the purpose of exploitation by the removal of organs for transplantation (*6*).

Transplant commercialism is a policy or practice in which an organ is treated as a commodity, including by being bought or sold or used for material gain.

Travel for transplantation is the movement of organs, donors, recipients, or transplant professionals across jurisdictional borders for transplantation purposes. Travel for transplantation becomes *transplant tourism* if it involves organ trafficking and/or transplant commercialism or if the resources (organs, professionals, and transplant centers) devoted to providing transplants to patients from outside a country undermine the country's ability to provide transplant services for its own population.

PRINCIPLES

1. National governments, working in collaboration with international and nongovernmental organizations should develop and implement comprehensive programs for the screening, prevention, and treatment of organ failure, which include the following:
   a. The advancement of clinical and basic science research;
   b. Effective programs, based on international guidelines, to treat and maintain patients with end-stage diseases, such as dialysis programs for renal patients, to minimize morbidity and mortality, alongside transplant programs for such diseases;
   c. Organ transplantation as the preferred treatment for organ failure for medically suitable recipients.

2. Legislation should be developed and implemented by each country or jurisdiction to govern the recovery of organs from deceased and living donors and the practice of transplantation, consistent with international standards.
   a. Policies and procedures should be developed and implemented to maximize the number of organs available for transplantation, consistent with these principles;
   b. The practice of donation and transplantation requires oversight and accountability by health authorities in each country to ensure transparency and safety;
   c. Oversight requires a national or regional registry to record deceased and living donor transplants;
   d. Key components of effective programs include public education and awareness, health professional education and training, and defined responsibilities and accountabilities for all stakeholders in the national organ donation and transplant system.

3. Organs for transplantation should be equitably allocated within countries or jurisdictions to suitable recipients without regard to gender, ethnicity, religion, or social or financial status.
   a. Financial considerations or material gain of any party must not influence the application of relevant allocation rules.

4. The primary objective of transplant policies and programs should be optimal short- and long-term medical care to promote the health of both donors and recipients.
   a. Financial considerations or material gain of any party must not override primary consideration for the health and well-being of donors and recipients.

5. Jurisdictions, countries, and regions should strive to achieve self-sufficiency in organ donation by providing a sufficient number of organs for residents in need from within the country or through regional cooperation.
   a. Collaboration between countries is not inconsistent with national self-sufficiency as long as the collaboration protects the vulnerable, promotes equality between donor and recipient populations, and does not violate these principles;
   b. Treatment of patients from outside the country or jurisdiction is only acceptable if it does not undermine a country's ability to provide transplant services for its own population.

6. Organ trafficking and transplant tourism violate the principles of equity, justice, and respect for human dignity and should be prohibited. Because transplant commercialism targets impoverished and otherwise vulnerable donors, it leads inexorably to inequity and injustice and should be prohibited. In Resolution 44.25, the World Health Assembly called on countries to prevent the purchase and sale of human organs for transplantation.
   a. Prohibitions on these practices should include a ban on all types of advertising (including electronic and print media), soliciting, or brokering for the purpose of transplant commercialism, organ trafficking, or transplant tourism.
   b. Such prohibitions should also include penalties for acts—such as medically screening donors or organs, or transplanting organs—that aid, encourage, or use the products of, organ trafficking or transplant tourism.
   c. Practices that induce vulnerable individuals or groups (such as illiterate and impoverished persons, undocumented immigrants, prisoners, and political or economic refugees) to become living donors are incompatible with the aim of combating organ trafficking, transplant tourism, and transplant commercialism.

PROPOSALS

Consistent with these principles, participants in the Istanbul Summit suggest the following strategies to increase the donor pool; to prevent organ trafficking, transplant commercialism, and transplant tourism; and to encourage legitimate, life-saving transplantation programs:

To Respond to the Need to Increase Deceased Donation

1. Governments, in collaboration with health care institutions, professionals, and nongovernmental organizations should take appropriate actions to increase deceased organ donation. Measures should be taken to remove obstacles and disincentives to deceased organ donation.
2. In countries without established deceased organ donation or transplantation, national legislation should be enacted that would initiate deceased organ donation and create transplantation infrastructure, so as to fulfill each country's deceased donor potential.

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3. In all countries in which deceased organ donation has been initiated, the therapeutic potential of deceased organ donation and transplantation should be maximized.
4. Countries with well-established deceased donor transplant programs are encouraged to share information, expertise, and technology with countries seeking to improve their organ donation efforts.

To Ensure the Protection and Safety of Living Donors and Appropriate Recognition for Their Heroic Act While Combating Transplant Tourism, Organ Trafficking, and Transplant Commercialism

1. The act of donation should be regarded as heroic and honored as such by representatives of the government and civil society organizations.
2. The determination of the medical and psychosocial suitability of the living donor should be guided by the recommendations of the Amsterdam and Vancouver Forums (*2–4*).
   a. Mechanisms for informed consent should incorporate provisions for evaluating the donor's understanding, including assessment of the psychological impact of the process;
   b. All donors should undergo psychosocial evaluation by mental health professionals during screening.
3. The care of organ donors, including those who have been victims of organ trafficking, transplant commercialism, and transplant tourism, is a critical responsibility of all jurisdictions that sanctioned organ transplants utilizing such practices.
4. Systems and structures should ensure standardization, transparency, and accountability of support for donation.
   a. Mechanisms for transparency of process and follow-up should be established;
   b. Informed consent should be obtained for both donation and follow-up processes.
5. Provision of care includes medical and psychosocial care at the time of donation and for any short- and long-term consequences related to organ donation.
   a. In jurisdictions and countries that lack universal health insurance, the provision of disability, life, and health insurance related to the donation event is a necessary requirement in providing care for the donor;
   b. In those jurisdictions that have universal health insurance, governmental services should ensure that donors have access to appropriate medical care related to the donation event;
   c. Health and/or life insurance coverage and employment opportunities of persons who donate organs should not be compromised;
   d. All donors should be offered psychosocial services as a standard component of follow-up;
   e. In the event of organ failure in the donor, the donor should receive:
      i. Supportive medical care, including dialysis for those with renal failure, and
      ii. Priority for access to transplantation, integrated into existing allocation rules as they apply to either living or deceased organ transplantation.
6. Comprehensive reimbursement of the actual, documented costs of donating an organ does not constitute a payment for an organ, but is rather part of the legitimate costs of treating the recipient.
   a. Such cost-reimbursement would usually be made by the party responsible for the costs of treating the transplant recipient (such as a government health department or a health insurer);
   b. Relevant costs and expenses should be calculated and administered using transparent methodology, consistent with national norms;
   c. Reimbursement of approved costs should be made directly to the party supplying the service (such as to the hospital that provided the donor's medical care);
   d. Reimbursement of the donor's lost income and out-of-pockets expenses should be administered by the agency handling the transplant rather than paid directly from the recipient to the donor.
7. Legitimate expenses that may be reimbursed when documented include:
   a. The cost of any medical and psychological evaluations of potential living donors who are excluded from donation (e.g., because of medical or immunologic issues discovered during the evaluation process);
   b. Costs incurred in arranging and effecting the pre-, peri-, and postoperative phases of the donation process (e.g., long-distance telephone calls, travel, accommodation, and subsistence expenses);
   c. Medical expenses incurred for postdischarge care of the donor;
   d. Lost income in relation to donation (consistent with national norms).

APPENDIX

The Participants in the International Summit on Transplant Tourism and Organ Trafficking and the manner in which they were chosen and the meeting was organized were as follows:

Process and Participant Selection

Steering Committee

The Steering Committee was selected by an Organizing Committee consisting of Mona Alrukhami, Jeremy Chapman, Francis Delmonico, Mohamed Sayegh, Faissal Shaheen, and Annika Tibell.

The Steering Committee was composed of leadership from The Transplantation Society, including its President-elect and the Chair of its Ethics Committee, and the International Society of Nephrology, including its Vice President and individuals holding Council positions. The Steering Committee had representation from each of the continental regions of the globe with transplantation programs.

The mission of the Steering Committee was to draft a declaration for consideration by a diverse group of participants at the Istanbul Summit. The Steering Committee also had the responsibility to develop the list of participants to be invited to the Summit meeting.

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Istanbul Participant Selection

Participants at the Istanbul Summit were selected by the Steering Committee according to the following considerations:

- The country liaisons of The Transplantation Society representing virtually all countries with transplantation programs;
- Representatives from international societies and the Vatican;
- Individuals holding leadership positions in nephrology and transplantation;
- Stakeholders in the public policy aspect of organ transplantation; and
- Ethicists, anthropologists, sociologists, and legal scholars well recognized for their writings regarding transplantation policy and practice.

No person or group was polled with respect to their opinion, practice, or philosophy before the Steering Committee selection or the Istanbul Summit.

After the proposed group of participants was prepared and reviewed by the Steering Committee, they were sent an letter of invitation to the Istanbul Summit, which included the following components:

- the mission of the Steering Committee to draft a declaration for all Istanbul participants' consideration;
- the agenda and work group format of the Summit;
- the procedure for the selection of participants;
- the work group topics;
- an invitation to the participants to indicate their work group preferences;
- the intent to communicate a draft and other materials before the Summit convened;
- the Summit goals to assemble a final Declaration that could achieve consensus and would address the issues of organ trafficking, transplant tourism and commercialism, and provide principles of practice and recommended alternatives to address the shortage of organs;
- an acknowledgment of the funding provided by Astellas Pharmaceuticals for the Summit;
- provision of hotel accommodations and travel for all invited participants.

