DOCUMENT OF AGUASCALIENTES

EXPLANATORY PREAMBLE

The important techno-scientific advances obtained over the last six decades have permitted the establishment of transplants of organs as optimal treatment alternatives for an ever-increasing number of patients with irreversible organ failures. The possibility of offering these procedures to the patients has required great generosity and altruism on the part of the donors and their relatives.

Ever since the fifties in the last century, when the first transplants in human beings were performed, [1-3] the enormous complexity of a bioethical order involved in the carrying-out of the transplants has been made manifest; [4-6] initially, because of the necessity to establish criteria regarding death and consequently, because of the fact that the practice of transplant medicine incorporated a hitherto unheard-of and extremely complex variable: The organ donor.

The questionings of a bioethical order, related to organ transplants, posed in the second half of the twentieth century, have motivated intense debates and have constituted an authentic challenge for the scientific, legal, moral and religious ambits during all these years.[4-11]

It must be recognized that the result of those debates has led, very gradually, to establishing international order in the practice of transplants. The criteria for encephalic death have been clearly defined [12-18] and for the last 4 decades, have been accepted in an almost universal manner; [19-22] likewise, it has been possible to define the rules and optimum conditions for the carrying-out of the transplants.

The question would then be asked as to why – half a century later – the debate regarding the bioethics of transplants is still open?

There are various arguments that explain this situation; perhaps the most important are those which have inspired the realization of this First Latin American Bioethics and Transplant Forum:

1. The transplants of organs have increasingly succeeded in forming part of the therapeutic armament for a large quantity of illnesses formerly considered as terminal. This creates the necessity to insure that the patients have opportune and fair access to medical attention and also, access to medical treatments that entail highly elevated costs.
2. The organs for transplants, obtained from deceased persons, have always been up till now a scarce resource. Because of the growing number of patients who require a transplant, it is absolutely indispensable to insure that conditions of equity exist in the access to this resource.
3. The case of living donors is no exception since, in the face of the growing demand for transplant services, there is always the possibility that the transplant programs may become more permissive in the acceptance of live donors, even to the extent of putting the safety of the donors at risk. Furthermore, the pressure represented by this demand can favor practices of commerce in transplants.
4. The countries require legislative systems which insure the optimum conditions for the donation and transplant of human organs.

Transplant medicine is practiced with great dignity and professionalism throughout the world. It forms a model branch of contemporary science and its scientific contribution has been vast and generous; thousands of human beings have benefited from it. Despite this, it is necessary to recognize that there are some focal points of attention in relation to the practicing of transplantation.

Recently, the Sixty-Third World Health Assembly unanimously subscribed to the Principles of the WHO on the transplant of Human Cells, Tissues and Organs and approved various measures to optimize the safety and the effectiveness of transplantation. The document declares the Organization's "opposition to organ trafficking and transplant tourism and urges those professionals in healthcare who are aware of such practices, to notify such to the corresponding authorities, and likewise to improve the safety and efficiency in the donation and transplantation, promoting the best international practices".[23]

However, the existing disproportion throughout the world between the growing demand and the limited supply of transplant organs has propitiated undesirable practices such as: "…*trafficking of human beings who are used as sources of organs and patient-tourists from rich countries who travel abroad to purchase organs from poorer people…*" as was presented and discussed in The Declaration of Istanbul.[24] The meeting from which said Declaration originated, adopted as its basis the principles of the Universal Declaration of Human Rights.[25] In said document, the imperious necessity for international collaboration is expounded in order to obtain world consensus with relation to the optimization of the practices of donation and transplantation. Its elaboration was the product of the work of more than 150 representatives of medical and scientific organizations from all over the world, government officials, social scientists and ethicist. In that meeting, the fact that "*The legacy of the transplants should be a celebration of the gift of health from one person to another and not impoverished victims of organ trafficking and transplant tourism*" was emphasized.[24] It should be added that the dialogue on the matter has a long history and tradition, where the main objective has always been the protection of the donor and the practice of transplantation under the best conditions, with programs, personnel and faculty, duly educated and certified.[26-32]

The effort by the health authorities and other worldwide organizations involved in transplantation, to divulge the Declaration of Istanbul has been meritorious, the purpose of which is focused on an unprecedented attempt to put in order and to standardize the best possible practices in the matter of donation and transplantation. Many countries have adopted the principles contained in the above-mentioned Declaration, and inclusively, have influenced positively in the adoption of its precepts.

