“LIVING CADAVERS” IN BANGLADESH:
ETHICS OF THE HUMAN ORGAN BAZAAR

by

Md Moniruzzaman

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the requirements
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Department of Anthropology
University of Toronto

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ABSTRACT

“Living Cadavers” in Bangladesh: Ethics of the Human Organ Bazaar

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Md Moniruzzaman

Department of Anthropology

University of Toronto

The “miracle” success of transplant technology, alongside the commercialization of health care, and the increasing polarization between rich and poor have created the conditions for an illegal but thriving trade in human body parts. Based on 15 months of challenging fieldwork, my research examines the ethics of the organ bazaar, particularly the experiences of 33 kidney sellers living in Bangladesh. On the underground bazaar, not only human kidneys but also livers and corneas are advertised for sale. Recipients, sellers, and brokers regularly post newspaper advertisements to buy and sell organs. The average price for a kidney is US $1,500 in Bangladesh, a country where 78% of people live on less than $2 a day. My research examines serious ethical questions, such as these: Is it right to purchase an organ, even if the organ sought provides longevity? Is the sale of one’s organ a justifiable means of fighting poverty? These questions allow me to examine the ethics of harvesting organs, particularly from the bodies of impoverished people.

Narrating the victims’ deeply moving testimonies, my ethnography reveals how organ buyers (both recipients and brokers) tricked and pressured Bangladeshi poor into selling their kidneys. In the end, these sellers were brutally deprived and deceived, and their suffering was extreme. In the post-vending period, sellers’ health, economic, and
social conditions significantly deteriorated, yet none of them received the promised post-operative care—not even one appointment.

My research therefore concludes that organ commodification is serious structural violence against the poor, at the terrible cost of harm and suffering to them. Examining the organ market proposition, I argue that the resulting violence and injustice against the poor provide a hefty reason to rebut this trade. Bangladeshi kidney sellers also stood up against organ commodification, speaking out about their suffering, and about various detrimental and unethical outcomes incurred in this deal. My research aims to offer insights to bioethics and to broaden the debate on human rights by exposing how technological advancement, structural violence, and grinding poverty intersect in the violation of justice to the poor, turning them into “living cadavers.”
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Md Moniruzzaman

East Lansing, Michigan

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SECTION I

CHAPTER ONE

Human Organs for Sale

We are now eyeing each others’ bodies greedily, as a potential source of detachable spare parts with which to extend our lives. – Tsuyoshi Awaya, a Japanese sociologist writing on “Friendly Cannibalism” (Awaya 1994 in Scheper-Hughes 1998a: 13)

The “miracle” success of transplant technology, alongside the commercialization of health care, and the increasing polarization between rich and poor have created the conditions for an illegal but thriving trade in human body parts. My research reveals the underground bazaar of human organs procured from live “donors” living in Bangladesh. In particular, I explore in detail how poor Bangladeshis typically sell their “fresh” kidneys to wealthy recipients. What are the lived realities that kidney sellers experience in trading their body parts? And, do these poor sellers support or resist organ commodification in the post-vending period? These questions allow me to examine the ethics of harvesting organs from the bodies of the poor and to illuminate why such a trade is seriously exploitative.

The commodification of body parts is recurrently understood as both a macro-economic and a macro-historical phenomenon, as it is embedded in larger systems of exchange and extraction across differences of wealth and encompasses the broad dynamics of both developed and developing countries. As Nancy Scheper-Hughes notes, the flow of organs follows the modern route of capital: from South to North, from Third to First World, from poor to rich, from black and brown to white, and from female to male (Scheper-Hughes 2000: 193). The emergence of “black” market for organs, which
was recognized by the World Health Organization almost two decades ago, has led to the
development of a novel form of exploitation of the Third World, where impoverished
bodies become sites for transplant harvesting (WHO 1991: 12). The historical
relationship of conquest, colonization, and extraction has shaped the transformation of
actual Third World bodies into raw materials in their own right. But, these processes also
need to be critically examined in terms of their micro-economic, political, and cultural
contexts in which organ commodification is locally and regionally grounded.

My research therefore examines the localized pattern of organ commodification in
Bangladesh, in which body parts are being trafficked from impoverished sellers to
affluent domestic and international recipients.¹ The research explores how historical and
structural processes have contributed to the extreme poverty, inequality, and corruption
that lead to organ harvesting from marginalized populations, particularly those living in
Bangladesh. My ethnography reveals how wealthy buyers regularly publish organ
classified ads in local newspapers (generating a deceptive discourse of donation), and
then deliberately remove organs from the bodies of the poor through widespread
deception, manipulation, and misinformed consent. This research illustrates how organ
commodification is a form of structural violence against the poor – a serious violation of
justice.

