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# The Black Market for Human Organs in India: A Criminological Analysis of Exploitation, Organised Crime, and Regulatory Failure under the Transplantation of Human Organs and Tissues Act, 1994

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GORANTLA UDAI DEEPAK\*  AND HARINATH REDDY G\*\* 

## ABSTRACT

*The illegal trade in human organs in India represents a serious intersection of organised crime, poverty, medical demand, exploitation, and regulatory failure. This paper examines the black market for human organs through a doctrinal, criminological, and interdisciplinary analysis of the Transplantation of Human Organs and Tissues Act, 1994 ("THOTA"), related rules, academic literature, and judicial decisions. It argues that organ trafficking should not be understood merely as an isolated violation of medical regulation. It is a networked form of exploitation involving brokers, vulnerable donors, recipients, medical professionals, hospitals, document facilitators, and administrative authorities. The paper analyses the economic and health consequences experienced by organ sellers, the role of poverty and debt in recruitment, the use of forged relationships and documents, and the involvement of legitimate medical infrastructure in concealing illegal transactions. It further examines six important judicial decisions concerning authorization, altruistic donation, administrative delay, and uniform implementation of transplantation law. The analysis demonstrates that THOTA provides an important statutory foundation but remains weakened by fragmented enforcement, inadequate hospital audits, insufficient victim protection, weak financial investigation, and inconsistent implementation. The paper concludes that effective prevention requires a coordinated framework combining criminal prosecution, medical regulation, financial investigation, donor rehabilitation, public-health reform, and national data-sharing. Protecting genuine altruistic donation must remain a central objective, but formal consent must never be allowed to conceal coercion, deception, or abuse of vulnerability.*

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\* Author is a Final-Year Law Student at Aurora Deemed to be University, Bhongir, Telangana, India. ORCID: <https://orcid.org/0009-0007-2798-4088>

\*\* Author is a Final-Year Law Student at Aurora Deemed to be University, Bhongir, Telangana, India. ORCID: <https://orcid.org/0009-0000-8354-6735>

**Keywords:** *Organ trafficking, THOTA, organised crime, kidney sale, human exploitation, Authorization Committees, transplant tourism, regulatory failure*

## I. INTRODUCTION

Human organ transplantation is one of modern medicine's most significant achievements. It provides life-saving treatment to persons suffering from organ failure and has enabled patients with otherwise fatal conditions to survive. Yet the development of transplantation has also created a hidden and profitable criminal market. Where the lawful supply of organs cannot satisfy demand, intermediaries may exploit vulnerable persons and connect them with recipients willing to pay for immediate treatment.

The black market for organs is fundamentally different from an ordinary commercial transaction. An organ is not a replaceable commodity. Its removal may have permanent physical, psychological, and economic consequences. A person who sells a kidney may experience a reduced capacity to perform manual labour, medical complications, social stigma, and continuing poverty. The recipient may obtain a life-saving medical benefit, whereas the donor may receive only a temporary payment that is often lower than promised.<sup>1</sup>

India is an important jurisdiction for studying this problem because it combines a large population requiring transplantation, unequal access to advanced healthcare, dependence upon living donors, and considerable socio-economic inequality. These conditions create an environment in which criminal intermediaries can recruit persons who are poor, indebted, unemployed, migrant, or socially marginalised. The donor may be persuaded that organ removal is a quick method of overcoming debt, paying education expenses, arranging medical treatment, or improving family conditions.

The principal statutory response is the Transplantation of Human Organs and Tissues Act, 1994 ("THOTA"). The long title of THOTA states that it provides for the regulation of the removal, storage, and transplantation of human organs and tissues for therapeutic purposes and for the prevention of commercial dealings in human organs and tissues.<sup>2</sup> The legislation therefore attempts to reconcile two competing objectives. It must permit legitimate and life-saving transplantation while preventing the human body from becoming an object of commercial exploitation.

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<sup>1</sup> Madhav Goyal, Ravindra L. Mehta, Lawrence J. Schneiderman & Ashwini R. Sehgal, *Economic and Health Consequences of Selling a Kidney in India*, 288 JAMA 1589, 1591–93 (2002), <https://doi.org/10.1001/jama.288.13.1589>.

<sup>2</sup> Transplantation of Human Organs and Tissues Act, No. 42 of 1994, long title, INDIA CODE (1994).

The original Act, then titled the Transplantation of Human Organs Act, 1994, was strengthened by the Transplantation of Human Organs (Amendment) Act, 2011, which also renamed it, and by the Transplantation of Human Organs and Tissues Rules, 2014. The amended framework expanded the law to tissues, recognised swap transplantation, broadened the category of near relatives, and created a more extensive institutional structure involving the National Organ and Tissue Transplant Organisation (“NOTTO”), State Organ and Tissue Transplant Organisations (“SOTTOs”), hospitals, and Authorization Committees.

