

COMBATING THE KIDNEY COMMERCE

Civil Society against Organ Trafficking in Pakistan and Israel

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Can civil society bring governments to curb transnational crime? The article answers this question by analysing a most-likely case for civil-society influence: organ trafficking. Physicians' efforts to eliminate this practice are examined in Pakistan and Israel: two major participants in the global organ trade. In both countries, the physicians' pressure resulted in the enactment of organ-trade prohibitions. These, however, were not fully enforced. The analysis suggests that, even under favourable conditions, civil society's impact on transnational-crime policies is limited, yet not inconsequential. Pakistan's involvement in organ trafficking, and even more so Israel's, has declined. Beyond its contribution to understanding civil society's role in the criminalization process, the article sheds light on the hitherto little-studied politics of the organ trade.

Keywords: organ trafficking, illicit trade, Pakistan, Israel, civil society

Introduction

Civil society plays an important part in world politics. Many studies have examined how civil-society activists identify problems of international concern, establish norms or policy solutions to address these problems and convince governments to implement them. The influence of domestic and transnational activists has been analysed in a variety of areas: from human rights to the environment to development to armed conflict (e.g. Keck and Sikkink 1998; Busby 2010; Murdie and Davis 2012). In the area of transnational crime, however, the involvement of civil society has received less attention. To be sure, many accounts of anti-trafficking campaigns have highlighted the role of societal activists and non-governmental organizations (NGOs) in demanding action against illicit trade (Nadelmann 1990; Skinner 2009; Efrat 2012). Yet, despite growing evidence of activists' contribution to and influence on anti-trafficking efforts, we still lack a systematic understanding of how and when activists matter and the extent to which they affect criminal-policy outcomes.

This article takes an important step towards developing such an understanding through a close look at the medical community's fight against the organ trade. In the framework of the international efforts against organ trafficking, civil society's role and influence can be isolated, as these efforts are being led by civil society with little involvement of the US government or other governments. Furthermore, as a most-likely case, the organ trade is a critical arena in which to examine civil society's impact. Since the organ trade is of small economic significance and relatively easy to eliminate in terms of policing efforts, we would expect governments to be more responsive to civil society's advocacy against the organ trade, as compared to other illicit trades.

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Empirically, I examine two major participants in the global organ trade: Pakistan and Israel, the former an *organ-exporting country*, the latter an *organ-importing country*. Both countries enacted legislative prohibitions on the organ trade at approximately the same time, following the demands of local physicians. Although the Pakistani and Israeli physicians differed in their advocacy strategies and access to policy makers, in both cases *they* were the force driving the legislation, with support from the national press and the international medical community. In terms of enforcement, however, the influence of civil society has been weaker. Despite persistent pressure from Pakistan's medical community, the authorities have failed to enforce the organ-trade prohibition, although the identities of the perpetrators are well known. The Israeli authorities enforced a prohibition on the official funding of transplantations that involve organ trafficking, while failing to eliminate these transplantations altogether. Overall, the two cases suggest that moral pressure exerted by civil society can induce governments to enact criminal prohibitions, but not necessarily to enforce them, even in an easy case such as the organ trade. Nonetheless, even prohibitions that are not fully enforced may reduce criminal activity.

Beyond advancing our understanding of civil society's role in the criminalization process, the article contributes to the study of the organ trade's political dynamic. To date, the trade in organs has been analysed primarily by physicians, bioethicists and lawyers (Goodwin 2006; Satel 2008; Epstein 2009; Delmonico 2011). Within the social sciences, the organ trade has been examined by anthropologists (Scheper-Hughes 2000; Hamdy 2012). This article, by contrast, offers a *political* analysis of the efforts against the organ trade: it explains why government indifference has given way to laws aimed at suppressing the trade, and why such laws are not being fully enforced.

Civil Society against Transnational Crime: State of Knowledge and Expectations

Studies of transnational crime control highlight the role of civil-society actors—'moral entrepreneurs'—in convincing governments to criminally prohibit certain activities. American missionaries' concern about China's opium problem was an important motivation for initiating international drug control in 1909; feminist activists advocated against trafficking in women at the turn of the twentieth century, as they did a century later; and it was an NGO coalition that raised international awareness of conflict diamonds, leading to the Kimberley Process. NGOs also had an important presence in the campaigns against the illicit small-arms trade, the trade in looted antiquities and the illegal movement of hazardous wastes (Taylor 1969; Nadelmann 1990; Clapp 2001; Grant and Taylor 2004; Efrat 2012). In all these cases, civil-society actors—such as advocacy groups, religious organizations and professional associations—drew attention to the negative effects of certain commercial activities and demanded that they be prohibited. Yet, the questions of how, to what extent and under which conditions activists make a difference in the fight against transnational crime have largely been left unanswered by the transnational-crime literature. Existing studies, for example, do not isolate the influence of civil-society activists from other possible motivations for suppressing crime, such as government self-interest or interstate pressure. It is therefore difficult to determine whether any policy change should be attributed to the activists or to other influences. Nor do we have a clear account of variations in activists' influence across different criminal activities and between countries.

In developing a more advanced understanding of activists' influence on transnational-crime policies, we can draw on the extensive literature that has examined transnational activism in other areas of international affairs (e.g. [Betsill and Corell 2001](#); [Carpenter 2011](#); [Murdie and Davis 2012](#)). Early on, the literature sought to demonstrate simply that civil-society demands may indeed prompt governments to change their policies. Having established that civil society matters, the literature moved on to examine more nuanced questions, identifying when and why activists have succeeded or failed ([Price 2003](#)). The insights stemming from this literature are a good starting point for exploring civil society's impact on transnational-crime policies. Such an exploration could delve into activists' involvement in the establishment of global prohibitions: how activists push for an international agreement to criminalize an activity that they deem harmful. My analysis, however, focuses on civil society's influence at the *national* level: Are activists capable of convincing governments to *implement* international prohibitions, namely to incorporate those prohibitions into domestic legislation? Can they also motivate governments to put such legislation into effect? My goal is thus to examine whether civil society indeed contributes to the national implementation and enforcement of global prohibitions, and whether that contribution varies across countries.

