WHO

Prepared by Alleysha Razwill, Co-Chair of WHO

TISKLMUN'26

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Assessing the Legality of Human Euthanasia and Physician-Assisted Suicide

Addressing Black Market Medical Practices and Forced Organ Harvesting

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Dais Introduction

Head Chair - Olivia Pearl

Hello dear delegates,

I'm grateful to serve as your chair for TISKLMUN and I hope you read and thoroughly understand the research report. Please read it, your co chair and I put some elbow grease into this report. If you have any questions regarding the topics or your position paper/ delegation, feel free to drop me a message at my email below!

Happy reading,
Olivia

Email : augustonyx11@gmail.com

Co-Chair - Alley

Ethan here, Alley didn't want an intro, but it looked wierd to have this space empty so this is filler thank you. I hope our most popular council will have a great time at TISKLMUN'26.

Email : alleyhascat@gmail.com

Position Paper Guidelines

Attention: Submissions of Position Papers are mandatory to be considered for any awards.

Formatting

Delegates are required to adhere to the following format when writing Position Papers:

1. Position Papers should be titled as such TISKLMUN26_PP_[Country]_[Name of delegate] E.g: TISKLMUN26_PP_Russia_Anya Ivanov
2. Position Papers are to be written in English only with a competent degree of formality. Any other languages may be used if context necessarily requires.
3. State out your council, agenda, country represented, and your name in the Position Paper.
4. Position Papers are to be written in Times New Roman, font size of 12, and in justified format.
5. Usage of bold, italics, and underlines are allowed.
6. Delegates are required to cite any referenced sources in a bibliography section at the end of the position paper, following the 7th Edition APA Style.
7. Both agendas must be addressed in one Position Paper.
8. Your Position Paper should not exceed 2 pages, excluding the bibliography.
9. Do not include any images, flags, logos, personal names, or names of any school/institution.

Content

These are the basic guidelines on what content can be included but need not be followed strictly and reasonable omissions/additions are allowed.

1. Introduction of your country's profile, and how it might relate to the agenda.
2. Introduction to your country's stance on the agenda.
3. Your country's past actions pertaining to the agenda.
4. Give a brief idea of how you will approach the issue throughout the conference; do note that you need not rigidly adhere to this during the conference.

You are highly discouraged from using Wikipedia as a source of research. AI is strictly prohibited, and if we find the use of AI in your position paper it will be grounds for the disqualification of awards.

All position papers are due 11:59PM GMT+8, 5th February 2026.
Submit position papers via the form here:
https://forms.gle/UeuatpwBfxqCr9Gc6

HMUN ROP

HMUN mainly focuses on a delegate's ability to speak. Rules of Procedure (ROP) can be understood as a procedure that dictates how a council shall proceed. For HMUN ROPs, A visual aid for the flow of the HMUN ROP is listed on the next page:

Open (for first council session)/Resume Debate

⇩

Roll Call (Attendance)

Present: May abstain from substantial voting.

Present and voting: May not abstain from substantial voting.

⇩

Primary Speaker's List (PSLs will only happen once)

⇩

(Motion to) Setting Agenda

⇩

General Speaker's List

⇩

Points and Motions

⇩

Dealing with Draft Resolutions (Amendments/Debate/Voting)

⇩

Adjourn (for last council session only)/Suspend Debate

The full version of the ROP can be found here.

Terms

Draft Resolution	A document that contains the solution to the agenda at hand.
Working Paper	A document that conveys a certain idea to the council. It can come in any form, such as a video, an essay, or even a meme.
Amendments	A submission that serves to change parts of a Draft Resolution. An amendment would require to target a specific clause, and specify how it would be changed (e.g: rephrased, deleted, or add a new clause).
Foreign Policy	A set of strategies that a country employs to achieve their goals. It encompasses objectives in fields such as defense, economy, and politics.
Decorum	Etiquette; behavior in keeping with good taste and propriety.
Motion	A formal proposal to a committee. In HMUN context: to propose to move the committee into a certain procedure.
General Speakers List (GSL)	A list in which delegates may add themselves into to speak generally about the agenda at hand.