Despite the statutory framework, reports of illegal kidney sales, forged relationships between donors and recipients, broker-controlled transplantation, and professional complicity continue to emerge. The persistence of these activities demonstrates that criminalisation alone cannot eliminate the market. A law may prohibit the sale of organs, but its effectiveness depends on the probability of detection, the quality of hospital monitoring, the independence of Authorization Committees, the protection of victims, and the prosecution of the entire network.

The central argument of this paper is that organ trafficking in India should be understood as organised exploitation rather than merely as an isolated violation of medical regulation. The market is sustained by four interconnected conditions: the scarcity of legally available organs, the economic vulnerability of donors, access to legitimate medical infrastructure, and fragmented regulation. THOTA is an essential legal instrument, but it must operate alongside anti-trafficking law, financial investigation, hospital accountability, and social-welfare measures.

The problem also has a constitutional dimension. The State must protect the dignity and bodily integrity of potential donors while ensuring that patients are not denied timely access to life-saving treatment. This creates a difficult regulatory balance. A system that treats every unrelated donor as suspicious may discourage legitimate altruistic donation, whereas a system that accepts documents without investigating the circumstances of consent may legitimise commercial exploitation. The proper approach must therefore combine protection of autonomy with protection against the abuse of vulnerability.

The paper further argues that the black market should be examined as a chain of connected decisions rather than as a single criminal act. Recruitment, persuasion, documentation, medical testing, authorization, surgery, payment, and concealment may be performed by different persons. Each stage creates evidence, and each stage also creates a possible point of intervention. A successful legal response must identify the complete chain and not limit prosecution to the broker or the person who physically removes the organ.

## II. RESEARCH METHODOLOGY

This paper adopts a doctrinal, criminological, and interdisciplinary methodology. The doctrinal analysis examines THOTA, the 2011 Amendment, the 2014 Rules, relevant constitutional principles, and judicial decisions concerning organ transplantation and Authorization Committees. The criminological analysis applies the concepts of organised crime, criminal opportunity, exploitation, networked offending, and regulatory failure. The interdisciplinary analysis draws on medical, ethical, public-health, and socio-economic research.

The study is based on academic articles, empirical research, international instruments, statutory provisions, and reported judicial decisions. It does not attempt to calculate the exact size of India's illegal organ market, because organ trafficking is concealed, underreported, and frequently disguised as lawful donation. Instead, it investigates the factors that permit the market to develop and the weaknesses that allow criminal actors to circumvent the legal framework.

The paper follows a qualitative approach. The literature is used to identify recurring patterns of vulnerability, while the statutory and judicial materials are used to assess whether the existing legal framework responds adequately to those patterns. The case-law analysis is not limited to criminal convictions. Decisions concerning authorization, delay, donor autonomy, and institutional uniformity are equally relevant because they determine how the legal transplantation system operates in practice. The paper therefore treats judicial review as an important source for understanding the strengths and limitations of the regulatory structure.

## III. REVIEW OF LITERATURE

### A. Medical, legal, and ethical perspectives

S. Shroff's analysis of organ donation and transplantation explains the legal and ethical foundation of India's transplantation regime. The study identifies THOTA as an attempt to regulate transplantation, recognise brain-stem death, encourage legitimate donation, and prevent commercial dealings.<sup>3</sup> Shroff's work is important because it shows that the legal regulation of transplantation cannot be assessed only by examining criminal penalties. It must also consider informed consent, donor safety, medical ethics, and public trust.

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<sup>3</sup> Sunil Shroff, *Legal and Ethical Aspects of Organ Donation and Transplantation*, 25 INDIAN J. UROLOGY 348, 348–55 (2009), <https://doi.org/10.4103/0970-1591.56203>.

K. Mathiharan's discussion of organ transplantation in India similarly emphasises the tension between medical necessity and the prohibition of commercialisation.<sup>4</sup> A restrictive legal system may prevent genuine donations, but an insufficiently regulated system may expose poor persons to exploitation. The challenge is therefore to protect altruistic donation while ensuring that apparent consent is not manufactured by money, deception, or coercion.

The ethical literature also demonstrates that a donor's signature cannot be treated as conclusive proof of genuine consent. Consent must be informed, voluntary, and independent. If a donor is pressured by debt, hunger, threats, or a lack of alternatives, formal consent may conceal substantive exploitation.

### **B. Economic consequences of kidney sales**

The empirical study by Goyal, Mehta, Schneiderman, and Sehgal is central to the Indian literature. It examined the economic and health consequences of kidney sales and found that many donors continued to experience poverty and debt after the procedure.<sup>5</sup> The study challenges the assumption that organ sale provides a durable economic benefit. In many cases, the money received was quickly consumed, while the donor's health and ability to work deteriorated.

This research is significant criminologically because it demonstrates that the organ market does not solve poverty. It commercialises poverty. The donor's economic desperation becomes the mechanism through which recruitment is achieved. The payment appears to be voluntary, but the surrounding circumstances may deprive the individual of meaningful choice.