Latin America and the Caribbean form a multicultural region, of great diversity and contrasts, which also possesses points of coincidence with relation to the practice of transplantation, since, despite its disparate development in education and health, studies from the last ten years reveal that all countries in the Region, without exception, are growing in this activity in a progressive manner. The results of the Latin American Transplant Registry, a part of the Latin American and Caribbean Transplant Society ("STALYC") [33] show that the activity of donation with a deceased donor increased in 6 years 3,8 ppm, with the perspective of reaching an average of 20 ppm in 10 years at an annual growth rate of 1-1,5 ppm.

The same tendency is observed in the transplant of the different organs during the same period of analysis (ten years). The annual growth in kidney transplants was of 7%, the index being 15,7 ppm; with the liver this was even greater, 11%, rising to an index of 3,4 ppm, and the increase in cardiac transplants was of 5.8%.[33]

This potentiality places the region in a particularly interesting scene that will allow us to investigate the progress obtained, mitigating the weaknesses of the system, principally the product of the socioeconomic reality and the existing healthcare policies in each country.

Hence, there is a resulting necessity to advance in plans which guarantee accessibility, transparency and quality in the activity of transplantation in Latin America and the Caribbean.

The idea to carry out the first Forum on Transplant Bioethics was conceived in the core of the Latin American and Caribbean Transplant Society. The Forum originated due to the necessity of creating a space that would permit the analysis of the existing problems in the region. The necessity for reflection was detected, solutions had to be looked for in some cases; in others, we would look to establishing a consensual positioning; in other aspects we would limit ourselves to proposing solutions. The transplant community of Latin America could not remain detached from such a series of problems; they considered it a duty never to be given up.

The Forum has not limited itself to treating in an exclusive manner aspects concerned with transplant bioethics, which are its priority; it has also set out to evaluate the bases that are applied in those countries on the subject of legislation in transplantation and on the distribution of organs originating from deceased donors, recognizing their virtues and proposing solutions for their deficiencies, aspects that are also closely related with the correct application of the fundamental ethical principles. In the same way, it is indispensable to get to know the way in which the healthcare authorities of the countries in the region attend to the permanent and universal coverage of the care required by the patients receiving the transplants, including the immunosuppressive therapy and the quality of this, and likewise, the implied commitment in the short and long-term follow-up of the living donors.

For the purpose of producing a sufficiently inclusive and useful document, the participation of doctors involved in the practice of transplantation and specialists in

bioethics from Latin America and the Caribbean were invited to participate, who, prior to the development of the Forum and by allocation of the subjects included, undertook the task of studying in detail the practices currently prevailing in our countries, of detecting the weaknesses and proposing solutions which at the appropriate time were evaluated and discussed in work-groups during the course of the First Forum on Transplant Bioethics held in Aguascalientes, Mexico on 2nd – 4th September, 2010. During the event, the coordinators of each of the four work-tables and the participating group at each one of the tables, analyzed the opinions and agreed upon proposals. At the conclusion of the individual discussions at each table, the Forum participants met in a plenary session in which the results and proposals for each topic were presented and a consensus formed of the general opinions. With the product of this work, a draft document was produced and sent to all the participants for their evaluation and final comments, under the principles of reflection, analysis criteria and action guidelines.

Due to reasons of logistics and organization, four topics were chosen to be discussed during the First Forum on Transplant Bioethics:

I. Living Donor
II. Transplant Tourism and Commercialism
III. The Government Role in Legislation, Distribution and Coverage for Transplants
IV. Access and Quality of Immunosuppression

LIVING DONOR

Although the evaluation of a potential donor should be circumscribed solely to the donor's particular bio-psychological aspects, it is difficult to be able to withdraw the individual from other underlying environmental circumstances that could be capable of influencing in the final decision to donate.

In the case of the kidney donor, neither the surgical act nor the future mono-renal state is free of risks. In fact, quite a few persons considered to be good candidates for renal donation according to present criteria find themselves in a boundary situation, for example regarding age, weight, arterial pressure, and that they could be at risk in a short or long term because of this procedure. Similar situations can arise in living donors of other organs (i.e. liver).

