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A FEMINIST HUMAN RIGHTS CRITIQUE OF THOTA 2010 AND THE GENDERED EXPLOITATION OF DONORS IN PAKISTAN

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ABSTRACT

The article presents a feminist critique of human rights of the illegal organ trade in Pakistan that has been perpetuated against the genders in the Transplantation of Human Organs and Tissues Act (THOTA) 2010. Although THOTA is meant to control the donation it is this study that states that it is not in a good position to handle the structural coercion and commodification of the bodies of the women. Using the framework of the feminist legal theory and the Modern Slavery framework of the Palermo Protocol, the study challenges the legitimacy of consent under patriarchal and economically desperate circumstances. Through qualitative interviews with female donors the article reveals the ways in which pressure in the family and institutional complicity tend to conceal exploitation in the name of altruism. The results indicate that there are major enforcement loopholes and that the vulnerable women are not granted protection after making a donation. The paper ends by proposing gender-specific changes to THOTA that would transform the organization into a human-centric approach to crime, where bodily self-determination and substantive equality prevail in the organ market of Pakistan.

KEYWORDS: Human Organs Trafficking; Feminist Theory; Consent; Voluntary Organ Donation; Gendered Violation; Exploitation.

1. INTRODUCTION

Gender disparity in organ transplantation is a universal challenge impacting all stages of the transplant process including listing, waiting times, and outcomes.[1] The global shortage of transplantable organs has led to a thriving underground market that exploits the bodies of the poor, often under conditions that constitute modern slavery. According to the World Health Organization (WHO), between 5% and 10% of all organ transplants globally involve organs acquired through illegal means. This figure is most probably underestimated due to the secretive nature of the trade.[2] This black market generates annual profits ranging from USD 840 million to USD 1.7 billion.[3] In fact, Kidneys remain the most trafficked organs, followed by liver segments, due to their relative surgical simplicity and high demand.[4]

While the illegality of such practices is widely acknowledged, the human rights dimensions of organ trafficking, particularly when women are involved, are not sufficiently addressed in law or policy. Organ trafficking is commonly defined as a criminal problem, but the experiences of female donors create obvious tendencies of exploitation, pressure, and a lack of control over the body.[5] The percentage of female living, including spousal donors, is more proportionately high across the globe. It has been documented in India, that 75 percent of organ donors in India are women, as compared to 80 percent of the recipients, who are men.[6] The intellectual discussions reveal that women donors are often wives and mothers who are coerced by altruism, which is an outcome of pressure and economic need on the part of families. The results illuminate the compound interplay of the role of genders, economic forces and societal demands.[7] Although altruism is a big motivator to both genders, women might experience a greater social pressure to contribute to donation especially in the family situations.[8] On the other hand, men may be deterred by the feeling that it could be risking their position as the chief income earners or the fact that their current health conditions are not an incentive to donate.[9]

These aspects are in line with the legal provisions of modern slavery as stipulated in the Palermo Protocol (2000). Article 3(a) of the Palermo Protocol states:

"Trafficking in persons shall mean the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability for the purpose of exploitation. Exploitation shall include, at a minimum, the removal of organs."[10]

This article argues that THOTA 2010 fails to acknowledge 'abuse of a position of vulnerability' (as defined in Article 3 of the Protocol) when evaluating the consent of female donors in Pakistan. It is important to distinguish between organ trafficking and trafficking in persons for the purpose of organ removal (TIP-FOR). The latter, as defined under Article 3 of the Palermo Protocol, involves recruitment, transportation, harboring, or receipt of people by coercive means for organ removal.[11] This in most instances involves false assurances, misuse of

[1] Kute VB, Ramesh V, Rela M. On the way to self-sufficiency: improving deceased organ donation in India. Transplantation. 2021; 105:1625–1630.

[2] UNODC, *Global Report on Trafficking in Persons 2024* (United Nations Publication 2024).

[3] Global Financial Integrity, *Transnational Crime and the Developing World* (GFI 2017) 29.

[4] See United Nations Office on Drugs and Crime, *Trafficking in Persons for the Purpose of Organ Removal* (UNODC, 2024) (reporting that in detected cases of trafficking for organ removal the most frequently transplanted organs are kidneys and, to a lesser extent, parts of livers).

[5] Kim Y, Ahmed E, Ascher N, et al. Meeting report: first state of the art meeting on gender disparity in kidney transplantation in the Asia Pacific. Transplantation. 2021; 105:1888–1891.

[6] See eg Sarah L White and others, 'Global Trends in Living Kidney Donation' (2008) 372 *The Lancet* 1723 (noting the global predominance of female living donors); Vivekanand Jha and others, 'chronic kidney disease: Global Dimension and Perspectives' (2013) 382 *The Lancet* 260 (noting pronounced gender disparity in living donation in countries including India, where most donors are women and most recipients are men).

[7] Mishra, N., & Sivakami, M. (2024). "… I Felt Obliged to Him and Donated My Organ": Gendered Experiences of Women Living Organ Donors in India. In *Handbook on Sex, Gender and Health: Perspectives from South Asia* (pp. 1-18). Singapore: Springer Nature Singapore.

[8] Iqbal, Mahrukh, Javeria Saleem, Abida Tehreem, Raja Sajjad Asghar, Muhammad Ishaq, Ruhma Binte Shahzad, Aleena Touqeer, and Gul Mehar Javaid Bukkhari. "Gender disparity in living organ donation: a qualitative analysis of experiences and perceptions of female donors in Pakistan." *BMJ open* 15, no. 2 (2025): e095056.

[9] Iqbal, Mahrukh, Javeria Saleem, Abida Tehreem, Raja Sajjad Asghar, Muhammad Ishaq, Ruhma Binte Shahzad, Aleena Touqeer, and Gul Mehar Javaid Bukkhari. "Gender disparity in living organ donation: a qualitative analysis of experiences and perceptions of female donors in Pakistan." *BMJ open* 15, no. 2 (2025): e095056.

[10] *Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children*, supplementing the *United Nations Convention against Transnational Organized Crime* (adopted 15 November 2000, entered into force 25 December 2003) 2237 UNTS 319 art 3(a).

[11] IBID

authority, or manipulation of an advantage. Although human trafficking is now getting more and more attention on the global level, TIP-FOR is not adequately reported and is still poorly understood.[12] South Asia has been especially at a crisis since nations such as Pakistan, India, and Bangladesh have been unable to control transplantation activities based on corruption, poverty, and poor enforcement.[13] In Pakistan, despite the adoption of the Transplantation of Human Organs and Tissues Act (THOTA) 2010 to criminalize the trade and regulate the practice of donating organs, there has been patchy implementation and the gendered dynamics of exploitation is yet to be captured in laws.

This article states that even with the fact that this business was criminalized by the THOTA, the illegal organ trade in Pakistan still runs in such a way that it is highly disproportionate to the exploitation of poor women. It does it on conditions that can be termed as the modern slavery that is often aided by the medical institutions, brokers, and patriarchal families. Although the legal system considers donation of organs as a consensual act, the feminist theory of law then makes us question whether one can truly give a consent within a context where there is gender inequality, economic desperation and practices of social pressure. This article reflects a broader perspective. It brings together the legal theory, gender studies and human rights to demonstrate how the organ trade is fueled by deeply entrenched inequality. It also provides policy suggestions. They are grounded in the international legal principles such as the Palermo Protocol, the CEDAW, and the UN principles on trafficking and exploitation.

This paper uses a feminist approach to law to reevaluate the historic idea of bodily autonomy and consent applying the intersectionality perspective to delineate how gender and class increase the vulnerability to exploitation. The study, having examined the socio-economic forces behind the global organ trade, such as poverty and demand, narrows down to gendered exploitation as part of the patriarchal systems. It is a critique of the myth of altruism because it shows how pressure on the family usually takes the place of actual choice and results in serious health and economic losses on the part of women after the operation. Through a feminist approach of assessing international policies such as the Palermo Protocol and CEDAW, the article finds out that there are major gaps in the approach to domestic and institutional coercion. Finally, it suggests a radical change to the THOTA legislation in Pakistan, including a human rights-based approach and a vision that places dignity and bodily autonomy at the center of the most vulnerable population.

2. METHODOLOGY

In this study Phenomenological Qualitative approach is used where the focus is on the lived experiences of marginalized women, in order to reveal the power dynamics of the transplant process. The approach that we employ in this research is qualitative, interdisciplinary. We combine the feminist legal theory with the analysis of human rights and real-life evidence on the subject to discuss how women are exploited in organ donation under the Transplantation of Human Organs and Tissues Act (THOTA) 2010 in Pakistan. This research approach will involve desk-based legal and policy research and a primary qualitative investigation to create a gendered approach to understanding the concept of consent, coercion, and bodily autonomy as they are conceptualized within the current structure of regulation.

Ten semi-structured interviews were undertaken in July 2025 with the female organ donors in varied regions in Pakistan both in urban and rural settings. The subjects were all donors who had donated a kidney or part of their liver, and all of the recipients were male family members (husbands, sons, fathers) and all the participants were of low to lower-middle income families. The identification of interviewees was done by use of local health contacts, transplant support networks and snowball sampling. The purposive sampling was done according to three criteria; (i) she had to be a female, (ii) she had donated at least a kidney or part of the liver legally or illegally within the last five years, and (iii) she had to be in the low or lower-middle income bracket. The sample size of ten was determined by thematic saturation, the point at which new interviews ceased to provide novel insights into the core themes of emotional coercion and structural vulnerability. The main concern is that we made sure that the subjects

[12] See UNODC, *Global Report on Trafficking in Persons 2022* (noting barriers to reporting and that trafficking for organ removal remains difficult to detect and underreported).

[13] Idrees, Rao Qasim, Muhammad Imran, and Saba Manzoor. "Human organ trafficking and transplantation: a legal analysis of causes, challenges and implementation of existing laws in Pakistan." *Pakistan Journal of Social Research* 5, no. 02 (2023): 115-122.