List of Points and Motions

Points

Point of Personal Privilege: **t**his can be used to interrupt the current speaker. Used when you have an issue that is not related to the council's affairs (e.g request to have the air conditioner turned off).

Point of Clarification: this can be used to interrupt the current speaker. Used when a delegate wishes to clarify something from the speaker's speech (e.g definition of a word used).

Point of Order: used when you believe that the chairs made an error in the rules of procedures.

Point of Information: used when a delegate finished their speech (in GSL only) and opened themselves to any Point(s) of Information. When granted, members of a council can raise a Point of Information to ask a question to this delegate. Delegates asking the question may request for the chair to grant a follow up. When granted, the delegate may ask a question that adds depth to their inquiry.

Point of Parliamentary Inquiry: used when a delegate has any questions directed to the chair regarding council related affairs (e.g asking for the current issue being discussed)

Right to Reply: this can be used to interrupt the current speaker. Used when a delegate believes that the speaker has offended (intentional or otherwise) the country they represent. Whoever raised this Right shall explain why it is raised (to the chairs). If granted, the delegate will have 1 minute to explain (not retaliate) to the speaker regarding the weight of their issue.

Motions

Motion to suspend/adjourn debate: only raised at the end of a council session. Suspend is to stop council session for a short break; adjourn is to stop council session indefinitely (used at the end of a conference).

Motion to start/resume debate: only raised at the beginning of a council session. Motion to start debate is only raised in the first council session. Motion to amend individual speaking time in GSL Used when a delegate wishes to amend the individual speaking time in GSL. Remember to propose a new individual speaking time when you raise this motion.

Motion for Moderated Caucus: used when you wish to propose a moderated caucus. Remember to specify the topic, total speaking time, and individual speaking time.

Motion for Unmoderated Caucus: used when you wish to propose an unmoderated caucus. Remember to specify the total duration. Unmoderated Caucuses can be extended by 50% at most.

Motion for Consultation of the Whole: used when you wish to propose a consultation of the whole. Remember to specify the topic and total speaking time.

Motion to Introduce Working Paper: used when you have a working paper you wish to show to the council. Please remember to submit your working paper to the chairs before you raise this motion.

Motion to Introduce Draft Resolution: used when you have a draft resolution you wish to show to the council. Please remember to submit your draft resolution to the chairs before you raise this motion.

Motion to Introduce Amendment: used when you have an amendment you wish to show to the council. Please remember to submit your amendment (usually via a google form created by the chairs) to the chairs before you raise this motion.

Motion for straw poll voting: used when you wish to propose a straw poll vote. Upon entering this motion, an informal vote will be conducted upon a target Draft Resolution.

Motion to vote for... Used when you wish to enter into formal voting procedures for an amendment/draft resolution.

Motion to vote clause by clause: used when you wish to propose the council to vote for a Draft Resolution clause by clause. A final vote will be immediately conducted (after striking off unfavored clauses) to determine if said Draft Resolution passes or fails.

Motion to divide the house: **w**hen passed, delegates who abstained are forced to vote. This motion can only be used after voting for a Draft Resolution and if doing so may potentially change the outcome of the vote.

Committee Introduction

**This is taken directly from WHO's website.*

WHO is the United Nations agency that connects nations, partners and people to promote health, keep the world safe and serve the vulnerable – so everyone, everywhere can attain the highest level of health. It was founded in 1948.

WHO leads global efforts to expand universal health coverage. We direct and coordinate the world's response to health emergencies. And we promote healthier lives – from pregnancy care through old age. WHO's Triple Billion targets outline an ambitious plan for the world to achieve good health for all using science-based policies and programmes.

The committee works with 194 Member States across 6 regions and on the ground in 150+ locations, the WHO team works to improve everyone's ability to enjoy good health and well-being. WHO collaborates with governments and civil society all the way to international organizations, foundations, advocates, researchers and health workers, we mobilize every part of society to advance the health and security of all.