Therefore, it is considered to be the responsibility of each transplant program to establish a system that insures a meticulous evaluation for the donor hence minimizing the additional risks to those inherent to the operation. Ideally, this task should be carried out by an independent group, already experienced in transplantation that would evaluate the donor at each phase: the pre-surgical evaluation, the surgery, the immediate post-operative care, and the long-term management for monitoring the renal and integral health of this person. An interdisciplinary transplantation committee to help in this decision is also indispensable.

The non-harm principle should be assumed and favored above the other bioethics principles, in order to be able to protect the bearer donor from additional risks, even when this donor wishes to exercise his/her autonomy insisting in donating.

A. DEFINITIONS

1. ***Living donor of blood relationship*** – Donor genetically related with the recipient in the first, second, third or fourth degree of consanguinity (father, mother, grand-parents, uncles, aunts or cousins).
2. ***Living donor not related by consanguinity***

A. *Emotionally related living donor* – those donors who do not have consanguinity or genetic relationship, but who have a *strong link of an emotional type* which is discernible and obvious, and which can be objective and evidenced. The *husband or wife, concubines, step-fathers and step-mothers, step-sons and step-daughters* fall in this category.

B. *Non-related living donor*: those who are not related either by consanguinity or emotionally, who could be:

- *Altruistic donor* – That person who offers to donate an organ to any other person who may be ill, even if this is an unknown person, taking great care and pleasure in the well-being of others and for purely human reasons.
- *Paired donation* – The using of donor couples to recipient couples in a cross-matching manner, when in a close, genetic or emotional relationship, there exists ABO incompatibility, sensitizing, hereditary renal illness or absence of another available donor.
- *Paid donor* – This includes the person subject to the sale of organs, whether "regulated" or illegal.

B. RECOMMENDATIONS FOR THE ACCEPTANCE OF THE LIVING DONOR

Living donor related by consanguinity: the donor of first, second, third or fourth degree is acceptable.

Paired donor: These are only acceptable between couples with living donors who are related by consanguinity or emotionally. All the couples must be evaluated by specialized hospital commissions and must obtain authorization from the corresponding Health and Judicial Authorities.

Living donor not related either by consanguinity or emotionally is not acceptable except those included in the following category:

Altruistic donor: Without directed donation is acceptable. We recommend that all the cases are carefully evaluated by committees of experts and authorized by the corresponding Health and Judicial Authorities.

Emotionally-related living donor: Includes husband or wife, concubines, step-fathers and step-mothers, step-sons and step-daughters; these are acceptable when legally verified and approved by the corresponding Judicial Department.

Paid donor: This donor must not be accepted under any circumstance whatsoever.

C. GENERAL PRINCIPLES RECOMMENDED:

The fundamental bioethics principles which should be contemplated are: Dignity and beneficence, integrity and non-harming, precaution and/or vulnerability, autonomy and responsibility, and distributive and local justice.

Bioethics as a science and as an art is found to be in continuous evolution. Hence, new principles have been formulated to shed light on the conflicts which the progress in the Sciences of Life creates, in addition to resuming other previously established principles. If the first principles of Bioethics corresponding to Beneficence, Non-harming, Autonomy and Justice were elaborated in an Anglo-Saxon context, the

internationalization of Bioethics especially in our environment, insist on the new contributions that have been made in the field of human knowledge and action.

For **Human Dignity** we mean that the person has an intrinsic value and has no price, in other words the person is not an object for profiting with. **The principle of beneficence**: in this context is understood as acting for the best benefit of the donor and the recipient.

For **integrity and non-harming**, we assume the right of the subject to preserve his/her functional unit, and for **Precaution and/or Vulnerability**, we express the threat towards the frailty of a totality in biological, psychological and cultural danger.

Autonomy: The word autonomy is derived from the Greek “autos” (own) and “nomos” (rule), authority or law. To be autonomous implies assuming one’s right to have one’s own opinions, to choose and to carry out actions based on one’s values as personal beliefs. We must respect the points of view and rights of the persons as long as their ideas and actions do not imply harm for others or for themselves.[34, 35]

The principle of **Responsibility** is defined as the obligation of all those who have access to science and technology to be conscientious of their own actions, which should be in accordance with respect for human life and the preservation of the same.[36]

Distributive and Local Justice: The term distributive justice refers to the adequate fragmentation of the goods and/or the burdens of a society, in order to compensate the inequalities in which the society lives. In this way, the resources, the taxes and the opportunities are distributed in an equitable way.

