The Indian Journal for Research in Law and Management

Open Access Law Journal – Copyright © 2026

Editor-in-Chief – Dr. Muktai Deb Chavan; Publisher – Alden Vas; ISSN: 2583-9896

FROM PROHIBITION TO PROTECTION: NOTA, INDIA'S ORGAN TRAFFICKING CRISIS, AND THE IMPERATIVE FOR A HARMONIZED INTERNATIONAL LEGAL FRAMEWORK

~ Amme Akash

Abstract

The global shortage of transplantable organs has produced a shadow economy in which the bodies of the poor are converted into spare parts for the affluent. This paper examines that economy through India, a country whose transplantation law was, from its inception, modelled on the prohibitory logic of earlier statutes such as the United States' National Organ Transplant Act 1984 (NOTA)[1], yet which has never escaped the trafficking networks that prohibition was meant to eliminate. Tracing the Transplantation of Human Organs Act 1994 through its 2011 amendment and 2014 Rules, the paper argues that India's domestic regime, though doctrinally sound, has been undermined by fragmented state-wise implementation, weak Authorisation Committee enforcement, and the absence of any binding link to the international anti-trafficking architecture developing alongside it. Drawing on documented rackets such as the Gurgaon "kidney king" scandal and the Amritsar transplant network, alongside the Supreme Court's recent intervention in *Indian Society of Organ Transplantation v Union of India* (2025), the paper shows that domestic prohibition alone cannot address a crime that is transnational by design. It surveys the instruments relevant to organ trafficking — the Palermo Protocol, the WHO Guiding Principles, the Declaration of Istanbul, and the Santiago de Compostela Convention — to show that these remain disconnected, unevenly ratified, and largely unenforceable against India's transplant-tourism corridors. The paper concludes that the movement its title describes, from prohibition to protection,

[1]WHO, Guiding Principles on Human Cell, Tissue and Organ Transplantation, WHA Res 63.22 (21 May 2010); Council of Europe, 'Santiago de Compostela Convention – Countering the Trafficking in Human Organs' (coe.int) <https://www.coe.int/en/web/trafficking-human-organs/the-convention> accessed 6 July 2026.

requires India to ratify the Santiago de Compostela Convention, harmonise its penal provisions with Palermo-style trafficking definitions, and champion a binding global instrument treating organ sellers as victims rather than criminals.

Keywords: *organ trafficking; Transplantation of Human Organs Act; National Organ Transplant Act; Declaration of Istanbul; Palermo Protocol; Santiago de Compostela Convention; transplant tourism; comparative health law; harmonization; human trafficking*

I. INTRODUCTION

Organ transplantation is one of the genuine triumphs of twentieth-century medicine, converting what was once an inevitable death sentence for end-stage kidney, liver, heart, and lung disease into a treatable condition. That triumph rests on a resource that cannot be manufactured, only given: the human organ. The gap between what medicine can now do and what donors are willing, or able, to supply has widened steadily since the 1980s, and into that gap has stepped a global trade that treats the bodies of the poor as an inventory to be drawn upon by the affluent.[2] India has long occupied an uncomfortable position within this trade, alternately celebrated as a hub of accessible, technically excellent transplant surgery and condemned as a marketplace in which impoverished labourers sell kidneys to intermediaries who profit many times over.[3] The country's principal legislative response, the Transplantation of Human Organs Act 1994 (THOA), renamed in practice the Transplantation of Human Organs and Tissues Act (THOTA) after its 2011 amendment, was self-consciously prohibitory: it banned commercial dealing in organs outright, much as the United States' National Organ Transplant Act 1984 (NOTA) had done a decade earlier.[4] Yet more than three decades after THOA came into force, organ trafficking rackets continue to surface in Indian cities with disturbing regularity, and the Supreme Court, as recently

[3]Adv Tapan Choudhury, 'Supreme Court Calls for Uniform Organ Transplantation Policy in India to Ensure Fair Access & Donor Protection' (Legal Service India, 20 November 2025) <https://www.legalserviceindia.com/Legal-Articles/uniform-organ-transplantation-policy-india/> accessed 6 July 2026.

[4]Transplantation of Human Organs Act 1994 (India), Act No 42 of 1994; National Organ Transplant Act 1984 (US), Pub L No 98-507, 98 Stat 2339, codified at 42 USC § 274e.

as November 2025, found it necessary to direct the Union Government to construct a coherent national policy because state-level implementation of the Act remains so fragmented.[5]

This paper argues that the persistence of India's organ trafficking crisis cannot be explained solely by domestic enforcement failure, though such failure is real and well documented. It is, more fundamentally, a symptom of a deeper structural mismatch: organ trafficking is an inherently transnational crime, involving donors recruited in one jurisdiction, brokers operating across borders, and recipients who travel specifically to evade the protective laws of their own countries, yet the legal response to it remains stubbornly national and prohibitory in character.[6] Domestic statutes such as THOA and NOTA were drafted to prevent a domestic market from forming; they were not designed, and have proved ill-suited, to intercept an international supply chain. The international community has, in fits and starts, attempted to build a complementary architecture — the Palermo Protocol's definition of trafficking for organ removal, the World Health Organization's Guiding Principles, the medically-authored Declaration of Istanbul, and the Council of Europe's Santiago de Compostela Convention — but these instruments remain fragmented, unevenly ratified, and largely disconnected from India's domestic enforcement machinery.[7]

The paper proceeds in eight further parts, moving from NOTA's comparative pedigree (Part II), through THOA's statutory evolution (Part III), the anatomy of India's trafficking crisis (Part IV), judicial engagement culminating in the Supreme Court's 2025 intervention (Part V), the international legal architecture (Part VI), comparative lessons from Iran and Pakistan (Part VII), a diagnosis of the resulting gaps (Part VIII), and concrete recommendations before concluding (Part IX).