WHO's work remains firmly rooted in the basic principles of the right to health and well-being for all people, as outlined in their 1948 Constitution. The World Health Assembly is the decision-making body of WHO and is attended by delegations from all Member States. They are committed to the principle of accountability – a core value for an organisation that is entrusted by countries and other donors to use limited resources effectively to protect and improve global health.

Agenda A : Assessing The Legality of Euthanasia and Physician Assisted Suicide

Keywords

Euthanasia	The act or practice of killing or permitting the death of hopelessly sick or injured individuals (such as persons or domestic animals) in a relatively painless way for reasons of mercy.
Physician assisted suicide	Suicide assisted by a medical professional providing a lethal drug to the suicidal patient.
Beneficence	The belief of advancing human development.
Non-maleficence	The obligation of the physician not to harm the patient.
Sanctity	Something sacred or holy.
Palliative	Relieving symptoms without dealing with the disease.

Introduction

Euthanasia is defined as 'the act or practice of killing or permitting the death of hopelessly sick or injured individuals (such as persons or domestic animals) in a relatively painless way for reasons of mercy.' We see euthanisation happen often, such as the act of 'putting down' a dog or cat due to violent behaviour or an incurable disease. Under euthanasia there is also another term, physician assisted suicide (PAS), where 'a physician provides, at the patient's request, a prescription for a lethal dose of medication that the patient can self-administer by ingestion, with the explicit intention of ending life.' The prominent difference between the two is that euthanasia is administered to the patient by a medical professional, while PAS involves the medical expert providing the tools necessary for the patient to commit suicide.

There is both active and passive euthanasia; active euthanasia refers to a purposeful and intentional act, while passive refers to the withholding or withdrawing of medical treatment to a usually terminally ill patient. There are three types of examples for active euthanasia, being,

1. Voluntary euthanasia,
2. Nonvoluntary euthanasia,
3. Involuntary euthanasia.

Voluntary euthanasia is when the patient is euthanised at their request, nonvoluntary is when the patient is euthanised without their consent(e.g, given a large dose of morphine, a drug known to hasten the process of dying), and, lastly, involuntary euthanasia is when a patient is euthanised while not being in a position to give consent (e.g, brain dead patients).

In this section we will go on further to discuss the ethicality of euthanasia and PAS, various comparisons between international legal frameworks surrounding euthanasia and PAS, concerns and the impact on the medical society, and points of contention. The main focus for euthanasia in this research report will be voluntary, active euthanasia (VaAE), as nonvoluntary active and involuntary active euthanasia is widely accepted and considered as unethical since it does not consider the patient's consent.

Ethicality

1. **Autonomy**: It has been argued that denying a patient euthanasia or assisted suicide is overriding their autonomy, where autonomy is supposed to respect an informed patient's decision regarding their healthcare and end of life. In 2022, a judgment made by the German Federal Constitutional Court showed that it understood assisted suicide 'as an expression of the person's right to a self-determined death.' Therefore, restrictions on assisted suicide for 'benificence' are, ironically, restricted as per the court's ruling in Germany. Some suggest that assisted suicide should rather be considered a person's autonomous action than a medical procedure. Arguments against this state that autonomy cannot be used to justify everything, the same way we avoid voluntary enslavement.

2. **Beneficence**: the belief of advancing humanity collectively, beneficence can view euthanasia and PAS as exactly that - it relieves suffering, therefore it is advancing human development. The process of dying in the modern day can be prolonged, painful, and frankly unbearable for patients, especially if they are terminally ill or have lost massive function of their limbs.

Therefore it furthers their wellbeing to relieve them of their pain and suffering instead of allowing them to withstand it until their last breath. Arguments against this state that inadequate treatment is the cause of many patient's pain and suffering, and that if their diseases are treated adequately such suffering would not exist.

3. **Non-maleficence:** it argues that the hippocratic oath that all medical professionals take is directly contradicted as they are using it in a way that 'wrongs' them. The main premise of the oath is that the professional will use their knowledge for good rather than to injure or wrong patients. However, it can be argued that there is objectively no wrong being done to the patient if the patient consents and explicitly wants the outcome,

4. **Sanctity of life:** Many religions and belief systems argue that life is a fundamental value, and this is in turn upheld by various legal systems and even in the European Convention of Human Rights (ECHR).