Of approximately 170 persons invited, 160 agreed to participate and 152 were able to attend the Summit in Istanbul on April 30 to May 2, 2008. Because work on the declaration at the Summit was to be carried out by dividing the draft document into separate parts, Summit invitees were assigned to a work group topic based on their response concerning the particular topics on which they wished to focus their attention before and during the Summit.

Preparation of the Declaration

The draft declaration prepared by the Steering Committee was furnished to all participants with ample time for appraisal and response before the Summit. The comments and suggestions received in advance were reviewed by the Steering Committee and given to leaders of the appropriate work group at the Summit. (Work group leaders were selected and assigned from the Steering Committee.)

The Summit meeting was formatted so that breakout sessions of the work groups could consider the written responses received from participants before the Summit as well as comments from each of the work group participants. The work groups elaborated these ideas as proposed additions to and revisions of the draft. When the Summit reconvened in plenary session, the Chairs of each work group presented the outcome of their breakout session to all Summit participants for discussion. During this process of review, the wording of each section of the declaration was displayed on a screen before the plenary participants and was modified in light of their comments until consensus was reached on each point.

The content of the declaration is derived from the consensus that was reached by the participants at the Summit in the plenary sessions that took place on May 1 and 2, 2008. A formatting group was assembled immediately after the Summit to address punctuation, grammatical, and related concerns and to record the declaration in its finished form.

Participants in the Istanbul Summit

Last Name	First Name	Country
Abboud	Omar	Sudan
*Abbud-Filho	Mario	Brazil
Abdramanov	Kaldarbek	Kyrgyzstan
Abdulla	Sadiq	Bahrain
Abraham	Georgi	India
Abueva	Amihan V.	Philippines
Aderibigbe	Ademola	Nigeria
*Al-Mousawi	Mustafa	Kuwait
Alberu	Josefina	Mexico
Allen	Richard D.M.	Australia
Almazan-Gomez	Lynn C.	Philippines
Alnono	Ibrahim	Yemen
*Alobaidli	Ali Abdulkareem	United Arab Emirates
*Alrukhaimi	Mona	United Arab Emirates
Álvarez	Inés	Uruguay
Assad	Lina	Saudi Arabia
Assounga	Alain G.	South Africa
Baez	Yenny	Colombia
*Bagheri	Alireza	Iran
*Bakr	Mohamed Adel	Egypt
Bamgboye	Ebun	Nigeria
*Barbari	Antoine	Lebanon
Belghiti	Jacques	France
Ben Abdallah	Taieb	Tunisia
Ben Ammar	Mohamed Salah	Tunisia
Bos	Michael	The Netherlands
Britz	Russell	South Africa
Budiani	Debra	USA
*Capron	Alexander	USA
Castro	Cristina R.	Brazil
*Chapman	Jeremy	Australia
Chen	Zhonghua Klaus	People's Republic of China
Codreanu	Igor	Moldova
Cole	Edward	Canada
Cozzi	Emanuele	Italy
*Danovitch	Gabriel	USA

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Davids	Razeen	South Africa
De Broe	Marc	Belgium
*De Castro	Leonardo	Philippines
*Delmonico	Francis L.	USA
Derani	Rania	Syria
Dittmer	Ian	New Zealand
Domínguez-Gil	Beatriz	Spain
Duro-Garcia	Valter	Brazil
Ehtuish	Ehtuish	Libya
El-Shoubaki	Hatem	Qatar
Epstein	Miran	United Kingdom
*Fazel	Iraj	Iran
Fernandez Zincke	Eduardo	Belgium
Garcia-Gallont	Rudolf	Guatemala
Ghods	Ahad J.	Iran
Gill	John	Canada
Glotz	Denis	France
Gopalakrishnan	Ganesh	India
Gracida	Carmen	Mexico
Grinyo	Josep	Spain
Ha	Jongwon	South Korea
*Haberal	Mehmet A.	Turkey
Hakim	Nadey	United Kingdom
Harmon	William	USA
Hasegawa	Tomonori	Japan
Hassan	Ahmed Adel	Egypt
Hickey	David	Ireland
Hiesse	Christian	France
Hongji	Yang	People's Republic of China
Humar	Ines	Croatia
Hurtado	Abdias	Peru
Ismail Moustafa	Wesam	Egypt
Ivanovski	Ninoslav	Macedonia
*Jha	Vivekanand	India
Kahn	Delawir	South Africa
Kamel	Refaat	Egypt
Kirpalani	Ashok	India
Kirste	Guenter	Germany
*Kobayashi	Eiji	Japan
Koller	Jan	Slovakia
Kranenburg	Leonieke	The Netherlands
*Lameire	Norbert	Belgium
Laouabdia-Sellami	Karim	France
Lei	Ruipeng	People's Republic of China
*Levin	Adeera	Canada
Lloveras	Josep	Spain
Löhmus	Aleksander	Estonia
Luciolli	Esmeralda	France
Lundin	Susanne	Sweden
Lye	Wai Choong	Singapore
Lynch	Stephen	Australia
*Maïga	Mahamane	Mali
Mamzer Bruneel	Marie-France	France
Maric	Nicole	Austria
*Martin	Dominique	Australia
*Masri	Marwan	Lebanon
Matamoros	Maria A.	Costa Rica
Matas	Arthur	USA
McNeil	Adrian	United Kingdom
Meiser	Bruno	Germany
Meši	Enisa	Bosnia
Moazam	Farhat	Pakistan
Mohsin	Nabil	Oman
Mor	Eytan	Israel
Morales	Jorge	Chile
Munn	Stephen	New Zealand
Murphy	Mark	Ireland
*Naicker	Saraladevi	South Africa
Naqvi	S.A. Anwar	Pakistan
*Noël	Luc	WHO
Obrador	Gregorio	Mexico
Oliveros	Yolanda	Philippines
Ona	Enrique	Philippines
Oosterlee	Arie	The Netherlands
Oyen	Ole	Norway
Padilla	Benita	Philippines
Pratschke	Johann	Germany
Rahamimov	Ruth	Israel
Rahmel	Axel	The Netherlands
Reznik	Oleg	Russia
*Rizvi	S. Adibul Hasan	Pakistan
Roberts	Lesley Ann	Trinidad and Tobago
*Rodriguez-Iturbe	Bernardo	Venezuela
Rowinski	Wojciech	Poland
Saeed	Bassam	Syria
Sarkissian	Ashot	Armenia
*Sayegh	Mohamed H.	USA
Scheper-Hughes	Nancy	USA
Sever	Mehmet Sukru	Turkey
*Shaheen	Faissal A.	Saudi Arabia
Sharma	Dhananjaya	India
Shinozaki	Naoshi	Japan
Simforoosh	Nasser	Iran
Singh	Harjit	Malaysia
Sok Hean	Thong	Cambodia
Somerville	Margaret	Canada
Stadtler	Maria	USA
*Stephan	Antoine	Lebanon
Suárez	Juliette	Cuba
Suaudeau	Msgr. Jacques	Italy
Sumethkul	Vasant	Thailand
Takahara	Shiro	Japan
Thiel	Gilbert T.	Switzerland
*Tibell	Annika	Sweden
Tomadze	Gia	Georgia
*Tong	Matthew Kwok-Lung	Hong Kong
Tsai	Daniel Fu-Chang	Taiwan
Uriarte	Remedios	Philippines

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Vanrenterghem	Yves F.C.	Belgium
*Vathsala	A.	Singapore
Weimar	Willem	The Netherlands
Wikler	Daniel	USA
Young	Kimberly	Canada
Yuldashev	Ulugbek	Uzbekistan
Zhao	Minggang	People's Republic of China

*Members of the Steering Committee. (William Couser, USA, was also a member of the Steering Committee but was unable to attend the Summit.)

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Editorial

The Declaration of Istanbul on Organ Trafficking and Transplant Tourism

Participants in the International Summit on Transplant Tourism and Organ Trafficking convened by The Transplantation Society and International Society of Nephrology in Istanbul, Turkey, 30 April to 2 May 2008*

Preamble

Organ transplantation, one of the medical miracles of the 20th century, has prolonged and improved the lives of hundreds of thousands of patients worldwide. The many great scientific and clinical advances of dedicated health professionals, as well as countless acts of generosity by organ donors and their families, have made transplantation not only a life-saving therapy but also a shining symbol of human solidarity. Yet these accomplishments have been tarnished by numerous reports of trafficking in human beings who are used as sources of organs and of patient-tourists from rich countries who travel abroad to purchase organs from poor people. In 2004, the World Health Organization called on member states 'to take measures to protect the poorest and vulnerable groups from transplant tourism and the sale of tissues and organs, including attention to the wider problem of international trafficking in human tissues and organs' [1].

