legislation. Specifically, world society's sacralization of the individual, models and norms of human rights and dignity, a

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argument seeking to explain the counter-intuitive results for economic development is only an initial, developing hypothesis rather than a conclusive explanation. The author acknowledges that much more evidence and greater research are required to better understand (if not substantiate) this particular process (i.e. wealthy countries viewing the organ trade as a mechanism to reduce shortages). It is quite possible that other factors (as yet to be fully understood) are behind this result. While there is clear evidence that wealthy countries are generally faced with a significant shortage of organs, it is difficult to locate independent evidence that reasonably and clearly explains why or how wealthy, developed countries are less likely or slower to pass legislation. Moving forward, the collection of more data (i.e. information about more countries) may help to reveal the specific processes underlying these results. Additionally, more interviews (particularly with officials, ministry authorities, and policy-makers) would be highly beneficial towards understanding and explaining these important results.

state's embeddedness within such a society, and the role of the medical community in receiving and diffusing global cultural principles have a strong, positive impact on increasing countries' likelihood of banning the organ trade.

Overall, quantitative results within Chapter Five reflect WC/WPT's account of how the global diffusion of state political, economic, and structural policies or practices occurs as a consequence of world society and culture. World societal norms, scripts, and models were developed, spread, and institutionalized through INGOs, the epistemic community, and human rights documents. Norms, scripts, models, and legitimate goals for action promoted the dignity and inviolability of the individual, and delegitimized the organ trade. Subsequently, as responsible, authoritative, and ritualized actors within a world society that imposes duties, expectations, norms, and obligations, states enacted and implemented global cultural models, thus ultimately leading to the global diffusion of laws banning the organ trade. In this context, even though legislation involves a domestic, legislative procedure, the global trend in legislation banning the organ trade is largely shaped by external, global cultural factors.

As well, the historical review and quantitative results offer another example of how states are far from the sole, prime movers on the international scene (e.g. Boli and Thomas 1997; Keck and Sikkink 1998). Lacking a central, overarching authority, world society is governed by norms, scripts, and models that organize and shape actions and behaviors. Although nation-states remain important players, world society defines and legitimates a vast array of other actors – individuals, sub-state entities, interest groups, and as shown by this project, INGOs and epistemic communities – that can also function as important sources of and mechanisms for change, influence, and development.

Potentially, this project may also elicit a question frequently asked of the WC/WPT framework: does world culture really matter? Specifically, the question revolves around the idea that world culture and global discourse may fail to lead to tangible, substantive outcomes. For example, Hafner-Burton and Tsutsui (2007; 2005) suggest that although the global institutionalization and discourse of human rights has led states to make a range of legal commitments to human rights, these commitments frequently have little bearing on states' practices. Additionally, while global cultural principles of human rights, integrity, and dignity helped lead to anti-female genital cutting laws in many countries, the practice did not decrease (Boyle 2002).

However, although laws and reforms are certainly significant, it is important to recognize that world culture and the world polity function beyond "just" helping to produce laws. Rather, they also promote and legitimate social movement activities, alter governmental priorities broadly, and help reshape people's attitudes, discourse, and behaviors around the world, which in the long run can lead to perceptible change (Frank et al. 2000; Boyle et al. 2002; Meyer et al. 1992; Ramirez et al. 1997; Schofer and Hironaka 2005: 27). Furthermore, many changes can occur across multiple levels of society (Schofer and Hironaka 2005: 27).

Here, examples of world culture's substantive impact upon the organ trade and society include the Philippines, where regulations and government initiatives combating the organ trade, arising out of cooperation between the global Declaration of Istanbul Custodian Group (DICG) and local organizations, led to "a dramatic fall in transplant tourism" (Danovtich and Al-Mousawi 2012: 360; Martin 2014: 6), while the establishment of new regulations in Qatar, directly supported by the DICG, saw "the

number of [Qatari] patients travelling abroad…[decrease] by about 90 percent" (Qatar Health n.d. 15).