It is not entrenched in the ECHR that the right to die is a fundamental human right, however, in contrast, the right to live is a fundamental and most basic human right that is entrenched in essentially every human rights treaty or document there is. Therefore it is up to a nation's government to legalise euthanasia and PAS - there is no one global agreement and consensus on the use and ethicality of euthanasia and PAS.

While some nations, such as The Netherlands and Colombia, allow the use of euthanasia and PAS whilst heavily regulating them, other nations have taken the measure of criminalising and illegalising euthanasia and PAS, such as Malaysia, and the United Kingdom.

Research from a 2011 article shows that it seems as though regulations and restrictions imposed by nations who legalised euthanasia and PAS become more lax as the years pass - regulations become less strict and slowly become more loose, almost not adhered to at all. Evidence shows that almost 50% of euthanasia cases are not reported, and this comes from cases where mostly there was no explicit, written consent of the procedure, where euthanasia was involuntary, and where euthanasia was non-voluntary.

Initially euthanasia and PAS were restricted to a very small number of terminally ill patients but some places have widened the scope for those eligible for euthanasia, including newborns, children, and people with dementia. In 2011 euthanasia for those over the age of 70 who had no interest in living their lives anymore were being considered given the option of euthanasia. A statistic from 2005 shows that for every five people euthanised lawfully, one is euthanized without giving explicit consent.

Many non-voluntary euthanasia cases occur because a patient is comatose, has dementia, or professionals euthanised them because they personally felt that it was in the patient's best interest to be euthanised, e.g relieving them of their pain and suffering. In a small minority of the cases, they were euthanised without being informed as discussing it with the patient would prove to be harmful to the patient.

Possible Courses of Action

Clinical and ethical guidelines

Issue clinical and ethical guidelines on euthanasia and PAS that outline restrictions and guidelines on end-of-life processes in an ethical manner. It is recommended to create standardised terminology surrounding euthanasia and PAS, and establish minimum requirements, or rather standards, for capacity assessment, informed consent, and pain management.

Strengthen Palliative Care Accessibility and Capacity

Expand programmes to include an widen global access to palliative care in LEDCs and MEDCs. This includes providing training and assistance to healthcare workers in LEDCs especially, and encouraging nations to integrate palliative care into their national health systems.

Establish Monitoring, Data Collection, and Research Mechanisms

Encourage an increase in efforts to monitor euthanasia and PAS, whilst also establishing a global database that commissions data collection and input, as well as research on public opinion and ethical concerns of euthanasia and PAS.

Further Reading

Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls - PMC

Questions a Resolution Must Answer(QARMA)

1. Does consent from a sane, well-informed adult provide sufficient legal justification for euthanasia and PAS?

2. Should intent to relieve suffering differ from the intent to maliciously cause death?

3. What restrictions and regulations should be imposed on the use of and access to euthanasia and PAS? How can it be enforced better?

4. How will different forms of euthanasia be regulated?

5. What is the ethicality of euthanasia and PAS?

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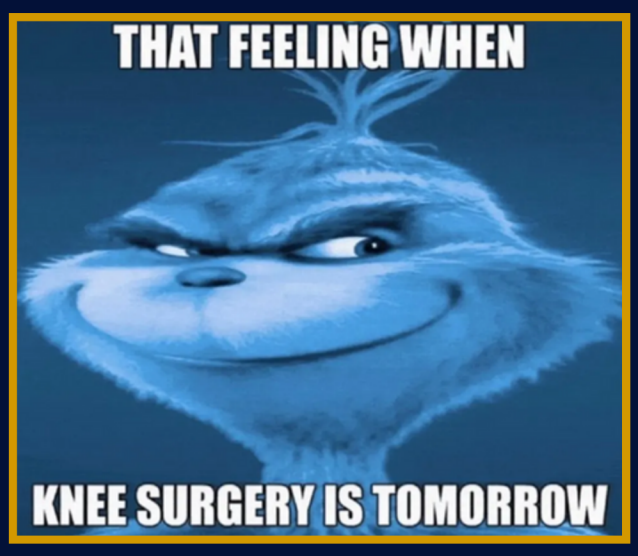
Agenda B: Addressing Black Market Medical Practices and Forced Organ Harvesting