To address the urgent and growing problems of organ sales, transplant tourism and trafficking in organ donors in the context of the global shortage of organs, a summit meeting of more than 150 representatives of scientific and medical bodies from around the world, government officials, social scientists and ethicists, was held in Istanbul from 30 April to 2 May 2008. Preparatory work for the meeting was undertaken by a Steering Committee convened by The Transplantation Society (TTS) and the International Society of Nephrology (ISN) in Dubai in December 2007. That committee's draft declaration was widely circulated and then revised in light of the comments received. At the Summit, the revised draft was reviewed by working groups and finalized in plenary deliberations.

This declaration represents the consensus of the Summit participants. All countries need a legal and professional framework to govern organ donation and transplantation activities, as well as a transparent regulatory oversight system that ensures donor and recipient safety and the enforcement of standards and prohibitions on unethical practices.

Unethical practices are, in part, an undesirable consequence of the global shortage of organs for transplantation. Thus, each country should strive both to ensure that programmes to prevent organ failure are implemented and to provide organs to meet the transplant needs of its residents from donors within its own population or through regional cooperation. The therapeutic potential of deceased organ donation should be maximized not only for kidneys but also for other organs, appropriate to the transplantation needs of each country. Efforts to initiate or enhance deceased donor transplantation are essential to minimize the burden on living donors. Educational programmes are useful in addressing the barriers, misconceptions and mistrust that currently impede the development of sufficient deceased donor transplantation; successful transplant programmes also depend on the existence of the relevant health system infrastructure.

Access to healthcare is a human right but often not a reality. The provision of care for living donors before, during and after surgery—as described in the reports of the international forums organized by TTS in Amsterdam and Vancouver [2–4]—is no less essential than taking care of the transplant recipients. A positive outcome for a recipient can never justify harm to a live donor; in contrast, for a transplant with a live donor to be regarded as a success means that both the recipient and the donor have done well.

This declaration builds on the principles of the Universal Declaration of Human Rights [5]. The broad representation at the Istanbul Summit reflects the importance of international collaboration and global consensus to improve donation and transplantation practices. The Declaration will be submitted to relevant professional organizations and to the health authorities of all countries for consideration. The legacy of transplantation must not be the impoverished victims of organ trafficking and transplant tourism but rather a celebration of the gift of health by one individual to another.

Definitions

Organ trafficking is the recruitment, transport, transfer, harbouring or receipt of living or deceased persons or their organs by means of the threat or use of force or other forms of

*The participants in the International Summit on Transplant Tourism and Organ Trafficking and the manner in which they were chosen and the meeting was organized are given in the Appendix.

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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 [6].

Transplant commercialism is a policy or practice in which an organ is treated as a commodity, including by being bought or sold or used for material gain.

Travel for transplantation is the movement of organs, donors, recipients or transplant professionals across jurisdictional borders for transplantation purposes. Travel for transplantation becomes *transplant tourism* if it involves organ trafficking and/or transplant commercialism or if the resources (organs, professionals and transplant centres) devoted to providing transplants to patients from outside a country undermine the country's ability to provide transplant services for its own population.

Principles

1. National governments, working in collaboration with international and non-governmental organizations, should develop and implement comprehensive programmes for the screening, prevention and treatment of organ failure, which include
   a. the advancement of clinical and basic science research;
   b. effective programmes, based on international guidelines, to treat and maintain patients with end-stage diseases, such as dialysis programmes for renal patients, to minimize morbidity and mortality, alongside transplant programmes for such diseases;
   c. organ transplantation as the preferred treatment for organ failure for medically suitable recipients.
2. Legislation should be developed and implemented by each country or jurisdiction to govern the recovery of organs from deceased and living donors and the practice of transplantation, consistent with international standards.
   a. Policies and procedures should be developed and implemented to maximize the number of organs available for transplantation, consistent with these principles;
   b. the practice of donation and transplantation requires oversight and accountability by health authorities in each country to ensure transparency and safety;
   c. oversight requires a national or regional registry to record deceased and living donor transplants;
   d. key components of effective programmes include public education and awareness, health professional education and training, and defined responsibilities and accountabilities for all stakeholders in the national organ donation and transplant system.
3. Organs for transplantation should be equitably allocated within countries or jurisdictions to suitable recipients without regard to gender, ethnicity, religion, or social or financial status.
   a. Financial considerations or material gain of any party must not influence the application of relevant allocation rules.
4. The primary objective of transplant policies and programmes should be optimal short- and long-term medical care to promote the health of both donors and recipients.
   a. Financial considerations or material gain of any party must not override primary consideration for the health and well-being of donors and recipients.
5. Jurisdictions, countries and regions should strive to achieve self-sufficiency in organ donation by providing a sufficient number of organs for residents in need from within the country or through regional cooperation.
   a. Collaboration between countries is not inconsistent with national self-sufficiency as long as the collaboration protects the vulnerable, promotes equality between donor and recipient populations, and does not violate these principles;
   b. treatment of patients from outside the country or jurisdiction is only acceptable if it does not undermine a country's ability to provide transplant services for its own population.
6. Organ trafficking and transplant tourism violate the principles of equity, justice and respect for human dignity and should be prohibited. Because transplant commercialism targets impoverished and otherwise vulnerable donors, it leads inexorably to inequity and injustice and should be prohibited. In Resolution 44.25, the World Health Assembly called on countries to prevent the purchase and sale of human organs for transplantation.
   a. Prohibitions on these practices should include a ban on all types of advertising (including electronic and print media), soliciting or brokering for the purpose of transplant commercialism, organ trafficking or transplant tourism;
   b. such prohibitions should also include penalties for acts—such as medically screening donors or organs, or transplanting organs—that aid, encourage or use the products of organ trafficking or transplant tourism;
   c. practices that induce vulnerable individuals or groups (such as illiterate and impoverished persons, undocumented immigrants, prisoners, and political or economic refugees) to become living donors are incompatible with the aim of combating organ trafficking, transplant tourism and transplant commercialism.

Proposals

Consistent with these principles, participants in the Istanbul Summit suggest the following strategies to increase the donor pool and to prevent organ trafficking, transplant commercialism and transplant tourism and to encourage legitimate, life-saving transplantation programmes.

To respond to the need to increase deceased donation:

1. Governments, in collaboration with health care institutions, professionals and non-governmental organizations, should take appropriate actions to increase deceased organ donation. Measures should be taken to remove obstacles and disincentives to deceased organ donation.
2. In countries without established deceased organ donation or transplantation, national legislation should be enacted that would initiate deceased organ donation and create transplantation infrastructure, so as to fulfil each country's deceased donor potential.
3. In all countries in which deceased organ donation has been initiated, the therapeutic potential of deceased organ donation and transplantation should be maximized.
4. Countries with well-established deceased donor transplant programmes are encouraged to share information, expertise and technology with countries seeking to improve their organ donation efforts.

To ensure the protection and safety of living donors and appropriate recognition for their heroic act while combating transplant tourism, organ trafficking and transplant commercialism:

1. The act of donation should be regarded as heroic and honoured as such by representatives of the government and civil society organizations.
2. The determination of the medical and psychosocial suitability of the living donor should be guided by the recommendations of the Amsterdam and Vancouver Forums [2–4].
   a. Mechanisms for informed consent should incorporate provisions for evaluating the donor's understanding, including assessment of the psychological impact of the process;
   b. all donors should undergo psychosocial evaluation by mental health professionals during screening.
3. The care of organ donors, including those who have been victims of organ trafficking, transplant commercialism and transplant tourism, is a critical responsibility of all jurisdictions that sanctioned organ transplants utilizing such practices.
4. Systems and structures should ensure standardization, transparency and accountability of support for donation.
   a. Mechanisms for transparency of process and follow-up should be established;
   b. informed consent should be obtained both for donation and for follow-up processes.
5. Provision of care includes medical and psychosocial care at the time of donation and for any short- and long-term consequences related to organ donation.
   a. In jurisdictions and countries that lack universal health insurance, the provision of disability, life and health insurance related to the donation event is a necessary requirement in providing care for the donor;
   b. in those jurisdictions that have universal health insurance, governmental services should ensure that donors have access to appropriate medical care related to the donation event;
   c. health and/or life insurance coverage and employment opportunities of persons who donate organs should not be compromised;
   d. all donors should be offered psychosocial services as a standard component of follow-up;
   e. in the event of organ failure, the donor should receive
      i. supportive medical care, including dialysis for those with renal failure, and
      ii. priority for access to transplantation, integrated into existing allocation rules as they apply to either living or deceased organ transplantation.
6. Comprehensive reimbursement of the actual, documented costs of donating an organ does not constitute a payment for an organ, but is rather part of the legitimate costs of treating the recipient.
   a. Such cost reimbursement would usually be made by the party responsible for the costs of treating the transplant recipient (such as a government health department or a health insurer);
   b. relevant costs and expenses should be calculated and administered using transparent methodology, consistent with national norms;
   c. reimbursement of approved costs should be made directly to the party supplying the service (such as to the hospital that provided the donor's medical care);
   d. reimbursement of the donor's lost income and out-of-pocket expenses should be administered by the agency handling the transplant rather than paid directly from the recipient to the donor.
7. Legitimate expenses that may be reimbursed when documented include
   a. the cost of any medical and psychological evaluations of potential living donors who are excluded from donation (e.g. because of medical or immunologic issues discovered during the evaluation process);
   b. costs incurred in arranging and effecting the pre-, peri- and post-operative phases of the donation process (e.g. long-distance telephone calls, travel, accommodation and subsistence expenses);
   c. medical expenses incurred for post-discharge care of the donor;
   d. lost income in relation to donation (consistent with national norms).