Moving forward, research on the organ trade can be improved in several ways. Empirical research on the organ trade "is thin" and there are few sociological analyses of topic (Healy 2006: 7). Amongst the principal impediments to better understanding the organ trade has been the dearth of data and statistics, stemming from the fact that it is an underground, hidden activity. Generally, although awareness of the organ trade has undoubtedly grown (Shimazono 2007), much data remain elusive (Delmonico 2009: 117), information on trafficking in persons for the removal of organs is incomplete (Ezeilo 2013), and the organ trade still remains the least researched form of human trafficking (Yea 2010: 359). According to Dr. David Rothman, part of the Bellagio Task Force that investigates the global organ trade, "[we] are just beginning to learn about the trafficking in organs for transplantation" (Rothman 1998: 1).

However, there have been important, recent data and information collection efforts, including by the Organization for Security and Co-operation in Europe (OSCE 2013), the Coalition for Organ Failure Solutions (Budiani-Saberi 2014), and the Global Observatory on Donation and Transplantation (GODT 2014). Ultimately, collecting more (and "better quality") data may prove fruitful in presenting a fully comprehensive picture of legislation and the organ trade.

Additionally, while many countries have passed legislation, the organ trade persists and "enforcement of current transplantation legislation is uneven in many countries" (Jha and Chugh 2006: 466). With the global organ trade delegitimized, why does enforcement still vary "greatly from one place to another" (Epstein 2012: 131), and

what is the particular relationship between policy implementation and outcomes? Is conformity to global models and scripts delegitimizing the organ trade purely "ceremonial" or does it produce tangible, substantive results?

The world culture approach notes that although there is isomorphism of laws and policies within the world polity, there are often striking differences between states in terms of implementation and application of common models (Meyer et al. 1997; Meyer and Rowan 1977; Schofer and Hironaka 2005; Swiss 2011).[199] Importantly, examining whether legislation is simply "ceremonial" will help reveal differences in enforcement amongst states, promote increased understanding of why or how the organ trade persists, and help outline potentially more efficient, effective methods to combat the problem. Furthermore, exploring enforcement of organ trafficking laws will extend my existing line of research, particularly within the broader topic of human trafficking, exploring laws and subsequent enforcement by states.[200] Specifically, my general findings within this line of research have shown that compliance and enforcement efforts against human trafficking are impacted by a combination of world culture and government capacity; consequently, my future work can explore whether these findings extend to enforcement against the organ trade.

Another possible direction for further research is examining the impact of recent international policy initiatives, such as the Declaration of Istanbul (2008) and the Council of Europe's (CoE) Convention against Trafficking in Human Organs (2014). These documents represent the institutionalization of the global fight against the organ trade,