Keywords

Organ Transplantation	Surgical procedure to replace a failing or damaged organ with a healthy one from a donor
Prisoners of Conscience	Individuals imprisoned for beliefs, religion, or peaceful activism
Informed Consent	A fundamental medical and legal principle requiring patients to voluntarily agree to procedures after being fully informed of risks, benefits, and alternatives
Medical Complicity	Direct or indirect participation of healthcare professionals in unethical practices, including silence, falsification of records, or cooperation with abusive systems
Transplant Tourism	The act of traveling to another country to obtain an organ transplant through illegal, unethical, or unregulated means
Forced Organ Harvesting	The involuntary removal of organs from living or deceased individuals without their free and informed consent

Black Market	Underground economy for organs and other goods or services not legally sanctioned
Transplant Waiting List	Official registry of patients awaiting organ transplants, usually prioritised based on medical urgency, compatibility, and time on the list.

Introduction



Imagine going under anaesthesia for something as simple as knee surgery, and then waking up without your vital organs. That's only if you're lucky enough to be sedated throughout the entire process. The discovery of organ transplantation, nothing short of revolutionised the world of modern medicine, allowing for the replacement of failing organs, extending life expectancy, and offering hope to patients who would otherwise face certain death. But what exactly happens when the want and greed of humans and their lifespan grow, the normalisation and exposure to hazardous environments increase, putting their organs at a higher risk? With the massive spike of demand for organ transplants since the first successful one in 1954, everyone thinks "I need an organ", but no one really questions where these organs are coming from.

Organ transplant systems did not appear overnight. In the early days of organ transplantation, particularly in the first half of the 20th century, transplants were rare, experimental, and largely unregulated. Decisions about who received an organ were made by individual doctors or

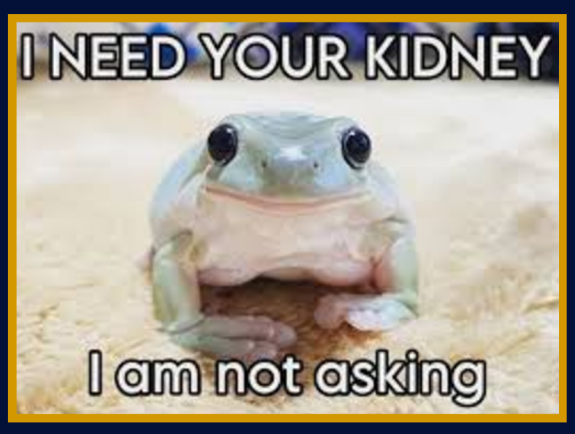
hospitals, often based on personal judgment rather than standard medical criteria. Most successful transplants involved living relatives, such as identical twins, because the human body would otherwise reject foreign organs. At this stage, there were no formal systems to ensure fairness or equal access. A committee at Harvard Medical School set statutory criteria for brain death in 1968, but the medical profession itself had to make conclusions on issues specific to the transplant area. In order to reduce the burden of permanently comatose patients on families and hospitals and to resolve the dispute surrounding the acquisition of organs for transplantation, the study sought to designate irreversible coma as a condition for death.

During the 1960s and 1970s, major scientific breakthroughs altered the situation. The discovery of tissue typing and the development of immunosuppressive drugs made it possible to transplant organs between unrelated individuals. As survival rates improved, demand for organs increased rapidly. However, organ supply remained limited, and the lack of coordination between hospitals led to serious ethical concerns. Wealthier or better-connected patients were often prioritised, and allocation practices varied widely across regions. From the beginning, the high cost of surgery, post-operative care, and long-term immunosuppressive treatment meant that transplantation was never financially neutral.