The consequences of kidney sales also reveal an inequality between donor and recipient. The recipient obtains a continuing medical benefit, while the donor may receive an inadequate and temporary payment. The donor may also lack access to long-term follow-up care because the transaction was illegal.

### **C. Regulatory failure in Tamil Nadu**

Muraleedharan, Jan, and Ram Prasad's study of the trade in human organs in Tamil Nadu describes organ trafficking as a problem of regulatory failure.<sup>6</sup> Their analysis demonstrates that the existence of a statutory framework does not guarantee effective enforcement. Hospitals,

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<sup>4</sup> Karunakaran Mathiharan, *Ethical and Legal Issues in Organ Transplantation: Indian Scenario*, 51 MED. SCI. & L. 134, 134–40 (2011), <https://doi.org/10.1258/msl.2011.010134>.

<sup>5</sup> Goyal et al., *supra* note 1, at 1591–93.

<sup>6</sup> V.R. Muraleedharan, Stephen Jan & S. Ram Prasad, *The Trade in Human Organs in Tamil Nadu: The Anatomy of Regulatory Failure*, 1 HEALTH ECON. POL'Y & L. 41, 41–57 (2006), <https://doi.org/10.1017/S1744133105001052>.

authorization authorities, and medical professionals may fail to identify commercial arrangements concealed through false relationships and apparently valid documents.

The concept of regulatory failure is particularly useful in the Indian context. Criminal networks do not necessarily defeat the law through open defiance. They may use the law's own procedures as instruments of concealment. A fabricated marriage certificate, false affidavit, or manufactured declaration can create the appearance of legal compliance. The result is a gap between formal legality and substantive legality.

#### **D. Global organ trafficking and transplant tourism**

Jafar's study links organ trafficking to the global shortage of kidneys and the growth of transplant tourism.<sup>7</sup> The study argues that international efforts to prevent organ trafficking must be supported by effective implementation, professional accountability, and transparent transplantation systems.

Ambagtsheer, Zaitch, and Weimar caution against treating organ trafficking as a single, uniform form of crime controlled by stereotypical mafias.<sup>8</sup> Their research demonstrates that the trade may involve brokers, physicians, hospitals, laboratories, document facilitators, recipients, and cross-border agents. Some networks are hierarchical, while others are flexible and loosely connected.

This insight is relevant to India because organ-trafficking networks may operate through professional respectability rather than visible violence. A doctor, hospital administrator, broker, and document agent may perform different functions without belonging to a traditional criminal gang. The absence of physical violence does not make the crime unorganised. Deception, economic pressure, abuse of vulnerability, and medical authority may perform the same controlling function.

#### **E. Organised crime and professional silence**

Research using crime-script analysis shows that illegal kidney transplantation requires preparation, recruitment, medical testing, documentation, transportation, surgery, payment, and concealment.<sup>9</sup> The process creates multiple points at which authorities may intervene.

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<sup>7</sup> Tazeen H. Jafar, *Organ Trafficking: Global Solutions for a Global Problem*, 54 AM. J. KIDNEY DISEASES 1145, 1145–57 (2009), <https://doi.org/10.1053/j.ajkd.2009.08.014>.

<sup>8</sup> Frederike Ambagtsheer, Damián Zaitch & Willem Weimar, *The Battle for Human Organs: Organ Trafficking and Transplant Tourism in a Global Context*, 14 GLOBAL CRIME 1, 1–26 (2013), <https://doi.org/10.1080/17440572.2012.753323>.

<sup>9</sup> Frederike Ambagtsheer & Roos Bugter, *The Organization of the Human Organ Trade: A Comparative Crime Script Analysis*, 80 CRIME L. & SOC. CHANGE 1, 1–32 (2023), <https://doi.org/10.1007/s10611-022-10068-5>.

Other research concerning transplant professionals indicates that organ trafficking is difficult to detect because healthcare workers may be uncertain about their reporting duties or may remain silent about suspicious cases.<sup>10</sup> This silence may arise from institutional loyalty, fear of reputational damage, financial interests, or uncertainty about whether the donor's consent is genuine.

The literature therefore establishes three central propositions. First, poverty and debt create vulnerability to organ exploitation. Second, organ trafficking is a networked activity requiring professional and institutional access. Third, regulatory weakness allows illegal transactions to be presented as lawful donations.

The literature also reveals a gap. Medical and ethical studies frequently focus on donor welfare and informed consent, while legal scholarship often concentrates on statutory interpretation and authorization procedures. Criminological studies, in contrast, explain the role of networks, brokers, and institutional concealment. A complete analysis must combine these approaches. Organ trafficking is simultaneously a health issue, a human-rights issue, a criminal-law issue, and a problem of institutional governance. This paper attempts to bridge that gap by examining how the social causes of exploitation interact with the legal design and implementation of THOTA.