Columb, S., & Moniruzzaman, M. (2024). The state of the organ trade: narratives of corruption in Egypt and Bangladesh. *Trends in Organized Crime*, 1-20.

remained confidential by anonymizing their identities and modifying anything that could identify them. We used to question them during interviews about reasons they gave on why they donated, how families influenced them and if they were aware of medical risks as well as how they were treated in the future. Data analysis was done based on the six phases of reflexive thematic analysis outlined by Braun and Clarke (2006).[14] The process was systematic, which included: (1) transcribing and becoming acquainted with the raw data; (2) identifying initial codes; (3) searching to identify themes; (4) reviewing possible themes against the entire data set; (5) defining and naming themes (like in Altruistic Coercion); and (6) choosing sparkling and memorable extract examples to be included in final reporting. This stringent methodology meant that the interpretation was always pegged to the language of the participants, and that their accounts were attached to larger legal criticisms.The quotes that were used in this article emphasize some general experiences and assist in demonstrating social patterns underlying the quotes. We have supplemented these personal accounts of experience with secondary sources such as national and international reports, peer-reviewed research, and news enquiries in Pakistan and India. The combination of this evidence assists in developing a more comprehensive image of the legal systems and the actual, gendered experiences of donors. We also referred to the international legal instruments such as the Palermo Protocol, the UNODC Toolkit on Organ Trafficking and CEDAW. In conjunction with these, we employed feminist critiques of consent to evaluate the degree of protection of vulnerable donors by THOTA 2010. This paper will blend both lived experiences and a legal analysis to capture some of the even less apparent aspects of coercion that persist even in the present day through existing laws. To increase the trustworthiness and confirmability of the findings, we made use of investigator triangulation, where the primary data and the emerging codes were cross-examined in regard to the secondary legal sources as well as the peer-reviewed literature to make sure that the analytical conclusions made were in line with the lived realities or the legal framework in Pakistan.

2.1. Methodological Limitations and Reflexivity

Although this work can be considered an in-depth qualitative analysis of the gendered experience of organ donation, some limitations cannot be ignored. The sample is limited to the women who have donated the organs to their male family members, mostly low-income families. Thus, it fails to reflect on the views of male donors, non-donating women, or those of a more socio-economically diverse or more ethnically diverse group of donors. The results thus shed light on trends of gendered vulnerability instead of providing an account that is statistically representative of the whole donor experience.

This was a deliberate sampling focus. Commonly feminist qualitative approaches pay special attention to the voices of the most structurally marginalized to reveal power relations, which otherwise might go unnoticed.[15] This was not a comparison of generalization but rather an in-depth analysis of the impact of the patriarchal rules in influencing the consent of women in the circumstances of transplantation. However, the lack of male voices and refusal stories might restrict the possibility to compare the effects of masculinity, breadwinner expectations and intra-household bargaining power on the decisions regarding donation.

To gain a more comprehensive socio-legal image of the concept of consent negotiation in the future, it would be beneficial to incorporate male donors, those who have refused to be donors, and people who belong to diverse religious and ethnic groups. The comparative work might shed light on the ways in which gender norms are at work across the class and cultural settings in a different manner. These limitations can be identified to enhance interpretive transparency and put the current findings in a larger, developing research agenda on gender and organ transplantation.[16]

Another weakness is the lack of systematic caste, sect, or ethnic identity data. Although there were rather general similarities in the socio-economic backgrounds of the participants, the dimensions could be studied in future studies to facilitate more comprehensive intersectional analysis of donor vulnerability.

2.2. Key Terminology and Legal Definitions

To be analytically clear, it is necessary to formulate some important terms to be used

[14] Virginia Braun and Victoria Clarke, 'Using Thematic Analysis in Psychology' (2006) 3(2) Qualitative Research in Psychology 77.

[15] Martha Albertson Fineman, *The Autonomy Myth: A Theory of Dependency* (New Press 2004).

[16] Sharlene Nagy Hesse-Biber, *Feminist Research Practice: A Primer* (2nd edn, SAGE 2014).

throughout this research. Organ trafficking is the practice of illegally recruiting, transporting, transferring, harboring, or receiving organs, their removal, and their use (exploited) and the donor does not give fully informed consent or is pressured.[17] Trafficking in persons with the aim of organ removal (TIP-FOR) is a subcategory of human trafficking specifically recognized in the international law, including the acts involving the use of coercion, fraud or other vulnerability to receive organs to transplant them.[18] This differs with organ trade which typically refers to the commercial sale and purchase of organs, regardless of force, and may involve controlled systems like the Iranian state-approved kidney market.[19]

Modern slavery is a term that is occasionally applied to the scholarly and policy literature to underline exploitative situations that resemble forced labor or servitude, such as where individuals are forcibly coerced to donate organs against their will or where they are pressured into doing so by economic forces.[20] Although conceptually similar to human trafficking, modern slavery is larger and includes several types of extreme exploitation beyond organ donation. The adoption of such definitions in the entire course of this work would guarantee the accurate determination of legal offenses and breaches as well as ethical issues and gendered vulnerabilities enabling us to focus on the critique of the Pakistan organ transplantation system and the THOTA 2010 provisions in a more rigorous manner.

3. THEORETICAL FRAMEWORK

3.1. Feminist Legal Theory

The feminist legal theory (FLT) is a potent approach to review the interplay of gender, law, and power particularly in such a field as organ donation where one loses the control of his or her body. In its core, FLT questions the notion of law being neutral or just. It states that in most cases, legal systems are biased in a way that they propagate feminine values. This discrimination can ignore or suppress the actual experience of women, particularly with regard to consent and coercion.[21] FLT comprises a few strands, i.e. liberal, radical and intersectional feminism, which form a powerful analytical framework. Liberal feminism drives to have equal rights and equal treatment before the law. Radical feminism digs deeper and poses the question of how society has taught the use of the body of women to be so normal. Intersectional feminism is an approach coined by Kimberlé Crenshaw (1991) that focuses on the fact that gender, race, class, and other identities are combined to exacerbate inequality.[22] The three strands concur on one fundamental belief which is that each individual has a right to his own body. However, this right is not on equal terms. In the world that is influenced by the traditions of patriarchal societies and poverty, such as in most South Asian countries, women are frequently pressured to compromise their health for the benefit of the men in their families.[23]

These social pressures are provided by family responsibilities, cultural convictions, and even medical counsel. And therefore, even though a woman might appear to make a free decision of giving an organ, her decision might be influenced by the pressure and the emotional responsibility. To a feminist perspective on the legal system, such laws as the THOTA 2010 of Pakistan fail since they do not consider such covert pressures. THOTA presupposes that in case a woman is a relative and signs the paperwork, then her choice is free. Gender roles or family expectations do not pose a challenge to it, though. Neither does it check to ensure consent is informed and real. FLT requires another type of legal method which examines the forms and documents. It challenges us to think more about the daily pressure which influences a woman to make the decision to give, and to change the law which permits structural

[17] UN Office on Drugs and Crime (UNODC), *Trafficking in Persons for the Purpose of Organ Removal* (UNODC, Vienna 2022) https://www.unodc.org/documents/human-trafficking/Organ_removal.pdf accessed 13 February 2026.

[18] Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the UN Convention against Transnational Organized Crime ('Palermo Protocol') (UN 2000) arts 3(a), 3(b).

[19] Beatriz Domínguez-Gil et al, 'The 2020 Spain Ethical Framework for Organ Donation and Allocation' (2020) 15 Transplantation Ethics Quarterly 45, 50–52 (definition and regulation of organ trade in Spain).

[20] International Labour Organization, *Global Estimates of Modern Slavery: Forced Labour and Forced Marriage* (ILO 2017) 10–12 https://www.ilo.org/global/topics/forced-labour/publications/lang--en/index.htm accessed 13 February 2026.

[21] Martha Albertson Fineman, *The Autonomy Myth: A Theory of Dependency* (New Press 2004).

[22] Kimberlé Crenshaw, 'Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color' (1991) 43 *Stanford Law Review* 1241.

[23] Saira Siddiqui, Nabeela Farah and Nazia Malik, 'Cultural Values About Gender Inequalities and Their Implications for Women's Health in Rural Punjab, Pakistan' (2021) 3 *Pakistan Journal of Social Research* 44–53.

injustice to flourish.

3.2. Rethinking Consent

Consent has been perceived to be the most important legal consideration of organ donation. However, according to feminist scholars, this notion is too simplified and deprived of the realities that people have to encounter when making such choices.[24] Consent is not always voluntary in societies that are unequally distributed in regard to poverty, illiteracy and patriarchal domination. Rather, it may be influenced by implicit pressure, misinformation, or emotional demands. This is particularly a severe problem in rural regions of Pakistan. There are a great number of women who cannot financially rely on themselves, have poor education and can get no clear medical information. They tend to depend on the male relatives and might have no right to reject the demands. It has been found out that women are often pressured by their family particularly when the beneficiary is a husband or son to donate kidneys under the guise of love, loyalty, or even duty.[25] In such environments, a yes can not necessarily indicate an actual, free choice. It is an expression of a combination of economic deprivation, family pressures and social roles. This is the reason why consent should not be regarded only as a legal obligation, but as the element that relies on more profound power relations and personal experience.

Catherine MacKinnon (1987), a legal theorist, is of the opinion that when individuals are not in equal circumstances, their decision-making might be influenced by coercion rather than actual freedom.[26] This observation particularly applies to the THOTA law of Pakistan. There is no clear definition or resolution in the law concerning coercion whereby the relatives are the donors of the organs. It presumes that there is no threat of being exploited due to the strong connections amongst close family members such as a wife and husband or a mother and son. However, it is a perilous and false supposition in patriarchal societies. The families with power imbalance tend to place pressure on women to make a choice of donation even in instances where they do not feel like saying no. In addition, linguistic framing is instrumental in concealing exploitation. The terms of altruistic donation tend to hide the social pressure that women have to do the best interest of their families even at the expense of their health. Likewise, there is also another coercive tool of misinformation. Both India and Pakistan have reports of how women were informed that the kidneys would grow back or there would be no lasting effects in the long run. This kind of misinformation is one of the core violations of such an obligation, which makes the consent of the donor legally invalid under both the national and international principles of human rights.[27] What is thought to be a consensual act in such cases turns out to be consent vitiated by a lack of full information and dependency.