¹ Organ commodification creates an exploitative relationship not only between First World and Third
World countries, but also within Third World settings. Most of the Bangladeshi recipients are local wealthy
citizens who usually fly with poor Bangladeshi sellers to India to obtain organ transplant; some of these
recipients also buy kidneys from overseas sellers there (Frontline 1997: 16). In addition, some Bangladeshi-
born foreign nationals (as well as Japanese recipients, it is claimed; see Awaya 1998: 50) also come to
Bangladesh to seek kidney sellers; after matching tissues with kidney sellers, they fly abroad to obtain an
organ transplant. Thus, a complex network of exploitation has been developed through organ
commodification at local and regional levels, not to mention transnational levels.
While the relationships between wealthy recipients and impoverished kidney sellers are structurally exploitative, any understanding of organ trafficking must examine the detailed processes and profound experiences of commodifying body parts, especially through the eyes of the poor kidney sellers, as they provide subaltern voices against the dominant ones. Offering rich narratives, my research illustrates how poor Bangladeshis encounter buyers, exchange their organs for money, and experience selling their own body parts. To what extent are they suffering, being harmed, deprived, and oppressed in this trade? And, is their body integrity violated, self damaged, and dignity lost from selling body parts? Exploring these questions also helps me to illuminate how organ commodification exploits the poor, at the high cost of their suffering.

The current practice of organ commodification raises serious ethical questions, such as the following: Is it right to purchase an organ, even if the organ sought provides longevity? Is the sale of one’s organ a justifiable means of fighting poverty? Universal human rights and social justice issues are also relevant here, as modern medicine, such as organ transplantation, justifies a system for prolonging the lives of the “haves” over the lives of the “have nots.” Such issues ought to be contextualized in a local ethnographic setting. As philosopher Barry Hoffmaster argues, ethics and ethnography are not only complementary, they are indispensable to one another (Hoffmaster 1992: 1429). My research therefore explores local ethnographic details to understand and perhaps resolve global ethical complexities of the organ trade. The research aims to offer invaluable insights to bioethics and biomedicine and to broaden the debate on human rights by exposing how technological advancement, neo-liberal capitalism, and structural violence
intersect in the exploitation of impoverished people, causing them serious harm and suffering, and turning them into “living cadavers.”

Moving Organs

Western biomedicine has a long history of modifying human bodies and improving function and form through the incorporation of devices, products, and extensions. From prosthetic legs to eyeglasses to hearing aids, biomedicine has aspired to improve and repair bodies through reconstruction and redesign. In the 20th century, this trend towards repair and redesign came to include the transplantation of cells, body parts, and, in the last 50 years, organs themselves (Moniruzzaman 2006: 179). Organ and tissue transplantation is not a new medical practice. Blood transfusions and skin grafts have been used in biomedical interventions for over a century. Since the 1950s, techniques such as corneal transplants, bone marrow and other tissue transplants, as well as functional organ reconstructive surgery have continued to develop, reaching the point today where whole or part organ transplantation, either from living or post-mortem donors, has become a commonplace, if expensive, procedure in many parts of the world.

Throughout the history of organ and cell transplantation, medical research has been concerned with issues of risk and quality of life, but almost entirely for the organ recipients. As the New York Task Force on Transplantation noted, although whole or partial organ transplantation often saves and prolong lives, it does not restore full health; instead, it “substitutes the side effects of immunosuppressive drugs and life long battle against rejection for the underlying disease” (New York Task Force Report 1986: viii). The invention of cyclosporine (a fungal extract that combats organ rejection) in 1971
provided new hope for successful kidney transplantation from an unrelated donor. Although, until the 1990s, cyclosporine was considered the most powerful and effective agent for creating successful organ transplantation, this drug is responsible for many side effects and health problems, not to mention considerable human suffering. Even though transplantation provides hope, it is accompanied by fear and anxiety about organ rejection (Hamilton 2001; Helman 1988; Nolen 1971; Reitz 2002; Scumacker 1992; Townsend 2001). The history of organ transplantation is, at one level, a record of scientific and technical success, while on the other hand it is a record of social and ethical problems (Lamb 1996: 22).