By the 1980s, many countries recognised that organ transplantation required national oversight. Governments began introducing laws to regulate transplants, prohibit the sale of organs, and ensure ethical allocation. In the United States, this led to the creation of a nationwide

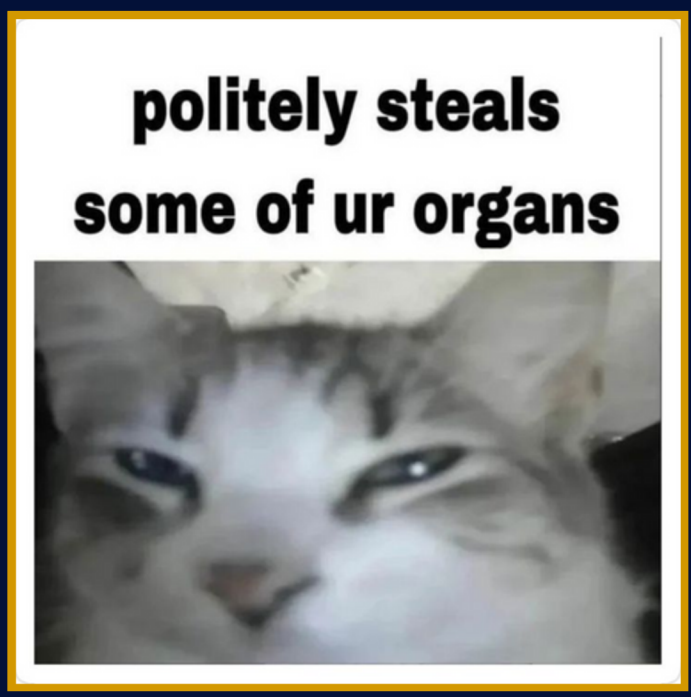
system that centrally matched donors and recipients using medical criteria such as urgency and compatibility. Similar systems emerged in Europe and the United Kingdom, often within public healthcare frameworks. These systems replaced informal decision-making with standardised waiting lists and allocation rules, but even when organs themselves were donated, access to transplantation often depended on a patient's ability to pay hospital fees, travel costs, and lifelong medical expenses. So, pairing systems, computer-based (to remain neutral) or not, still brought us back to the same dilemma, where only the privileged had access to life-saving transplants.

Points of contention



With demand comes supply, arguably one of the core principles of the black market trades, would of course inevitably find its way to the medical field. It seemed like a win-win situation, I mean, why would you give away your kidney for free, when you can get up to 100,000 US dollars for it on the black market. For those facing poverty, debt, or coercion, the promise of financial relief can override concerns about long-term health risks, legal consequences, or informed consent. What is framed as a "choice" is often anything but voluntary. As the government patches the bugs in the systems that allow networth or namesakes having any possible say in the ever-growing legal organ requirement list, money truly can buy everything. In many cases, individuals are pressured by brokers, criminal networks, or even state-linked institutions into surrendering organs, while recipients (often from wealthier backgrounds)

When the systems fail you, its natural to want to take things into your own hands, forced organ harvesting refers to the removal of organs from individuals without their free, informed, and voluntary consent, victims are often prisoners, detainees, refugees, undocumented migrants, or individuals living in extreme poverty. In some reported cases, organs are removed while victims are still alive, leading directly to death. Unlike voluntary organ trafficking (where consent may be present but coerced), forced harvesting eliminates agency entirely. This practice violates core principles of medical ethics, particularly autonomy, non-maleficence, beneficence, and justice, which form the foundation of ethical healthcare worldwide.



The criminalisation of selling and buying organs is one thing, but where exactly can the true fault be vested, when people are merely pawns in a global game of chess? Organ trafficking thrives in the shadows created by a persistent shortage of legal donors, exploiting the poor and vulnerable through deception, coercion, and sometimes outright abduction. Cases in Indonesia illustrate this starkly: in 2023, traffickers deceived 122 people into selling kidneys in Cambodia, while earlier reports noted mutilated corpses of migrant workers returned to their families.

In 2024, over 103,000 Americans and 13,000 Europeans awaited transplants, while in Indonesia, 70,000 people were in need of organs but only 234 transplants were performed through legal family donations.