Appendix. Process and participant selection

Steering Committee

The Steering Committee was selected by an organizing committee consisting of Mona Alrukhami, Jeremy

Chapman, Francis Delmonico, Mohamed Sayegh, Faissal Shaheen and Annika Tibell.

The Steering Committee was composed of leadership from The Transplantation Society, including its President-elect and the Chair of its ethics committee, and the International Society of Nephrology, including its vice president and individuals holding council positions. The Steering Committee had representation from each of the continental regions of the globe with transplantation programmes.

The mission of the Steering Committee was to draft a declaration for consideration by a diverse group of participants at the Istanbul Summit. The Steering Committee also had the responsibility to develop the list of participants to be invited to the Summit meeting.

Istanbul participant selection

Participants at the Istanbul Summit were selected by the Steering Committee according to the following considerations:

- the country liaisons of The Transplantation Society representing virtually all countries with transplantation programmes;
- representatives from international societies and the Vatican;
- individuals holding leadership positions in nephrology and transplantation;
- stakeholders in the public policy aspect of organ transplantation and
- ethicists, anthropologists, sociologists and legal scholars well recognized for their writings regarding transplantation policy and practice.

No person or group was polled with respect to their opinion, practice or philosophy prior to the Steering Committee selection or the Istanbul Summit.

After the proposed group of participants was prepared and reviewed by the Steering Committee, they were sent a letter of invitation to the Istanbul Summit, which included the following components:

- the mission of the Steering Committee to draft a declaration for all Istanbul participants' consideration;
- the agenda and work group format of the Summit;
- the procedure for the selection of participants;
- the work group topics;
- an invitation to the participants to indicate their work group preferences;
- the intent to communicate a draft and other materials before the Summit convened;
- the Summit goals to assemble a final declaration that could achieve consensus and would address the issues of organ trafficking, transplant tourism and commercialism, and provide principles of practice and recommended alternatives to address the shortage of organs;
- an acknowledgement of the funding provided by Astellas Pharmaceuticals for the Summit;
- provision of hotel accommodations and travel for all invited participants.

Of ~170 persons invited, 160 agreed to participate and 152 were able to attend the Summit in Istanbul on 30 April–2 May 2008. Because work on the Declaration at the Summit was to be carried out by dividing the draft document into separate parts, Summit invitees were assigned to a work group topic based on their response concerning the particular topics on which they wished to focus their attention before and during the Summit.

Preparation of the declaration

The draft declaration prepared by the Steering Committee was furnished to all participants with ample time for appraisal and response prior to the Summit. The comments and suggestions received in advance were reviewed by the Steering Committee and given to leaders of the appropriate work group at the Summit. (Work group leaders were selected and assigned from the Steering Committee.)

The Summit meeting was formatted so that breakout sessions of the work groups could consider the written responses received from participants prior to the Summit as well as comments from each of the work group participants. The work groups elaborated these ideas as proposed additions to and revisions of the draft. When the Summit reconvened in plenary session, the Chairs of each work group presented the outcome of their breakout session to all Summit participants for discussion. During this process of review, the wording of each section of the Declaration was displayed on a screen before the plenary participants and was modified in light of their comments until consensus was reached on each point.

The content of the Declaration is derived from the consensus that was reached by the participants at the Summit in the plenary sessions that took place on 1 and 2 May 2008. A formatting group was assembled immediately after the Summit to address punctuation, grammatical and related concerns and to record the Declaration in its finished form.

Participants in the Istanbul Summit

Last name	First name	Country
Abboud	Omar	Sudan
[a]Abbud-Filho	Mario	Brazil
Abdramanov	Kaldarbek	Kyrgyzstan
Abdulla	Sadiq	Bahrain
Abraham	Georgi	India
Abueva	Amihan V.	Philippines
Aderibigbe	Ademola	Nigeria
[a]Al-Mousawi	Mustafa	Kuwait
Alberu	Josefina	Mexico
Allen	Richard D.M.	Australia
Almazan-Gomez	Lynn C.	Philippines
Alnono	Ibrahim	Yemen
[a]Alobaidli	Ali Abdulkareem	United Arab Emirates
[a]Alrukhaimi	Mona	United Arab Emirates
Álvarez	Inés	Uruguay
Assad	Lina	Saudi Arabia
Assounga	Alain G.	South Africa

continued

(continued)

Last name	First name	Country
Baez	Yenny	Colombia
[a]Bagheri	Alireza	Iran
[a]Bakr	Mohamed Adel	Egypt
Bamgboye	Ebun	Nigeria
[a]Barbari	Antoine	Lebanon
Belghiti	Jacques	France
Ben Abdallah	Taieb	Tunisia
Ben Ammar	Mohamed Salah	Tunisia
Bos	Michael	The Netherlands
Britz	Russell	South Africa
Budiani	Debra	USA
[a]Capron	Alexander	USA
Castro	Cristina R.	Brazil
[a]Chapman	Jeremy	Australia
Chen	Zhonghua Klaus	People's Republic of China
Codreanu	Igor	Moldova
Cole	Edward	Canada
Cozzi	Emanuele	Italy
[a]Danovitch	Gabriel	USA
Davids	Razeen	South Africa
De Broe	Marc	Belgium
[a]De Castro	Leonardo	Philippines
[a]Delmonico	Francis L.	USA
Derani	Rania	Syria
Dittmer	Ian	New Zealand
Domínguez-Gil	Beatriz	Spain
Duro-Garcia	Valter	Brazil
Ehtuish	Ehtuish	Libya
El-Shoubaki	Hatem	Qatar
Epstein	Miran	United Kingdom
[a]Fazel	Iraj	Iran
Fernandez Zincke	Eduardo	Belgium
Garcia-Gallont	Rudolf	Guatemala
Ghods	Ahad J.	Iran
Gill	John	Canada
Glotz	Denis	France
Gopalakrishnan	Ganesh	India
Gracida	Carmen	Mexico
Grinyo	Josep	Spain
Ha	Jongwon	South Korea
[a]Haberal	Mehmet A.	Turkey
Hakim	Nadey	United Kingdom
Harmon	William	USA
Hasegawa	Tomonori	Japan
Hassan	Ahmed Adel	Egypt
Hickey	David	Ireland
Hiesse	Christian	France
Hongji	Yang	People's Republic of China
Humar	Ines	Croatia
Hurtado	Abdias	Peru
Ismail Moustafa	Wesam	Egypt
Ivanovski	Ninoslav	Macedonia
[a]Jha	Vivekanand	India
Kahn	Delawir	South Africa
Kamel	Refaat	Egypt
Kirpalani	Ashok	India
Kirste	Guenter	Germany
[a]Kobayashi	Eiji	Japan
Koller	Jan	Slovakia
Kranenburg	Leonieke	The Netherlands
[a]Lameire	Norbert	Belgium
Laouabdia-Sellami	Karim	France
Lei	Ruipeng	People's Republic of China
[a]Levin	Adeera	Canada
Lloveras	Josep	Spain
Lõhmus	Aleksander	Estonia
Luciolli	Esmeralda	France

(continued)

Last name	First name	Country
Lundin	Susanne	Sweden
Lye	Wai Choong	Singapore
Lynch	Stephen	Australia
[a]Maïga	Mahamane	Mali
Mamzer Bruneel	Marie-France	France
Marie	Nicole	Austria
[a]Martin	Dominique	Australia
[a]Masri	Marwan	Lebanon
Matamoros	Maria A.	Costa Rica
Matas	Arthur	USA
McNeil	Adrian	United Kingdom
Meiser	Bruno	Germany
Meši	Enisa	Bosnia
Moazam	Farhat	Pakistan
Mohsin	Nabil	Oman
Mor	Eytan	Israel
Morales	Jorge	Chile
Munn	Stephen	New Zealand
Murphy	Mark	Ireland
[a]Naicker	Saraladevi	South Africa
Naqvi	S.A. Anwar	Pakistan
[a]Noël	Luc	WHO
Obrador	Gregorio	Mexico
Oliveros	Yolanda	Philippines
Ona	Enrique	Philippines
Oosterlee	Arie	The Netherlands
Oyen	Ole	Norway
Padilla	Benita	Philippines
Pratschke	Johann	Germany
Rahamimov	Ruth	Israel
Rahmel	Axel	The Netherlands
Reznik	Oleg	Russia
[a]Rizvi	S. Adibul Hasan	Pakistan
Roberts	Lesley Ann	Trinidad and Tobago
[a]Rodriguez-Iturbe	Bernardo	Venezuela
Rowinski	Wojciech	Poland
Saeed	Bassam	Syria
Sarkissian	Ashot	Armenia
[a]Sayegh	Mohamed H.	USA
Scheper-Hughes	Nancy	USA
Sever	Mehmet Sukru	Turkey
[a]Shaheen	Faissal A.	Saudi Arabia
Sharma	Dhananjaya	India
Shinozaki	Naoshi	Japan
Simforoosh	Nasser	Iran
Singh	Harjit	Malaysia
Sok Hean	Thong	Cambodia
Somerville	Margaret	Canada
Stadtler	Maria	USA
[a]Stephan	Antoine	Lebanon
Suárez	Juliette	Cuba
Suaudeau	Msgr. Jacques	Italy
Sumethkul	Vasant	Thailand
Takahara	Shiro	Japan
Thiel	Gilbert T.	Switzerland
Tibell	Annika	Sweden
Tomadze	Gia	Georgia
[a]Tong	Matthew Kwok-Lung	Hong Kong
Tsai	Daniel Fu-Chang	Taiwan
Uriarte	Remedios	Philippines
Vanrenterghem	Yves F. C.	Belgium
[a]Vathsala	A.	Singapore
Weimar	Willem	The Netherlands
Wikler	Daniel	USA
Young	Kimberly	Canada
Yuldashev	Ulugbek	Uzbekistan
Zhao	Minggang	People's Republic of China

[a]Members of the Steering Committee. (William Couser, USA, was also a member of the Steering Committee but was unable to attend the Summit.)