At the same time, the medical success of the transplantation of organs – mostly kidneys, but also liver lobe, single cornea, single lung, and part pancreas – has produced a high demand for living unrelated donors, which is the core of this research. At present, the waiting list for an organ transplant increases more quickly than does the legal supply of donors worldwide. According to the World Health Organization, at least 200,000 people are on the waiting list to receive a kidney (Garwood 2007: 5); of that number, most people likely die without receiving one. In the USA, 84,700 people registered for kidney transplants as of May 2009; however, only 13,152 donated organs (from 7,185 deceased donors and 5,967 living donors) were available in 2008 (United Network for Organ Sharing 2009: 1). This picture illustrates the severity of the organ shortage in the US. As a result of the shortage, the average waiting time for a kidney transplant is more than three years there; median waiting time is about 5.5 years (UNOS Annual Report 2003 in OrganDonor.Gov 2010: 2). In 2008 alone, 4,573 patients died waiting for a kidney (National Kidney Foundation 2010: 1). To reduce the escalating waiting time,
wealthy recipients from all over the world create new paths to harvest “fresh” organs from living unrelated donors. Japanese, Americans, Australians, Canadians, Europeans, Israelis, and Middle Eastern people are the major organ buyers, as Organ Watch, an organization based at the University of California, Berkeley, identifies (Organ Watch 2009: 1). The World Health Organization calculates that about 10% of the 63,000 kidney transplants carried out worldwide every year involve commercial transactions (Garwood 2007: 5).

Yosuke Shimazono (2007) notes that the most common way to obtain an organ from a living unrelated donor is through “medical tourism,” in which potential recipients travel abroad to undergo organ transplant and buy live organs from the host country (e.g. Japanese recipients receiving transplants from Chinese sellers in China). In addition, there are reported cases of living donors of different nationalities who have been brought to recipients’ countries for the transplant surgery (e.g. a Moldovan seller to an American recipient or a Nepalese seller to an Indian recipient). In other cases, both recipients and living donors from different countries travel to a third country for the transplant surgery (e.g. an Israeli recipient and an Eastern European seller travel to South Africa) (Shimazono 2007: 956-57; see also Scheper-Hughes 2005: 26; Ram 2002). In Bangladesh, most recipients and living donors travel from their own country to a different country to undergo organ transplant (i.e. both the recipient and the seller are Bangladeshis, but the transplant tends to be performed in India; see Figure 1.2 of domestic organ trafficking on Page 36). Thus, wealthy recipients find all possible pathways to purchase organs from living unrelated donors, even though organ trafficking is outlawed in almost every country in the world.
Organ Hubs

The technology-driven demand for the extraction of organs has expanded so rapidly that a number of developing countries, such as Pakistan, China, the Philippines, Colombia, and Egypt have become “hot spots” for wealthy overseas recipients, as identified by the World Health Organization (WHO 2009a: 1). As organ commodification is fairly new, concealed, and outlawed, I depend on existing media reports, survey data, and a few empirical studies to map out the black markets for organs, which operate predominantly in the developing world.

At present, China is one of the major centers for trafficking organs. This country procures organs from executed prisoners, alleged mainly to be Falun Gong practitioners. A Canada-based special investigation group notes that 60,000 transplants were performed between 2000 and 2005 in China; of these, at least 40,000 transplants were likely performed on executed prisoners (Yu 2008: 1). Amnesty International estimates that as much as 99% of transplanted organs comes from executed prisoners (Amnesty International 2006: 5). In 2007, due to international pressures, China passed legislation to end organ harvesting, restrict transplants to foreigners, and give priority to Chinese citizens. Yet, the trade continues, and in many cases the organs of executed prisoners have been removed without consent (Yu 2008: 1). In February 2009, 17 Japanese “tourists” were accused of buying kidneys and livers illegally from executed prisoners in a hospital located in Guangzhou in southern China (McDonald 2009: 1). Nicholas Bequelin, a researcher for Human Rights Watch, notes that “China’s dependence on
death row inmates for organs was so high because there have been no system in place for organ donation” (Bequelin in Wong 2009: 1).