On the basis of the existing literature, one might expect to find little influence of civil society on implementation and enforcement. Indeed, the literature highlights the role of moral entrepreneurs in the establishment of global prohibitions, while suggesting that Great Power pressure is necessary for convincing governments to implement and enforce the prohibitions nationally ([Andreas and Nadelmann 2006](#); [Efrat 2012](#), Chapter 5). Alternatively, we could draw a distinction between implementation and enforcement. The human-rights literature suggests that while civil-society pressure may motivate governments to reduce human-rights violations that are easier or less costly to curb, other violations persist ([Franklin 2008](#); [Hafner-Burton 2008](#)). Along these lines, we would expect civil society to have a greater influence at the implementation stage: a government may respond to civil-society pressure by passing legislation in conformity with the global prohibition. However, convincing a government to enforce the legislation and suppress the criminal activity is a greater challenge, more difficult for activists to meet. That challenge may be met when the enforcement of the prohibition requires little effort and few resources or faces limited resistance. If, however, enforcement requires substantial effort or encounters stiff resistance from influential constituencies, activists' demands for vigorous government action may not suffice.

The human-rights literature also suggests that the impact of civil-society pressure is not conditional on the type of political regime: established democracies are no more responsive to such pressure than young democracies or non-democracies ([Hafner-Burton 2008](#); [Murdie and Davis 2012](#)). We shall see whether the same holds true in the area of transnational crime.

Analytical Strategy: Organ Trafficking as a Convenient and Most-Likely Case for Identifying Civil-Society Influence

Organ transplantation is a wonder of modern medicine, which has saved, prolonged and improved countless lives worldwide. Enjoying the benefits of transplantation, however, depends on the availability of human organs. Beginning in the 1980s, and increasingly

since the mid-1990s, the growing demand for and diminishing supply of organs have fuelled an illicit trade. Unable to receive an organ through legitimate channels, desperate patients resort to obtaining organs for transplantation—usually kidneys—by buying them from other individuals. Such a *commercial transplantation* typically violates local laws that prohibit the provision or acceptance of monetary compensation for an organ; the practice is also contrary to the guiding principles on transplantation issued by the World Health Organization (WHO), which require organ donations to be altruistic and non-commercialized (World Health Assembly 2004; 2010).

Despite the national and international prohibitions, the organ trade has become global. The internet and the ease of international travel and communication have facilitated a form of organ trafficking known as *transplant tourism*: patients from rich countries travel to poorer countries, where they purchase an organ from a paid donor and undergo the transplantation. Like other illicit trades, organ trafficking therefore involves ‘exporting countries’ whose impoverished citizens are the source of organs and ‘importing countries’ from which the organ-buying patients originate. In 2007, a WHO-commissioned study identified China, the Philippines, Pakistan, Egypt and Colombia as major organ-exporting countries (Shimazono 2007). The major organ-importing countries have been the rich countries of East Asia (Japan, Taiwan, South Korea, Malaysia and Singapore) and the Middle East (especially Saudi Arabia and Israel).

Governments typically have responded to the organ trade with indifference. In both organ-exporting and organ-importing countries, the authorities have shown little concern over this practice. The organ trade, however, has been of great concern to the medical community since the early 2000s. Local physicians, national medical associations and international medical societies have demanded that governments ensure ethical transplantation practices, in conformity with the WHO standards. Consistently with these demands, several countries that had long overlooked organ trafficking—from Japan to the Philippines to Egypt—have passed transplantation laws and regulations or revised existing ones, with the aim of eliminating the trade in organs or encouraging altruistic organ donations (Danovitch and Al-Mousawi 2012).

The following analysis examines the national-level involvement of civil-society actors—physicians and their professional associations—in establishing and enforcing the organ-trade prohibition, in order to identify whether and under what conditions that involvement mattered. Indeed, organ trafficking offers a convenient area for exploring civil society’s influence on anticrime efforts. A key challenge in studying NGO influence is to establish that a policy outcome did in fact *result* from the NGOs’ demands and actions, and is not merely correlated with them (Betsill and Corell 2001). In the case of organ trafficking, any policy changes can with reasonable confidence be attributed to civil society’s influence, in the absence of other potential motivators of action.

Typically, one such motivation is crime’s negative effects on society. Governments seek to curb criminal activities when such activities threaten the public or create pressing social problems, such as gun violence or widespread drug abuse (Efrat 2012). The negative effects of the trade in organs, however, are not as tangible or easy to see. At the heart of the kidney commerce is a transaction that seems voluntary and mutually beneficial: the donor receives funds that supplement a meagre income, while the patient may potentially regain his health. In reality, however, that bargain may turn out to be far from advantageous. Paid donors often experience physical and mental

health problems, which could lead to a reduced income, rather than the hoped-for economic improvement. For patients, commercial transplantations carry the risks of surgical complications and infections, and likely result in lower patient and graft survival, compared with ethically compliant transplantations (Goyal *et al.* 2002; Delmonico 2011; Anker and Feeley 2012). Such negative effects, however, are not readily observable. The direct bearers of these effects—paid donors and patients—are either unaware of the risks or desperate enough to accept them. From governments' viewpoint, the organ trade is an easy and immediate solution to the shortage of altruistic organ donations.