While getting paid thousands of dollars for a vital organ you can survive without sounds like the dream, the sad truth is that most people don't get to make that choice. The scarcity pushes patients and healthcare systems toward illegal channels, resulting in "transplant tourism," where wealthy recipients travel to countries like India, China, or Nepal to receive organs sourced from trafficked donors. Asia has become a notorious hub, with entire communities, such as Nepal's so-called "Kidney Valley," exploited for organ procurement. In extreme cases, forced harvesting has extended to political prisoners or marginalised groups, underscoring how the crime intersects with broader human rights abuses.

Nowhere have these concerns been more persistent and deeply scrutinised than in the People's Republic of China, where allegations centre on the use of prisoners of conscience particularly Falun Gong practitioners, and more recently Uyghur detainees, as involuntary sources of organs for transplantation. The origins of these allegations date back to 2006, when reports published by the Falun Gong–affiliated Epoch Times claimed that detainees were being killed for their organs at facilities such as the Sujiatun Thrombosis Hospital in Liaoning Province. While initial claims relied on whistleblower testimony and circumstantial evidence, they catalysed broader investigations by independent researchers and legal experts. Former Canadian Secretary of State David Kilgour and international human rights lawyer David Matas undertook a comprehensive inquiry despite being denied entry into China. Their findings, first released in 2006 and later expanded into the book Bloody Harvest, estimated that more than 41,500 organ transplants conducted between 2000 and 2005 could not be explained by known sources such as executed death-row prisoners or voluntary donors.

They concluded that Falun Gong practitioners, detained en masse following the 1999 nationwide crackdown, were the most plausible source of these organs.

The persecution of Falun Gong provides critical context for these allegations. Once widely practised in China, Falun Gong was declared illegal by the Chinese Communist Party in 1999, triggering mass detentions, forced labour, torture, and extrajudicial killings. Human rights organisations, including Amnesty International and the UN Special Rapporteur on Torture, documented extensive abuses. Detainees reported unusual medical examinations focused on blood typing, organ imaging, and tissue compatibility rather than routine health checks, suggesting organ matching rather than standard care. The scale of detention and systematic nature of these tests indicates an organised organ procurement system targeting prisoners of conscience.

It is estimated that around 65,000 Falun Gong practitioners were killed for their organs between 2000 and 2008, with earlier cases in the 1990s in Xinjiang involving Uyghur prisoners during "strike hard" campaigns. Enver Tohti, a former Chinese surgeon, testified that he was ordered to remove organs from a prisoner who had not yet died, highlighting the involvement of medical professionals in these abuses.

Statistical anomalies further support these allegations. After 1999, China's transplant capacity surged, with liver centres growing from fewer than two dozen to over 500 within a decade. Waiting times for vital organs were often weeks or days, despite the absence of a voluntary donation system, while countries with advanced infrastructures and millions of donors experience multi-year waits.

Ethicists argue this suggests a pre-screened pool of living donors whose deaths could be scheduled.

Commercial incentives exacerbated the abuse. With declining state healthcare funding in the 1990s, hospitals, particularly military-affiliated ones, were encouraged to generate revenue. Transplant tourism emerged, with foreign patients sometimes scheduling surgeries in advance, impossible under voluntary, post-mortem systems. These financial incentives, combined with weak oversight and political repression, created conditions ripe for systemic abuse.

In 2018, this evidence was presented to the Independent Tribunal into Forced Organ Harvesting of Prisoners of Conscience in China (the China Tribunal), chaired by Sir Geoffrey Nice KC. The tribunal heard over 50 witnesses, including surgeons, former prisoners, statisticians, and human rights experts. In its 2019 judgment, it concluded that forced organ harvesting had occurred across China on a significant scale, with Falun Gong practitioners likely the primary victims. The tribunal found these acts constituted crimes against humanity and saw no credible evidence that the practice had ceased.