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Editorial Comments

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The development of the Declaration of Istanbul on Organ Trafficking and Transplant Tourism

Francis L. Delmonico

In this issue of *Nephrology Dialysis and Transplantation*, the Declaration of Istanbul on Organ Trafficking and Transplant Tourism is presented from a multicultural representation of the international community as a resolve to combat unethical practices that have been long standing. Organ trafficking, transplant tourism and transplant commercialism, which threaten to undermine the nobility of transplantation worldwide, became the subject of a summit convened in Istanbul from 30 April to 1 May 2008 by The Transplantation Society (TTS) and the International Society of Nephrology (ISN). The result of these deliberations was the *Istanbul Declaration on Organ Trafficking and Transplant Tourism*. The initial text of the Declaration was prepared by a multicultural Steering Committee, which issued the invitations to medical and scientific professionals, representatives of governmental and social agencies, social scientists, legal scholars and ethicist to participate. None of the 152 participants from 78 countries was polled with respect to his or her opinion, practice or philosophy prior to selection. The consensus achieved at the Istanbul Summit was remarkable.

The development of the Istanbul Summit and Declaration was derived from a direction by the World Health Assembly in 2004 when it adopted resolution WHA57.18 urging member states: 'to take measures to protect the poorest and vulnerable groups from transplant tourism and the sale of tissues and organs, including attention to the wider problem of international trafficking in human tissues and organs'. As a consequence of the widespread shortage of organs and the increasing ease of internet communication, organ trafficking and transplant tourism have become global problems accounting for ~10% of organ transplants that are performed annually around the world. Vulnerable populations (such as illiterate and impoverished persons, undocumented immigrants, prisoners and political or economic refugees) in resource-poor countries have been a major source of organs for rich patient-tourists who are prepared to travel and can afford to purchase organs.

Although the WHA 2004 resolution was unambiguous in its objection to trafficking and transplant tourism, a comprehensive description of these unethicalpractices was still needed. Organ trafficking, transplant tourism and transplant commercialism are now comprehensively defined by the Declaration and it provides principles of practice based on those definitions. For example with regard to transplant tourism, not all recipients travel to a foreign country to undergo transplantation is unethical. Transplant tourism may be *ethical* if the following conditions are fulfilled.

For transplantation from a live donor:

- if the recipient has a dual citizenship (in the country of residence and also in the destination country) and wishes to undergo transplantation from a live donor that is a family member in the destination country of citizenship that is not their residence;
- if the donor and recipient are genetically or emotionally related and wish to undergo donation and transplantation in a country not of their residence to gain access to better health services.

For transplantation from a deceased donor:

- if official regulated bilateral or multilateral organ sharing programs exist between or among jurisdictions (countries) that are based on a reciprocated organ sharing programs between or among the jurisdictions.

The Istanbul Declaration notes the following: travel for transplantation is the movement of organs, donors, recipients or transplant professionals across jurisdictional borders for transplantation purposes. Travel for transplantation becomes *transplant tourism* if it involves organ trafficking and/or transplant commercialism or if the resources (organs, professionals and transplant centres) devoted to providing transplants to patients from outside a country undermine the country's ability to provide transplant services for its own population.

The Istanbul participants emphasized that organ trafficking and transplant tourism should be prohibited because they violate the principles of equity, justice and respect for human dignity. The Declaration is also clear regarding the consequences of transplant commercialism. Because transplant commercialism targets impoverished and otherwise vulnerable donors, it leads inexorably to inequity and injustice and should also be prohibited. To be effective, these prohibitions must include bans on all types of advertising (electronic and print), soliciting or brokering for the purpose of transplant commercialism.

At this time, most of the countries from which transplant tourists originate, as well as those destinations to which

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they travel to obtain transplants, are just beginning to address their responsibilities to protect their people from exploitation and to develop national self-sufficiency in organ donation. The medical leaders who played major roles in the promulgation of laws and regulations within the past 2 years in China, Pakistan and Philippines were participants in the Istanbul Summit meeting. The Declaration describes universal approaches to providing care for the living donor and also emphasizes the need for effective practices that support deceased organ donation.

The implications of the Istanbul Declaration definitions, principles and recommendations are profound. They call for a legal and professional framework in each country to govern organ donation and transplantation activities. They call for a transparent regulatory oversight system that ensures donor and recipient safety and enforces the prohibitions of unethical practices. Governments should ensure that the provision of care and follow-up of living donors be no less than the care and attention provided for transplant recipients. Professional societies should not continue to enable membership status for those individuals that violate the principles of the Declaration. Pharmaceutical companies and public and private funding agencies must affirm the Declaration in their consideration of clinical research support.

The Istanbul Declaration preserves the goodness of the act of organ donation without victimizing the poor of the world to be the targeted source of organs for the rich.

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Editorial comment with reply: The continuing salt war: the final battle?

Salt intake and cardiovascular disease

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Keywords: blood pressure; cardiovascular disease; salt intake

McCarron, in his review on salt [1], makes some serious and misleading mistakes. For example, he claimed that, in two of our own randomized double-blind crossover trials of modest salt restriction [2,3], we restricted potassium intake. This is incorrect and can be ascertained from a superficial reading of both papers. The average potassium intake on the individuals' usual diet, as measured by 24-h urinary potassium excretion, was the same as that for the UK population. Secondly, there was no significant change in 24-h urinary potassium with a reduction in salt intake during the run-in period while individuals were on a reduced salt diet. Thirdly, not like McCarron implied, participants did not change their diet during the randomized crossover phase of the studies. Instead they took slow sodium and placebo tablets in a randomized double-blind crossover manner to achieve a difference in salt intake. There was no significant change in 24-h urinary potassium excretion throughout the studies. These results can be clearly seen in the table on page 353 of the first paper [2] and the table on page 1245 of the second paper [3]. Our studies, therefore, contrary to McCarron's claims, clearly document that a modest reduction in salt intake lowers blood pressure in hypertensive individuals without any change in potassium intake.

Our results are strongly supported by the Dietary Approaches to Stop Hypertension (DASH)-Sodium study that is a similar well-controlled, but open, feeding trial where a reduced salt intake has a significant effect on blood pressure, not only on the usual American diet with no change in potassium intake but also on the DASH diet that is rich in fruits, vegetables and low-fat dairy products [4]. Our results are also supported by the Cochrane review of all of the longer term modest salt reduction trials, which demonstrates significant reductions in blood pressure both in hypertensive and normotensive individuals. Additionally, there is a clear dose–response relationship. A reduction of 6 g/day of salt intake would lower blood pressure

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Special Article

The Declaration of Istanbul on Organ Trafficking and Transplant Tourism

Participants in the International Summit on Transplant Tourism and Organ Trafficking Convened by The Transplantation Society and International Society of Nephrology in Istanbul, Turkey, April 30 through May 2, 2008

Organ commercialism, which targets vulnerable populations (such as illiterate and impoverished persons, undocumented immigrants, prisoners, and political or economic refugees) in resource-poor countries, has been condemned by international bodies such as the World Health Organization for decades. Yet in recent years, as a consequence of the increasing ease of Internet communication and the willingness of patients in rich countries to travel and purchase organs, organ trafficking and transplant tourism have grown into global problems. For example, as of 2006, foreigners received two-thirds of the 2000 kidney transplants performed annually in Pakistan.

The Istanbul Declaration *proclaims that the poor who sell their organs are being exploited, whether by richer people within their own countries or by transplant tourists from abroad. Moreover, transplant tourists risk physical harm by unregulated and illegal transplantation. Participants in the Istanbul Summit concluded that transplant commercialism, which targets the vulnerable, transplant tourism, and organ trafficking should be prohibited. And they also urged their fellow transplant professionals, individually and through their organizations, to put an end to these unethical activities and foster safe, accountable practices that meet the needs of transplant recipients while protecting donors.*

Countries from which transplant tourists originate, as well as those to which they travel to obtain transplants, are just beginning to address their respective responsibilities to protect their people from exploitation and to develop national self-sufficiency in organ donation. The Declaration *should reinforce the resolve of governments and international organizations to develop laws and guidelines to bring an end to wrongful practices. "The legacy of transplantation is threatened by organ trafficking and transplant tourism. The* Declaration of Istanbul *aims to combat these activities and to preserve the nobility of organ donation. The success of transplantation as a life-saving treatment does not require—nor justify—victimizing the world's poor as the source of organs for the rich" (Steering Committee of the Istanbul Summit).*

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Organ transplantation, one of the medical miracles of the 20th century, has prolonged and improved the lives of hundreds of thousands of patients worldwide. The many great scientific and clinical advances of dedicated health professionals, as well as countless acts of generosity by organ donors and their families, have made transplantation not only a life-saving therapy but a shining symbol of human solidarity. Yet these accomplishments have been tarnished by numerous reports of trafficking in human beings who are used as sources of organs and of patient-tourists from rich countries who travel abroad to purchase organs from poor people. In 2004, the World Health Organization called on member states "to take measures to protect the poorest and vulnerable groups from transplant tourism and the sale of tissues and organs, including attention to the wider problem of international trafficking in human tissues and organs" (1).