A second potential motivation for suppressing transnational crime is interstate pressure. Governments may tackle criminal activities because they are urged—or outright coerced—to do so by other countries. Indeed, the literature has emphasized the central role of the major powers—first and foremost, the United States—in the efforts against illicit trade. From drugs to counterfeit goods to sex trafficking, American pressure has brought reluctant governments to take measures against illicit flows (Bewley-Taylor 2001; Andreas and Nadelmann 2006). In the case of organ trafficking, though, neither the United States nor any other country has demanded action. While organ trafficking can be considered a form of trafficking in persons, the American campaign against human trafficking worldwide (US Department of State 2001) has largely overlooked the organ trade. Developing countries in which the organ trade thrives have also made little effort to initiate international action.

The lack of government concern about the organ trade and absence of interstate pressure to curb it allow us to rule out two possible explanations for government action against the organ trade. In such circumstances, official action against the trade may plausibly be attributed to a third influence: civil society. Furthermore, the organ trade is a 'crucial case' in which to examine the role of civil society (George and Bennett 2005: 120–3). If civil society is found to have limited or no influence in this most-likely case, it would cast doubt on its ability to affect transnational-crime policy in more difficult cases.

Why is organ trafficking a most-likely case for civil-society influence? Generally speaking, governments tend to resist calls for curbing any trade that is of major economic importance as a source of jobs and income, such as the trade in drugs or counterfeit goods. Organ trafficking, however, is a modest 'business' that financially benefits only a small group of brokers and physicians. The annual value of the global organ trade is less than \$1 billion (Shimazono 2007)—far lower than the estimates for the global trade in illegal drugs or counterfeits: \$320 billion and \$200 billion, respectively (OECD 2008; UNODC 2012). Furthermore, compared to other transnational crimes, elimination of the organ trade entails low policing costs, namely modest investment of resources in detecting and suppressing the illegal activity. Policing costs rise the more widespread and hidden the activity is; the organ trade, however, involves a rather modest number of transactions—about 10,000 globally every year (World Health Organization 2007)—and these are relatively exposed. Indeed, commercial organ transplantation takes place in only a few locations that are fairly easily identifiable: hospitals. Moreover, those involved are easy to recognize and track down. The identities of the transplant surgeons who perform commercial transplantations are often known to the authorities or can be discovered; and the patients can be identified as well. Prior to the transplantation, they are transplant candidates on the waitlist; after undergoing the procedure, they receive continuing care, including immunosuppressive drugs. The ease of detecting the organ

trade, alongside its low economic significance, should make it easier for governments to suppress the trade in response to civil-society demands.

Organ trafficking is also conducive to civil-society influence given the identity of the activists involved. Studies have suggested that activists enjoy greater influence when they are seen as authoritative based on their professional knowledge or moral stature (Price 2003; Busby 2010). The civil-society actors campaigning against the organ trade are *physicians* who possess both sources of authority. As health care professionals, physicians have unique expertise and knowledge that allow them to make a compelling case against organ trafficking. Their longstanding interaction with patients and donors and their understanding of the consequences of commercial transplantations enable physicians to authoritatively claim that organ trafficking is detrimental both to those directly involved and to society at large. Beyond their professional authority, moreover, physicians are often seen as *moral* authorities. Caring for people's health and committed to professional ethics, they are perceived by many as selfless professionals dedicated to the general welfare. Physicians' high moral stature has fostered a sense of *trust* in their judgment: confidence in their ability to diagnose illness and prescribe a cure, as well as deference towards their views on health policy more broadly (Imber 2008). The trust and respect that physicians enjoy give them an advantage compared with other activists. Respectful of doctors, policy makers and publics should be more inclined to accept the medical establishment's denunciation of commercial transplantation as an unethical and harmful practice.

The combination of pressures from both above and below also makes the organ trade a likely case for civil-society influence. As various studies have suggested, when the efforts of local activists are coupled with the efforts of transnational activists or other international allies, the joint pressure is more likely to be effective: the external ties give domestic activists material support, advice and effective ways to frame their arguments and demands (Tsutsui and Shin 2008; Murdie and Davis 2012). The local physicians demanding an end to the organ trade indeed received external support. In 2004, the WHO urged member states to comply with its transplantation guidelines by protecting the poor and vulnerable from the sale of organs (World Health Assembly 2004). Next, the WHO established collaborative relations with the Transplantation Society (TTS), an international association of transplantation professionals. The TTS has provided expert advice to the WHO, while also seeking to build a consensus against the organ trade *within the profession*. This consensus received formal expression in 2008, when the TTS established an international code of practice: the Declaration of Istanbul on Organ Trafficking and Transplant Tourism (Transplantation Society and International Society of Nephrology 2008). We would expect that the advocacy efforts of the WHO and TTS legitimized and reinforced the efforts of the domestic medical community. Importantly, the involvement of international bodies and the norms they promulgated magnify the reputational consequences of a government failure to curb the organ trade.

In summary, the organ trade's small economic significance and the relative ease of suppressing it; respect for physicians—the anti-trade advocates; and the combination of domestic advocacy with international norms and pressures—all of these should increase a government's receptiveness to civil society's demand for a trade prohibition. There are, indeed, certain considerations that may pull governments in the opposite direction. Unlike sex trafficking, for example, the organ trade satisfies a real need and solves an acute problem: the shortage of altruistic organ donations. Suppressing the organ trade

requires governments to tackle the organ shortage through other means that are more complex and expensive. Yet, on balance, organ trafficking is still less costly to eliminate than other illicit trades and thus constitutes a most-likely case for civil-society influence.

The cases: Pakistan and Israel

On many of the relevant dimensions, Pakistan and Israel exhibit significant similarity. Both countries became major participants in the global organ trade in the mid-1990s and earned a negative reputation within the international medical community as the countries that, respectively, sell and buy organs. Pakistan and Israel are also similar in terms of the transplantation-relevant cultural and legal terrain. Pakistani and Israeli societies both hold religious-cultural attitudes that favour leaving the dead intact. The result, in both countries, is a low rate of deceased organ donation (GODT 2010) and hence a shortage of organs for transplantation, which fuels the organ trade. Furthermore, throughout the 1990s and until the late 2000s, both countries had no transplantation law. In the absence of a statutory prohibition, the kidney commerce thrived.