#### **IV. CRIMINOLOGICAL DRIVERS OF ORGAN TRAFFICKING**

##### **A. Scarcity and medical demand**

The first driver of the black market is the gap between lawful demand and supply. Patients with end-stage organ failure may face long waiting periods and uncertain access to deceased-donor organs. Medical urgency can place considerable pressure upon patients and their families.

Scarcity alone does not cause crime. It becomes criminogenic when combined with unequal access to healthcare and weak regulation. A financially powerful recipient may be able to travel, contact intermediaries, and pay for an illegal transplant. A poor donor may be recruited because the donor lacks lawful credit, stable employment, or social protection.

The market therefore reflects a structural inequality. The recipient's financial capacity is matched against the donor's economic vulnerability. The broker profits by bringing these unequal parties together.

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<sup>10</sup> Frederike Ambagtsheer & Linde Van Balen, "I'm Not Sherlock Holmes": *Suspensions, Secrecy and Silence of Transplant Professionals in the Human Organ Trade*, 17 EUR. J. CRIMINOLOGY 764, 764–83 (2020), <https://doi.org/10.1177/1477370818825331>.

The scarcity problem is also connected with public confidence. Families may hesitate to consent to deceased donation because of religious, cultural, or informational concerns. Inadequate awareness about brain-stem death and uncertainty regarding allocation procedures can reduce the lawful supply of organs. When patients believe that the lawful system is inaccessible or opaque, private intermediaries acquire greater influence. Strengthening the legitimate system is therefore not merely a welfare measure; it is also a crime-prevention strategy.

### **B. Poverty, debt, and coercive circumstances**

Poverty is not merely a background condition; it is frequently the means of recruitment. Brokers may approach persons who are indebted, unemployed, responsible for family expenses, or dependent on informal moneylenders. The promise of a large payment may appear attractive when the donor is facing eviction, hunger, medical expenses, or educational costs.

A donor may technically agree to the transaction, but the agreement must be analysed in its social context. Economic pressure does not always constitute legal coercion in the narrow sense, yet it may destroy meaningful choice. A person who agrees to surrender a kidney because no lawful alternative exists cannot be treated in the same manner as a broker who creates and profits from the transaction.

Empirical research shows that kidney sellers may remain in debt even after receiving payment.<sup>11</sup> The sale therefore fails to achieve its stated objective and may intensify vulnerability. The donor may lose both health and earning capacity.

### **C. Brokers and intermediaries**

Brokers are the principal organisers of the illegal market. They identify potential donors, locate recipients, negotiate prices, arrange documentation, coordinate medical examinations, and manage payments. They may operate through village contacts, labour networks, informal lenders, social media, or hospital connections.

The broker also controls information. The donor may not know the identity of the recipient, the actual value of the organ, the medical risk, or the legal consequences. The recipient may not know that the donor was deceived or coerced. This information imbalance makes the broker indispensable.

Section 19 of THOTA is important because it reaches beyond the person who makes or receives payment for an organ to persons who seek a person willing to supply an organ for payment, offer an organ for payment, initiate or negotiate a paid arrangement, take part in the management

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<sup>11</sup> Goyal et al., *supra* note 1, at 1591–93.

or control of a body of persons engaged in such arrangements, advertise, or abet the preparation or submission of false documents.<sup>12</sup> The provision reflects the organised nature of the crime.

#### **D. Medical professionals and hospitals**

Illegal transplantation generally requires access to medical facilities, diagnostic testing, surgical expertise, and post-operative care. Medical professionals may participate actively by falsifying records, ignoring suspicious circumstances, or performing procedures with knowledge of payment. Hospitals may also be negligent by failing to verify documents or investigate inconsistencies.

A hospital's legitimacy can provide criminal actors with a protective appearance. Once an unlawful transaction enters a registered facility, the broker may be able to present it as a lawful transplant. The hospital may therefore become part of the concealment structure.

Institutional responsibility must consequently be examined. Investigations should consider the roles of surgeons, anaesthetists, hospital coordinators, administrators, laboratories, and financial departments. A network cannot be dismantled if only the local broker is prosecuted.

#### **E. Forged relationships and documents**

THOTA distinguishes between near-relative donation and unrelated donation. An unrelated donor may donate only with the prior approval of the Authorization Committee, which must be satisfied that the donation is made by reason of affection or attachment towards the recipient, or for another special reason, and is not commercial.

This safeguard creates an opportunity for document fraud. Criminal networks may fabricate marriage certificates, photographs, identity records, affidavits, address proofs, and declarations. A paid donor may be presented as a spouse, relative, or close family friend.

A documentary approach is therefore insufficient. The Committee must conduct substantive verification by interviewing the donor and recipient separately, examining their history, assessing the donor's socio-economic circumstances, and identifying evidence of payment or brokerage.