The principle of Justice in Bioethics makes mention of the access to the healthcare resources and the promoting of health, with the capacity of answering to the necessities of the community and the protection of the State.

In order to explain distributive justice in the health services, the terms of equity, merit and ownership or what one has a right to, have been used. It is said that the situation is just when the person receives the benefits to which they have a right. Injustice arises when an individual is deprived of attention that corresponds to him/her considering his/her necessity or social condition.

Distributive justice seeks to supervise the methods employed for successfully allocating a substitute therapy such as a transplant, for the purpose of avoiding discriminatory effects.[37-39]

The Document of Aguascalientes gives a hierarchical structure to the following concepts: **Solidarity and Subsidizing**.

Solidarity: Whereas every human being has the right to find what he/she needs for his/her growth and development, solidarity implies that we make ours the necessities of those who do not have those resources, in order that they may obtain means for subsistence and the instruments for personal progress.

Subsidizing: In a social reality with notable differences of opportunities, with this principle, the aim is that those who know more, are more capable and have more may see and attend to those who are lacking in any of those ambits. The above does not limit either the initiative or the responsibility of the persons and social groups; on the contrary, they will value, promote and increase these.

In addition to the aforementioned, we consider that it is fundamental to establish a joint-responsibility with the handling team and the donor-recipient couple and their social environment. This joint-responsibility of the handling team does not exempt the State from its responsibility. Accordingly, it is indispensable to point out the following:

Informed consent: In the Document of Aguascalientes, we reiterate the obligatory factor for the use of the Informed Consent with all its components for the purpose of safeguarding the autonomy of the donor and the patient for all transplant procedures. We resume these components as follows:

Voluntarism: This must guarantee that the persons freely choose to submit themselves to a procedure, medical treatment or clinical study without their permission having been obtained by means of coercion, persuasion or manipulation.

The right to information: This should be comprehensible and include the objective of the medical analysis, treatment or procedure. The benefits and short, medium and long-term risks of the procedure or medical treatment must be clearly explained to the persons and likewise, the therapeutic alternatives.

Comprehension: The level of comprehension of the patient must be evaluated by different persons apart from the explaining doctor. This information can be obtained through the psychologist, social worker or nursing personnel who understand and know in detail the procedure which is offered to the patient or to the organ donor. The information should be given to the patient in their mother tongue or dialect of the region. A translator or interpreter should be present for the patient during the whole time that he/she is receiving information. In the case of the written document which the potential donor will sign granting his/her authorization not being in the mother tongue, this must bear the signature of his/her translator and of at least two officials of the institution, testifying that what they consent to in writing is the same as that to be found in the document. It is necessary to take into account the level of schooling and social development of the person in order to insure that the person has fully understood what has been explained verbally and in writing.

Each country's societies should use strategies in order that, together with its legislators, national laws may be generated based on international model laws, for the purpose of obtaining or maintaining optimum results and of protecting the rights of the recipients and donors.

TRANSPLANT TOURISM AND COMMERCIALISM

The recent happenings in relation with organ transplantation, the laxity in the resource of non-related living donors, and the utilization of organs of prisoners condemned to death in China, have provoked world criticism. In its concern about the situation that has been denounced, the Latin American and Caribbean Transplant Society consider it necessary to make an emphatic pronouncement regarding the transplant tourism and the sale of organs. The unethical practices in transplantation that foment the inequality and the exploitation of persons are of common knowledge. [40] These unethical practices are based on false arguments such as the "benefit" and the "opportunity" that a person can obtain to improve their economic condition. In the same way, an appeal is made to their "autonomy" to justify the right that the persons have of selling their organs. However, this is solely a disguise for an "illicit business" in which the poor people in need of money are not the ones who benefit from the sale of their organs, but rather,

those who get rich are the intermediaries in this type of sale. It is clearly defined that the poor will be those who most take the risk in participating in this type of procedures because of the vulnerable condition in which they find themselves. The situation of polarization of the distribution of richness in countries in our region, the high rate of poverty and the low level of schooling, challenge Latin America to take the necessary measures to protect the vulnerable population from these new forms of human exploitation such as the trafficking and the commercialism of organs.