To address the urgent and growing problems of organ sales, transplant tourism, and trafficking in organ donors in the context of the global shortage of organs, a Summit Meeting of more than 150 representatives of scientific and medical bodies from around the world, government officials, social scientists, and ethicists, was held in Istanbul, Turkey, from April 30 to May 2, 2008. Preparatory work for the meeting was undertaken by a Steering Committee convened by the Transplantation Society and the International Society of Nephrology in Dubai in December 2007. That committee's draft declaration was widely circulated and then revised in light of the comments received. At the Summit, the revised draft was reviewed by working groups and finalized in plenary deliberations.

This Declaration represents the consensus of the Summit participants. All countries need a legal and professional framework to govern organ donation and transplantation activities, as well as a transparent regulatory oversight system that ensures donor and recipient safety and the enforcement of standards and prohibitions on unethical practices.

Unethical practices are, in part, an undesirable consequence of the global shortage of organs for transplantation. Thus, each country should strive both to ensure that programs to prevent organ failure are implemented and to provide organs to meet the transplant needs of its residents from donors within its own population or through regional cooperation. The therapeutic potential of deceased organ donation should be maximized not only for kidneys but also for other organs, appropriate to the transplantation needs of each country. Efforts to initiate or enhance deceased donor transplantation are essential to minimize the burden on living donors. Educational programs are

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The Council of the American Society of Nephrology (ASN) unanimously endorses The Declaration of Istanbul on Organ Trafficking and Transplant Tourism. ASN stands with The Transplantation Society, the International Society of Nephrology, and other organizations in condemning these practices.

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useful in addressing the barriers, misconceptions, and mistrust that currently impede the development of sufficient deceased donor transplantation; a successful transplant programs also depend on the existence of the relevant health system infrastructure.

Access to health care is a human right but often not a reality. The provision of care for living donors before, during, and after surgery, as described in the reports of the international forums organized by the Transplantation Society in Amsterdam and Vancouver (2–4), is no less essential than taking care of the transplant recipient. A positive outcome for a recipient can never justify harm to a live donor; on the contrary, for a transplant with a live donor to be regarded as a success means that both the recipient and the donor have done well.

This Declaration builds on the principles of the Universal Declaration of Human Rights (5). The broad representation at the Istanbul Summit reflects the importance of international collaboration and global consensus to improve donation and transplantation practices. The Declaration will be submitted to relevant professional organizations and to the health authorities of all countries for consideration. The legacy of transplantation must not be the impoverished victims of organ trafficking and transplant tourism but rather a celebration of the gift of health by one individual to another.

Definitions

Organ trafficking is the recruitment, transport, transfer, harboring or receipt of living or deceased persons or their organs by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability, or of the giving to, or the receiving by, a third party of payments or benefits to achieve the transfer of control over the potential donor, for the purpose of exploitation by the removal of organs for transplantation (6).

Transplant commercialism is a policy or practice in which an organ is treated as a commodity, including by being bought or sold or used for material gain.

Travel for transplantation is the movement of organs, donors, recipients, or transplant professionals across jurisdictional borders for transplantation purposes. Travel for transplantation becomes **transplant tourism** if it involves organ trafficking and/or transplant commercialism or if the resources (organs, professionals, and transplant centers) devoted to providing transplants to patients from outside a country undermine the country's ability to provide transplant services for its own population.

Principles

1. National governments, working in collaboration with international and nongovernmental organizations, should develop and implement comprehensive programs for the screening, prevention, and treatment of organ failure, which include:

a. The advancement of clinical and basic science research;

b. Effective programs, based on international guidelines, to treat and maintain patients with end-stage diseases, such as dialysis programs for renal patients, to minimize morbidity and mortality, alongside transplant programs for such diseases;

c. Organ transplantation as the preferred treatment for organ failure for medically suitable recipients.

2. Legislation should be developed and implemented by each country or jurisdiction to govern the recovery of organs from deceased and living donors and the practice of transplantation, consistent with international standards.

a. Policies and procedures should be developed and implemented to maximize the number of organs available for transplantation, consistent with these principles;

b. The practice of donation and transplantation requires oversight and accountability by health authorities in each country to ensure transparency and safety;

c. Oversight requires a national or regional registry to record deceased and living donor transplants;

d. Key components of effective programs include public education and awareness, health professional education and training, and defined responsibilities and accountabilities for all stakeholders in the national organ donation and transplant system.

3. Organs for transplantation should be equitably allocated within countries or jurisdictions to suitable recipients without regard to gender, ethnicity, religion, or social or financial status.

a. Financial considerations or material gain of any party must not influence the application of relevant allocation rules.

4. The primary objective of transplant policies and programs should be optimal short- and long-term medical care to promote the health of both donors and recipients.

a. Financial considerations or material gain of any party must not override primary consideration for the health and well-being of donors and recipients.

5. Jurisdictions, countries, and regions should strive to achieve self-sufficiency in organ donation by providing a sufficient number of organs for residents in need from within the country or through regional cooperation.

a. Collaboration between countries is not inconsistent with national self-sufficiency as long as the collaboration protects the vulnerable, promotes equality between donor and recipient populations, and does not violate these principles;

b. Treatment of patients from outside the country or jurisdiction is only acceptable if it does not undermine a country's ability to provide transplant services for its own population.

6. Organ trafficking and transplant tourism violate the principles of equity, justice, and respect for human dignity and should be prohibited. Because transplant commercialism targets impoverished and otherwise vulnerable donors, it leads inexorably to inequity and injustice and should be prohibited. In Resolution 44.25, the World Health Assembly called on countries to prevent the purchase and sale of human organs for transplantation.

a. Prohibitions on these practices should include a ban on all types of advertising (including electronic and print media), soliciting, or brokering for the purpose of transplant commercialism, organ trafficking, or transplant tourism.

b. Such prohibitions should also include penalties for acts, such as medically screening donors or organs, or transplanting organs, that aid, encourage, or use the products of, organ trafficking or transplant tourism.

c. Practices that induce vulnerable individuals or groups (such as illiterate and impoverished persons, undocumented immigrants, prisoners, and political or economic refugees) to become living donors are incompatible with the aim of combating organ trafficking, transplant tourism, and transplant commercialism.

Proposals

Consistent with these principles, participants in the Istanbul Summit suggest the following strategies to increase the donor pool and to prevent organ trafficking, transplant commercialism, and transplant tourism and to encourage legitimate, lifesaving transplantation programs:

To respond to the need to increase deceased donation

1. Governments, in collaboration with healthcare institutions, professionals, and nongovernmental organizations should take appropriate actions to increase deceased organ donation. Measures should be taken to remove obstacles and disincentives to deceased organ donation.

2. In countries without established deceased organ donation or transplantation, national legislation should be enacted that would initiate deceased organ donation and create transplantation infrastructure, so as to fulfill each country's deceased donor potential.

3. In all countries in which deceased organ donation has been initiated, the therapeutic potential of deceased organ donation and transplantation should be maximized.

4. Countries with well-established deceased donor transplant programs are encouraged to share information, expertise, and technology with countries seeking to improve their organ donation efforts.

To ensure the protection and safety of living donors and appropriate recognition for their heroic act while combating transplant tourism, organ trafficking, and transplant commercialism

1. The act of donation should be regarded as heroic and honored as such by representatives of the government and civil society organizations.

2. The determination of the medical and psychosocial suitability of the living donor should be guided by the recommendations of the Amsterdam and Vancouver Forums (2–4).

a. Mechanisms for informed consent should incorporate provisions for evaluating the donor's understanding, including assessment of the psychologic impact of the process;

b. All donors should undergo psychosocial evaluation by mental health professionals during screening.

3. The care of organ donors, including those who have been victims of organ trafficking, transplant commercialism, and transplant tourism, is a critical responsibility of all jurisdictions that sanctioned organ transplants using such practices.

4. Systems and structures should ensure standardization, transparency, and accountability of support for donation.

a. Mechanisms for transparency of process and follow-up should be established;

b. Informed consent should be obtained both for donation and for follow-up processes.

5. Provision of care includes medical and psychosocial care at the time of donation and for any short- and long-term consequences related to organ donation.

a. In jurisdictions and countries that lack universal health insurance, the provision of disability, life, and health insurance related to the donation event is a necessary requirement in providing care for the donor;

b. In those jurisdictions that have universal health insurance, governmental services should ensure donors have access to appropriate medical care related to the donation event;

c. Health and/or life insurance coverage and employment opportunities of persons who donate organs should not be compromised;

d. All donors should be offered psychosocial services as a standard component of follow-up;

e. In the event of organ failure in the donor, the donor should receive:

i. Supportive medical care, including dialysis for those with renal failure, and

ii. Priority for access to transplantation, integrated into existing allocation rules as they apply to either living or deceased organ transplantation.