The Pakistani and Israeli cases are also similar in terms of the forces demanding action against the organ trade. In both countries, the anti-trafficking drive in the mid-2000s was led by a small, cohesive group of transplant physicians, supported by national medical associations. In both cases, the physicians' demands were similar: enactment of a transplantation law that would ban commercial transactions in organs and encourage legitimate organ donations. Importantly, the efforts of the local medical community in both countries were reinforced by the urging from international medical bodies.

At the same time, the two cases offer an important variance: Israel is an established democracy with a stronger rule of law and lower level of corruption than Pakistan—a country that has been transitioning in recent years from military to civilian rule.¹ The two cases thus allow us to examine whether the influence of civil society varies with the political and institutional environment.

Following Tsutsui and Shin (2008), in each of the two cases, the analysis examines several influences on the organ-trafficking ban: the advocacy methods used by local physicians, the political and media environment, and the international pressure. I first examine how these factors affected the enactment of an organ-trade prohibition; their impact on enforcement is examined next. A comparison of the two cases and an assessment of the findings follow.

Tackling Pakistan's 'Kidney Bazaar'

Background

In 1994, India enacted the Transplantation of Human Organs Act, which made the purchase of organs there more difficult. Transplant tourists then turned to neighbouring Pakistan, which offered an environment conducive to organ trafficking: a large number of poor people desperate enough to sell their kidneys; skilled transplant surgeons and

¹ In 2011, Israel was ranked in the world's 80th percentile in terms of rule of law and 73rd percentile for corruption control. Pakistan was ranked in the 20th and 15th percentiles, respectively (World Bank Worldwide Governance Indicators).

advanced medical facilities in the private health sector; and an absence of government oversight of transplant activity. The inflow of foreign patients into Pakistan increased further in 2003, as the Iraq War ended the practice of transplant tourism that had flourished under Saddam Hussein's rule. Whereas in 1991, 75 per cent of the kidneys transplanted in Pakistan were donated by family members to their relatives, 80 per cent of the kidneys transplanted in 2003 were bought from unrelated donors. By 2007, some 2,000 commercial transplantations were being performed annually in Pakistan, the majority of which—roughly 1,500—on foreigners. Transplant tourists arrived from the United States, Europe and India. Middle Easterners, however, constituted the largest group. Lured by newspaper and internet ads offering 'transplant packages', the patients underwent the transplantations in private hospitals in Punjab, typically paying \$10,000–\$40,000 (Moazam 2006; Naqvi *et al.* 2008; Rizvi *et al.* 2010).

Like paid donors in other organ-exporting countries (Zargooshi 2001; Goyal *et al.* 2002), the Pakistani donors are among the poorest members of society. Most are agricultural labourers who earn \$1 a day or less. With such meagre wages, the labourers are often forced to take loans from their landowner and accumulate debt that is impossible to pay back. Effectively bound to the landowner, they see no choice but to sell their kidneys for a promised amount of \$1,000–\$2,000. In reality, however, the donors receive far less than the promised amount—usually no more than \$800—and also suffer a deterioration of their physical and mental health (Naqvi *et al.* 2007; 2008; Moazam *et al.* 2009; Rizvi *et al.* 2010).

Pushing for enactment of a prohibition

Physicians' advocacy

A group of physicians based at the Sindh Institute of Urology and Transplantation (hereinafter, SIUT or the institute) led the efforts to eliminate organ trafficking in Pakistan. SIUT is a public health care institution renowned for treating kidney and liver disease and, in particular, for kidney transplantation. Viewing health care as a fundamental human right that should be available to everyone, free of charge, SIUT serves patients unable to pay for health services. Its commitment to helping the country's poor has earned SIUT much respect among the public and policy makers. Dr Adib Rizvi, the institute's founder and director, is a widely admired figure in Pakistan (Rahman 2010).

SIUT's social status and prestige were instrumental in its anti-trafficking campaign. The institute had been calling for the enactment of transplant legislation since the early 1990s, yet the surge in transplant tourism in the early 2000s prompted a renewed effort. A critical component of the campaign, which reached its full momentum in 2006–07, was the production and distribution of information on organ trafficking and its consequences. Moral entrepreneurs typically use their knowledge and expertise to educate policy makers about illicit trade and its negative effects. They disseminate information that exposes the detrimental consequences of trafficking, identifies the perpetrators, and lends urgency and credibility to the demand that the trade be eliminated (Keck and Sikkink 1998; Grant and Taylor 2004). Indeed, the SIUT physicians published several studies that documented the practices, dynamics and consequences of the organ trade. A socio-economic study portrayed the mostly illiterate donors whose hopes for economic improvement following the kidney sale were never

fulfilled (Naqvi *et al.* 2007). Medical studies showed that the paid donation jeopardized the health of both donors and recipients (Naqvi *et al.* 2008; Rizvi *et al.* 2009), while an ethnographic, interview-based study described the donors' predicament and revealed the well-oiled process—involving brokers and hospital staff—whereby the kidneys were obtained (Moazam *et al.* 2009).

The SIUT studies scientifically confirmed the organ trade's adverse consequences and identified those responsible: physicians at Punjab's private hospitals, brokers and middle/upper-class patients from Pakistan and abroad. The SIUT physicians realized, however, that generating political pressure would require a broader base of support. To raise public awareness, SIUT held several seminars, symposia and press conferences that highlighted the exploitation of paid donors and called on the government to enact a transplantation law (Alam 2005; Rizvi *et al.* 2010: 194). Op-eds and letters to the press were another advocacy tool (Moazam 2006). SIUT also sought to establish a societal coalition to demand action against organ trafficking. In addition to four national medical associations, SIUT brought on board other civil-society actors of high moral stature, such as educators and members of the clergy, as well as individuals who had benefited from dialysis and transplantation. In public and media appearances, members of the coalition argued that commercial transplantations violated fundamental moral norms and called for the pursuit of ethical alternatives—first and foremost, deceased organ donation. Further reinforcement of the physicians' demands came from external actors. On visits to Pakistan, WHO and TTS representatives made it clear that the country's organ trade was an international concern and that it violated the international standards in the area of transplantation. SIUT physicians used these standards to justify and support their demand for action. As a member of the WHO, they argued, Pakistan should adhere to the organization's principles and rehabilitate its tarnished reputation within the international medical community (SIUT physician, personal communication).