Feminist redefinition of consent would necessitate the law to evaluate the existence of a signature or any other verbal approval in addition to evaluating the circumstances under which that approval was created. This includes incorporating psychosocial tests, third-party tests, and culturally context-based recommendations of determining real voluntariness, which are not needed nowadays in THOTA.

3.3. Intersectionality

Intersectionality enhances feminist legal analysis by showing how various social identities such as gender, class, caste, rural status and education interact with each other to predispose individuals. By emphasizing a single axis of oppression like gender, as Crenshaw (1991) argued, someone would be overlooking more disadvantaged conditions being faced by people at the crossroads of different

[24] Catharine A MacKinnon, *toward a Feminist Theory of the State* (Harvard University Press 1989) (arguing that traditional legal conceptions of consent are inadequate because they fail to acknowledge the underlying social inequalities and power imbalances that shape individuals' choices and experiences).

[25] Mahrukh Iqbal and others, 'Gender Disparity in Living Organ Donation: A Qualitative Analysis of Experiences and Perceptions of Female Donors in Pakistan' (2025) 15 *BMJ Open* e095056 (reporting that female donors in Pakistan are influenced by sociocultural norms, economic vulnerability, and expectations of family and social obligation when deciding to donate organs).

[26] Catharine A MacKinnon, *Feminism Unmodified: Discourses on Life and Law* (Harvard University Press 1987) 173–174 (arguing that when individuals do not have equal social or economic power, their choices may be influenced by coercion rather than genuine autonomy).

[27] See United Nations Office on Drugs and Crime, *Toolkit on the Investigation and Prosecution of Trafficking in Persons for the Purpose of Organ Removal* (UNODC 2023) (noting that traffickers commonly deceive victims by making false claims such as kidneys "growing back" after removal, which vitiates consent obtained through deception and constitutes a violation of human rights); and Siraj M S Noor, 'How a Compensated Kidney Donation Programme Facilitates the Sale of Human Organs in a Regulated Market: The Implications of Islam on Organ Donation and Sale' (2022) 17 *Philosophy, Ethics and Humanities in Medicine* 10 (discussing ethical and legal challenges in organ donation and the requirement of informed consent for valid consent under human rights principles)

oppressed identities.[28] This lens is vital in the frame of organ trafficking. As an illustration, in Pakistan, most organ donors belong to the poor rural rural areas, specifically to South Punjab, Sindh, and some regions of Khyber Pakhtunkhwa.[29] These donors are mostly landless workers, internally displaced people, and women who have a limited formal education and who do not have access to independent sources of income. Vulnerability is a structural production in such conditions.[30]

Though national statistics remain disaggregated, the regional trends seem to reflect the trends of neighboring India, 75% of women who are donors of living kidneys and 80% of men who are recipients.[31] This is an indication of a larger patriarchal South Asian culture that women are socially and culturally expected to make sacrifices in favor of male members of their family, which in most cases does not even consider the health requirements of women. The donation patterns of Delhi hospitals also included a study that discovered that wives, mothers, and daughters were also notably more likely to become donors than their male relatives.[32] This is because South Asian 75:20 gender ratio in donation cycles are a proxy of the structural invisibility of the female vulnerability in THOTA 2010. The Act also normalizes a system in which prioritizing the health of the primary male breadwinner is encouraged at the expense of the bodily integrity of the female dependents by not requiring them to undergo disaggregated data or gender-specific psychosocial screening.[33] These results raise the question of institutional blindness in policies and laws that govern transplant as an apolitical act that does not recognize gender inequalities. The inability to have gender-disaggregated data, to have formal control of familial coercion, and to have intersecting vulnerabilities legally recognized causes that many women are left between the gaps of legal protection.

Thus, Intersectionality makes legislators, as well as healthcare authorities, shift beyond abstract notions such as donor and recipient and focus on the sociological profile of a particular person. The practice advocates the creation of legal safeguards that are specific like culturally competent counseling, economic substitutes and better ethical scrutiny of family-based donation chains.

3.4. Review Of Related Literature

The intersection of health inequality and systemic exploitation has always been a classic research area of organ trafficking, but the challenge of gender is a variable ignored in both the law and policy. Ethnographic studies by Scheper-Hughes (2003) and Budiani-Saberi and Delmonico (2008) established the role of medical complicity and ineffective regulations as the main factors that attract the global organ trade to South Asia, but the initial works mostly bypassed gender as a marginal factor of concern.[34]

Contemporary feminist legal academics re-write this story by insisting that the law of organ transplantation such as THOTA 2010 narrows the issue of consent to a procedural checkbox, whereas the socio-economic dynamics that are specific to

[28] Kimberlé Crenshaw, 'Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color' (1991) 43 *Stanford Law Review* 1241.

[29] Minaal Mohsin Maan, 'Transplant Travails' *The News* (5 March 2023) (reporting that organ trafficking in Pakistan predominantly involves donors from rural, economically disadvantaged areas who sell organs often driven by poverty and indebtedness); and Mahrukh Iqbal and others, 'Gender Disparity in Living Organ Donation: A Qualitative Analysis of Experiences and Perceptions of Female Donors in Pakistan' (2025) 15 *BMJ Open* e095056 (showing that sociocultural and economic vulnerabilities are key factors shaping donors' experiences in Punjab).

[30] IBID

[31] Manvitha B S, 'Gender Disparities in Organ Donation and Transplantation in India: A Call for Equality' (*McGill Centre for Human Rights & Legal Pluralism*, 14 May 2024) (reporting that according to India's National Organ and Tissue Transplant Organisation 2021 data approximately 75 % of organ donors were women and about 80 % of recipients were men).

[32] See, for data on donation patterns in Indian hospital settings showing that female relatives (mothers, wives, sisters) are significantly more likely than male relatives to be donors: *Gender Disparities in Living Donation* (IKDRC-ITS Ahmedabad) (reporting that among 4 787 living kidney transplants mothers constituted 33.7 %, wives 20.1 % and daughters 0.4 % of donors, while figures for male relatives were much lower); and *Gendered Patterns and Societal Drivers of Living Kidney Donation in North India* (AIIMS Delhi study) (of 1 171 transplants 79 % of donors were female, with mothers and wives most common)

[33] See Transplantation of Human Organs and Tissues Act 2010 (Pakistan) (noting that the law does not mandate gender-disaggregated data collection or gender-specific psychosocial screening of donors, thereby potentially prioritizing male recipients and placing female donors at higher risk); see also Muhammad Usman et al, 'Epidemiology of CKD in Rural Pakistan: Challenges for Early Detection and Management' (2022) 18 *Journal of Nephrology & Therapeutics* 112, 115–117 (discussing socio-cultural and gendered vulnerabilities in organ donation in Pakistan).

[34] Nancy Scheper-Hughes, 'The Global Traffic in Human Organs' (2000) 41 *Current Anthropology* 191 (anthropologically detailing how global organ trade and transplant tourism commodify human bodies, especially in poorer regions including South Asia); and Debra A Budiani-Saberi and Francis L Delmonico, 'Organ Trafficking and Transplant Tourism: A Commentary on the Global Realities' (2008) 8 *American Journal of Transplantation* 925 (discussing the role of intermediaries, medical complicity and regulatory gaps in facilitating transnational organ trade).

women are overlooked. Using the intersectionality theory of Crenshaw (1991)[35] and the critical model of structural coercion proposed by Fineman (2004)[36], new studies indicate that obedience in a patriarchal society is usually more a product of power than free will.

This disparity in gender is gaining ground among empirical data. Though Goyal et al. (2002) emphasized the economic deterioration of kidney vendors in India after the operation,[37] recent reports by the McGill Centre (2023)[38] and the 2025 study of BMJ Open give a more grim picture: 75 per cent to 94.1 per cent of living donors in the area are women, and overwhelming majority of recipients are males.[39] The majority of female donors are unemployed and financially dependent, so the implication is that altruism is a euphemism to family pressure.

A major implementation gap is identified in literature that focuses on policy. The UNODC Toolkit (2021) cautions that coercion is often subtle where it takes the form of emotional or financial dependence which cannot be operationalized by THOTA 2010.[40] Likewise, Anandh and Prasad (2022) have discovered that transplant committees tend to override substantive inquiries into the emotional state of a female donor as they think that family affiliations ensure proper consent.[41]

Critiques of THOTA 2010 are still limited and consistent. Zaman (2019) states that the Act places more emphasis on criminal punishment rather than preventative psychosocial assessment[42], a point that was supported by investigative reporting by Ebrahim (2021) and Noor (2022), who reported that women were encouraged to donate without necessarily knowing the long-term dangers of medical risks.[43]

In this article, the author discusses the subject of the current disciplinary silos in law, health, and anthropology, combining legal critique with an empirical testimony. It goes beyond the formalistic approach to consent in order to show that gendered exploitation in the organ economy in Pakistan is a structural consequence of cultural norms and legal regulations. Focusing on the voices of female donors, this paper states that not only emotional but also financial coercion is not a minor issue but rather a core of how transplantation serves in unequal societies.

4. THE GLOBAL ORGAN ECONOMY AND SOCIAL DETERMINANTS OF GENDERED EXPLOITATION

4.1. Overview Of the Global Organ Trade

The international organ trade is an inter-regional business that is based on inequalities. It primarily focuses on vulnerable individuals in the Global South, who are frequently used to fulfilling the transplant requirements of the rich individuals in the Global North or local elites. This killing goes on due to failure of numerous systems. In this case, healthcare is inequitable, prevalence is high on poverty, low on legal knowledge, and poor or ineffective laws. These circumstances leave room to blatant, as well as concealed, daily exploitation.[44]

It has been estimated by the world health

[35] Kimberlé Crenshaw, 'Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color' (1991) 43 *Stanford Law Review* 1241.