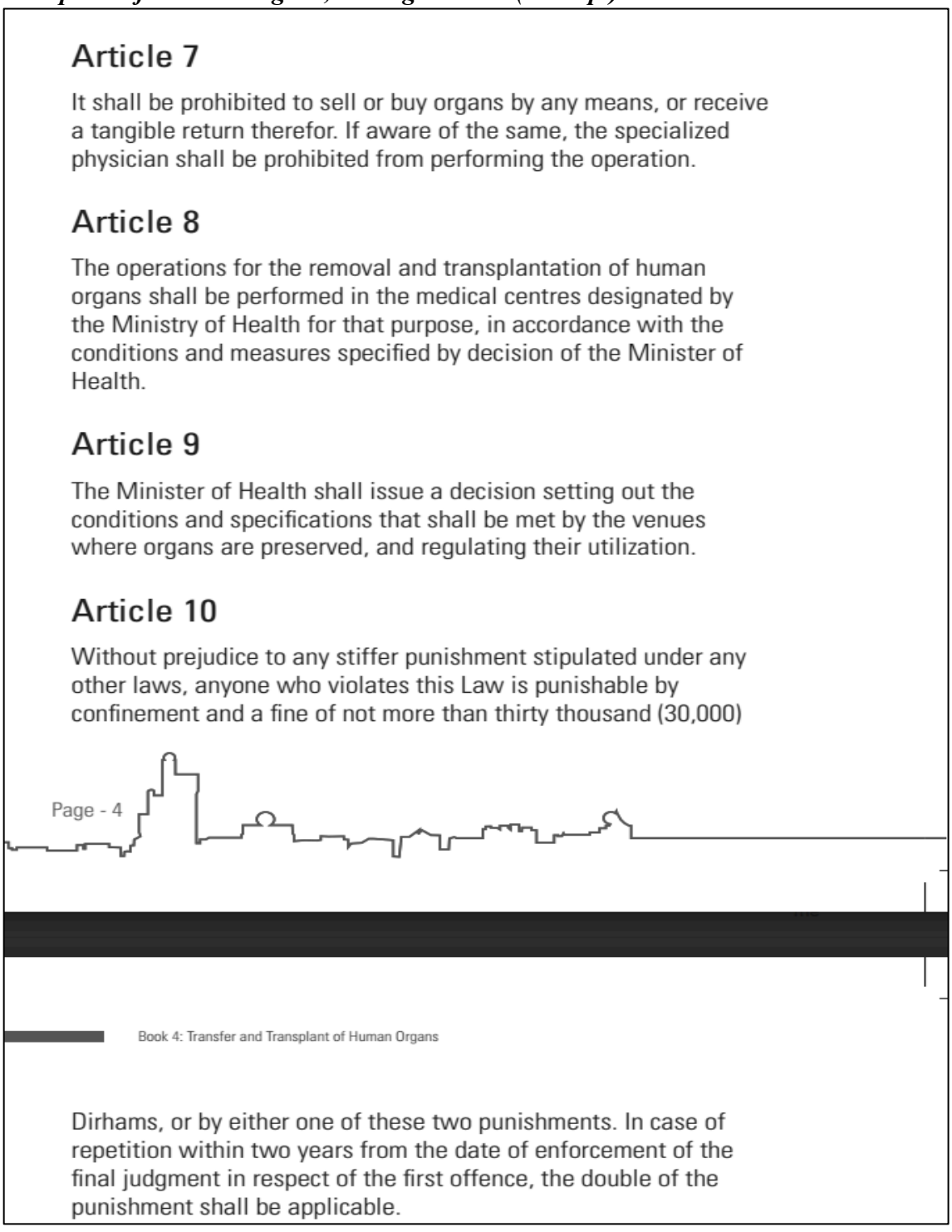
[199]This phenomenon is described as decoupling, or a "disjuncture between institutionalized policies and substantive outcomes" (Schofer and Hironaka 2005: 26).
[200]Useful examples of the possible direction of this line of focus on enforcement, or policy outcomes in general, are Frank et al.'s (2009) examination of global rape-law reforms and outcomes, and Schofer and Hironaka's (2005) study of the effects of world society on environmental protection outcomes.

and as data on their influence upon states become more complete and readily available over time, they offer an opportunity for beneficial research.

Overall, with the organ trade increasingly seen as a global problem, further research is needed to understand its occurrence, recognize its various implications, and ultimately stem its harmful outcomes.

Appendix 1.1

United Arab Emirates – ***Federal Law No. (15) of 1993, Regulating the Transfer and Transplant of Human Organs, 21 August 1993 (Excerpt)***



Article 7

It shall be prohibited to sell or buy organs by any means, or receive a tangible return therefor. If aware of the same, the specialized physician shall be prohibited from performing the operation.

Article 8

The operations for the removal and transplantation of human organs shall be performed in the medical centres designated by the Ministry of Health for that purpose, in accordance with the conditions and measures specified by decision of the Minister of Health.

Article 9

The Minister of Health shall issue a decision setting out the conditions and specifications that shall be met by the venues where organs are preserved, and regulating their utilization.