We subscribe to the Document of Aguascalientes with the following definitions arising from the Declaration of Istanbul[24]:

Organ trafficking *is the obtaining, transport, transfer, harboring or receipt of living or deceased persons or their organs by means of threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of vulnerability both by the one who delivers the organ and by the one who receives such organ, including third party payments or benefits to achieve the transfer or the control over a potential donor, for the purpose of exploitation by the removal of organs for transplantation.*

Organ commercialism *is a practice in which an organ is treated as a commodity that can be bought, sold or used as merchandise.*

Travel for transplantation *is the movement of organ donors, recipients or professionals related with transplantation who cross jurisdictional borders for the purpose of carrying out transplants. Travel for transplantation becomes* ***Transplant Tourism*** *if it involves organ trafficking and/or commercialism of the same or of other resources such as professionals or transplant centers dedicated to carrying out transplants in patients from outside of the country, hence undermining the country's ability to provide adequate transplant services for its own population.*

The Document of Aguascalientes is emphatically opposed to any idea or mechanism that tends towards the commercialism of organs and tissues on the part of the individuals or the States. It is opposed to any mechanism that disguises the trading of organs or rather, to the functioning of any type of organization that establishes that organs are marketable articles; like for example, the regulated market, the free sale of organs, or the payment to the donors of higher sums than those derived from

evaluation studies, surgical procedure, follow-up and complications after an act of donating an organ.

THE STATE ROLE IN LEGISLATION, DISTRIBUTION AND COVERAGE FOR TRANSPLANTATION

On the understanding that our States are responsible for the well-being of the citizens and have the intention of promoting the common good, it is worth pointing out their role in the functions of governing, financing, safeguarding, provision, control and vigilance of the activity linked with the transplantation of organs, tissues and cells of human origin occurring in their own countries.

The growing demand for donated biological material of human origin to attend to the situation of thousands of our citizens, demands of our countries the orderly development of systems for donation and transplantation, and the specific policies framed in an ethical and legal context that contemplate the common good with the characteristic of universal access.

In each one of our countries, to a greater or lesser degree, there exists a strong and increasing disequilibrium between offer and demand of transplant organs, a fragmentation in the attention, and a partial or restricted access to transplantation as a therapeutic alternative for large sectors of the population of Latin America and the Caribbean.

Even though in many of our countries there exists a ample margin of growth in the rate of deceased donors, today other internationally-used alternatives are being analyzed which, if considered as appropriate, would demand a strict ethical-legal and citizen control.

In view of this situation, the only acceptable attitude is that of an ever-increasing responsibility and commitment on the part of the different components of our society, especially from those who have major political, ethical-legal, sanitary, technical and economic responsibilities.

In this new context, a very special role corresponds to the civil society, with a more active and organized attitude towards the defense of their rights.

The political decision to give impulse to these systems with clear objectives, such as guaranteeing the right to transplantation, increasing the number of transplants, reducing the waiting lists and improving the results of the same, should be effected with the elaboration of donation and transplantation policies, in order to attend the problems of access and equity, coverage and integrative attention. [41,42] It is necessary to make it clear that the correct application of these measures requires that the States guarantee the universal coverage of the health services to all the individuals who need transplantation. These measures should consider the organizational particularities of each State obeying "correct" ethical guidelines.

In those countries where there is no existing donation and transplantation activity, the authorities should make their maximum efforts to develop systems for attending to the necessities of their population with the objective of self-sufficiency.

In each case, the population must have available all the information regarding access to the transplant programs in force, to the results of survival of patients and implants of the programs carrying out the transplants, availability, coverage levels and allocation criteria.

The access to the information on the part of the various actors, including the patients, allows the guaranteeing of transparency in the allocation and obliges the presenting of their results.

ACCESS AND QUALITY OF IMMUNOSUPPRESSION

The objective is to guarantee the health of the patients with the use of medicines of an approved quality and effectiveness, by means of a process defined and endorsed by a scientific-academic institution;[43] this does not imply the approval or disapproval of the use of generic medicines but demands the fulfillment of the conditions mentioned.