II. TWO PROHIBITORY MODELS: NOTA AND THE GENESIS OF THOA

[5]Indian Society of Organ Transplantation v Union of India, Writ Petition (Civil) No 39 of 2025 (Supreme Court of India, 19 November 2025) <https://indiankanoon.org/doc/38973404/> accessed 6 July 2026.

[6]Interpol, Trafficking in Human Beings for the Purpose of Organ Removal (Interpol 2021) 12–14 <https://www.interpol.int/content/download/16690/file/2021%2009%2027%20THBOR%20ENGLISH%20Public%20Version%20FINAL.pdf> accessed 6 July 2026.

[7]Inter-Agency Coordination Group against Trafficking in Persons (ICAT), Issue Brief 11: Trafficking in Persons for the Purpose of Organ Removal (ICAT 2021) <https://icat.un.org/sites/g/files/tmzbdl461/files/publications/icat_brief_tip_for_or_final.pdf> accessed 6 July 2026.

The choice facing any legislature confronted with organ scarcity is stark: either tolerate, and attempt to regulate, a market in which organs change hands for money, or prohibit such exchanges outright and rely on altruistic donation supplemented by state-coordinated allocation. The United States chose the latter path in 1984. Enacted against the backdrop of dramatically improving transplant survival rates following the introduction of cyclosporine, NOTA created the Organ Procurement and Transplantation Network to coordinate a national, non-commercial system of organ allocation, and, in its Title III, made it "unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce," with violations punishable by a fine of up to $50,000, imprisonment of up to five years, or both.[8] The statute's drafters were explicit about their reasoning: the Senate committee that reported the bill concluded simply that "individuals or organizations should not profit by the sale of human organs for transplantation."[9] NOTA has since been amended to exempt legitimate reimbursement of a donor's travel, housing, and lost wages, and, following the Charlie W. Norwood Living Organ Donation Act of 2007, to clarify that paired-exchange donation does not constitute prohibited "valuable consideration."[10] What NOTA has never done, however, is address organ commerce beyond United States borders; it is, definitionally, a statute confined to transfers affecting interstate commerce, and it says nothing about American citizens who travel abroad to purchase an organ from a vendor in Manila, Lahore, or Chennai.

India's Transplantation of Human Organs Act followed a similar prohibitory logic roughly a decade later, though its legislative genesis was considerably more protracted. The statute originated in the recommendations of the L.M. Singhvi Committee, whose report was accepted by the Union Cabinet in October 1991 after examining the United Kingdom's Human Organ

[8]National Organ Transplant Act 1984 (US), Pub L No 98-507, § 301, 98 Stat 2346, codified at 42 USC § 274e(a); Congress.gov, 'S.2048 — National Organ Transplant Act' (98th Congress, 1983–1984) <https://www.congress.gov/bill/98th-congress/senate-bill/2048> accessed 6 July 2026.

[9]American Bar Association, 'Legal Issues in Payment of Living Donors for Solid Organs' (americanbar.org) <https://www.americanbar.org/groups/crsj/resources/human-rights/archive/legal-issues-payment-living-donors-solid-organs/> accessed 6 July 2026.

[10]Charlie W Norwood Living Organ Donation Act 2007 (US), Pub L No 110-144, 121 Stat 1813, amending 42 USC § 274e; Organdonor.gov, 'Organ Donation and Transplantation Legislation History' (US Department of Health and Human Services) <https://www.organdonor.gov/about-us/legislation-policy/history> accessed 6 July 2026.

Transplants Act 1989 as a comparative model.[11] The resulting Bill was passed by the Rajya Sabha on 5 May 1993, referred to a Select Committee that proposed, among other things, compensation for living donors — a recommendation the Union Cabinet rejected — and was finally passed by the Lok Sabha on 15 June 1994, receiving presidential assent on 8 July of that year.[12] Because health is a state subject under India's constitutional scheme, THOA could not simply apply nationwide; it was adopted, in the first instance, by Maharashtra, Himachal Pradesh, and Goa under Article 252(1) of the Constitution, with other states subsequently opting in by resolution, a mechanism that would later prove to be one of the Act's most persistent structural weaknesses.[13] Substantively, THOA criminalised the removal of organs without authority and the making or receiving of payment for organs, while simultaneously legitimising, for the first time in Indian law, the concept of brain-stem death, thereby opening the door to cadaveric donation of vital organs such as the liver and heart.[14]

The parallel between NOTA and THOA is instructive because it reveals a shared blind spot. Both statutes were built to close a domestic market, and both largely succeeded in driving commercial dealing underground rather than eliminating it. In the United States, continuing proposals to permit compensated donation, and ongoing litigation over the boundaries of "valuable consideration," attest to unresolved pressure on the prohibitory model.[15] In India, the underground market did not merely persist; it became transnational, drawing in foreign patients seeking to circumvent a prohibition their own countries, in many cases, also maintained. Neither statute, drafted before transplant tourism was a recognised phenomenon, contained any mechanism for extraterritorial cooperation, extradition, or mutual legal assistance specific to organ crimes — a gap that is the starting point for the argument developed below.

[11]The Amikus Qriae, 'Organ Trafficking in India: A Legal and Ethical Analysis' (2025) <https://theamikusqriae.com/organ-trafficking-in-india-a-legal-and-ethical-analysis/> accessed 6 July 2026.

[12]Lex Scripta Magazine, 'Organ Trafficking in India: A Critical Analysis of Judicial Responses and Enforcement Gaps' (Integrity Education India, 2026) <https://lexscriptamagazine.com/organ-trafficking-in-india-a-critical-analysis-of-judicial-responses-and-enforcement-gaps/> accessed 6 July 2026.

[13]Transplantation of Human Organs Act 1994 (India), s 1(2)–(3); ROTTO Guwahati, 'THOA Acts' (rottoguwahati.org) <https://rottoguwahati.org/thoa-acts/> accessed 6 July 2026.