6. Comprehensive reimbursement of the actual, documented costs of donating an organ does not constitute a payment for an organ but is rather part of the legitimate costs of treating the recipient.

a. Such cost-reimbursement would usually be made by the party responsible for the costs of treating the transplant recipient (such as a government health department or a health insurer);

b. Relevant costs and expenses should be calculated and administered using transparent methodology, consistent with national norms;

c. Reimbursement of approved costs should be made directly to the party supplying the service (such as to the hospital that provided the donor's medical care);

d. Reimbursement of the donor's lost income and out-of-pocket expenses should be administered by the agency handling the transplant rather than paid directly from the recipient to the donor.

7. Legitimate expenses that may be reimbursed when documented include:

a. the cost of any medical and psychologic evaluations of potential living donors who are excluded from donation (*e.g.*, because of medical or immunologic issues discovered during the evaluation process);

b. costs incurred in arranging and effecting the preoperative, perioperative, and postoperative phases of the donation process (*e.g.*, long-distance telephone calls, travel, accommodation, and subsistence expenses);

c. medical expenses incurred for postdischarge care of the donor;

d. lost income in relation to donation (consistent with national norms).

The participants in the International Summit on Transplant Tourism and Organ Trafficking and the manner in which they were chosen and the meeting was organized were as follows:

Process and Participant Selection

Steering Committee

The Steering Committee was selected by an Organizing Committee consisting of Mona Alrukhami, Jeremy Chapman, Francis Delmonico, Mohamed Sayegh, Faissal Shaheen, and Annika Tibell.

The Steering Committee was composed of leadership from the Transplantation Society, including its President-elect and the Chair of its Ethics Committee, and the International Society of Nephrology, including its Vice President and individuals holding Council positions. The Steering Committee had representation from each of the continental regions of the globe with transplantation programs.

The mission of the Steering Committee was to draft a Declaration for consideration by a diverse group of participants at the Istanbul Summit. The Steering Committee also had the responsibility to develop the list of participants to be invited to the Summit meeting.

Istanbul Participant Selection

Participants at the Istanbul Summit were selected by the Steering Committee according to the following considerations:

The country liaisons of the Transplantation Society representing virtually all countries with transplantation programs; representatives from international societies and the Vatican; individuals holding leadership positions in nephrology and transplantation; stakeholders in the public policy aspect of organ transplantation; and ethicists, anthropologists, sociologists, and legal scholars well recognized for their writings regarding transplantation policy and practice.

No person or group was polled with respect to their opinion, practice, or philosophy before the Steering Committee selection or the Istanbul Summit.

After the proposed group of participants was prepared and reviewed by the Steering Committee, they were sent a letter of invitation to the Istanbul Summit, which included the following components:

the mission of the Steering Committee to draft a Declaration for all Istanbul participants' consideration;

the agenda and work group format of the Summit;

the procedure for the selection of participants;

the work group topics;

an invitation to the participants to indicate their work group preferences;

the intent to communicate a draft and other materials before the Summit convened;

the Summit goals to assemble a final Declaration that could achieve consensus and would address the issues of organ trafficking, transplant tourism, and commercialism and provide principles of practice and recommended alternatives to address the shortage of organs;

an acknowledgment of the funding provided by Astellas Pharmaceuticals for the Summit;

provision of hotel accommodations and travel for all invited participants.

Of approximately 170 persons invited, 160 agreed to participate and 152 were able to attend the Summit in Istanbul, Turkey, on April 30-May 2, 2008. Because work on the Declaration at the Summit was to be carried out by dividing the draft document into separate parts, Summit invitees were assigned to a work group topic based on their response concerning the particular topics on which they wished to focus their attention before and during the Summit.

Preparation of the Declaration

The draft Declaration prepared by the Steering Committee was furnished to all participants with ample time for appraisal and response before the Summit. The comments and suggestions received in advance were reviewed by the Steering Committee and given to leaders of the appropriate work group at the Summit. (Work group leaders were selected and assigned from the Steering Committee.)

The Summit meeting was formatted so that breakout sessions of the work groups could consider the written responses received from participants before the Summit as well as comments from each of the work group participants. The work groups elaborated these ideas as proposed additions to and revisions of the draft. When the Summit reconvened in plenary session, the Chairs of each work group presented the outcome of their breakout session to all Summit participants for discussion. During this process of review, the wording of each section of the Declaration was displayed on a screen before the plenary participants and was modified in light of their comments until consensus was reached on each point.

The content of the Declaration is derived from the consensus that was reached by the participants at the Summit in the plenary sessions, which took place on May 1 and 2, 2008. A formatting group was assembled immediately after the Summit to address punctuation, grammatical, and related concerns and to record the Declaration in its finished form.

Appendix: Participants in the Istanbul Summit

Omar Abboud (Sudan); Mario Abbud-Filho* (Brazil); Kaldarbek Abdramanov (Kyrgyzstan); Sadiq Abdulla (Bahrain); Georgi Abraham (India); Amihan V. Abueva (Philippines); Ademola Aderibigbe (Nigeria); Mustafa Al-Mousawi* (Kuwait); Josefina Alberu (Mexico); Richard D.M. Allen (Australia); Lynn C. Almazan-Gomez (Philippines); Ibrahim Alnono (Yemen); Ali Abdulkareem Alobaidli* (United Arab Emirates); Mona Alrukhaimi* (United Arab Emirates); Inés Álvarez (Uruguay); Lina Assad (Saudi Arabia); Alain G. Assounga (South Africa); Yenny Baez (Colombia); Alireza Bagheri* (Iran); Mohamed Adel Bakr* (Egypt); Ebun Bamgboye (Nigeria); Antoine Barbari* (Lebanon); Jacques Belghiti (France); Taieb Ben Abdallah (Tunisia); Salah Ben Ammar Mohamed (Tunisia); Michael Bos (The Netherlands); Russell Britz (South Africa); Debra Budiani (United States); Alexander Capron* (United States); Cristina R. Castro (Brazil); Jeremy Chapman* (Australia); Klaus Chen Zhonghua (Peo-

ple's Republic of China); Igor Codreanu (Moldova); Edward Cole (Canada); Emanuele Cozzi (Italy); Gabriel Danovitch* (United States); Razeen Davids (South Africa); Marc De Broe (Belgium); Leonardo De Castro* (Philippines); Francis L. Delmonico* (United States); Rania Derani (Syria); Ian Dittmer (New Zealand); Beatriz Domínguez-Gil (Spain); Valter Duro-Garcia (Brazil); Ehtuish Ehtuish (Libya); Hatem El-Shoubaki (Qatar); Miran Epstein (United Kingdom); Iraj Fazel* (Iran); Eduardo Fernandez Zincke (Belgium); Rudolf Garcia-Gallont (Guatemala); Ahad J. Ghods (Iran); John Gill (Canada); Denis Glotz (France); Ganesh Gopalakrishnan (India); Carmen Gracida (Mexico); Josep Grinyo (Spain); Jong-won Ha (South Korea); Mehmet A. Haberal* (Turkey); Nadey Hakim (United Kingdom); William Harmon (United States); Tomonori Hasegawa (Japan); Adel Hassan Ahmed (Egypt); David Hickey (Ireland); Christian Hiesse (France); Yang Hongji (People's Republic of China); Ines Humar (Croatia); Abdias Hurtado (Peru); Moustafa Wesam Ismail (Egypt); Ninoslav Ivanovski (Macedonia); Vivekanand Jha* (India); Delawir Kahn (South Africa); Refaat Kamel (Egypt); Ashok Kirpalani (India); Guenter Kirste (Germany); Eiji Kobayashi* (Japan); Jan Koller (Slovakia); Leonieke Kranenburg (The Netherlands); Norbert Lameire* (Belgium); Karim Laouabdia-Sellami (France); Ruipeng Lei (People's Republic of China); Adeera Levin* (Canada); Josep Lloveras (Spain); Aleksander Lõhmus (Estonia); Esmeralda Luciolli (France); Susanne Lundin (Sweden); Choong Lye Wai (Singapore); Stephen Lynch (Australia); Mahamane Maïga* (Mali); Marie-France Mamzer Bruneel (France); Nicole Maric (Austria); Dominique Martin* (Australia); Marwan Masri* (Lebanon); Maria A. Matamoros (Costa Rica); Arthur Matas (United States); Adrian McNeil (United Kingdom); Bruno Meiser (Germany); Enisa Meši (Bosnia); Farhat Moazam (Pakistan); Nabil Mohsin (Oman); Eytan Mor (Israel); Jorge Morales (Chile); Stephen Munn (New Zealand); Mark Murphy (Ireland); Saraladevi Naicker* (South Africa); S.A. Anwar Naqvi (Pakistan); Luc Noël* (WHO); Gregorio Obrador (Mexico); Yolanda Oliveros (Philippines); Enrique Ona (Philippines); Arie Oosterlee (The Netherlands); Ole Oyen (Norway); Benita Padilla (Philippines); Johann Pratschke (Germany); Ruth Rahamimov (Israel); Axel Rahmel (The Netherlands); Oleg Reznik (Russia); S. Adibul Hasan Rizvi* (Pakistan); Lesley Ann Roberts (Trinidad and Tobago); Bernardo Rodriguez-Iturbe* (Venezuela); Wojciech Rowinski (Poland); Bassam Saeed (Syria); Ashot Sarkissian (Armenia); Mohamed H. Sayegh* (United States); Nancy Scheper-Hughes (United States); Sukru Sever Mehmet (Turkey); Faissal A. Shaheen* (Saudi Arabia); Dhananjaya Sharma (India); Naoshi Shinozaki (Japan); Nasser Simforoosh (Iran); Harjit Singh (Malaysia); Thong Sok Hean (Cambodia); Margaret Somerville (Canada); Maria Stadtler (United States); Antoine Stephan* (Lebanon); Juliette Suárez (Cuba); Msgr. Jacques Suaudeau (Italy); Vasant Sumethkul (Thailand); Shiro Takahara (Japan); Gilbert T. Thiel (Switzerland); Annika Tibell* (Sweden); Gia Tomadze (Georgia); Matthew Kwok-Lung Tong* (Hong Kong); Daniel Fu-Chang Tsai (Taiwan); Remedios Uriarte (Philippines); Yves F.C. Vanrenterghem (Belgium); A. Vathsala* (Singapore); Willem Weimar (The Netherlands); Daniel Wikler (United States); Kimberly Young (Canada); Ulugbek Yuldashev (Uzbekistan); Minggang Zhao (People's Republic of China).