The Philippines is another lucrative destination for overseas transplant tourists, who can easily purchase kidneys and livers from poor slum dwellers living in Manila, as well as obtain access to world-class health-care facilities at an affordable price. According to the Philippine Renal Registry, a total of 1,046 kidney transplants were done in the Philippines in 2007, but more than 50% of the recipients were foreigners, which violates the 10% cap, imposed in 2003, on the number of foreign patients permitted for organ transplant in this country. It was also reported that more than 80% of the Filipino donors were unrelated to their recipients (Linao 2008: 1). To curb this rampant activity in organ trafficking, the Philippines banned organ sales in 2008 and barred all overseas patients from having organ transplants done there. However, the legislation could not stop the trade in this country; a number of foreigners continue to go there for transplant tourism. Just two months after this legislation was passed, the National Transplant and Ethics Committee issued exemptions for nine Israeli patients to undergo kidney transplant in the Philippines, citing “humanitarian reasons” (Linao 2). According to www.liver4you.org, one of the websites that arranges medical tourism services, an organ transplant can be arranged in the Philippines in less than 10 days (Calderon 2008: 3). The poor Filipinos usually receive between $1,500 and $2,000 for their kidneys.2

Egypt is currently considered a hotbed of organ trafficking, a situation that is out in the open, since a transplant law has yet to be enacted there. Egypt does not have a cadaveric organ donation program due to religious and cultural resistance, even though deceased donation is allowed in many other Muslim countries. A draft law is expected to

2 All prices are in US Dollar.
be placed in the Egyptian parliament in the early 2010 to ban the sale of organs, prohibit transplant to foreign patients, restrict operations to public hospitals, and impose a sentence of up to 15 years in prison and $180,000 in fines for violations (Keyser 2009: 2). Due to the absence of organ commodification law, as well as difficulties in traveling to distant countries, regional organ recipients are reportedly flocking to Egypt. Although there is no dependable data, a generous estimate indicates that about 500 unrelated kidney transplants are performed each year in Egypt, but evidence shows that this figure could be much higher (Keyser 3). As in many other countries, the organ trade in Egypt is ghoulish, as one of the newspapers wrote: The poverty of Cairo slums forces many poor to sell their organs, while brokers tuck into their clothes as little as $2,000 and dump them in taxis, even though they are semiconscious just after the operation (Keyser 1).

Colombia introduced a transplant law in 2004, offering priority for organ transplants to its own citizens and then to foreigners, but all transplantation must be approved by Colombia’s national health agency (Fabregas 2007: 3). However, the country’s relative proximity to the US has helped established Colombia as a hot spot for transplant tourism due to available donors and low surgery costs (WHO 2009a: 1; Reuters 2007: 2). A Colombian transplant surgeon reported that 69 out of 873 organ transplants in that country were performed on foreigners in 2006; however, there are allegations that organs of deceased donors were used in organ transplants that were commercially arranged for foreigners (Fabregas 2007: 3; see also Shimazono 2007: 3). Several websites offer to arrange new livers and kidneys in Colombia within 90 days. One of them states, “Don’t wait until there is nothing left to do” (Fabregas 1).
Moldova, called the organ center of the West, holds the leading spot among European countries for illegal organ trafficking. A newspaper reports that 10% of all kidneys donated worldwide originated in Moldova. The report also claims that Moldova’s illegal organ harvesting rings “operate with impunity and de-facto government protection,” even though abductions for organs, often carried out by gangs, are apparent in Moldova. In 2007, the government put a ban on the organ trade, but the law fails to keep organ brokers from continuing their activities on the black market. The newspaper report adds that government officials are also deeply involved in the organ trade, as they reap enormous profits from it. As the report also notes, the law in Moldova is so muddled and full of loopholes that the vested interests are still doing business, just like before (Ryan 2007: 1). A Moldovan kidney seller usually receives $2,700, the lowest price for a European kidney (Schep-er-Hughes 2003b: 1647).

Meanwhile, South Asia (including India, Pakistan, and Bangladesh) serves as one of the major hubs of organ commodification; this region is frequently called the “warehouse of kidneys” (Jayakrishnan and Jeeta 2003: 187). India offers low-cost and almost immediate availability of an organ, which makes it one of the oldest and largest organ bazaars in the world. Almost two decades ago, the price in US dollars of body parts in India was $4,425 for a cornea, $2,000 for a kidney, and $55 for a patch of skin (Chandra 1991: 53). This price is now declining due to the high supply of living donors: for example, a fresh Indian kidney currently costs about $1,000. With the average monthly income for an Indian worker at $11, and with a vast destitute underclass, trade in kidneys has boomed so rapidly in India that 2,000 or more kidneys changed bodies each year, as reported almost two decades ago (Chengappa 1990: 62; see also Fox and Swaze
1992; Transplantation of Human Organ Act 1994; Shimazono 2007). Although India outlawed organ trafficking in 1994, the law evidently fails to stop the illicit hunt for organs. Rather, the organ trade continues in major cities such as Mumbai, Jaipur, Hyderabad, and Chennai (Bos 2008: 9). Media reports in February 2008 reveal that Amit Kumar, an Indian doctor who was the mastermind of one of the underground organ trafficking rackets, allegedly harvested kidneys from approximately 500 unsuspecting Indians, some of whom were coerced, abducted, and kidnapped (Brazao 2008: 1). Even the transplant authorization committee members, who are in charge of preventing organ selling in India, are alleged to be working with brokers on the sale of kidneys from poor citizens (Muraleedharan et al. 2006: 51).