Verification must also be sensitive to language, literacy, gender, and social hierarchy. A donor may agree with a broker or recipient during a joint interview because of fear or dependence. A person who cannot read the forms may not understand the medical consequences of the procedure. Independent counselling and private interviews are consequently essential. The Committee should record whether the donor understands the risks, whether the donor knows

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<sup>12</sup> Transplantation of Human Organs and Tissues Act, No. 42 of 1994, § 19, INDIA CODE (1994).

the recipient independently of the proposed transplant, and whether any person has promised money, employment, debt relief, or other benefits.

## **V. LEGAL FRAMEWORK UNDER THOTA**

### **A. Legislative purpose**

THOTA's long title establishes two connected objectives: therapeutic regulation and the prevention of commercial dealings.<sup>13</sup> The Act does not prohibit transplantation. It creates a controlled system within which lawful transplantation may occur.

This balance is necessary. A total ban on living donation would harm patients and prevent genuine altruism. An unregulated system, however, would permit the sale of organs and the exploitation of poor persons.

### **B. Authorization Committees**

Section 9 imposes restrictions on the removal and transplantation of organs from living donors. Where the donor is not a near relative, the prior approval of the Authorization Committee is required, and the Committee must determine whether the proposed donation is genuine and free from commercial consideration.<sup>14</sup>

The Committee's role is not merely documentary. It must examine whether the donor understands the procedure, whether consent is voluntary, whether a relationship actually exists, whether money has been promised, and whether the donor has been influenced by debt or coercion.

The Committee must also avoid arbitrary suspicion. Economic disparity or the absence of a blood relationship may justify inquiry but cannot automatically prove illegality. Both under-enforcement and over-enforcement are harmful. The former permits trafficking; the latter discourages legitimate donation.

### **C. Registration and institutional regulation**

THOTA requires hospitals and institutions involved in transplantation to comply with statutory conditions. Registration is intended to ensure that transplantation occurs only in facilities with appropriate infrastructure and qualified personnel.

However, registration cannot substitute for monitoring. Hospitals must be audited regularly. Authorities should examine repeated unrelated donors, donors from distant States, multiple cases involving the same broker, inconsistent documentation, and unusually rapid approval.

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<sup>13</sup> *Id.* long title.

<sup>14</sup> *Id.* § 9(3).

Hospitals should also maintain records of independent donor counselling, separate interviews, risk disclosure, medical follow-up, and financial declarations. These records are essential for both patient protection and criminal investigation.

#### **D. Commercial dealings under Section 19**

Section 19 criminalises commercial dealings in human organs. It covers making or receiving payment for the supply of an organ, seeking a person willing to supply an organ for payment, offering to supply an organ for payment, initiating or negotiating a paid arrangement, taking part in the management or control of a body of persons engaged in such arrangements, publishing advertisements, and abetting the preparation or submission of false documents, including false affidavits, to establish that a donor is a near relative or is donating out of affection or attachment.<sup>15</sup> The provision is broad enough to reach brokers, medical facilitators, and other intermediaries.

The challenge is proof. Illegal transactions may be conducted in cash or through intermediaries. False documents may conceal the parties' actual relationship. Investigators must therefore trace bank accounts, phone communications, medical records, travel documents, and witness testimony.

#### **E. Unauthorised removal under Section 18**

Section 18 punishes any person who renders services to or at a hospital and who, for purposes of transplantation, conducts, associates with, or helps in the removal of a human organ without authority.<sup>16</sup> It is particularly relevant where the donor did not provide genuine consent, where consent was obtained through deception, or where the procedure was conducted outside the statutory framework.

The provision must be interpreted alongside trafficking principles. A person who appears to consent on paper may still be a victim if the consent was obtained through fraud, coercion, or abuse of vulnerability.

Section 18 is particularly important in cases involving deception. A donor may sign a form but may have been told that the operation is a minor procedure or that the organ will be restored. In such circumstances, formal documentation cannot be treated as conclusive evidence of informed consent. Investigators should examine the explanation given to the donor, the

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<sup>15</sup> *Id.* § 19 (prescribing imprisonment of not less than five years, which may extend to ten years, and a fine of not less than twenty lakh rupees, which may extend to one crore rupees).

<sup>16</sup> *Id.* § 18(1) (prescribing imprisonment which may extend to ten years and a fine which may extend to twenty lakh rupees).

language of the consent process, the role of intermediaries, and the medical information actually communicated.

#### **F. The 2011 Amendment and 2014 Rules**

The 2011 Amendment expanded THOTA to tissues and introduced further institutional mechanisms. The 2014 Rules provide detailed procedures concerning Authorization Committees, donor-recipient interviews, documentation, and hospital compliance.

The amended law also recognised swap transplantation. Swap arrangements may increase lawful access, but they require transparent national coordination and safeguards against commercial influence.

In *Indian Society of Organ Transplantation v. Union of India*, the Supreme Court recorded that certain States had not adopted the 2011 Amendment or the 2014 Rules and requested the Union Government to persuade them to do so, in the interest of uniform implementation.<sup>17</sup> This demonstrates that regulatory fragmentation is itself a vulnerability.