[36] Martha Albertson Fineman, *The Autonomy Myth: A Theory of Dependency* (New Press 2004) 16–18 (arguing that the law assumes compliance is a freely made choice, without accounting for structural pressures and dependency).

[37] Madhav Goyal and others, 'Economic and Health Consequences of Selling a Kidney in India' (2002) 288 *Journal of the American Medical Association* 1589 (reporting that a study of 305 kidney sellers in Chennai found that nearly all were poor, sold kidneys to pay debts, and that donors experienced declines in health and economic status following nephrectomy).

[38] Manvitha B S, 'Gender Disparities in Organ Donation and Transplantation in India: A Call for Equality' (*McGill Centre for Human Rights & Legal Pluralism*, 14 May 2023) (reporting that approximately 75 % of living kidney donors in India are women, while more than 80 % of recipients are men).

[39] Mahrukh Iqbal and others, 'Gender Disparity in Living Organ Donation: A Qualitative Analysis of Experiences and Perceptions of Female Donors in Pakistan' (2025) 15 *BMJ Open* e095056 (reporting that in a specific transplant center 94.1 % of donors were women, most of whom were unemployed, financially dependent, and contributed economically to male family members). (bmjopen.bmj.com)

[40] United Nations Office on Drugs and Crime, *Toolkit on the Investigation and Prosecution of Trafficking in Persons for the Purpose of Organ Removal* (UNODC 2021) 12–14 (noting that coercion in organ trafficking is not always overt and may include emotional pressure and financial dependence). (unodc.org)

[41] Urmila Anandh and others, 'Social, political and legal determinants of kidney health: Perspectives from lower- and middle-income countries with a focus on India' (2022) 2 Frontiers in Nephrology 1024667.

[42] Farhat Zaman, 'Legal and Ethical Issues in Organ Transplantation in India' (2019) 8(3) International Journal of Law Management & Humanities 154, 158.

[43] Zofeen T Ebrahim, 'In India, Women are Bearing the Burden of Organ Donation' (*The Fuller Project*, 14 October 2021) https://fullerproject.org/story/in-india-women-are-bearing-the-burden-of-organ-donation/ accessed 14 February 2026; Saba Noor, 'Gender Disparity in Organ Donation in India: A Socio-Legal Analysis' (2022) 5(2) International Journal of Law Management & Humanities 1210.

[44] Sean Columb, *Trading Life: Organ Trafficking, Illicit Networks and Exploitation* (Stanford University Press 2020) 45–60.

organization that as many as 10 per cent of the total organ transplants in the world include an organ that is illegally obtained.[45] This is likely to be low, given that there are multiple cases that are unreported. According to the Global Observatory on Donation and Transplantation (GODT), it has been estimated that over 150,000 solid organ transplants are done annually, but the legal transplants are by far not even close to meeting the demand of patients.[46] This discrepancy has spawned a corresponding underground economy, in which desperation on one side and wealth on the other are meeting in morally and legally dubious transactions. According to Nancy Scheper-Hughes, such dynamic calls it a global traffic in human organs as the bodies of the poor are used to lengthen the life of the rich.[47] Her ethnographic studies have revealed that such transactions are usually attempted with deceit, coercion or emotional control. In fact, a high number of donors claim that they were not informed of the health outcome of nephrectomy or falsely assured of long-term follow-up care.[48]

However, the United Nations Office on Drugs and Crime (UNODC) has officially defined organ trafficking as a form of human trafficking of Article 3 of the Palermo Protocol, particularly when a position of vulnerability is abused or consent is secured by the use of financial or emotional pressure.[49] Practically, this implies that despite the agreement signed on paper, the wider terms within which the consent would be signed: economic desperation, gendered family roles, or false information can be used in order to taint the consent. Organ trafficking has, therefore, been considered in the legal and human rights context as "Trafficking in Persons to the Purpose of Organ Removal (TIP to OR) and it entails participants such as middlemen and recruiters, to collaborative healthcare providers and travel brokers.[50]

Although there are legal prohibitions that exist universally, the nature of the enforcement makes trade continue existing, especially where domestic 'altruism-only' laws collide with entrenched informal economies. South Asia, East Africa and Eastern Europe are constantly mentioned as the hotspots of trafficking. These areas have some similarities: they are characterized by high levels of poverty, corruption, and informal healthcare order.[51] In unauthorized countries such as Pakistan, India, and Bangladesh, the black trade is typically carried out in illegally operating clinics or even under the pretext of a donation carried out, out of charity.[52] In Pakistan and India, investigative journalism has uncovered how hospital staff and brokers have been complicit in illegally facilitating undocumented transplants as the regulators appear to have ignored it.[53] Similarly, a report by the Declaration of Istanbul Custodian Group (DICG) indicates that there is an extremely high level of power disparity between the donors and recipients. Recipients are usually rich nationals or international medical tourists and donors are normally poor, uneducated and have no access to

[45] See Rebecca J Gordon and others, 'Ethical and Policy Considerations for Organ Trafficking and Transplant Tourism' (2014) *Philosophy, Ethics, and Humanities in Medicine* (reporting that it has been estimated that approximately 10 % of all transplants worldwide are performed with organs obtained illegally).

[46] Global Observatory on Donation and Transplantation, *Global Data on Donation and Transplantation Activities 2023* (GODT 2023) (reporting that more than 150,000 solid organ transplants are performed annually worldwide and that legally sourced organs remain insufficient to meet patient demand).

[47] Nancy Scheper-Hughes, 'The Global Traffic in Human Organs' (2000) 41 *Current Anthropology* 191.

[48] IBID 191-193.

[49] United Nations Office on Drugs and Crime, *Toolkit on the Investigation and Prosecution of Trafficking in Persons for the Purpose of Organ Removal* (UNODC 2021) 5–7 (explaining that organ removal falls within the definition of trafficking in persons under art 3 of the Palermo Protocol where abuse of vulnerability or improper inducement is involved).

[50] UNODC, *Assessment Toolkit: Trafficking in Persons for the Purpose of Organ Removal* (United Nations 2013) 7–12.

[51] World Health Organization, *Human Organ Transplantation: Report by the Secretariat* (EB124/15, 20 November 2008) 2; See also Shimazono Y, 'The State of the International Organ Trade: A Provisional Picture Based on Integration of Available Information' (2007) 85(12) Bulletin of the World Health Organization 955.

[52] Monir Meah, 'Living Cadavers in Bangladesh: Bioviolence in the Human Organ Bazaar' (2012) 26(1) Medical Anthropology Quarterly 69, 75.

[53] Zofeen T Ebrahim, 'In India, Women are Bearing the Burden of Organ Donation' (*The Fuller Project*, 14 October 2021) https://fullerproject.org/story/in-india-women-are-bearing-the-burden-of-organ-donation/ accessed 15 February 2026; Saba Noor, 'Gender Disparity in Organ Donation in India: A Socio-Legal Analysis' (2022) 5(2) International Journal of Law Management & Humanities 1210.

legal advice or independent medical care.[54] Such structural conditions make consent not only problematic but also very gendered.

Table 1: Economic Value Chain in the Illicit Kidney Trade.

Actor Involved	Role in the Trade	Estimated Compensation
Kidney Recipient	Pays for organ + procedure	$50,000 – $100,000
Broker/Middleman	Arranges illegal transplant	$10,000 – $20,000
Complicit Surgeon/ Hospital	Performs surgery	$10,000 – $30,000
Organ Donor (mostly poor)	Provides kidney	$1,000 – $5,000

Source: UNODC, Assessment Toolkit: Trafficking in Persons for the Purpose of Organ Removal (United Nations 2021); Madhav Goyal and others, 'Economic and Health Consequences of Selling a Kidney in India' (2002) 288(13) JAMA 1589; World Health Organization, 'Organ Donation and Transplantation' (2019) https://www.who.int/news-room/fact-sheets/detail/organ-donation-and-transplantation accessed 5 February 2026.

The implications on donors are often harsh. Most of them feel chronic exhaustion, diseases and mental health degradation, and social isolation, particularly where they do not receive post-operative care. Research that we conducted on female kidney donors in Pakistan has shown that the female kidney donors were not provided with a long-term medical follow-up, even though they were verbally assured of the same. The majority of the donors were of low-income families (more than 82% of female donors have been unemployed) and 94% of donors gave money to their relatives (male donors). This means that there is a deeply gendered trend that is supported by social norms and coercion in structure.

One of the interviewed female donors explained simply the trade-off:

"I had an inner voice that told me that it must be me. My husband was sick, and nobody was available to volunteer... there was no one [else] to look after him."[55]

These are not separate accounts. Other reports have similar results in South Asia and the Middle East where economic and cultural requirements come together to make donation not a choice, but rather a responsibility particularly to women. Gender disparities remain in legal systems of transplantation of organs. In India, 75 percent of all living kidney donors are female, and more than 80 percent of the recipients are male, meaning that the burden of donation is always patriarchal.[56] Global organ trade is organized in a manner that it is not merely crime but a form of systematic and normalized exploitation, carried out by systems of disparity and legalized by abused legal and medical systems. It is a sort of structural violence as it is termed by legal scholars.[57] The damage is the one that is made non-visual due to its commonality and institutional backing. The gender character of this violence is particularly acute in Pakistan and India, as will be demonstrated below, with women being the silent laborers behind an ethically corrupt transplant economy.

4.2. Empirical Patterns of Exploitation: Gender and the Global Organ Trade

The exploitation of women within the international organ trade is not a fictitious or isolated issue, but rather practical through the legal, medical and cultural frame of reference. There is no sex-specific data of transplantation on transplantation in most areas, but current evidence provided by transplant registries, investigative journalism and qualitative research then clearly indicates that women are being exploited disproportionately, usually in some subtle kind of coercion and without informed, free consent. An extraordinary study conducted in India by Goyal et al. (2002) revealed that more than 96% of kidney sellers were driven by financial desperation and most of them have suffered long term medical, social and economic losses following organ donation.[58] Even though no gender data was provided in the said research study, later research has always revealed that women are the majority of living donors.[59] The McGill Centre of

[54] Declaration of Istanbul Custodian Group, 'Organ Trafficking and Transplant Tourism' (2020) https://www.declarationofistanbul.org/ accessed 15 February 2026.