Consistently with the physicians' demands, President Pervez Musharraf issued the Transplantation of Human Organs and Tissues Ordinance (hereinafter, the transplantation ordinance or the ordinance) in September 2007. The ordinance included a prohibition on unrelated living organ donation, with exceptional cases requiring the approval of the hospital's evaluation committee; a prohibition on transplanting organs from Pakistani donors to foreigners; prohibitions on commercial dealings in human organs, including severe penalties for violations; provisions addressing deceased donation; and establishment of a federal monitoring authority to oversee the country's transplant activity and investigate violations. SIUT did raise an alarm about several loopholes in the ordinance, but its main concern was to protect the legislation from attempts to weaken it—attempts waged by the owners and physicians of the private hospitals involved in commercial transplantations. With a financial stake in the organ trade, and using its ties to high-level officials, the organ-trade lobby sought to amend and, in fact, undermine the ordinance by relaxing the prohibitions on unrelated donation and payment to donors; the lobby further suggested that allowing foreigners to receive transplants would help the country's economy. A legislative proposal along those lines was submitted to the National Assembly, only to be withdrawn in January 2009 thanks to a counter-lobbying effort in which SIUT and the medical associations played a major role. Publicly defending the ordinance, they argued that it had significantly curbed commercial transplantations, and that the proposed amendments might

turn the country back into the ‘laughingstock of the transplant world’ (Alam 2008a; Moazam 2011: 324, 332).

Political and media environment

The anti-organ-trade coalition received considerable support from the national media. Dramatic news reports brought to light the paid donors’ plight and exploitation, revealing how jobless youths saw no choice but to sell their kidneys (Mehdi 2005) and how a ‘kidney mafia’ lured them into doing so, yet enjoyed impunity in the absence of a transplantation law (Tahir 2007). The reports further emphasized that the beneficiaries were rich foreigners who had come to Pakistan for the purpose of buying kidneys from the poor (Hussain 2006). They also indicated that stories of Pakistan’s organ trade had been circulating in the international press, earning the country the dubious reputation of a ‘kidney bazaar’ (Yousafzai 2006; Malik 2007; see Walsh 2005). On television, several programmes featured testimonies of individuals who had sold their kidneys and gave SIUT physicians an opportunity to speak out against this practice. One documentary showed a poor village where a majority of male residents had sold their kidneys.

In terms of the political environment, the physicians’ main alliance was not with political parties or bureaucrats, but with the judiciary. In 2006, following the evidence presented by the press and the urging of SIUT, the Chief Justice of Pakistan’s Supreme Court called on the federal and provincial authorities to curb the organ trade. In July 2007, while the government was dragging its feet on the promulgation of a transplantation ordinance, the Supreme Court ordered that the ordinance be established (Dawn 2007). Once the transplantation ordinance was in place, the Federal Shariat Court, tasked with ensuring the consistency of the country’s laws with Islam, was asked to strike down several provisions as contradictory to Sharia. The petitioner, owner of a private hospital in Rawalpindi, argued that allowing the donation of a kidney only to a blood relative or a spouse violated the Qur’an’s call on Muslims to save a life whenever they can. The respondents, the Ministry of Law and Justice and the Ministry of Health, advanced their own religion-based arguments to demonstrate the ordinance’s consistency with Islam. In addition, they highlighted Pakistan’s social inequalities that fuelled the organ trade, and presented economic and medical data demonstrating the harm that donors suffer following the nephrectomy. The respondents further emphasized that a resurgence of transplant tourism would violate international norms and damage the country’s reputation. In litigating the case, the government received assistance from three medical associations, and the SIUT physicians were prominently visible throughout the court’s hearings (Moazam 2011). In April 2009, the Federal Shariat Court unanimously rejected the petition based, among other things, on the sanctity of treaties in the Qur’an. As an Islamic nation that is a WHO member, the court reasoned, Pakistan had to follow the organization’s guidelines prohibiting organ sale.

Pushing for enforcement

The battle over the enactment of the transplantation ordinance was only the first round in the campaign against organ trafficking in Pakistan. With the end of Musharraf’s rule in 2008, the democratically elected parliament had to convert the ordinance into a law. Once again, the SIUT physicians launched an advocacy effort that involved attendance

at parliamentary hearings, meetings with legislators and mobilizing a coalition of civil-society actors in demand of a transplantation law (SIUT physician, personal communication). With support from the media, the two chambers of parliament passed the legislation unanimously and, in March 2010, the Transplantation of Human Organs and Tissues Act (hereinafter, the transplantation act or the act) came into existence.

The transplantation ordinance and the act thereafter replaced the regulatory vacuum with strict rules and prohibitions enforced by the Human Organs Transplantation Authority (HOTA). This made commercial transplantations a riskier business than before. The immediate effect was a significant reduction of such transplantations and a diminishing inflow of foreign patients (Rizvi *et al.* 2010). Yet, problems have been evident from the start. In fact, HOTA's own credibility was called into question, as its inspectors included individuals who had been involved in commercial transplantations (Alam 2008b). Due to the inadequate enforcement, the organ trade resurfaced shortly after the establishment of the act, reversing some of the decline that had followed the 2007 ordinance. Commercial transplantations started rising again, and the inflow of foreign patients regained momentum. As is often the case with illicit trade (Becker *et al.* 2006), the prohibition on commercial transplantation drove up prices and made the trade even more profitable; it also sparked the transfer of some surgeries from hospitals to improvised clinics in private houses (Mustafa 2012). While the resurgent trade did not reach its pre-ordinance magnitude, its revival threatened to undo the progress that Pakistan had made since 2007.