The coverage for transplants should comprehend the necessity of implementing health care strategies that insure the access, quality, transparency, equity and effectiveness of the attention to the patient; permitting the rapid registration on the waiting list, remaining in the waiting situation for brief periods and the possibility of receiving a transplant with the perspective of full reincorporation into society by the patient.

The activity of transplantation implies an ethical commitment from the professional, not only with the patient but with the community with its spirit of solidarity that makes possible the donation of a common and scarce organ, and which also involves responsibility with the patient who remains on the waiting list.

The State must look to maintaining the physician-patient link within the ethical framework which assumes respect for the dignity and autonomy of the individual. Any change or disposition that alters this balance threatens the psycho-physical well being of the patient.

The problematic issues regarding the incorporation of generic medicines on the market used in Immunosuppression have great prevalence. This is a universal debate and, to date, there is insufficient bibliographical information about the therapeutic safety of the generic immunosuppressants and least of all about the results of the interchangeability of these.

The supervision of the quality of the immunosuppressant medicine that the patient receives is the ethical obligation of the transplant doctor. Therefore, an adequate respect for the prescription issued must be guaranteed, and likewise the patient should be granted all the information to be able to exercise his/her autonomy and make a free decision. Any change in the immunosuppressant treatment must be authorized by the patient by means of the signature of informed consent, legally provided for. In the same manner, there must be agreement on who will have the legal responsibility for the consequences due to the change in medication.

The immunosuppressants form a special category of medicines that present special characteristics and make them different from other therapeutic groups.[44] These are medicines with a high health risk since they present a reduced therapeutic opening and have high inter-population and intra-individual variability. Hence, errors in dosage even when minimal can result in: 1) lack of effectiveness with loss of the transplant, 2) an excessive immunosuppression accompanied by infections or 3) undesirable grave

effects due the toxicity peculiar to the medicine. This results in the variability in the bio availability of the immunosuppressant medicines in the transplanted patients being significantly greater than in healthy volunteers. Hence the results of studies on pharmacokinetic bioequivalence performed on healthy volunteers cannot be extrapolated directly to the highly heterogenic population of the patients with transplants. Therefore it is necessary to carry out clinical studies on the effectiveness and the safety of the generic immunosuppressants which would provide evidence of equivalence, or at least of non-inferiority, with respect to the immunosuppressants with a certified patent.[45]

We consider that it is necessary that the healthcare authorities, by means of the entities dedicated to the regulation of medicines, submit the generic immunosuppressant medicines to studies of therapeutic monitoring of serum, plasma or blood concentrations in transplanted patients in order to evaluate the intra- and inter-individual variability of the different formulations available. Also, studies of intensive pharmacovigilance will be commenced in order to recognize the variables that can interfere in the disposition of the new formulations.[45]

It is also necessary to adjust and have available an instrument of data capture so that all the doctors may provide information regarding adverse effects and that this may be found in public web pages of scientific societies in conjunction with the regulating authorities, to facilitate the fulfillment of the pharmacovigilance. It is recommended that the scientific societies of each country generate a flow of information about pharmacovigilance to be circulated in the transplanting hospitals and in the health units where follow-up is made of patients with low immunological risk.

The interchangeability between innovative immunosuppressants and generic immunosuppressants is not recommendable if the complete process of verification of the clinical effect of the generic has not been performed. Pediatric patients, elderly adults and patients with a high immunological risk represent vulnerable groups and should not be incorporated in any interchangeability plan.[45]

The argument regarding costs in the acquisition of generic immunosuppressants at lower prices is not valid within the framework of the bioethical principles which should be fulfilled in patient attention such as beneficence and not causing harm. Moreover, it should be taken into consideration that the pharmacoeconomy does not only include the acquisition costs but also the costs associated with the lack of effectiveness and

safety of a medicine. If the use of generics results in a major rate of transplant rejection, the savings generated by the price of the medicine will be amply exceeded by the costs associated with a therapeutic failure. Therefore, the use of a generic immunosuppressant of a bad quality results in additional expenses. In contrast, a generic immunosuppressant that presents effectiveness and safety, comparable with the innovative type but having a lower cost, results in a significant saving. This is the type of generic immunosuppressant medicine that should be stimulated by the regulatory authority.[45]

Finally, we consider that it is an opportunity for the health authorities to define policies that permit the guarantee of the best universal coverage of the immunosuppressive treatment and that together with the regulatory authorities the commercialization of the new generic drugs be authorized when these same drugs have an assured standard of quality.[46-48]

RECOMMENDATIONS AT A COUNTRY AND PROGRAM LEVEL.