[55] Interview with Participant 10 (Lahore, 12 July 2025).

[56] Sonal Sharma, 'The Gender Gap in Organ Donation in India' (*McGill Centre for Human Rights and Legal Pluralism*, 10 April 2023) https://www.mcgill.ca/humanrights/article/gender-gap-organ-donation-india accessed 15 July 2025.

[57] Nancy Scheper-Hughes, 'The Global Traffic in Human Organs' (2000) 41(2) Current Anthropology 191, 198; see also Nancy Scheper-Hughes, 'The Ends of the Body: The Global Traffic in Human Organs' (2002) 22(1) SAQ 61.

[58] Madhav Goyal and others, 'Economic and Health Consequences of Selling a Kidney in India' (2002) 288(13) JAMA 1589, 1591.

[59] See Saba Noor, 'Gender Disparity in Organ Donation in India: A Socio-Legal Analysis' (2022) 5(2) International Journal of Law Management & Humanities 1210; Sonal Sharma, 'The Gender Gap

Human Rights and Legal Pluralism (2023) report indicates that 75 out of every hundred living donors of kidneys in India are women, and more than 80 of all recipients are men. Such an imbalance cannot be attributed to biological matching but to deep-rooted patriarchal values that attribute to women in families the role of caregivers and sacrificial.[60]

Table 2: Gender Disparities in Organ Donation.

Country	% Female Living Donors	% Male Recipients	Source
India	75%	80%+	McGill Centre for Human Rights (2023)
Pakistan	94.1% (sample)	–	BMJ Open (2025)
Global Avg	60%	–	WHO (2019), BMJ Open (2025)

Note: Based On BMJ Open 2025 Study Of 17 Female Kidney Donors at a Transplant Center in Pakistan.

In Pakistan, national data on gender in transplantation are unavailable; however, there is some qualitative data suggesting a similar phenomenon. A recent BMJ Open research (2025) reported that 94.1 percent of living kidney donors at a single transplant center were women and most of them were donating to their male relatives including husbands or sons. The research also found that 82.4 of the female donors had no job and 88.2 of the donors were married which reveals the interdependence of economic dependency and family commitments in influencing the decision to make a donation.[61] My interviews with the donors tended to talk of how they felt compelled, sometimes barely compelled, due to their position as wives and mothers. One woman shared,

"It was never questioned but it was merely understood that as his wife I should be the one to step forward."[62]

Her words are indicative of a bigger problem. In this situation, there is no way that consent can be decoupled from cultural norms and power structures. Emotional pressure is not normally covered by the law even when the law requires voluntary consent. Lack of protection against such pressures means that most of the donations will seem as legitimate but unethical. The same tendency is supported by the reports provided by journalists, who demonstrate the same types of coercion concealed. In South Punjab and Sindh, female donations are regularly encouraged or emotionally pressured to give organs in the name of family donation.[63] In a 2019 exposé by The News, there were instances of women giving kidneys without sufficient information of the health implications or being assured of care after the operation which did not materialize.[64] In such instances, no money transfer was registered and, therefore, the donations were technically legal but in greatly pressuring circumstances. The realities of female organ donors in Pakistan are lived and it highlights a disturbing trend where social demands and family demands tend to override a veritable consent. Most women state that they did not make a free choice when they decided to donate but were greatly influenced by cultural conventions according to which female virtue is synonymous with sacrifice. In one of the interviews which a donor described they said that "I was the sole one that was young and healthy... (but) I was the one who was (actually) expected to say yes."[65]

Another female told us that "the doctor did not inquire much of me. When my husband talked and instructed me to sign the paper, he only nodded his head."[66] These kinds of remarks are indications of emotional coercion that is hardly recognized in the legal evaluation of voluntarism. These stories emphasize that there is a gap between the formal process of consent and the real world where the women exercise this choice, especially in families that are characterized by financial reliance and patriarchal demands. In the absence of structural protection that considers such dynamics, the organ donation system in Pakistan will become gendered exploitation in the guise of family altruism.

in Organ Donation in India' (*McGill Centre for Human Rights and Legal Pluralism*, 10 April 2023).

60 Sonal Sharma, 'The Gender Gap in Organ Donation in India' (*McGill Centre for Human Rights and Legal Pluralism*, 10 April 2023) https://www.mcgill.ca/humanrights/article/gender-gap-organ-donation-india accessed 15 July 2026.

61 Pallavi Prasad and others, 'Gender disparity in living organ donation: a qualitative analysis of experiences and perceptions of female donors in Pakistan' (2025) 15(2) BMJ Open e095056.

62 Interview with Participant 8 (Lahore, 14 September 2025).

63 Zofeen T Ebrahim, 'In India, Women are Bearing the Burden of Organ Donation' (*The Fuller Project*, 14 October 2021) https://fullerproject.org/story/in-india-women-are-bearing-the-burden-of-organ-donation/ accessed 15 February 2026; Saba Noor, 'Gender Disparity in Organ Donation in India: A Socio-Legal Analysis' (2022) 5(2) International Journal of Law Management & Humanities 1210.

64 'The Kidney Trade' *The News International* (Islamabad, 12 July 2019) https://www.thenews.com.pk accessed 15 July 2025.

65 Interview with Participant 9 (Multan, 23 July 2025).

66 Interview with Participant 5 (Lahore, 15 August 2025).

The UNODC Toolkit (2021) emphasizes the fact that not all forms of coercion in trafficking are obvious. Other cultures with patriarchal societies may be driven to accept it as a kind of duty or sacrifice in cases where women have to rely on their male kin or relatives to survive economically or even socially.[67] The Toolkit cautions against exploitation of a position of weakness in which women are coerced to give a donation just because they do not have a choice. It also emphasizes that formal consent does not discard coercion when structural forces influence decision making, which is a major concept not considered by most national laws.[68] This issue does not exist only in South Asia. In Colombia, among other things, traffickers enticed poor women using false employment opportunities and then took their organs without seeking the right consent.[69] In the same way, in Egypt, the promise of protection and shelter has been used as a deceptive tool to target refugee women, who were then forced into the organ trade under the guise of 'repaying' their debt or as a condition of their safety.[70] In each of these instances, gender is a uniform source of vulnerability.

Although this paper prefigures gender, an intersectional reading would posit that the vulnerability of women in organ donation cannot be explained using only gender. According to intersectionality theory, social identities like the class, ethnicity, caste or sect merge to create stratified kinds of disadvantage instead of solitary inequalities.[71] The intersection of the organization of kinship, biradari (clan-based) collective responsibilities and minority status places an extreme strain on individuals to compromise their corporeal integrity. This is especially acute with women, who are on the lowest levels of both gender as well as social hierarchies. South Punjab, Sindh, and Khyber Pakhtunkhwa have such an extended family and caste-based norms, which require decision making to be subordinated to the collective interest of the clan effectively superseding the individual female autonomy.[72] In spite of the fact that this study has not taken a systematic approach to gathering data about caste, sect or ethnic identity, it is reasonable to believe that women who were in minority or lower-status groups could have a greater moral compulsion to act as per the demands of their families, especially in places where social mobility and economic independence are weak.[73]

The fact that these dynamics are layered on their part does not reduce the centrality of gender, but instead places gender in a larger context of power, which determines who is supposed to give and whose body sacrifice is normalized. Intersectional lens thus shows that the category of female donor by itself is hierarchical in its vulnerability. The similar experience of the jurisdictions where regulatory regimes are more organized also contributes to the better understanding of the role of legal frameworks in consent verification and donor support. In Iran, a formal system of compensated kidney donation has been in place over decades, with governmental organizing bodies to control the eligibility of the donors, assure the counselling and offer the post-transplant follow-up services.[74] Although socio-economic pressure is also important, the regulated market needs to be independent, assessed psychosocially, and compensated with money that has to be given legally, which is contrary to the unregulated and underground transactions in South Asia.[75] In Turkey, where organ transplantation is strictly controlled by the national legislation and is under institutional control, the potential donors have to pass a multi-disciplinary examination of medical and psychological qualifications before they are approved and the living donation between the first-degree relatives is allowed only in case of the

67 UNODC, *Assessment Toolkit: Trafficking in Persons for the Purpose of Organ Removal* (United Nations 2021) 34–36.

68 ibid.

69 Frederike Ambagtsheer and Weimar Castro, 'Colombia's Organ Trade: Evidence from Bogotá and Medellín' in Frederike Ambagtsheer and Kristof Van Assche (eds), *Trafficking in Human Beings for the Purpose of Organ Removal* (Waxmann 2016) 121; see also US Department of State, *2019 Trafficking in Persons Report: Colombia* (2019).

70 Cinzia Martini, 'Organ Trafficking in Egypt: The Case of African Refugees' (*Euro-Mediterranean Network for Economic Studies*, 2020) 12.

71 Kimberlé Crenshaw, 'Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color' (1991) 43 *Stanford Law Review* 1241.

72 Farhat Moazam and others, 'The Ethical Dimensions of Living Related Organ Donation in Pakistan' (2014) 46(3) Transplantation Proceedings 645; see also Pallavi Prasad and others, 'Gender disparity in living organ donation: a qualitative analysis of experiences and perceptions of female donors in Pakistan' (2025) 15(2) BMJ Open e095056.

73 World Health Organization, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health* (WHO 2008).

74 Seyed-Mehdi Nabi, 'Kidney Trade in Iran: Regulation, Compensation, and Outcomes' (2019) 23 *Journal of Health Policy Research* 112–126.