More recent allegations suggest that Uyghur detainees in Xinjiang may now be subjected to similar abuses. Since 2020, researchers have reported credible evidence of involuntary blood testing and organ examinations conducted on Uyghur detainees, raising fears that they are being entered into organ registries without consent. UN human rights experts expressed alarm in 2021, noting that such practices could not be medically justified and mirrored earlier patterns observed in the persecution of Falun Gong.

The Chinese government has consistently denied allegations of forced organ harvesting, while acknowledging that organs from executed prisoners were previously used for transplants, a practice it claims to have ended in favour of voluntary donation. However, scepticism persists due to the present data inconsistencies, limited transparency, and restrictions on independent investigation. Attempts to audit transplant systems or verify donor consent remain tightly controlled, in the name of privacy and sovereignty, undermining confidence in official reforms.

Possible Courses of Action

Course 1

One of the most direct ways to combat forced organ harvesting is to create strong legal frameworks that explicitly criminalise all aspects of organ trafficking. This includes prohibiting not only the sale and purchase of organs but also coercion, deception, and non-consensual removal of organs from living or deceased individuals. However, legislation alone is insufficient; enforcement is critical. Governments must establish specialised law enforcement units trained to identify and investigate organ trafficking networks, while courts must be equipped to prosecute offenders, including complicit medical practitioners and corrupt officials. International cooperation is also essential, given that organ trafficking frequently spans borders. Measures such as shared intelligence databases, joint investigations, and extradition agreements can help dismantle transnational trafficking rings. Transparency in reporting cases, along with whistleblower protections for healthcare workers who expose illegal activity, would further reinforce accountability and deter participation in these crimes.

Course 2

Another key approach is to reduce reliance on the illicit organ market by expanding ethical, legally regulated organ donation. Many countries currently operate on an opt-in system, where organs can only be donated if an individual explicitly consents. For a big percentage of the privileged population, advertising and education severely lack in these areas, where donating organs doesn't even cross their minds. Introducing an opt-out system (where all individuals are presumed donors unless they actively refuse) would dramatically increase the number of legally available organs. This reduces the demand that fuels illegal trafficking and ensures that transplantation occurs ethically. Complementing legislative changes, governments can conduct public education campaigns to dispel misconceptions about organ donation, highlighting how organs are allocated fairly, and that donations save lives. Health authorities must also maintain strict oversight of hospitals and transplant centres, including auditing surgical procedures and tracking the origin of organs, to prevent corruption or collusion with illicit markets

Course 3

Rather than monetising organs, donors can be reimbursed for the tangible costs and sacrifices associated with donation, such as medical expenses, travel costs, lost wages, and time off work. By covering these costs, donors are not financially burdened for their altruistic contribution, and the act of donation remains voluntary and ethical. Countries such as the United States and some European nations already provide frameworks for reimbursing living donors for legitimate expenses, ensuring that financial concerns do not deter donation.

Expanding these systems could increase the number of legally available organs, reducing the incentive for individuals to turn to illicit organ markets or risk exploitation by traffickers. Importantly, safeguards must be established to prevent these reimbursements from being interpreted as "payment for organs," which would then throw us back into a grey ground. Additionally, ethical donor compensation could include support services such as counselling, long-term health monitoring, and insurance coverage for complications arising from donation.

Further Reading

https://youtu.be/VRRbOsQgRXU?si=PyO_sF-_BI1yol3b

https://youtu.be/5SDNmeStmGQ?si=YOcPr87ciSrOpOrr

https://youtu.be/vGIQCxZJQwY?si=RWZY0d7HbWegwqXJ

https://globalrightscompliance.org/wp-content/uploads/2025/05/legal-advisory-report-do-no-harm-grc-july-2022.pdf

QARMA (Questions A Resolution May Answer)

1. How can governments effectively detect and prosecute forced organ harvesting operations?

2. What measures can be implemented to increase ethical organ donation and reduce black-market demand?

3. How can international cooperation be strengthened to dismantle transnational organ trafficking networks?

4. How can transparency in organ donation and transplantation systems be standardised globally to prevent state-sponsored or state-tolerated exploitation?

5. What support systems can protect vulnerable populations from being exploited by traffickers?

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