### **VI. JUDICIAL ANALYSIS**

#### **A. *Kuldeep Singh v. State of Tamil Nadu***

In *Kuldeep Singh v. State of Tamil Nadu*, the Supreme Court examined the object of transplantation legislation and emphasised the need to prevent commercial dealings while permitting lawful transplantation.<sup>18</sup> Holding that the Authorization Committee must satisfy itself as to the real purpose of the donor in authorising removal, the Court also decided that, where the proposed transplant was to take place in another State, the Authorization Committee of the State to which the donor and recipient belonged was the appropriate body to examine the application. The decision is important because it confirms that THOTA must be interpreted purposively.

The Authorization Committee cannot be treated as a ceremonial body. It must verify the genuineness of the proposed donation. At the same time, the law does not permit the Committee to reject every unrelated donation merely because the parties are not biologically connected.

The case establishes a balance between autonomy and protection. Genuine altruism must be respected, but apparent altruism must be examined where circumstances suggest payment, brokerage, or deception.

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<sup>17</sup> *Indian Soc’y of Organ Transplantation v. Union of India*, 2025 INSC 1361 (India) (recording that Andhra Pradesh had not adopted the 2011 amendment and that Karnataka, Telangana, Andhra Pradesh and Manipur had not adopted the 2014 Rules, and requesting the Union of India to persuade those States to do so).

<sup>18</sup> *Kuldeep Singh v. State of Tamil Nadu*, (2005) 11 SCC 122 (India).

**B. Balbir Singh v. Authorisation Committee**

In *Balbir Singh v. Authorisation Committee*, the Delhi High Court considered the refusal of approval for a liver donation by the petitioner's brother, which had been withheld because HLA tissue typing did not confirm the claimed relationship.<sup>19</sup> The Court held that the near-relative relationship could be established by other acceptable evidence, observed that tissue matching was not even essential for a liver transplant, and directed the constitution of a committee to review the Act and the Rules.

The decision rejects a mechanical insistence on a single form of proof. An inconclusive test result may raise questions, but it is not conclusive proof that a claimed relationship is false where other reliable evidence establishes it.

At the same time, the judgment does not weaken THOTA's anti-commercial purpose. The Committee remains required to investigate possible payment, coercion, or brokerage. The appropriate approach is a reasoned evaluation of evidence rather than blind acceptance or mechanical suspicion.

**C. S. Samson v. Authorisation Committee**

In *S. Samson v. Authorisation Committee for Implementation of Human Organ Transplantation*, the Madras High Court emphasised that the Authorization Committee must provide cogent and convincing reasons for its decision.<sup>20</sup> A vague refusal prevents meaningful review and may unjustifiably obstruct a genuine transplant.

Reasoned decision-making also assists anti-trafficking enforcement. A proper order should record whether the Committee examined financial circumstances, donor understanding, relationship evidence, and possible intermediary involvement.

The decision demonstrates that Authorization Committees require trained personnel capable of identifying coercion, forged documents, and trafficking indicators. A legal duty to provide reasons is meaningful only if the Committee conducts a serious inquiry.

**D. Sudha Mathesan v. Authorisation Committee**

In *Sudha Mathesan v. Authorisation Committee*, the Madras High Court held that genuine altruistic donation by non-relatives should not be rejected without credible material indicating

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<sup>19</sup> *Balbir Singh v. Authorisation Committee*, AIR 2004 Del 413 (India).

<sup>20</sup> *S. Samson v. Authorisation Committee for Implementation of Human Organ Transplantation*, 2008 SCC OnLine Mad 317 (India).

commercial dealing.<sup>21</sup> The Court recognised that affection and attachment may exist even where there is no blood relationship.

The decision protects autonomy and prevents arbitrary administration. However, it must be applied with caution. The absence of direct evidence of payment does not automatically establish that no payment exists. Commercial transactions are often concealed.

The Committee must therefore examine indirect evidence, including financial circumstances, the duration of the relationship, communication history, travel arrangements, inconsistent statements, and the presence of brokers. The correct approach is evidence-based scrutiny.

#### ***E. Amar Singh Bhatia v. Sir Ganga Ram Hospital***

In *Amar Singh Bhatia v. Sir Ganga Ram Hospital*, the Delhi High Court addressed delay in the transplantation process.<sup>22</sup> The case involved a patient suffering from serious kidney disease who challenged administrative delay in processing the transplant application, and the Court went on to prescribe timelines for the stages of the approval process.

The Court stressed that regulation must facilitate safe and lawful transplantation rather than create avoidable delay. A patient may deteriorate while waiting for approval. Excessive delay may also encourage recipients to approach illegal intermediaries who promise faster results.

The judgment has criminological importance because an inefficient legal process creates demand for brokers. A time-bound system can reduce the incentive to use illegal channels. Nevertheless, efficiency must not replace substantive verification.