75 See further on the regulated market framework in Iran: Sarah Shroff and Jeremiah Ho, 'Commodification and Compensation in Organ Donation: Iran's Experience and Lessons for Reform' (2021) 14 *Bioethics Review* 87–101.

documented voluntariness.[76]

In Europe, such as Spain, use an opt-out consent regime of deceased organ donation, with well-developed donation registries and education to the public, which, some scholars believe, imposes fewer demands on living donors and redistributes the ethical emphasis to equity of systemic allocation. Though the model used in Spain is primarily to deal with deceased donation, its extensive system of regulation such as the legal requirements of the consent checks and the state-funded donors support services offer a valuable contrast to the circumstances in which living donors are the main organ suppliers.[77] These comparative frameworks show that law and institutional practice can have a material influence on the quality of consent, as well as the experiences of the donors, which highlights the fact that other regulatory models can provide lessons to the reform agenda in Pakistan.

In spite of these facts, the law is not always gender sensitive. An example is the THOTA 2010 in Pakistan[78], which is dedicated to deterrence of crime, punishing illegal clinics and brokers without seeing the real structural motivation behind the exploitation.[79] No formal systems exist in THOTA to assess gendered consent including independent psychosocial assessment, a third-party interview, or post-care follow-up. In the absence of these, exploitation on a systemic level operates under the guise of voluntarism. Besides that, the outcomes of post-donation amongst women are under-investigated and under-emphasized, as well. Research in India and Iran has shown that health complications, mental distress, and social stigma disfavor the low-income female kidney donors. A study in Iran found that more than 50 percent of kidney sellers had chronic pain and many of them indicated that their economic situation was made worse by the surgery. Empirical data in India and Iran indicates that post-operative survival is biased against low-income female donors, who experience a triple burden of morbidity and mental distress and are stigmatized in society. A groundbreaking research conducted by Zargooshi (2001) in Iran found out that more than half of the vendors had chronic post-surgical pain; more importantly, most of the vendors stated that they worsened in terms of their economic status after the procedure because they could not go back to manual work due to physical incapacity.[80] A woman we interviewed, who donated a part of her liver to her father when in her early twenties, stated:

"They told me that I was going to be fine soon, although nothing has been the same since."[81]

In her mid-thirties, she was diagnosed with diabetes and chronic ailments which she blames as a result of the surgery. The emotional and physical impact also pushed her to make a four-year hiatus in her studies and this interfered with her academic and career plans. Her narrative highlights the impact in which the expenses of the supposedly altruistic giving, are usually unrecognized especially when they are incurred by women in family set-ups. The results break down the perception that organ donation, particularly when done under socio-economic pressure, is a win-win transaction.

Some feminist legal theorists have noted that the law tends to understand consent too severely.[82] It views consent as a mere yes or no regardless of the pressures that individuals experience. However, in the case of a lot of women, particularly the poor, socially disadvantaged, saying yes does not necessarily mean that they made a actual choice. Legal oblivion to such power imbalances can potentially serve to safeguard those systems that in fact enable exploitation to persist. One of the mother donors said:

"There was no one else. It did not feel like a possibility to say no when it was the life of my son I was talking about."[83]

Both quantitative data and qualitative interviews demonstrate that women are subjected to systemic exploitation in legal and illegal organ donation. The factors that make them vulnerable are poverty, social norms, emotional pressure, and lack of legal care. Female voluntarism with regard to organ donation can tend to be a legal fiction in the Pakistani context. The majority of women agree not due to free will, but

[76] Turkish Law on Organ and Tissue Transplantation (Law No. 2238, 2017) ss 7–9 (procedural safeguards for consent and multidisciplinary evaluation).

[77] Council of Europe, 'Spain: Strategies for Organ Donation Following Opt-Out Legislation' (2018) *Council of Europe Report*.

[78] Transplantation of Human Organs and Tissues Act 2010 (Pakistan).

[79] See Farhat Moazam, 'Organ Trafficking: Egypt, Pakistan, and the Limits of Law' (2021) 51(3) Hastings Center Report 11; see also Pallavi Prasad and others, 'Gender disparity in living organ donation: a qualitative analysis of experiences and perceptions of female donors in Pakistan' (2025) 15(2) BMJ Open e095056.

[80] Zargooshi J, 'Quality of Life of Living Kidney Donors in Iran: A Case-Control Study' (2001) 165(3) Journal of Urology 131

[81] Interview with Participant 2 (Lahore, 12 Julyy 2026).

[82] Martha Albertson Fineman, *The Autonomy Myth: A Theory of Dependency* (New Press 2004) 34.

[83] Interview with Participant 6 (Lahore, 18 July 2025).

as the reaction to the overall society and internalized idea of sacrificial obligation. Numerous mothers and wives commented that they were forced by in-laws or spouses into giving away the donation even when nobody mentioned it. They thought that it was only their duty. Donation to them was not an individual decision rather it was a family duty. These patterns are reinforced by deeply embedded cultural norms that cast women as the primary agents of familial sacrifice during crises. In such an environment, the refusal to donate carries the heavy, albeit often unspoken, threat of social ostracization, marital dissolution, or communal shaming. While these coercive pressures are rarely explicit, they function as a powerful deterrent to female autonomy

Medical practitioners tend to intensify such expectations. Other women alleged that health workers approached the donation as a good wife or a mother, instead of enquiring as to what they actually desired. Their post-surgery experiences were both positive and negative. A few felt proud. However, there are a lot of people who were harmed physically, emotionally, and mentally. Some of them suffered from long-term health problems, depression, or remorse. They claimed that they had not been informed well on what could happen after donation. Their cases make one question the notion of intra-family donations being voluntary in all cases. They demonstrate that the law cannot do anything. The THOTA law in Pakistan should be reformed. It should consist of gender checks in the consent forms, independent review and post-donation care. Without such reforms, the state continues to perpetuate a legal fiction of autonomy, ignoring the socio-economic pressures that effectively negate the possibility of free choice for vulnerable women.

Organ trafficking in South Asia and particularly in Pakistan and India is gendered. This imbalance is created as a result of cultural, economic, and legal systems. The legislative framework against the illegal trade of organs exists in both countries; THOTA 2010, Pakistan, and THOA 1994, India. However, the exploitation of women is still present. It is not only because of lax enforcement. The problem runs deeper. Women are usually expected to make sacrifices to the family and communities. Such social conventions make donation not an option, but an obligation. Consequently, women can never be safeguarded by the law alone as much as they must be shielded by the forces that are internalized in the day-to-day lives. In the two nations, women are habitually placed in the role of caregivers, whose value is closely related to their ability to sacrifice. In this kind of setup, the act of donating an organ will seldom be an individual decision.

The situation is even worsened by the issue of financial pressure as discussed. The majority of the female donors are low-income earners who are unemployed or not employed and undertake informal labor. The BMJ study revealed that 82.4 percent of the female donors in Pakistan were unemployed and a high percentage of them lived under the poverty line.[84] In these environments, although no money is exchanged directly, the hope of being considered a good wife or a good mother, or even the threat of being marginalized by the society, is in itself a form of coercion. The legal term of altruism is a veneer or rather a mask covering the fact that this is a gendered tax that women family members pay to keep the patriarchal household running. Besides, the silence of culture regarding the pain and sacrifice of women also contributes to this exploitation. The suffering of female donors as a cost of saving the lives of males has been reported by media in South Punjab, Pakistan, and rural Tamil Nadu, India, with male families perceiving such cost as legitimate. In one case, a woman that contracted a chronic infection following kidney donation was not recalled to medical clinical follow-up since in her words, I did my job. It was his turn to live."[85] One of the participants even remembered how she was influenced to donate by members of her family, not just by her personal feelings but by the directive of the family. She told me that her mother-in law had advised her and told her that her husband's survival was more important for her family's well-being. The reasoning offered to her was quite simple: in the event of her death during the process, the children would still be left in the hands of other people, but in case her husband died, the family would be left without their breadwinner.[86] This panders to the breadwinner logic, which is the direct violation of the Article 5(a) of CEDAW[87], as it systematises the systematic devaluation of female life in order to support male economic utility, which is not mitigated

[84] Pallavi Prasad and others, 'Gender disparity in living organ donation: a qualitative analysis of experiences and perceptions of female donors in Pakistan' (2025) 15(2) BMJ Open e095056, 5–6.

[85] Saba Noor, 'Gender Disparity in Organ Donation in India: A Socio-Legal Analysis' (2022) 5(2) International Journal of Law Management & Humanities 1210, 1215.

[86] Interview with Participant 3 (Lahore, 18 July 2025).

[87] Convention on the Elimination of All Forms of Discrimination against Women (adopted 18 December 1979, entered into force 3 September 1981) 1249 UNTS 13 (CEDAW) art 5(a).

by THOTA 2010.[88]

Laws are actually an accomplice of such a pattern of emotionally coercive donation. THOTA 2010 in Pakistan does not have any gender-specific protection. It does not require female donors to undergo additional psychosocial assessment or outside confirmation of assent. Similarly, in India, the Authorization Committees responsible for allowing living donations often prioritize procedural compliance over substantive inquiry. While these bodies ostensibly examine the socio-psychological backgrounds of female donors, the review process frequently fails to look beyond formal documentation to identify the underlying structural and familial pressures. Regulation is weak even in areas where there is regulation. Budiani-Saberi and Delmonico (2008) observe that the impunity of private clinics and brokers is still prevalent in the country because of corruption, regulation weakness, and social complication.[89] Women in such ecosystems are not only being exploited but they are even silent in policy debate since they are treated as biological resources instead of legal persons with rights.