[14]Transplantation of Human Organs Act 1994 (India), ss 2(d), 3, 18–19; LiveLaw, 'From Brain Death to Bureaucratic Delay: A Critical Appraisal of India's Organ Transplant Regime' (LiveLaw Law School Column, 2026) <https://www.livelaw.in/lawschoolcolumn/organ-transplantation-bureaucratic-delay-520698> accessed 6 July 2026.

[15]American Bar Association (n 8).

III. FROM THOA TO THOTA: THE EVOLUTION OF INDIA'S TRANSPLANTATION LAW

Despite THOA's ambition to eliminate commercial dealing, media investigations throughout the 1990s and 2000s repeatedly exposed rackets operating with apparent impunity, prompting Goa, Himachal Pradesh, and West Bengal to move a resolution in 2009 seeking parliamentary amendment.[16] The Transplantation of Human Organs (Amendment) Act 2011 was the result. It broadened the definition of "near relative" to include grandparents and grandchildren, easing rigidities that had pushed genuine family donors into the "unrelated donor" category subject to Committee scrutiny; extended coverage from organs alone to organs and tissues; required prior Authorisation Committee approval wherever the donor or recipient in a near-relative transplant is a foreign national, directly addressing transplant-tourism concerns; and created the National Human Organs and Tissues Removal and Storage Network together with a National Registry for Transplants.[17] The 2014 Rules operationalised these changes and gave birth to NOTTO, the apex body now responsible for promoting deceased-donor transplantation, maintaining the national registry, and coordinating Regional and State Organ and Tissue Transplant Organisations (ROTTOs and SOTTOs).[18]

On paper, the amended Act is a reasonably sophisticated instrument. Authorisation Committees at the state and hospital level are required to interview donor and recipient together, video-record the proceedings, satisfy themselves that no commercial transaction underlies the donation, and communicate their decision within twenty-four hours; the Committees additionally possess the investigative powers of a civil court, including the power to summon witnesses and documents.[19] Section 20 of the Act, as amended, punishes any contravention not separately provided for with imprisonment extending to five years and a fine extending to twenty lakh rupees,

[16]ROTTO Guwahati (n 12); PRS Legislative Research, 'The Transplantation of Human Organs (Amendment) Bill, 2011' (prsindia.org, 2011) <https://prsindia.org/files/bills_acts/acts_parliament/2011/Transplantation_of_Human_organs_Act,1994.pdf> accessed 6 July 2026.

[17]Transplantation of Human Organs (Amendment) Act 2011 (India), Act No 16 of 2011, ss 2(i), 8, 17; Organ India, 'Organ Transplant Laws Made Easy' (organindia.org) <https://www.organindia.org/organ-transplant-laws-made-easy/> accessed 6 July 2026.

[18]Transplantation of Human Organs and Tissues Rules 2014 (India); C Kute and others, 'Deceased-Donor Organ Transplantation in India: Current Status' (2020) 18(1) Experimental and Clinical Transplantation Supplement <https://www.ectrx.org/detail/supplement/2020/18/1/2/31/0> accessed 6 July 2026.

[19]Organ India (n 16).

reflecting Parliament's evident intention that the 2011 amendment should carry real deterrent weight.[20] And yet the gap between statutory design and practical outcome remains stark. India's national deceased-organ donation rate has been estimated at somewhere between 0.65 and 0.86 donors per million population, a figure dwarfed by rates in countries with comparable transplant infrastructure, and against roughly 180 million people living with end-stage kidney disease each year, only some 12,000 to 13,000 kidney transplants and, for liver disease, perhaps 1,500 transplants are actually performed.[21] That yawning demand-supply gap is precisely the pressure that sustains an illicit market: wherever legitimate supply cannot approach demand, and wherever payment remains the fastest route to a transplant, brokers will emerge to fill the space law has left vacant.

The most telling illustration of the amended Act's continuing fragility came in November 2025, when the Supreme Court, hearing a writ petition filed by the Indian Society of Organ Transplantation, found that a full fourteen years after the 2011 amendment, the State of Andhra Pradesh had still not adopted it, and that Karnataka, Telangana, and Manipur had yet to adopt the 2014 Rules at all.[22] Chief Justice B.R. Gavai, delivering directions on behalf of the Bench, observed that such non-adoption "severely impedes the possibility of adoption of a uniform national policy and national grid," and directed the Union Government, acting through NOTTO, to evolve model allocation criteria addressing gender, class, and regional discrimination, to constitute SOTTOs in Meghalaya and Nagaland, and to ensure that hospitals comply with the mandatory reporting obligations imposed by section 13D of the Act.[23] The judgment is significant not because it discloses any novel legal principle, but because it confirms, three decades into the statute's life, that India still lacks the uniform, functioning regulatory backbone that THOA's architecture presupposes — a backbone without which Authorisation Committees cannot reliably

[20]Transplantation of Human Organs Act 1994 (India), s 20, as inserted by Act 16 of 2011, s 17 (in force 10 January 2014) <https://www.indiacode.nic.in/bitstream/123456789/15433/1/transplantation_of_human_organs_and_tissues_act,_1994.pdf> accessed 6 July 2026.

[21]LiveLaw (n 13); Kute and others (n 17).

[22]Indian Society of Organ Transplantation (n 4) [4]; The Tribune, 'SC Asks Centre to Frame National Policy, Uniform Rules on Organ Transplantation' (Chandigarh, 19 November 2025) <https://www.tribuneindia.com/news/cadaverdonation/sc-asks-centre-to-frame-national-policy-uniform-rules-on-organ-transplantation> accessed 6 July 2026.

[23]Indian Society of Organ Transplantation (n 4) [4], [v].

perform the gatekeeping function on which the entire prohibition against commercial dealing depends.