Article 10

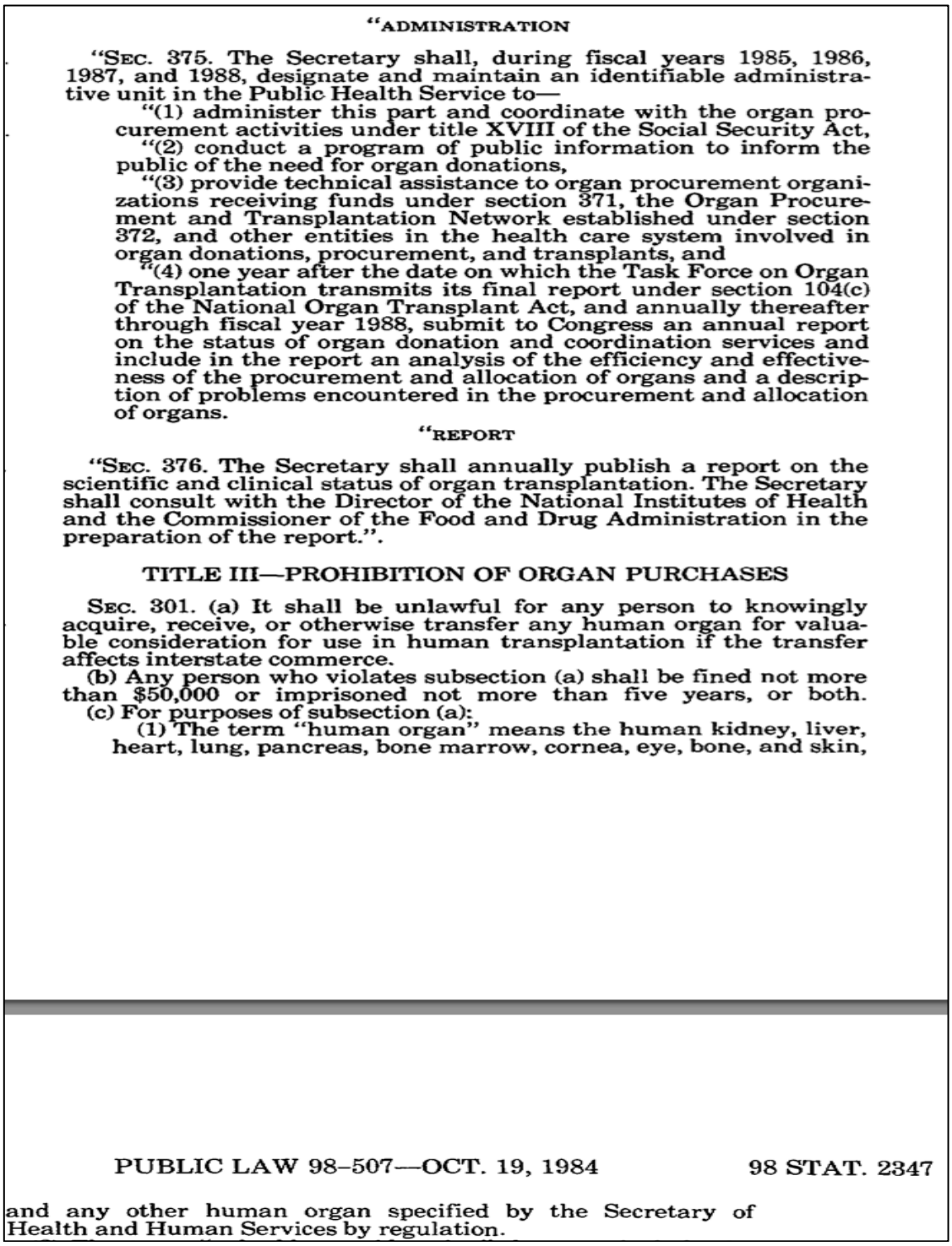
Without prejudice to any stiffer punishment stipulated under any other laws, anyone who violates this Law is punishable by confinement and a fine of not more than thirty thousand (30,000)

Dirhams, or by either one of these two punishments. In case of repetition within two years from the date of enforcement of the final judgment in respect of the first offence, the double of the punishment shall be applicable.