*Members of the Steering Committee (William Couser, United States, was also a member of the Steering Committee but was unable to attend the Summit).

Disclosures

None.

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The declaration of Istanbul on organ trafficking and transplant tourism

Participants in the International Summit on Transplant Tourism and Organ Trafficking convened by The Transplantation Society and International Society of Nephrology in Istanbul, Turkey, 30 April to 2 May 2008*

***The Participants in the International Summit on Transplant Tourism and Organ Trafficking and the manner in which they were chosen and the meeting was organized were as given in the Appendix**

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PREAMBLE

Organ transplantation, one of the medical miracles of the twentieth century, has prolonged and improved the lives of hundreds of thousands of patients worldwide. The many great scientific and clinical advances of dedicated health professionals, as well as countless acts of generosity by organ donors and their families, have made transplantation not only a life-saving therapy but also a shining symbol of human solidarity. Yet, these accomplishments have been tarnished by numerous reports of trafficking in human beings who are used as sources of organs and of patient-tourists from rich countries who travel abroad to purchase organs from poor people. In 2004, the World Health Organization, called on member states 'to take measures to protect the poorest and vulnerable groups from transplant tourism and the sale of tissues and organs, including attention to the wider problem of international trafficking in human tissues and organs.'[1]

To address the urgent and growing problems of organ sales, transplant tourism, and trafficking in organ donors in the context of the global shortage of organs, a Summit Meeting of more than 150 representatives of scientific and medical bodies from around the world, government officials, social scientists, and ethicists, was held in Istanbul from 30 April to 2 May 2008. Preparatory work for the meeting was undertaken by a Steering Committee convened by The Transplantation Society (TTS) and the International Society of Nephrology (ISN) in Dubai in December 2007. That committee's draft declaration was widely circulated and then revised in light of the comments received. At the Summit, the revised draft was reviewed by working groups and finalized in plenary deliberations.

This Declaration represents the consensus of the Summit participants. All countries need a legal and professional framework to govern organ donation and transplantation activities, as well as a transparent regulatory oversight system that ensures donor and recipient safety and the enforcement of standards and prohibitions on unethical practices.

Unethical practices are, in part, an undesirable consequence of the global shortage of organs for transplantation. Thus, each country should strive both to ensure that programs to prevent organ failure are implemented and to provide organs to meet the transplant needs of its residents from donors within its own population or through regional cooperation. The therapeutic potential of deceased organ donation should be maximized not only for kidneys but also for other organs, appropriate to the transplantation needs of each country. Efforts to initiate or enhance deceased donor transplantation are essential to minimize the burden on living donors. Educational programs are useful in addressing the barriers, misconceptions, and mistrust that currently impede the development of sufficient deceased donor transplantation; successful transplant programs also depend on the existence of the relevant health system infrastructure.

Access to healthcare is a human right but often not a reality. The provision of care for living donors before, during, and after surgery—as described in the reports of the international forums organized by TTS in Amsterdam and Vancouver[2–4]—is no less essential than taking care of the transplant recipient. A positive outcome for a recipient can never justify harm to a live donor; on the contrary, for a transplant with a live donor to be regarded as a success means that both the recipient and the donor have done well.

This Declaration builds on the principles of the Universal Declaration of Human Rights.[5] The broad representation at the Istanbul Summit reflects the importance of international collaboration and global consensus to improve donation and transplantation practices. The Declaration will be submitted to relevant professional organizations and to the health authorities of all countries for consideration. The legacy of transplantation must not be the impoverished victims of organ trafficking and transplant tourism but rather a celebration of the gift of health by one individual to another.

DEFINITIONS

Organ trafficking is the recruitment, transport, transfer, harboring, or receipt of living or deceased persons or their organs by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability, or of the giving to, or the receiving by, a third party of payments, or benefits to achieve the transfer of control over the potential donor for the purpose of exploitation by the removal of organs for transplantation.[6]

Transplant commercialism is a policy or practice in which an organ is treated as a commodity, including by being bought or sold or used for material gain.

Travel for transplantation is the movement of organs, donors, recipients, or transplant professionals across jurisdictional borders for transplantation purposes. Travel for transplantation becomes *transplant tourism* if it involves organ trafficking and/or transplant commercialism or if the resources (organs, professionals, and transplant centers) devoted to providing transplants to patients from outside a country undermine the country's ability to provide transplant services for its own population.

PRINCIPLES

(1) National governments, working in collaboration with international and non-governmental organizations, should develop and implement comprehensive programs for the screening, prevention, and treatment of organ failure, which include the following:
   (a) The advancement of clinical and basic science research.
   (b) Effective programs, based on international guidelines, to treat and maintain patients with end-stage diseases, such as dialysis programs for renal patients, to minimize morbidity and mortality, alongside transplant programs for such diseases.
   (c) Organ transplantation as the preferred treatment for organ failure for medically suitable recipients.

(2) Legislation should be developed and implemented by each country or jurisdiction to govern the recovery of organs from deceased and living donors and the practice of transplantation, consistent with international standards.
   (a) Policies and procedures should be developed and implemented to maximize the number of organs available for transplantation, consistent with these principles.
   (b) The practice of donation and transplantation requires oversight and accountability by health authorities in each country to ensure transparency and safety.
   (c) Oversight requires a national or regional registry to record deceased and living donor transplants;
   (d) Key components of effective programs include public education and awareness, health professional education and training, and defined responsibilities and accountabilities for all stakeholders in the national organ donation and transplant system.

(3) Organs for transplantation should be equitably allocated within countries or jurisdictions to suitable recipients without regard to gender, ethnicity, religion, or social or financial status.
   (a) Financial considerations or material gain of any party must not influence the application of relevant allocation rules.

(4) The primary objective of transplant policies and programs should be optimal short- and long-term medical care to promote the health of both donors and recipients.
   (a) Financial considerations or material gain of any party must not override primary consideration for the health and well-being of donors and recipients.

(5) Jurisdictions, countries, and regions should strive to achieve self-sufficiency in organ donation by providing a sufficient number of organs for residents in need from within the country or through regional cooperation.
   (a) Collaboration between countries is not inconsistent with national self-sufficiency as long as the collaboration protects the vulnerable, promotes equality between donor and recipient populations, and does not violate these principles.
   (b) Treatment of patients from outside the country or jurisdiction is only acceptable if it does not undermine a country's ability to provide transplant services for its own population.

(6) Organ trafficking and transplant tourism violate the principles of equity, justice, and respect for human dignity and should be prohibited. Because transplant commercialism targets impoverished and otherwise vulnerable donors, it leads inexorably to inequity and injustice and should be prohibited. In Resolution 44.25, the World Health Assembly called on countries to prevent the purchase and sale of human organs for transplantation.
   (a) Prohibitions on these practices should include a ban on all types of advertising (including electronic and print media), soliciting, or brokering for the purpose of transplant commercialism, organ trafficking, or transplant tourism.
   (b) Such prohibitions should also include penalties for acts—such as medically screening donors or organs, or transplanting organs—that aid, encourage, or use the products of organ trafficking or transplant tourism.
   (c) Practices that induce vulnerable individuals or groups (such as illiterate and impoverished persons, undocumented immigrants, prisoners, and political or economic refugees) to become living donors are incompatible with the aim of combating organ trafficking, transplant tourism and transplant commercialism.

PROPOSALS

Consistent with these principles, participants in the Istanbul Summit suggest the following strategies to increase the donor pool and to prevent organ trafficking, transplant commercialism, and transplant tourism and to encourage legitimate, life-saving transplantation programs:

To respond to the need to increase deceased donation:

(1) Governments, in collaboration with health-care institutions, professionals, and non-governmental organizations, should take appropriate actions to increase deceased organ