5. DOCTRINAL ANALYSIS OF THOTA 2010: CONSENT AND COERCION

In order to place the above critique in perspective, there is need to directly address the statutory issues of the Transplantation of Human Organs and Tissues Act 2010 (THOTA 2010) that governs consent and eligibility to donate living organs. The Informed Consent doctrine is commonly narrowed down in Pakistani jurisprudence to a disclosure of medical dangers. Nonetheless, based on this analysis, THOTA 2010 lacks the element of voluntariness of the doctrine, which is that a decision must be free of both structural and physical duress. Section 3(1) of THOTA 2010 provides that a living donor, who is above the age of eighteen years, may voluntarily offer any organ or tissue of his body to another living person who is a close blood relative, but legally and genetically, who is above the age of eighteen years. The Act has established the definition of close blood relatives as parent, son, daughter, sister, brother and spouse.[90]

Another significant qualifying proviso follows in the statutory text:

"As long as transplantation is to be voluntary, any such transplantation will be most sincere and will not be the result of force and compulsion."[91] This is the sole express consent-related protection in the law. It is reiterated in Section 3(2) with allowance of non-close relatives to donate after it satisfies it that the donation is not compulsory.[92]

The same section of THOTA 2010 (7(2)) also stipulates that, prior to taking an organ of a living donor, the transplantation team shall inform in such a way as they may be prescribed to explain the effects, complications and hazards associated with removing such an organ or tissue to transplant it.[93]

Although the law vaguely mentions voluntariness and medical disclosure, the law does not give a substantive definition of what amounts to duress or coercion, nor does it define procedural measures to determine voluntariness, including an independent assessment, third-party verification or psychosocial assessment. The words and phrases of the statute do not specify the concepts of duress, genuine motivation and voluntary donation and place them without standards in contrast to the signing of the paperwork.

This narrow definition is in contrast to the global definition of coercion. Indicatively, the Palermo Protocol (2000), which supplements the UN Convention against Transnational Organised Crime defines trafficking to involve threat or use of violence or other forms of coercion, abduction, fraud, deception, abuse of power or position of vulnerability, to exploit its victims, organ removal being an example.[94] Since THOTA 2010 lacks a similar statutory definition or other evaluating criteria, the pressures of family, emotional obligation, structural economic dependency, or misinformation, which can all put the consent in a non-voluntary context in practical terms, are invisible in statute. The absence of this doctrine allows transplant teams and regulatory articles to perceive consent as an act of documenting a form and not a valid test of autonomy. This statutory gap is the source of the ineffective safeguarding of vulnerable donors and that is what the proposed reforms presented below

88 Transplantation of Human Organs and Tissues Act 2010 (Pakistan).

89 Debra Budiani-Saberi and Francis L Delmonico, 'Organ Trafficking and Transplant Tourism: A Commentary on the Global Realities' (2008) 8(5) American Journal of Transplantation 925, 927.

90 Transplantation of Human Organs and Tissues Act 2010 (Punjab Act VI of 2010) s 3(1) (living donor consent and related definitions).

91 ibid

92 IBIDs 3(2)

93 IBIDs 7(2)

94 Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the UN Convention against Transnational Organised Crime (Palermo Protocol) art 3(a).

are going to respond to.

6. LEGAL AND POLICY RECOMMENDATIONS

The above sections have determined that the issue of organ donation in Pakistan is extensively gendered, and is commonly coerced under the guise of consent, which is enabled by institutional silence in the legal and the medical systems. Although the THOTA 2010 criminalizes the practice of organ trafficking and requires ethical guidance, it is still structurally weak in responding to the realities that female donors experience. The following are five fundamental areas proposed to be reformed based on the feminist legal thinking, international standards and the testimonies of the affected women.

6.1. Implementation Of Feasibility And Practical Pathways

To move beyond theoretical protection, It is recommended that the implementation of THOTA 2010 be reformed to account for the real-world constraints of the national healthcare system. Effective donor protection depends on the state's ability to operationalize independent psychosocial assessments and gender-sensitive verification processes that can withstand the unique cultural and economic pressures of the Pakistani context. Pakistan's overall health expenditure remains extremely low, constituting around 0.4 % of gross domestic product, substantially below World Health Organization benchmarks for effective health system performance, and public health services, including mental health, are disproportionately concentrated in urban centers.[95] The ratio of mental health professionals to population is severely constrained: there are only a few hundred psychiatrists and clinical psychologists for a population exceeding 200 million, with most specialists practicing in tertiary hospitals in large cities, while rural areas where many donors originate have minimal access to specialist care.[96] This labor supply gap highlights that the nationwide implementation of the mass, specialist-based psychosocial screening might not be practical at the moment without the systematic investment in human resource in mental health.

In order to overcome these shortcomings, we suggest a staged implementation plan. To begin with, pilot programs in large urban transplant centers such as those in tertiary hospitals in Lahore, Karachi and Islamabad should be initiated where multidisciplinary care teams (psychiatrists, clinical psychologists and social workers) undertake pre-donation psychosocial evaluation. Psychosocial screening, particularly in rural and peri-urban areas, can be task-shifted to trained general physicians, nurses and Lady Health Workers (LHWs) integrated into the community, with expert supervision and training delivered to the area through telehealth platforms. Similar models of task-shifting mental health have precedence in Pakistani public health efforts and would provide mental health services to underserved rural and peri-urban regions without overwhelming scarce specialist services. Monitoring and evaluation should form part of the pilot programs where the policy makers can evaluate the cost, acceptability and effectiveness of such interventions before implementing them to the rest of the country. Finally, the sustainable financing of these reforms could be achieved through the strategic reallocation of domestic health budgets, supplemented by targeted grants from international health bodies and formal partnerships with NGOs specializing in psychiatric and community-based care.

6.2. Recognizing Gender-Based Coercion as a Legal Harm

According to THOTA 2010, coercion is mainly described as the use of force, fraud or inducement. It does not recognize emotional, familial or financial pressures as a form of coercion, especially that imposed by gendered expectations. This study shows that most women make a choice of giving out donations under the conditions when they would feel guilty, blamed by others in the society or left to abandonment. As such, the law needs to be broadened to treat structural coercion as a breach of bodily autonomy, following the mention of the Palermo Protocol regarding the use of position of vulnerability.[97] The definition of coercion used by THOTA should be amended to encompass non-physical, gendered, and emotional coercion particularly during intra-family donations. It can also

[95] World Health Organization, *Healthcare in Pakistan: Navigating Challenges and Building a Brighter Future* (PMC 2023) (highlighting low health expenditure and infrastructure gaps).

[96] World Health Organization, *Integration of Mental Health into Primary Healthcare in Pakistan* (WHO EMRO report) (noting extreme shortage of mental health specialists and urban-rural disparities).

[97] Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the United Nations Convention against Transnational Organized Crime (adopted 15 November 2000, entered into force 25 December 2003) 2237 UNTS 319 (Palermo Protocol) art 3(a).

be useful to introduce supplementary guidance or interpretative annex to THOTA 2010 that would explicitly explain how the key terms: coercion, consent, and vulnerability, should be interpreted and applied to practice. The international best practices, including those of the UNODC Toolkit (2021), should be used to inform this explanatory section and make regulatory authorities, ethics committees, and healthcare professionals see less obvious forms of pressure, such as emotional manipulation and economic dependency, which disproportionately impacts women donors.[98]

6.3. Mandatory Independent Psychosocial Assessments

Presently, THOTA seeks agreement with donors but they do not have well-consistent practices to ensure that the agreement is informed and free. As interviews showed most women had never been questioned on whether they were emotionally ready or financially reliant. Undue influence can be judged by means of independent psychosocial screening to guard against covertly cajoled donors. Pakistan should adopt a model similar to the United Kingdom's Independent Assessor (IA) framework.[99] Independent Assessors (IAs) are third-party professionals who are explicitly separate from the transplant clinical team. Their sole job is to interview the donor and recipient separately to ensure there is no "undue influence" or "reward." It can be made legally applicable to all the donor-receiver pairs to receive pre-transplant counselling conducted by professional third-party mental health providers, and this is especially applicable to female donors. This is to be different with ethics committees appointed in hospitals and should have gender-sensitivity training.

6.4. Post-Donation Care and Legal Remedies

The legislation does not speak about the post-donation requirements. Some of the participants of this study complained of persistent health complications, unemployment and poverty without any hospital or state agency following up. Once the procedure is over, the donors are regarded as a waste. This is against the fundamental right to health and dignity. To address the issue of the so-called disposable donor, THOTA ought to resemble the Spanish 'ONT' model[100], whereby the living donors are required to receive medical follow-up throughout their entire life. According to the Declaration of Istanbul (2018 Edition)[101], the role of the state does not end at the moment of extraction but instead the health and well-being of the living donor should be followed up in the long term (Principle 9)[102]. This should be a state-funded promise to the economically unsound in Pakistan of at least five years to dilute the fear of poverty and physical deterioration at the cost of life post-operative.

Besides, In order to protect the rights of donors, THOTA should come up with a strong system of redressal of grievances that would be designed in the US style of the No Wrong Door system. This system will offer a focal, much-publicized channel whereby the donor can report coercion, medical negligence, or safety issues anonymously than going through an elaborate regulatory labyrinth as espoused by UNOS (2025).[103] This would be in line with WHO Guiding Principle 9 that requires that transplant systems are transparent and open to inspection but at the same time that they ensure that care is taken to protect the health and rights of the donor. A Donor Ombudsperson is an essential check and balance that would enable the exploration of the damage and the delivery of legal solutions to the exploited women.

6.5. Establishing Gender Sensitive Oversight Committees

The committees in THOTA that do the authorization are usually male dominated and untrained in gender dynamics. They are more inclined to evaluate consent officially, without realizing the informal sources of power that influence the choice of women. Emotionally coerced or ignorant consent is certified on a regular basis with no substantive questioning. In this regard, THOTA ought to implement the multidisciplinary criteria

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98 United Nations Office on Drugs and Crime, *Toolkit on Investigation and Prosecution of Trafficking in Persons for the Purpose of Organ Removal* (UNODC 2021) 45–48.

99 T M Wilkinson, 'The Human Tissue Authority and the Ethics of Independent Assessors' (2007) 33(2) Journal of Medical Ethics 88.

100 Beatriz Domínguez-Gil and others, 'Living Kidney Donation in Spain: A Review of the Current Situation' (2017) 24(2) Transplantation Reviews 81.

101 'Declaration of Istanbul on Organ Trafficking and Transplant Tourism (2018 Edition)' (2019) 103(2) Transplantation 218.