The following are conditions for the development of a healthy system of donation and transplantation in each country of the Region:

1. To count on specific legislation based on bioethical considerations that contemplate the regulation of donation, allocation, transplantation and follow-up.
2. To guarantee universal access to the health services, including access to transplantation, in all the countries of the region.
3. To establish a national state organization in charge of the donation, procurement and allocation of the organs, and likewise of the promotion and enforcement of transplantation policies at a national level.
4. To foment programs for deceased donors and the maximum utilization of the resources of each country and likewise for international cooperation, including the exchanging of medical-clinical, educational, bioethical and scientific investigation sources regarding donation, immunology and transplantation.

5. To have available a national waiting list for each organ or tissue, and allocation systems with defined criteria that promote order, certainty, transparency, credibility and traceability in the system.
6. To promote the establishment of necessary controls in the health institutions for the protection of the vulnerable population.
7. To put in order the principles of distributive justice in equality, usefulness and community.
8. To count on systems for monitoring and fiscal regulating of the allocation processes.
9. To promote the obligatory condition of reporting to the national system of donation and transplantation of each country and to the corresponding public health ministries regarding the performance of transplants with living donors and also data of value for traceability and follow-up.
10. To create evaluation committees for non-related donors in the hospitals carrying out transplants.
11. To create national registers of donation and transplantation that may insure the adequate analysis of short and long-term results.
12. To establish criteria for certifying hospitals where transplantation procedures are carried out.
13. To register and authorize the transplantation programs.
14. To establish national criteria and protocols for the selection of deceased donors and for procurement.
15. To define criteria for certifying the personnel dedicated to activities of procurement and transplantation.
16. To prepare clinical transplant teams for diverse organs, that are competent and qualified, with transplantation programs contemplating pre-transplant, implant and post-transplant activities.
17. To train personnel for donation and procurement activities.
18. To establish mechanisms for giving support and encouragement in the deceased donor and procurement programs in all the countries throughout the Region.
19. The companies initiating negotiations for the approval of the generic formulations of immunosuppressant drugs before the respective health ministries should fulfill the following:

a. Present references regarding the origin of the drug and its use in other countries.

b. Clinical transplant studies guaranteeing safety and therapeutic effectiveness with supervision by authorized third parties should be submitted to the generic formulation. These studies must be of adequate statistical importance.
c. The supply of the drug must be guaranteed for a period of a minimum of one year in order to avoid the risk of interruption and interchangeability of the medicines. It is frequent for the generic trader to experience problems of production and/or distribution which limit the adequate supply of the medicines.

20. To make known and announce the Document of Aguascalientes in all the transplant forums and congresses that are held in Latin America and the Caribbean.
21. To send this document to all the state institutions participating in health management in the region.

CONCLUSIONS

This document contains the result of the work sessions and discussion tables of the First Latin American Forum on Transplant Bioethics. Its publication fulfills the purpose of transmitting its content to all the professionals in health who day by day make their best effort towards the care of patients who need a transplant, to all the medical societies involved in transplant activities and to the health authorities of all the countries which form the Latin American and Caribbean Region.

The Document of Aguascalientes does not pretend to adopt a dogmatic character that censures the exercise of the transplants; least of all does it seek to assume a maniqueist attitude to define what is correct and what is not.

The Document of Aguascalientes reaffirms its identity with the highest values defining the practice of medicine; it reaffirms its commitment with dignity, its respect for life and the never-to-be given up duty of helping those who suffer.

Although the Document of Aguascalientes admits that each country and each transplant center have the prerogative of defining their own practices, it does pretend to serve as an instrument of expression on behalf of the groups with transplanting activity

in Latin America and the Caribbean, and its aim is to influence the realization of the transplant activities in an atmosphere of justice and equity.

Possibly the major challenge, and consequently the task which all the groups involved in transplants will have in the coming years, corresponds to granting the necessary continuation of the laudable measures suggested in this Document, in a desire to optimize – under the most strict ethical principles – the results in the matter of donation and transplants that can be obtained from the joint effort of the countries of the region.

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