In the face of persistent violations, the physicians who had campaigned for a transplant law renewed their demands for vigorous government action. In December 2010, a meeting of the Transplantation Society of Pakistan—with Dr Rizvi as its president—took notice of the growing number of illegal commercial transplants and publicly chastised the government for failing to enforce the law. The Society called on the president and prime minister to stop illegal transplant activities and ‘save Pakistan from becoming the cheapest organ bazaar of the world’ (Dawn 2011a). In July 2011, Dr Rizvi once again publicly criticized the government for not enforcing the transplantation act. Although evidence of the organ trade abounded—relevant reports had been shown on television—the authorities kept insisting that there was little proof, and not a single person involved in the trade had been prosecuted. Dr Rizvi called on Pakistan's Chief Justice, media and civil society, who had pushed for the enactment of transplant legislation, to once again pressure the government in demand of enforcement (Dawn 2011b). The media indeed heeded that call and urged the government to enforce the law, tackle the organ trade's resurgence and ‘put those engaged in the nefarious practice of exploiting the poor in that manner out of business’ (Dawn 2011c). The weakness of enforcement was all the more disappointing, reports suggested, since the identity of the perpetrators—hospitals and physicians—was well known to the Ministry of Health and HOTA (Mustafa 2011).

The Supreme Court also threw its weight in support of stronger enforcement. Twelve petitioners—including physicians, journalists, the Supreme Court Bar Association and NGOs in the fields of human rights, education and social services—asked the court to order the authorities to devise regulation for enforcing the transplantation act. In July–August 2012, the Supreme Court directed the provincial governments to take action and enact appropriate laws, imploring them to ‘have mercy on those [they] represent and who are forced to sell their kidneys’ (Dawn 2012). The Supreme Court's pressure ultimately led the provinces to enact their adaptations of the national transplantation act. Further support came from the legislative branch. The parliamentary human-rights

committee questioned the Ministry of Health's claim that commercial transplantations were all but gone and called on the ministry and provincial governments to tighten enforcement (Dawn 2011*d*).

Yet, government authorities continued to make limited enforcement efforts. The transplantation legislation apparently did not significantly alter the government's view of the organ trade as a non-harmful practice that merited little attention. Moreover, as the government's critics charged, the poor enforcement resulted from the ties between officials and unscrupulous physicians and middlemen:

... the organ mafia [is] ... hand in glove with the administration and the police. People have been caught red-handed but have been let off because high-ups are beneficiaries of the huge amounts that the trade generates. ... It speaks volumes for the 'integrity' of a government which cannot even nab a handful of individuals who have been so clearly identified. (Mustafa 2012)

In conclusion, in the Pakistani case, civil society's domestic pressure, reinforced by pressure from international medical bodies, resulted in a legislative prohibition on the organ trade. These pressures, however, were insufficient to motivate strong enforcement. Nevertheless, the prohibition did lead to a certain reduction in the organ trade.

Israeli Transplant Tourism

Background

In the 1990s and 2000s, Israeli patients travelled as far away as Colombia and the Philippines to undergo commercial transplantations with organs purchased from locals. In other cases, the Israeli patients and the foreign paid donors travelled to a third country (e.g. Israeli patients and Brazilian donors arrived for transplantations in South Africa). The popularity of transplant tourism among Israeli patients resulted from the local shortage of organs: compared to Western countries, Israel has a low rate of deceased organ donations (GODT 2010). The appeal of transplant tourism grew further following the adoption of an official policy, approved by the Ministry of Health in 1996, of reimbursing patients for commercial transplantations performed abroad. Using public funds, the non-profit Health Maintenance Organizations (HMOs)—the primary providers of health insurance in Israel—covered most of the costs of those overseas transplantations, even though they were prohibited in the countries where they were performed. By making transplant tourism affordable, the funding increased the number of Israeli patients who travelled abroad in pursuit of organs.

The policy of reimbursement for commercial transplantations overseas was adopted in response to patients' pleas. It was difficult for the HMOs and the Ministry of Health to condemn patients to languishing on the waitlist, when transplant tourism seemed to offer an immediate solution (Ministry of Health and HMO officials, personal communications). A second motivation for funding transplant tourism was financial, as commercial transplantations abroad resulted in significant savings for the state and the HMOs: paying for a one-off transplantation overseas was far cheaper than funding dialysis, an extremely expensive treatment that must be repeated throughout the patient's life (see Jarl and Gerdtam 2011). These motivations resulted in a no-questions-asked approach: the HMOs reimbursed patients without requiring information on the foreign donor's identity or how the donation was obtained. As in Pakistan, a legal lacuna

facilitated the buying of organs: Israel at the time had no transplantation law. In the absence of a legislative prohibition on transplant tourism, the HMOs were not breaking Israeli law, and neither were the patients and brokers.

That legislative vacuum, however, was filled in 2008 with the enactment of the Organ Transplantation Law, culminating a legislative process that had begun in 2003. Aiming to eliminate transplant tourism and increase the local supply of organs, the law prohibits the purchase, sale or brokering of organs for transplantation in Israel or abroad; it explicitly bans the funding of overseas transplantations that involve organ trafficking; and it puts in place measures to encourage living and deceased organ donations locally. What led to this policy transformation?