#### ***F. Indian Society of Organ Transplantation v. Union of India***

In *Indian Society of Organ Transplantation v. Union of India*, the Supreme Court addressed uniformity, equality, and access in India's transplantation system.<sup>23</sup> The Court noted that certain States had not adopted the 2011 Amendment or the 2014 Rules and called upon the Union Government to work towards national uniformity.

The decision is important because it treats institutional inconsistency as a national problem. Criminal networks can exploit differences between States, weak data-sharing, and inconsistent procedures. A national framework is therefore necessary for both lawful transplantation and crime prevention.

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<sup>21</sup> *Sudha Mathesan v. Authorisation Committee (Transplantation)*, 2024 SCC OnLine Mad 1633 (India).

<sup>22</sup> *Amar Singh Bhatia v. Sir Ganga Ram Hosp.*, 2024 SCC OnLine Del 30 (India).

<sup>23</sup> *Indian Soc'y of Organ Transplantation*, *supra* note 17.

The judgment also demonstrates that federal coordination is essential to the administration of a subject involving public health, hospitals, criminal investigation, and interstate movement. Uniformity does not mean that every State must adopt identical administrative practices in every minor matter. It does mean that the core safeguards, definitions, databases, authorization standards, and reporting duties must be consistent. Without such consistency, a donor or recipient may be moved to a jurisdiction perceived to have weaker scrutiny.

The Court also addressed the importance of NOTTO, SOTTOs, swap transplantation, and coordination. The judgment demonstrates that the response to organ trafficking cannot be limited to punishment. It must include national planning, consistent regulation, transparent allocation, and institutional accountability.

## **VII. REGULATORY FAILURE**

### **A. Fragmented institutional responsibility**

Organ transplantation involves the Union Government, State Governments, NOTTO, SOTTOs, Authorization Committees, hospitals, police authorities, and criminal courts. This plurality is necessary but may also create uncertainty regarding responsibility.

A hospital may rely on documents prepared by a broker. The Authorization Committee may rely on hospital verification. The police may investigate only forgery or cheating. The health department may take administrative action without tracing the criminal network.

A coordinated protocol is therefore necessary. Suspicious cases should be referred simultaneously to health authorities, the police, financial investigators, and the relevant transplant organisation.

The protocol should specify which authority must preserve medical records, who must interview the donor, when a transplant must be suspended, and how information is shared with other States. It should also draw a clear distinction between an administrative irregularity and evidence of a criminal transaction. Early coordination is important because records may be altered, brokers may disappear, and donors may be pressured to withdraw complaints after the surgery.

### **B. Insufficient hospital audits**

Hospital registration should be followed by continuous supervision. Authorities should examine unusual patterns, including repeated unrelated donors, applications involving distant States, false relationships, repeated use of the same intermediaries, and unexplained financial transactions.

Hospitals should be required to conduct private interviews with donors and recipients. Donors must be informed of medical risks, post-operative consequences, and the illegality of payment. The donor should have access to independent legal or social counselling.

### **C. Lack of victim protection**

A donor who participates in an illegal transaction may be both a statutory offender and a victim of exploitation. Treating every donor as an offender discourages reporting and protects the broker.

The law should distinguish the vulnerable donor from the organiser, the medical facilitator, and the recipient who knowingly participates in commercial dealing. Donors who report the network should receive protection from retaliation and access to medical care, compensation, counselling, and employment assistance.

### **D. Weak financial investigation**

Organ trafficking is profit-driven, but investigation often focuses upon the medical procedure. Authorities should trace payments, bank accounts, cash withdrawals, property, hospital bills, travel expenses, and broker commissions.

Financial investigation can reveal the structure of the network and identify the persons who receive the largest profits. Confiscation of criminal proceeds can also reduce the incentive to recruit donors.

### **E. Insufficient data and reporting**

A national database is necessary to identify repeated donors, recipients, brokers, hospitals, and suspicious patterns. Without data-sharing, a donor involved in multiple States may appear as a first-time donor in each location.

Hospitals and committees should be required to report suspicious cases. Medical professionals should receive protection for good-faith reporting. Failure to report serious irregularities should attract professional and institutional consequences.

## **VIII. RELATIONSHIP WITH HUMAN TRAFFICKING LAW**

Organ trafficking may constitute trafficking in persons where a person is recruited, transported, transferred, harboured, or received through force, fraud, deception, coercion, or abuse of vulnerability for the purpose of organ removal.<sup>24</sup> The United Nations Trafficking Protocol

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<sup>24</sup> Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the United Nations Convention Against Transnational Organized Crime art. 3(a), Nov. 15, 2000, 2237 U.N.T.S. 319.

provides a useful framework for distinguishing genuine consent from consent obtained through exploitation.

THOTA focuses primarily on the organ, the medical procedure, and commercial dealing. A trafficking framework focuses upon the person and the means through which the person was controlled. It therefore captures recruitment, transportation, deception, debt pressure, and threats that may occur before the surgery.