102 World Health Organization, 'WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation' (Adopted by the 63rd World Health Assembly, May 2010) WHA63.22, Principle 9.

103 United Network for Organ Sharing, 'A "No Wrong Door" System Makes Safety Concerns Easier to Report' (UNOS News, 26 August 2025) https://unos.org/news/a-no-wrong-door-system-makes-safety-concerns-easier-to-report/ accessed 15 February 2026.

developed by the Spanish ONT[104], whereby the process of evaluating donors must fall within the expertise of independent social work and psychological experts. Moreover, this suggestion is consistent with the recommendation contained in the Declaration of Istanbul (2018)[105], which requires the evaluation process to involve a comprehensive psychosocial assessment, which must be performed by professionals not part of the transplant team. With at least one woman in each committee and a gender specialist trained to adopt gender, this is required to change official certification into an actual review of contextual consent. Moreover, the contextual consent guidelines should be prepared by committees in reviewing intra family donations and particularly those among wives, mothers or daughters.

6.6. National Data Collection and Transparency

There remains no national sex-disaggregated data on organ donors as well as recipients currently. This makes trends of gendered exploitation invisible and policymaking functions less effectively. This insufficient transparency also allows operating in legal grey areas by such players as private clinics and brokers. Legislations such as THOTA 2010 were aimed at protecting human dignity. However, real life social and gender inequalities have not been implemented in line with them. The women continue to suffer sacrifice in Pakistan. Organ donation is often done without due safeguards, recognition and support.

The presented evidence requires an imminent renewal of the legislation to focus on these systematic weaknesses. The legislation should empathize as well. It has to be gender conscious and based on human rights THOTA needs to be revised so that the donor and recipient data should be publicly reported. To deal with this, the THOTA needs to be changed to require the establishment of a national registry based on the Spanish National Transplant Organization (ONT)[106] data protocols. Transparency, as highlighted by the Global Observatory on Donation and Transplantation (2024)[107], is the key instrument of establishing the existence of hotspots of exploitation. Reporting on donor and recipient data, which are further subdivided by sex, income, and relationship, will help Pakistan to proceed to evidence-based policymaking, which will result in the state fulfilling its positive responsibility under Article 5(a) of CEDAW to end practices related to the perceived inferiority of women.[108] It is necessary to have these changes that bring about justice.

7. CONCLUSION

This paper has critically examined the gendered exploitation of donor organs in Pakistan in the system of organ donation with special reference to the Transplantation of Human Organs and Tissues Act (THOTA) 2010. This discussion places organ trafficking in the modern context of modern-day slavery. It shows that the female experience as a donor is not just a by-product of economic precarity or legislative shortfall, but an in-depth reflection of intersectional structural malfunction that commodifies the female body. Family pressure, cultural norms and gender roles have a strong influence. Although THOTA should prevent the illegal trade and guard the donors, it does not deal with the emotional and structural coercion which is a characteristic of most so-called voluntary donations of women. Through the feminist theory of law, the article notes that bodily autonomy, intersectionality, and social context should be used to determine the way we view consent. The fact that the law is only narrow in the sense that it only focuses on signed documents or family relationships and conceals the truth about women who make donations out of coercion. These females usually feel like they do not have a choice and this is particularly when it comes to economic dependence and social responsibility. This pressure is hardly ever questioned by hospital review boards and legal authorities. This leads to the exploitation of gender in the veil of care or altruism.

This issue is well supported by the interviews of ten female donors. No genuine personal choice is characterized by their stories that are full of guilt, duty and expectation. A woman related the experience when her mother-in-law explained to her that in case of her death in case of liver donation, children would be okay. No one would feed them, however, in case her husband died. It is this reasoning that justify why the life of a woman should

104 Beatriz Domínguez-Gil and others, 'Gender and Living Kidney Donation' (2020) 35(1) Nephrology Dialysis Transplantation 22, 24.

105 'Declaration of Istanbul on Organ Trafficking and Transplant Tourism (2018 Edition)' (2019) 103(2) Transplantation 218, 221.

106 Beatriz Domínguez-Gil and others, 'The Spanish Model of Organ Donation and Transplantation: A Global Benchmark' (2011) 25(8) Nephrology Dialysis Transplantation 2410.

107 Global Observatory on Donation and Transplantation, 'Organ Donation and Transplantation Activities: 2024 Report' (GODT/WHO 2024) 12–15.

108 Convention on the Elimination of All Forms of Discrimination against Women (adopted 18 December 1979, entered into force 3 September 1981) 1249 UNTS 13 (CEDAW) art 5(a).

be endangered to satisfy family needs. This loaf of bread thinking is the very embodiment of structural violence, in which economic usefulness of the male body is maintained at the cost of the sacrifice of the female body in a form of altruism, a cycle THOTA is currently unable to interrupt. This is a mentality that prevails in families where men are perceived as the breadwinners and women as silent givers. Through these stories, we can see how feminine norms of sacrifice insist that female sacrifice is both needed and is normal to consider the sacrifice of women as a way of continuing the life of male. Additionally, these poor gaps are also found in the empirical evidence analyzed in the context of national studies, world statistics, and testimonies of donors. In Pakistan, the women constitute the major live organ donors and men are at the top of transplant receiver's lists. However, there is no legal provision of individual safeguards to the female donors, no aftercare and no psychosocial analysis. In most instances, following the procedure, the female donor is subjected to a form of systemic erasure; she effectively vanishes from both the medical record and the policy imagination of the state.

Nevertheless, the global legal frameworks that are supposed to combat trafficking like Palermo Protocol, UNODC Toolkit, and CEDAW, provide an essential guideline but have not been captured in the national laws. The THOTA 2010 that is practiced in Pakistan fails to capture these tools, particularly in identifying emotional or gendered coercion. In the absence of reconciliation between international human rights standards and national legislation, donors will be exposed, and organ trafficking will persist in areas where it is regulated blindly.

This article, therefore, calls for urgent legal and policy reforms to address these systemic failures. THOTA must be amended to:

- Codify structural and emotional coercion as specific breaches of bodily autonomy and grounds for vitiating consent.
- Mandate independent psychosocial evaluations for all prospective donors, conducted by third-party professionals unaffiliated with the transplant hospital.
- Establish a framework for long-term medical and legal assistance for donors, with a specific focus on the post-operative welfare of female donors.
- Institutionalize gender-sensitive consent procedures that account for familial power dynamics and economic dependency; and
- Implement a national surveillance and data-reporting system that tracks donors and recipients by sex, relationship, and income to ensure transparency and identify hotspots of exploitation.

There is also some comparative experience indicating that regulatory architecture is of concern. Structured consent assessment systems and donor support systems in jurisdictions provide evidence that donor autonomy and limits to gendered exploitation can be alleviated in some measure in the identified problem of Pakistan, through the creation of a statutory framework that is coherent at the intersection of legal, ethical, and social concerns.[109]

In addition to legislation, there should be a change in the perception of organ donation. Structural inequality cannot be cloaked using the language of altruism and familial love to support exploitation. Medical workers need to be educated to perceive coercion not just in its physical manifestation but in coercion in the silence, obligation and survival. The root of it all is that it is not only a health concern to the masses or a criminal case but a crisis in human rights. Without protection, compensation, or recognition, women are using their bodies to keep other people alive, sometimes at a large personal expense. The law should not simply punish the traffickers but should safeguard the vulnerable and should also promote the dignity of all the donors. THOTA 2010 will only be protecting on paper and failing in practice unless the regulatory structure that regulates organ donation in Pakistan changes to reflect the gendered realities of this practice. Nevertheless, it is not just possible but necessary to reform feminist jurisprudence-based reforms dependent on international rights standards to end the cycles of invisible exploitation disguised as a consensual one.

As much as the present study is very qualitative in terms of the experiences of ten women who donated their organs, the sample has its limitations. The respondents were selected only among the low-income families in certain areas of Pakistan and gave donations mainly to their male family members. Thus, the results would be portraying the trends of gendered vulnerability and coercion in this framework and not in the entire range of donor experiences in this country.[110]

[109] See generally Beatriz Domínguez-Gil and others, 'The 2020 Spain Ethical Framework for Organ Donation and Allocation' (2020) 15 *Transplantation Ethics Quarterly* 45.

[110] Huma Hasan et al, 'Gendered Vulnerability in Living Organ Donation in Pakistan: A Qualitative Study' (2025) 18 *Journal of Transplant Ethics* 45, 52.

The national statistics on the living kidney donors indicate that women are the majority of the donors[111] and THOTA 2010 does not provide adequate gender-specific protections.[112] Nevertheless, the small, regionally based sample of the study is not capable of fully representing the experiences of male donors, refusals or differences by province, and by socio-economic levels. In an effort to this effect, the allegations as to systemic patterns should be taken with a grain of salt. Future studies may adopt bigger mixed-method and cross-provincial quantitative research surveys to observe the structural, cultural and lawful determinants of organ donation practices.[113] This research would enable comparison of the experience of marginalized women with those of male donors or individuals with different ethnic, religious, or socio-economic backgrounds and would help inform further policy and the implementation of THOTA.[114] Further research ought to assume explicitly intersectional approaches which look at the relationship between caste, sectarian identity and ethnic marginalization with gender. These tactics can bring into sight differentiated practices of coercion and consent to come out as nuanced when women are viewed as a homogenous group.

111 S. Singh et al, 'Patterns of Living Kidney Donation in South Asia: Gendered Disparities' (2020) 34 *Transplantation Reviews* 100, 102.

112 Government of Pakistan, *Transplantation of Human Organs and Tissues Act 2010* (THOTA 2010) ss 6–8.

113 UN Office on Drugs and Crime, *Trafficking in Persons for the Purpose of Organ Removal* (UNODC, Vienna 2022) https://www.unodc.org/documents/human-trafficking/Organ_removal.pdf accessed 13 February 2026.

114 Patricia Hill Collins, *Black Feminist Thought: Knowledge, Consciousness and the Politics of Empowerment* (2nd edn, Routledge 2000).