IV. ANATOMY OF A CRISIS: NETWORKS, CASES, AND STRUCTURAL DRIVERS

The clearest demonstration of what happens when that gatekeeping function fails is the Gurgaon kidney racket exposed in January 2008. Operating out of a residential compound in Gurgaon for what investigators believed was six to seven years, Amit Kumar and his associates lured impoverished labourers from western Uttar Pradesh with promises of employment, then coerced or deceived them into "donating" a kidney for as little as thirty thousand rupees, before transplanting the organs into paying patients flown in from the United States, United Kingdom, Canada, Saudi Arabia, and Greece.[24] The racket was, on the evidence later assembled by the Central Bureau of Investigation, of industrial scale: Kumar was found to have performed several hundred transplants over roughly a decade, employing a network of touts across several states, and to have evaded serious consequence on at least three prior occasions when arrested on similar charges in Delhi, Andhra Pradesh, and Maharashtra, each time securing bail and resuming operations.[25] After his eventual arrest in Nepal in February 2008, a CBI special court did not deliver a final verdict until March 2013, convicting five accused, including Kumar himself, who received seven years' rigorous imprisonment along with a substantial fine, while five co-accused were acquitted.[26] The five-year gap between arrest and conviction, and the fact that Kumar continued extracting kidneys through an agent even while released on bail, together illustrate a recurring pattern in Indian organ-trafficking prosecutions: procedural delay and porous enforcement that allow networks to reconstitute themselves faster than the legal system can dismantle them.

A comparable pattern emerges from the Amritsar racket uncovered by Punjab police, in which a private surgeon, working with a network of brokers and at least one complicit hospital

[24]'Gurgaon Kidney Scandal' (Wikipedia) <https://en.wikipedia.org/wiki/Gurgaon_kidney_scandal> accessed 6 July 2026; Deepu Sebastian Edmond, 'India's Most Notorious Kidney-Transplant Racketeer' The Caravan (1 February 2019) <https://caravanmagazine.in/reportage/man-centre-Indias-most-notorious-kidney-transplant-racket> accessed 6 July 2026.

[25]Edmond (n 23); Defence Research and Studies, 'Organ Trafficking: Exploring Medico-Legal and Moral Dimension' (dras.in, 2025) <https://dras.in/organ-trafficking-exploring-medico-legal-and-moral-dimension/> accessed 6 July 2026.

[26]'Gurgaon Kidney Scandal' (n 23); Defence Research and Studies (n 24).

administrator who doubled as chairman of the local Authorisation Committee, coerced or deceived economically disadvantaged donors into selling kidneys that were then supplied to wealthier domestic and international recipients.[27] That a sitting Authorisation Committee chairman could simultaneously certify the absence of commercial transaction and participate in the very racket the Committee exists to prevent captures, in a single fact, the central institutional vulnerability of India's regulatory model: it relies on local committees, often staffed by the same medical establishment that stands to benefit from a completed transplant, to police transactions that are, by design, structured to appear altruistic on paper.[28] Commentators examining THOA's living-unrelated-donor provisions have observed that section 9(3)'s exception for donors motivated by "affection or attachment" toward the recipient has itself become a loophole, since a sufficiently well-compensated stranger can be coached to profess spontaneous affection convincingly enough to satisfy a Committee predisposed to approve the transplant.[29]

Beneath these scandals lie structural drivers that prosecution alone cannot address. Poverty remains the primary recruiting mechanism: daily-wage labourers, debt-trapped families, and residents of economically depressed districts reappear across nearly every documented racket, because economic desperation makes the offer of quick cash for an organ psychologically, if not legally, difficult to refuse.[30] India's continuing status as a preferred destination for medical tourism compounds the problem, converting its comparative advantage in surgical skill and cost into a comparative disadvantage in donor protection.[31] Chronic under-resourcing of the deceased-donor pathway — reflected in low brain-stem-death declaration rates and limited public awareness — perpetuates dependence on living donors precisely in the population segment most vulnerable to exploitation.[32] Together, these drivers suggest that organ trafficking in India is not an aberration from an otherwise well-functioning system, but a predictable consequence of a persistent gap between what the law promises and what the health system can deliver.

[27]Defence Research and Studies (n 24).
[28]ibid.
[29]ibid; Transplantation of Human Organs Act 1994 (India), s 9(3).
[30]Edmond (n 23); Defence Research and Studies (n 24).
[31]Lex Scripta Magazine (n 11); LiveLaw (n 13).
[32]Kute and others (n 17).

V. JUDICIAL RESPONSES AND THE LIMITS OF ENFORCEMENT

Indian courts have, over three decades, developed a cautious jurisprudence around THOA that reflects both genuine concern for donor protection and an evident reluctance to disturb the delicate balance the statute strikes between facilitating life-saving transplantation and preventing commercialisation. Early litigation, including a writ petition against the functioning of Authorisation Committees that led the Delhi High Court to direct the constitution of a review committee to examine the Act's operation, produced several of the recommendations that eventually fed into the 2011 amendment, illustrating that judicial intervention has historically served a corrective, gap-filling function where legislative reform has lagged behind demonstrated abuse.[33] More recently, when a public interest litigant sought to persuade the Bombay High Court to relax restrictions on swap transplants, a Division Bench declined to disturb the statutory scheme, emphasising instead the importance of Authorisation Committees in preserving the balance between expanding legitimate donation options and guarding against commercialisation — a decision that typifies the judiciary's general posture of deference to the existing regulatory architecture rather than wholesale re-engineering of it.[34]

That posture shifted, at least rhetorically, with the Supreme Court's November 2025 judgment in *Indian Society of Organ Transplantation v Union of India*, discussed in Part III above. Beyond its specific directions on state adoption of the 2011 amendment and 2014 Rules, the Court addressed a concern voiced repeatedly by transplant physicians and donor-advocacy groups alike: that living donors are frequently "left in the lurch" once the transplant is complete, with inadequate follow-up care and no institutional mechanism to monitor their long-term welfare.[35] Counsel for the petitioner invoked the WHO's Guiding Principles directly, in particular Guiding Principle 3, to argue that live donation is ethically acceptable only where professional care of donors is ensured and structured follow-up is guaranteed — an argument the Court appears to have accepted in directing NOTTO to evolve donor-welfare guidelines addressing informed and voluntary consent,

[33]Referred to in Ajit Kumar Sinha and others, 'Analysis of Transplantation of Human Organs Act and Its Amendments' (2019) 6 International Journal of Research and Analytical Reviews, discussing Balbir Singh v The Authorisation Committee (Delhi High Court) <https://www.ijrar.org/papers/IJRAR19J1027.pdf> accessed 6 July 2026.