Pushing for a prohibition

As in Pakistan, it was local physicians who put the issue of transplant tourism on the policy agenda and urged the Ministry of Health to prohibit it. Pakistani physicians felt embarrassment when foreign colleagues associated their country with the organ trade; Israel's leading transplant surgeons—Professor Jay Lavee and Professor Eytan Mor²—shared that feeling, as Israel faced heavy criticism in international medical circles for fuelling the global organ trade (Lavee and Mor, personal communications). Like the SIUT physicians, the Israeli surgeons were concerned about the ethical implications of transplant tourism, as well as its negative material consequences: the direct effects on patients, such as severe organ rejection or infections, and broader indirect effects, such as a stagnantly low rate of altruistic donations in Israel, given the option of buying organs abroad (Lavee 2006; Mor n.d.). In contrast to the Pakistani physicians, however, the Israeli physicians did not wage a public advocacy campaign. Instead, they used their ties with and access to the Ministry of Health's bureaucracy. As members of the ministry's National Transplant Center, the physicians were well positioned to influence transplantation policy from within. Together with a representative of the Israel Medical Association, the transplant surgeons also played a key role at the meetings of the Knesset subcommittee that considered the organ transplantation bill.

As in Pakistan, the Israeli media reinforced the medical community's efforts to promote ethical transplantation practices. News stories about Israeli transplant tourism, which were published throughout the process of legislating the Organ Transplantation Law, caused embarrassment and created a sense of urgency in regard to addressing the issue. One story revealed that dozens of Israelis, having despaired of waiting for an organ, 'are flying each month to China, where they get the organ that will save their lives—straight from the bodies of executed Chinese criminals' (Ifragan 2005). According to another story, 'after discovering Colombia, South Africa, and China, Israeli transplant tourists have arrived at Bulgaria', where they were buying kidneys from the very poor, including the Roma people (Gypsies) (Rosenblum and Hazan 2005).

International pressures reinforced the domestic demands for a prohibition. In meetings and correspondence with Israeli officials, Professor Francis Delmonico, one of the leaders of the TTS and a WHO advisor, made a strong case against the Israeli

² Lavee is director of the Heart Transplantation Unit at the Sheba Medical Center; Mor is director of the Department of Transplantation at the Rabin Medical Center.

involvement in organ trafficking. His advocacy on behalf of the international medical community had a significant impact on the Ministry of Health: he was seen as expressing the view of civilized countries, to which Israel aspires to belong. Furthermore, ministry officials were concerned about possible penalties that might result from the violation of WHO standards (Ministry of Health official, personal communication).

The combined pressures of the local and international medical community, together with the media reports, prompted the Ministry of Health to fundamentally change its view on transplant tourism. In the 1990s, the ministry had authorized the HMOs to fund transplant tourists. A decade later, the ministry came to recognize that there is a 'fundamental normative reason' to avoid public funding of overseas transplantations, alongside 'the fact that the funding could make the state complicit in acts that the enlightened world considers unethical and immoral; it could undermine the state's status as a member of equal rights and values in the international community'.³ Eliminating transplant tourism, it was hoped, would allow Israel to improve its international standing and reputation. Yet, as in Pakistan, the beneficiaries of the organ trade challenged this view and sought to obstruct the change of policy. In Israel, these were the kidney patients. During the Knesset deliberations, their representatives argued that the new law would inevitably doom patients to death by closing the door on overseas transplantations and prohibiting paid donations in Israel, while offering no real alternative. However, the patients lobby, lacking financial resources or other tools of influence, was unable to block or weaken the legislation (chairman of the kidney patients association, personal communication). Since the Ministry of Health's lawyers—the architects of the legislation—strongly opposed transplant commercialism, there was little that the patients lobby could do.

Enforcement

The 2008 Organ Transplantation Law prohibits Israelis from being involved in transplantations—in Israel or overseas—if they include monetary payment in exchange for an organ. The law also bans the HMOs from funding such transplantations overseas. Nevertheless, a patient who bought an organ and the donor who sold it are not subject to punishment, on the rationale that the two are victims rather than offenders, driven to engage in the prohibited transaction by a severe medical problem or economic hardship. Furthermore, given their desperation, a criminal sanction would have little deterrent effect on them. The law does impose punishment on the middlemen involved in commercial transplantations: organ brokers, as well as medical insurers who provide funding.

The prohibition on funding commercial transplantations overseas proved effective. Under threat of criminal liability and penalties, the HMOs began verifying the altruistic motivation of the foreign donor before reimbursing patients for transplantations performed abroad. Since such transplantations usually involve purchased organs, the HMOs have been denying the majority of reimbursement claims, resulting in a precipitous drop in the number of Israelis who receive transplants abroad: from 155 in 2006 to only 35 in 2011 (Lavee *et al.* 2013). This cut-off of the funding, however, was easy to put into effect and enforce. First, a funding suspension is a simple administrative measure

³ The Ministry of Health's position in case 2551/06 (Tel Aviv Labour Court), *Abelson v. Kupat Holim Me'uhedet* (2006).

that does not require investigations, raids or arrests. Second, since HMO officials did not benefit *personally* from the funding of transplant tourism, they had little incentive to violate the criminal prohibition on such funding. Third, since the HMOs are public entities that receive government funds, a continuation of the reimbursement policy would have been easy to detect.

The prohibition on organ brokering, by contrast, has seen little enforcement. The authorities indeed prosecuted several brokers who had lured vulnerable *Israelis* into selling their kidneys. These trials ended in plea bargains. The most highly publicized case involved an organ-trafficking ring led by a retired senior officer of the Israeli Defense Forces (Rofe-Ofir 2010); none of the ring members received prison sentences.⁴ As regards brokers who have arranged for Israeli patients to buy organs from foreign paid donors, enforcement has been even weaker. To date, no such broker has been prosecuted. Brokers thus continue to market commercial transplantations abroad as a solution to desperate patients, in violation of the Organ Transplantation Law. The weakness of enforcement against transplant tourism stands in contrast to the vigorous Israeli action against sex traffickers. In 2001, the State Department identified Israel as a country that does not meet the minimum standards for combating the sex trade. The American criticism made the elimination of this trade a law-enforcement priority, resulting in the criminal conviction and imprisonment of dozens of sex traffickers (Efrat 2012). Action against transplant tourism, by contrast, has remained a low-priority issue, as this practice causes little observable harm in Israel and given the sympathy for the patients, for whom transplantation abroad is a potential lifesaver.