Appendix 1.1 shows how the UAE's legislation bans the organ trade, while outlining both positive and negative dimensions for transplantation (similar to other countries).

Appendix 1.2

United States – ***National Organ Transplant Act, 19 October 1984 (Excerpt)***



"ADMINISTRATION

"SEC. 375. The Secretary shall, during fiscal years 1985, 1986, 1987, and 1988, designate and maintain an identifiable administrative unit in the Public Health Service to—

"(1) administer this part and coordinate with the organ procurement activities under title XVIII of the Social Security Act,

"(2) conduct a program of public information to inform the public of the need for organ donations,

"(3) provide technical assistance to organ procurement organizations receiving funds under section 371, the Organ Procurement and Transplantation Network established under section 372, and other entities in the health care system involved in organ donations, procurement, and transplants, and

"(4) one year after the date on which the Task Force on Organ Transplantation transmits its final report under section 104(c) of the National Organ Transplant Act, and annually thereafter through fiscal year 1988, submit to Congress an annual report on the status of organ donation and coordination services and include in the report an analysis of the efficiency and effectiveness of the procurement and allocation of organs and a description of problems encountered in the procurement and allocation of organs.

"REPORT

"SEC. 376. The Secretary shall annually publish a report on the scientific and clinical status of organ transplantation. The Secretary shall consult with the Director of the National Institutes of Health and the Commissioner of the Food and Drug Administration in the preparation of the report.".

TITLE III—PROHIBITION OF ORGAN PURCHASES

SEC. 301. (a) It shall be unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce.

(b) Any person who violates subsection (a) shall be fined not more than $50,000 or imprisoned not more than five years, or both.

(c) For purposes of subsection (a):

(1) The term "human organ" means the human kidney, liver, heart, lung, pancreas, bone marrow, cornea, eye, bone, and skin,

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and any other human organ specified by the Secretary of Health and Human Services by regulation.

Appendix 1.2 shows how US legislation bans the organ trade, while outlining both positive and negative dimensions for transplantation (similar to other countries).

Appendix 1.3

Montenegro – *The Removal and Transplantation of Human Body Parts for the Purposes of Medical Treatment Act, no. 76/2009, 18 November 2009 (Excerpt)*

Article 7

It is prohibited to traffic body organs, to announce the need for them and offer of body parts in media or by means of any other and media for advertisements or mediation in these matters.

Article 8

Procedure of removal and transplantation of body parts may be carried out only in health care institutions which meet conditions stipulated by this Act.

Medical workers who participate in the procedure of removal and transplantation of body parts are obliged to take all standard measures and activities in order to prevent risk from transferring of contagious or any other disease to recipient and to avoid influences to preservation of body parts for transplantation, in accordance with the regulation of the ministry competent for health affairs (hereinafter: "the Ministry").

Article 9

Data on donor and recipient of body parts shall be a professional secret.

The disclosure of any data whatsoever on the dead donor to the recipient or passing of any information on the recipient to the relatives of the dead donor, shall not be permitted.

The recipient's physician shall have the right to access to medical data of the donor, when the medically justified reasons require so.

Data referred to in the paragraph 1 of this Article shall be collected, stored and disclosed in accordance with a separate law.

Article 10

Funds for the procedures of removal and transplantation of body parts for the purposes of medical treatment, i.e. for health protection related to these procedures, as well as for the monitoring of the health condition of the donor and recipient shall be provided as rights from the obligatory health insurance.

Article 11

Ministry, health care institutions and medical workers involved in the procedures of removal, transplantation, preserving and exchange of body parts and other health care institutions shall work together on successful implementation, promotion and popularization of the procedure of donating of body parts.

Popularization of donation of body parts shall mean informing public about medical, legal, social, ethic and other aspects significant for implementation of the procedure of donation of body parts for the purpose of medical treatment.

Appendix 1.3 shows how Montenegro's legislation bans the organ trade, while outlining both positive and negative dimensions for transplantation (similar to other countries).

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