[34]Lex Scripta Magazine (n 11), discussing the Bombay High Court's disposal of a public interest litigation on swap transplants before a bench of Chellur CJ and Sonak J.

[35]Indian Society of Organ Transplantation (n 4) [13].

mandatory medical follow-up, and the prevention of commercialisation and exploitation.[36] That the Supreme Court found it necessary to import an international soft-law instrument into its reasoning is itself telling: it suggests an implicit judicial recognition that India's domestic statute, however frequently amended, does not on its own supply an adequate normative vocabulary for donor protection, and that courts must look outward to fill the resulting gap.

Even so, the limits of judicial intervention are apparent. Courts can direct the Union Government to frame policy and criticise non-compliant states, but they cannot themselves prosecute traffickers, compel effective investigation by resource-constrained police forces, or retrospectively cure the five-year delay that characterised the Gurgaon prosecution. Nor can domestic courts reach beyond India's borders to apprehend the foreign recipients and intermediaries who sustain transnational networks. Enforcement gaps identified by scholars examining the judicial record — weak monitoring, procedural delay, poor coordination among the Appropriate Authority, Authorisation Committees, and police, and outright corruption within enforcement agencies — are gaps that only a strengthened administrative and international cooperative framework, rather than further judicial pronouncement, can close.[37]

VI. THE INTERNATIONAL LEGAL ARCHITECTURE: PROMISE AND FRAGMENTATION

A. The Palermo Protocol

The first serious attempt to address organ removal within the broader framework of international criminal law came with the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime, adopted by General Assembly Resolution 55/25 in November 2000 and commonly known as the Palermo Protocol.[38] Article 3(a) defines trafficking in persons as the recruitment, transportation, transfer, harbouring, or receipt of persons by improper means — force, coercion, abduction, fraud, deception, abuse of power, or the exploitation of a position

[36]ibid [13], [x]; WHO, Guiding Principles on Human Cell, Tissue and Organ Transplantation (n 1), Guiding Principle 3.
[37]Lex Scripta Magazine (n 11).
[38]UNGA, Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the United Nations Convention against Transnational Organized Crime, GA Res 55/25 (15 November 2000) annex II.

of vulnerability — for the purpose of exploitation, which is defined to include, at a minimum, "the removal of organs."[39] Crucially, Article 3(b) provides that the consent of a trafficking victim is irrelevant where any of these improper means has been used, a provision that directly addresses the recurring defence, seen in cases like the Amritsar racket, that a donor "voluntarily" agreed to sell an organ.[40] India ratified the underlying Convention and all three of its supplementary protocols in May 2011, becoming, at the time, only the fourth South Asian state to do so, with the Central Bureau of Investigation designated as the nodal agency for related international cooperation.[41]

The Protocol's utility, however, is limited by design. Its focus, as commentators note, is trafficking in persons for the purpose of organ removal, not organ trafficking as such; a transaction in which a donor "voluntarily" sells a kidney without deception or coercion, however exploitative the underlying economic circumstances, may fall outside its scope altogether — a distinction the United States' own Trafficking in Persons Office has expressly acknowledged in describing the narrower American interpretation of the provision.[42] The Protocol also sits within a crime-control treaty whose primary obligations concern prosecution and border security rather than victim protection; its provisions on victim assistance are phrased permissively, "shall consider" rather than "shall provide," leaving states considerable latitude to under-invest in rehabilitation and compensation for survivors.[43] For India, ratification in 2011 has not been matched by domestic legislation squarely criminalising trafficking in persons for organ removal as a discrete offence; THOA's offences remain framed around commercial dealing rather than around the trafficking of

[39]ibid art 3(a); OHCHR, 'Protocol to Prevent, Suppress and Punish Trafficking in Persons' <https://www.ohchr.org/en/instruments-mechanisms/instruments/protocol-prevent-suppress-and-punish-trafficking-persons> accessed 6 July 2026.

[40]Palermo Protocol (n 37) art 3(b).

[41]UNODC, 'India: Significance of the United Nations Convention against Transnational Organized Crime (UNTOC) to Address Human Trafficking' (unodc.org, 2011) <https://www.unodc.org/unodc/en/human-trafficking/2011/india-significance-of-the-united-nations-convention-against-transnational-organized-crime-untoc-to-address-human-trafficking.html> accessed 6 July 2026.

[42]US Department of State, Trafficking in Persons for the Purpose of Organ Removal (Information Memorandum, 2024) 2 <https://acf.gov/system/files?file=documents/otip/IM-Organ-Removal.pdf> accessed 6 July 2026; EveryCRSReport, International Organ Trafficking: In Brief (22 December 2021) <https://www.everycrsreport.com/reports/R46996.html> accessed 6 July 2026.

[43]Socio.Health, 'The Palermo Protocol: Fighting Human Trafficking on a Global Scale' (socio.health, 2026) <https://socio.health/women-in-economy/palermo-protocol-global-human-trafficking/> accessed 6 July 2026.

the donor as a person, leaving an uncomfortable gap between international commitment and domestic implementation.