Discussion: The Organ Trade and Civil Society's Efforts against Crime

The case of organ trafficking allows us to clearly identify the effect of civil society on anti-trafficking efforts. In the absence of interstate pressure or government self-interest in curbing the organ trade, it was civil society—domestic physicians and their international colleagues—that demanded the elimination of the trade. I have also argued that this is a most-likely case for civil-society influence, given the expertise and elevated social status of physicians. Furthermore, the small economic significance of the organ trade and the ease of its detection, compared with other illicit trades, make it relatively unproblematic for governments to eliminate it. Since the key participants in the trade are rogue physicians, rather than violent criminal groups, the policing costs of suppressing the trade are quite low.

Indeed, in both Pakistan and Israel, physicians' professional and moral authority made officials attentive to their concerns. Many in Pakistan consider the practice of medicine a sacred profession, and physicians receive enormous respect as God's instruments on Earth (Moazam 2000). In Israel as well, the respect for and trust of physicians gave credibility to their contention that the kidney trade is an unethical and harmful practice damaging to the country's international reputation. In both countries, the physicians used familiar advocacy tools: provision of information on the organ trade and its effects, use of the media and 'mobilization of shame', namely demonstrating that the state was violating international norms (Keck and Sikkink 1998). The

⁴ Serious Criminal Case 10–10 (District Court of Nazareth) *State of Israel v. Michael Golub* (15 May 2011).

involvement of representatives of the international medical community reinforced the latter point. In other respects, however, the Pakistani and Israeli cases exemplify two different modes of civil-society advocacy. The Israeli physicians worked ‘within the system’, as they enjoyed significant access to and influence over the Ministry of Health. By contrast, the Pakistani physicians employed a more confrontational approach, which included the mobilization of a broad coalition of civil-society actors, media appearances and public criticism of the government (see [Stroup and Murdie 2012](#)). In both cases, the physicians’ endeavours produced a similar legislative outcome: a relatively strict prohibition on commercial dealings in organs.

Pakistan and Israel might have been expected to differ on enforcement. In Pakistan, the physicians and hospital owners involved in commercial transplantations had ties to government officials. Given the weakness of the country’s rule of law and the high level of corruption, even this small lobby could use its resources and influence to hinder enforcement. With a stronger rule of law and less corruption, Israel should have engaged in more determined action against the trade. Yet, Israeli authorities only enforced the prohibition on HMO funding of transplant tourism. By shutting down funding—an administrative measure that was easy to implement—the state ceased its official support of transplant tourism. But, beyond the ‘negative’ measure of cutting funding, there has been only a limited attempt to curb transplant tourism through enforcement against brokers.

Overall, this experience suggests that, even under the conducive conditions of a most-likely case, activists’ moral pressure is unlikely to result in wholehearted government efforts against transnational crime. Governments may placate activists by enacting legislative prohibitions, but fail to put that legislation into full effect. They may take action in the most glaring cases (such as public funding of transplant tourism), but not otherwise. Even when officials are concerned for the county’s international reputation and are persuaded by the activists’ moral arguments—as seems to be the case with the Israeli authorities—this has not translated into strict enforcement. The Pakistani and Israeli experience therefore suggests that activists’ moral pressure may not, by itself, motivate governments to enforce criminal prohibitions.

On the positive side, it is important to note that the legislative changes in Pakistan and Israel were indeed consequential, despite the weak enforcement. The cut-off of the HMO funding has made transplant tourism unaffordable for many Israeli patients; in Pakistan, the legislative prohibition drove up prices and made commercial transplantations riskier as they were pushed into improvised clinics. Overall, the prohibitions have led to a reduction in, but not elimination of, the organ trade.

Conclusion

The organ-trafficking case refines and advances our understanding of civil society’s role in combating transnational crime. It shows that activists can sometimes change official and public perceptions of illicit flows. Through production and distribution of information, societal mobilization and enlistment of the media, activists can convince governments to prohibit a trade that they previously tolerated. Importantly, states’ concerns for their international reputation give activists leverage. The physicians emphasized that Pakistan and Israel were perceived internationally as countries that were, respectively, selling and buying organs in violation of the WHO standards. It was therefore the combination of global norms and local activism that resulted in a normative

change. The international medical community gave the local physicians ammunition and new opportunities for claim making, while at the same time exerting top-down pressure on the governments (see Cortell and Davis 1996; Tsutsui and Shin 2008).

The analysis has found that civil society's effect on criminal policy did not vary with the type of political regime. Civil society had a similar impact in Israel—an established democracy—and in Pakistan—a country which, during the relevant period, was under authoritarian rule and later transitioned to democracy. In both political environments, persistent pressure by highly regarded activists led to a prohibition on illicit trade. In both environments, civil-society pressure was ultimately trumped by the resisting actors. In Pakistan, a very small lobby used its financial resources and political ties to undermine enforcement. The Israeli authorities may have eliminated the official funding of transplant tourism, but, sympathizing with the desperate patients, not the practice itself. Yet, even weak or partial enforcement of prohibitions may still reduce illegal activity—even dramatically so, as the Israeli case attests.

Organ-trafficking is a most-likely case for civil-society influence, given the small economic significance of the trade and the social status of the campaigning physicians. In other cases, activists seeking to influence transnational-crime policies will face even more formidable challenges. They would do well to learn from the experience of the physicians' campaign against organ trafficking. Mobilization of a domestic coalition, provision of information, media coverage, and the use of international norms and reputation as leverage—all of these had a significant effect on governments that long tolerated the organ trade. These means of advocacy may prove useful in other cases as well.

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