Indian criminal law may also apply where the conduct involves cheating, forgery, criminal conspiracy, intimidation, wrongful confinement, hurt, or trafficking.<sup>25</sup> THOTA should be applied alongside general criminal law rather than in isolation.

However, overlapping offences require specialised investigation. Police officers, prosecutors, and medical authorities must understand the elements of each offence and preserve medical, documentary, financial, and digital evidence.

## **IX. RECOMMENDATIONS**

First, India should establish specialised organ-trafficking units consisting of police officers, medical experts, financial investigators, cyber specialists, and social workers. These units should investigate the entire network instead of arresting only local brokers.

Second, Authorization Committees should adopt a uniform verification protocol. The protocol should require separate interviews, language assistance, independent counselling, socio-economic verification, financial scrutiny, and written reasons.

Third, hospitals should be subject to continuing audits. Institutions that knowingly facilitate illegal transplantation should face criminal prosecution, cancellation of registration, financial penalties, and professional disciplinary proceedings.

Fourth, donors should receive victim-oriented protection. Medical care, psychological counselling, compensation, legal assistance, and livelihood support should be available. Donors should not be treated in the same manner as brokers or medical organisers.

Fifth, India should strengthen deceased donation by improving public awareness, brain-stem-death certification, organ retrieval infrastructure, transparent allocation, and public confidence. Expanding lawful supply may reduce demand for illegal arrangements.

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<sup>25</sup> See Bharatiya Nyaya Sanhita, No. 45 of 2023, §§ 61 (criminal conspiracy), 111 (organised crime, which includes the continuing unlawful activity of trafficking of persons), 115 (voluntarily causing hurt), 127 (wrongful confinement), 143 (trafficking of person, whose Explanation 1 defines exploitation to include the forced removal of organs), 318 (cheating), 336 (forgery), 351 (criminal intimidation), INDIA CODE (2023).

Sixth, the Union and State Governments should ensure uniform adoption of the 2011 Amendment and the 2014 Rules. NOTTO and SOTTOs should be adequately funded and empowered.

Seventh, financial investigation should become compulsory in serious organ-trafficking cases. Authorities should trace proceeds, attach assets, and identify the persons who profit most from the transaction.

Finally, THOTA should be amended to include explicit victim-protection provisions, institutional liability, cross-border cooperation, and recognition of coercive economic circumstances. The statute must preserve genuine altruism while preventing poverty from being transformed into apparent consent.

Reform should also address post-operative responsibility. A person who has donated an organ, lawfully or unlawfully, should not be abandoned after the surgery. Hospitals and public authorities should maintain a system of medical follow-up, particularly for donors who are economically dependent upon physical labour. If the law protects only the moment of authorization and ignores the donor's later health, it fails to address the full harm caused by exploitation. Long-term donor care would also improve detection, because medical professionals may identify cases in which promised payment was withheld or the donor was deceived.

## **X. CONCLUSION**

The black market for human organs in India is a complex form of organised exploitation sustained by medical demand, scarcity, poverty, debt, brokers, professional participation, forged documents, and regulatory weakness. The donor is frequently placed in a position where an irreversible medical decision is made under severe economic pressure. The recipient may obtain a life-saving organ, while the donor remains poor, medically vulnerable, and without adequate aftercare.

THOTA provides an essential foundation. It regulates transplantation, establishes Authorization Committees, governs hospitals, and criminalises unauthorised removal and commercial dealings. Its provisions extend beyond the surgeon and can reach brokers, negotiators, facilitators, and other participants.

However, the continued existence of illegal organ markets demonstrates that statutory prohibition is insufficient. Regulatory failure occurs when documents replace investigation, hospital registration replaces monitoring, committees rely upon suspicion or superficial

verification, and victims are treated as offenders. The academic literature shows that organ sellers may remain in debt and suffer long-term health consequences. The case law demonstrates that authorization must be both strict and fair, reasoned and timely.

The judicial decisions analysed in this paper establish important principles. *Kuldeep Singh* affirmed the anti-commercial purpose of transplantation law. *Balbir Singh* rejected a mechanical insistence on a single form of proof of relationship, while *S. Samson* and *Sudha Mathesan* protected genuine altruistic donation and required reasoned decision-making. *Amar Singh Bhatia* emphasised the need for timely processing. *Indian Society of Organ Transplantation* highlighted the danger of regulatory fragmentation and the need for a uniform national framework.

The response must therefore be multidisciplinary. Criminal law must be combined with financial investigation, hospital regulation, medical ethics, victim rehabilitation, public-health reform, and national data-sharing. The donor must not be treated merely as a criminal participant, and the hospital must not be treated merely as a neutral location.

The objective is not to restrict legitimate transplantation. It is to ensure that transplantation occurs through informed consent, dignity, transparency, equality, and accountability. Unless India addresses both the shortage of lawful organs and the vulnerability of potential donors, the black market will continue to adapt around the law. THOTA must therefore be implemented as part of a comprehensive system capable of dismantling organised exploitation.

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