B. The WHO Guiding Principles

The World Health Organization has addressed organ transplantation through its Guiding Principles on Human Cell, Tissue and Organ Transplantation, first endorsed by the World Health Assembly in 1991 and substantially updated and re-endorsed by Resolution WHA63.22 in May 2010.[44] The Guiding Principles take an unambiguous position against commercialisation: payment for organs, and the offering of organs in exchange for payment, should be prohibited, on the basis that such payment is inconsistent with the most basic values underlying the Universal Declaration of Human Rights and violates the principles embodied in the WHO's own Constitution.[45] Guiding Principle 3 addresses live donation specifically, providing that such donation is acceptable only where the donor's consent is informed and voluntary, where professional care of the donor is assured before, during, and after the procedure, and where follow-up is well organised — the very principle India's Supreme Court invoked in its 2025 judgment.[46] The Principles further instruct physicians who have reason to believe an organ being offered for transplant was the product of a commercial transaction to decline to perform the procedure, thereby extending the prohibition's reach to the medical profession's own ethical obligations.[47]

As soft law, however, the Guiding Principles bind no state directly; they operate through moral suasion, professional self-regulation, and incorporation into domestic policy at each state's discretion. Their influence on India has been real, but indirect — visible in Authorisation Committee procedure and in judicial reasoning, as in the 2025 judgment, rather than in any binding treaty obligation that could be invoked against a trafficker or a complicit hospital.

C. THE DECLARATION OF ISTANBUL

[44]WHO, Guiding Principles on Human Cell, Tissue and Organ Transplantation (n 1); Sixty-Third World Health Assembly, Resolution WHA63.22 (21 May 2010).
[45]LiveLaw (n 13).
[46]WHO, Guiding Principles on Human Cell, Tissue and Organ Transplantation (n 1), Guiding Principle 3; Indian Society of Organ Transplantation (n 4) [13].
[47]LiveLaw (n 13).

Distinct from both the Palermo Protocol and the WHO Principles, the Declaration of Istanbul on Organ Trafficking and Transplant Tourism emerged not from an intergovernmental process but from the medical profession itself. Convened by The Transplantation Society and the International Society of Nephrology in response to the World Health Assembly's 2004 call, in Resolution WHA57.18, for states "to take measures to protect the poorest and vulnerable groups from transplant tourism and the sale of tissues and organs," more than 150 representatives of scientific bodies, government officials, and ethicists met in Istanbul between 30 April and 2 May 2008 to produce a consensus document.[48] The Declaration supplied, for the first time, precise working definitions of organ trafficking, transplant commercialism, and travel for transplantation, and distinguished the latter — the ordinary, legitimate movement of patients or organs across borders — from transplant tourism, which becomes unethical specifically where it involves trafficking, commercialism, or the diversion of a host country's transplant resources away from its own population.[49] In 2010, the Declaration of Istanbul Custodian Group (DICG) was formed to monitor implementation, and in 2018 the document was substantially revised, consolidating its original six principles and eleven proposals into eleven concise principles and introducing new defined terms including "trafficking in persons for the purpose of organ removal," "financial neutrality," and "self-sufficiency in organ donation and transplantation."[50] More than one hundred countries and numerous professional bodies have since endorsed the Declaration's principles, and several — including China, Israel, the Philippines, and Pakistan — have strengthened their domestic laws against commercial organ trade in its wake.[51]

The Declaration's strength is its granularity and acceptance within the transplant medicine community, giving it practical purchase in professional practice even where domestic law is permissive. Its weakness is that it is not law: it binds no state, creates no offence, and provides no mechanism for prosecution or extradition. India has not been a prominent participant in its

[48]Steering Committee of the Istanbul Summit, 'Organ Trafficking and Transplant Tourism and Commercialism: The Declaration of Istanbul' (2008) 372 The Lancet 5; The Declaration of Istanbul Custodian Group, 'The Declaration' (declarationofistanbul.org) <https://www.declarationofistanbul.org/the-declaration> accessed 6 July 2026.

[49]"The Declaration of Istanbul on Organ Trafficking and Transplant Tourism' (2008) 18(3) Indian Journal of Nephrology 135 <https://pmc.ncbi.nlm.nih.gov/articles/PMC2813140/> accessed 6 July 2026.

[50]F L Delmonico and others, 'A New Edition of the Declaration of Istanbul: Updated Guidance to Combat Organ Trafficking and Transplant Tourism Worldwide' Kidney International (online, 2019) <https://www.kidney-international.org/article/S0085-2538(19)30033-X/fulltext> accessed 6 July 2026.

[51]'Declaration of Istanbul' (Wikipedia) <https://en.wikipedia.org/wiki/Declaration_of_Istanbul> accessed 6 July 2026.

institutional structures, and while its influence is visible in the ethical language surrounding Authorisation Committee practice, it supplies no enforceable remedy for a trafficked donor in Amritsar or Gurgaon.

D. The Santiago de Compostela Convention

The most consequential recent development in this field is the Council of Europe Convention against Trafficking in Human Organs, opened for signature in Santiago de Compostela on 25 March 2015 and entering into force on 3 March 2018 following its fifth ratification.[52] It is, as the Council of Europe itself emphasises, the first and to date only binding international criminal-law instrument dedicated specifically to organ trafficking, as distinct from human trafficking generally.[53] The Convention criminalises the removal of organs without free, informed, and specific consent, the removal of organs in exchange for financial gain to the donor or a third party, the illicit solicitation and recruitment of donors and recipients for financial advantage, the corruption of healthcare professionals and officials involved in illicit removal or implantation, and the subsequent preparation, storage, transportation, and importation or exportation of illicitly removed organs, while explicitly excluding legitimate trade in medicinal products manufactured from organ tissue.[54] It extends liability to legal persons as well as natural persons, mandates victim assistance measures directed at physical, psychological, and social recovery, permits authorities to prosecute offences ex officio, and — critically for a genuinely global response — is open for accession not only to Council of Europe member states but to any state in the world prepared to work with the Council of Europe toward its objectives.[55]

That final feature makes the Santiago de Compostela Convention the single most promising vehicle currently available for the harmonization this paper argues India urgently needs. Unlike the Palermo Protocol, which addresses organ removal only incidentally within a broader trafficking framework, the Convention speaks directly to the conduct at issue in the Gurgaon and

[52]Council of Europe Convention against Trafficking in Human Organs (adopted 25 March 2015, entered into force 3 March 2018) CETS No 216.

[53]Council of Europe (n 1).

[54]Council of Europe Convention against Trafficking in Human Organs (n 51) arts 4–5, 7–9; eucrim, 'Council of Europe Convention Against Trafficking of Human Organs' (eucrim.eu, 2015) <https://eucrim.eu/articles/council-europe-convention-against-trafficking-human-organs/> accessed 6 July 2026.

[55]eucrim (n 53); Council of Europe Convention against Trafficking in Human Organs (n 51) arts 9–10, 15, 17, 22.

Amritsar rackets — illicit solicitation by brokers, corrupt certification by complicit officials, and cross-border transportation of both donors and organs — and does so through binding criminal-law obligations rather than soft-law aspiration. As of the most recent Council of Europe reporting, ratification remains concentrated among European states, with several further signatories yet to ratify; India, despite the Convention's openness to non-member accession and despite its own well-documented trafficking problem, has neither signed nor acceded to it.[56] This is, this paper contends, the single most consequential gap in India's engagement with the international legal architecture surrounding organ trafficking.

VII. COMPARATIVE PERSPECTIVES: THE REGULATED MARKETS OF IRAN AND PAKISTAN

No discussion of organ trafficking law would be complete without confronting the principal alternative to prohibition: regulated compensation. Iran adopted a government-regulated, compensated living-unrelated donor programme in 1988, in which the state pays donors a fixed stipend and provides a year of subsidised medical insurance, while recipients separately negotiate additional compensation directly with the donor under state oversight, with an advocacy body representing dialysis patients supervising the process to limit broker involvement.[57] The programme is credited with having eliminated Iran's kidney transplant waiting list within roughly a decade of adoption, and by 2021 the proportion of transplants sourced from deceased donors had risen to 72 per cent, suggesting that regulated compensation may, over time, coexist with and even support the development of a cadaveric donation system rather than permanently entrenching dependence on living vendors.[58]

[56]Council of Europe, 'Home – Countering the Trafficking in Human Organs' (coe.int) <https://www.coe.int/en/web/trafficking-human-organs> accessed 6 July 2026; Council of Europe, 'Spain Ratified the Council of Europe Convention against Trafficking in Human Organs' (coe.int, 2021) <https://www.coe.int/en/web/cdpc/activities/trafficking-human-organs-tissues-cells/-/asset_publisher/Ts2Kv0OJ6Xvl/content/spain-ratified-the-council-of-europe-convention-against-trafficking-in-human-organs> accessed 6 July 2026.

[57]A J Ghods and S Savaj, 'Iranian Model of Paid and Regulated Living-Unrelated Kidney Donation' (2006) 1 Clinical Journal of the American Society of Nephrology 1136.

[58]'20 Years Iranian Experience of Organ Donation: Shifting from Compensated Living Unrelated Kidney Transplantation' (2025) Kidney International Reports <https://www.kireports.org/article/S2468-0249(25)00057-9/fulltext> accessed 6 July 2026.

Pakistan's experience with a less tightly regulated market tells a considerably less flattering story. Comparative analysis of the two countries found that in 2007 alone, more than 2,500 renal transplants were performed in Pakistan, over seventy per cent involving donors from severely disadvantaged socio-economic backgrounds, with more than half of recipients being foreign nationals who paid between US$20,000 and US$30,000 for the procedure while donors received only a small fraction of that sum; recipients of vendor kidneys, moreover, experienced markedly poorer clinical outcomes and higher rates of infectious complication than recipients of related-donor organs.[59] The comparative literature's conclusion is unambiguous: "paid donation, regulated or commercial, leads to coercion and exploitation of the poor and benefits the rich" wherever the underlying economic inequality between donor and recipient populations is left unaddressed.[60] Iran's relative success appears to depend less on the fact of compensation per se than on features India's own system conspicuously lacks — a closed national market limited to citizen donors and citizen recipients, direct government administration rather than private brokerage, and an advocacy body positioned specifically to police the transaction from the donor's side rather than the hospital's.

The comparative lesson for India is not that it should abandon prohibition for compensation; the ethical and practical objections to organ markets retain considerable force, and Pakistan's experience shows how easily a compensated system can replicate exploitation under a veneer of legality. The lesson is rather that a prohibitory statute alone, whether India's THOA or America's NOTA, does not guarantee donor protection; what appears to matter, across both models, is the strength and independence of the institution policing the transaction — precisely the institutional strength that the Gurgaon and Amritsar cases show to be chronically deficient in India's Authorisation Committees.

VIII. THE IMPERATIVE FOR A HARMONIZED FRAMEWORK

Drawing the preceding analysis together, three distinct but reinforcing gaps emerge. The first is a definitional gap: India's domestic offences under THOA are built around the concept of

[59]S A H Rizvi and others, 'Regulated Compensated Donation in Pakistan and Iran' (2009) 14(2) Current Opinion in Organ Transplantation 124.
[60]ibid.

commercial dealing in organs, whereas the international instruments most capable of addressing transnational trafficking — the Palermo Protocol and the Santiago de Compostela Convention — are built around the concept of trafficking in persons, encompassing coercion, deception, and abuse of vulnerability regardless of whether a completed commercial transaction can be proven. A prosecution under THOA's section 19 requires evidence of payment; a prosecution under Convention-style provisions could proceed on evidence of coercive recruitment alone, a considerably lower evidentiary bar that would have been directly relevant to establishing liability against the touts who lured Gurgaon's donors under false pretences of employment.[61]

The second is a jurisdictional gap. Organ trafficking, as Gurgaon illustrates, routinely involves recipients who travel from the United States, United Kingdom, Canada, Saudi Arabia, and Greece specifically to obtain organs unavailable to them, at that price and speed, at home.[62] THOA possesses no extraterritorial reach whatsoever; it cannot touch the foreign recipient once returned home, nor compel foreign authorities to investigate intermediaries operating on their soil. The Santiago de Compostela Convention, by contrast, was designed to function as a basis for judicial cooperation and extradition between states lacking a bilateral treaty — precisely the scenario that arises whenever a racket's foreign clientele must be pursued abroad.[63] Without India's accession, that cooperative machinery does not operate in the cases where India's own trafficking problem is most acute.

The third is an institutional gap between soft-law aspiration and binding obligation. The WHO Guiding Principles and the Declaration of Istanbul have shaped the ethical vocabulary in which Indian courts and Authorisation Committees now discuss donor protection — the Supreme Court's invocation of Guiding Principle 3 in 2025 is proof of that influence — but neither instrument creates an offence, a sanction, or a mechanism of international accountability that could be deployed against a complicit Authorisation Committee chairman of the kind implicated in the Amritsar racket.[64] Only a binding instrument, domestically implemented, can convert ethical consensus into prosecutorial reality.

---

[61]Transplantation of Human Organs Act 1994 (India), s 19; Palermo Protocol (n 37) art 3(a)–(b).

[62]'Gurgaon Kidney Scandal' (n 23).

[63]Council of Europe Convention against Trafficking in Human Organs (n 51) art 17; eucrim (n 53).

[64]Defence Research and Studies (n 24); Indian Society of Organ Transplantation (n 4) [13].

Harmonization, in this sense, does not mean wholesale replacement of India's domestic statute; THOA's core prohibitory architecture, its Authorisation Committee mechanism, and its brain-stem-death provisions remain broadly sound and mirror structures found across comparative transplant law. What harmonization requires is threefold: first, that India accede to the Santiago de Compostela Convention, importing binding cross-border cooperation obligations and a trafficking-based definitional framework that supplements THOA's commercial-dealing offences; second, that Parliament amend THOA to create a discrete offence of trafficking in persons for organ removal, tracking Palermo Protocol Article 3 language and rendering donor "consent" irrelevant wherever coercion, deception, or abuse of vulnerability can be shown, closing the loophole through which section 9(3)'s "affection or attachment" exception has been manipulated; and third, that India's engagement with the Declaration of Istanbul Custodian Group and the WHO be formalised through NOTTO, so that ethical guidance translates into binding regulatory standard rather than persuasive rhetoric invoked only when a case reaches the Supreme Court.[65]

IX. TOWARDS REFORM: RECOMMENDATIONS

Several concrete steps follow from the preceding diagnosis. First, the Union Government should initiate accession to the Santiago de Compostela Convention through the accession mechanism the Convention provides for non-Council of Europe states, using that accession as the occasion for a corresponding THOA amendment introducing an explicit trafficking-in-persons-for-organ-removal offence carrying penalties commensurate with, or exceeding, those currently prescribed under section 20.[66] Second, Authorisation Committees should be restructured to include independent members drawn from outside the certifying hospital's own administrative and medical staff, precisely to prevent the conflict of interest that compromised the Amritsar Committee, with mandatory rotation of members and independent audit of a sample of approved unrelated-donor transplants each year. Third, NOTTO's mandate should be expanded, consistent with the Supreme Court's 2025 directions, to include a dedicated donor-welfare monitoring unit implementing WHO Guiding Principle 3 through mandatory, tracked medical follow-up rather than the current largely discretionary arrangement.[67] Fourth, given that the Supreme Court found Andhra Pradesh,

[65]Transplantation of Human Organs Act 1994 (India), s 9(3); Palermo Protocol (n 37) art 3.
[66]Council of Europe Convention against Trafficking in Human Organs (n 51) art 22.
[67]Indian Society of Organ Transplantation (n 4) [x].

Karnataka, Telangana, and Manipur still non-compliant with the 2011 amendment and 2014 Rules as of 2025, the Union Government should examine whether reliance on Article 252(1) resolutions remains appropriate for a matter requiring uniform national criminal-law treatment.[68] Fifth, India should press, through relevant multilateral forums, for a genuinely universal binding instrument on organ trafficking — potentially an additional protocol to the Palermo Protocol itself, given that instrument's near-universal ratification — combining the Santiago de Compostela Convention's criminal-law precision with the Palermo framework's broader reach.

X. CONCLUSION

The movement this paper's title describes, from prohibition to protection, is not a rejection of THOA's prohibitory foundations, which remain, on balance, ethically and practically preferable to the exploitation Pakistan's experience demonstrates an under-regulated compensated market readily produces. It is, rather, an argument that prohibition alone — whether embodied in America's NOTA or India's THOA — was never designed to reach a crime that crosses borders as readily as the patients and organs it exploits. The Gurgaon and Amritsar rackets, and the Supreme Court's own frustrated observation in 2025 that basic statutory adoption remains incomplete more than a decade after amendment, together demonstrate that domestic law, however frequently revised, cannot by itself close the gap between India's legal aspirations and its lived reality. The international instruments surveyed here — the Palermo Protocol, the WHO Guiding Principles, the Declaration of Istanbul, and above all the Santiago de Compostela Convention — supply, collectively, most of the conceptual and institutional apparatus a genuinely protective regime would require. What is missing is not architecture but commitment: India's accession to the one binding instrument built specifically for this crime, and the domestic amendment that would give that accession practical teeth. Until that commitment is made, the protection promised by India's transplantation law will remain, for the donors of Gurgaon and Amritsar and the villages beyond them, a promise deferred.

[68] Indian Society of Organ Transplantation (n 4) [4]; The Tribune (n 21).