Pakistan is usually called the “new Mecca” or a “haven” for organ trafficking. The World Health Organization rated this country as the world’s second-largest center for the organ trade (WHO 2009a: 1). It is estimated that 2,000 kidney transplants are performed each year in Pakistan; of these, two thirds are for foreign patients, mostly from the Middle East, India, and Europe (Naqvi et al. 2007: 934). Meanwhile, in the central Punjab, nearly 80% of the residents of Moninpura village have sold one of their kidneys (Najam 2008: 3). After a long battle, Pakistan passed an organ law in 2007 that does not allow organ transplant to foreign nationals there, but the trade continues in various parts of the country, a prominent local nephrologist claims (Askari 2009: 1). In 2007, Pakistani authorities broke up a gang of doctors, officials, and middlemen who were working as a kind of mafia, running the country’s organ business by abducting potential donors, drugging them, and removing their kidneys in exchange for $1,000 and then selling the organs on the black market for thousands of dollars (Rehman and Grisanti 2007: 2). A
local renowned auction website, www.bolee.com, advertised “a kidney for sale” on its front page last year, despite organ law prevailing in Pakistan (Najam 2008: 1).

Bangladesh serves as an emerging but thriving organ bazaar sustained by mostly domestic and some overseas wealthy recipients (almost all of them are Bangladeshi-born foreign nationals). Although there is no reliable data, according to my estimates, about 250 kidneys are trafficked each year from poor Bangladeshis to wealthy recipients; transplants are performed within Bangladesh and abroad. The absence of a cadaveric organ donation program and the presence of competing organ brokers in Bangladesh, a country where 78% of the people live on less than $2 a day, enhances the trade in human organs. In 1999, Bangladesh passed the Organ Transplant Act to outlaw this trade, yet the organ market is thriving, since wealthy buyers (both recipients and brokers) regularly post newspaper advertisements looking for impoverished organ “donors,” and then spitefully deceive, deprive, and exploit them by paying as little as $600 for their kidneys. Despite the Organ Transplant Act, not only kidneys, but also human livers and corneas are for sale in the underground bazaar of Bangladesh.

In sum, the common threads of this widespread organ trafficking are the following: i) living unrelated donation is becoming a mundane practice, since the demand for organs is on the rise; ii) wealthy domestic citizens and foreigners are the organ

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3 BIRDEM and Kidney Foundation, two major kidney transplant centers in Bangladesh, are currently performing about 150 kidney transplants each year. Other transplant centers, such as BSMMUH, Apollo, and NIKDU, also perform about 50 kidney transplants each year. Taken altogether, among these 200 kidney transplants that are performed within Bangladesh every year, about 50 of them are from unrelated donors (according to my estimates, since there is no reliable data). In addition, about 300 Bangladeshi recipients each year (based on my estimates, but the number could be higher) are going abroad, mostly to India, for a kidney transplant, since health-care infrastructure is highly inadequate in Bangladesh. Of this number, at least 200 kidneys are exchanged from unrelated donors, as almost all of Bangladeshi recipients traveling abroad bring their “donors” with them. This conservative estimate is based on my discussion with sellers, recipients, and doctors in Bangladesh. Due to widespread economic inequality, the numbers of trafficked organs is gradually rising in this country.
receivers, while poor villagers, slum dwellers, rickshaw pullers, bonded laborers, and executed prisoners are the organ givers; iii) recipients and sellers mutually trade organs, usually with the involvement of a broker; however, abduction, kidnapping, and gang participation are reported in this transaction; iv) both sellers and recipients experience suffering, while brokers, doctors, and government officials receive financial gain from this trade; v) to curb organ trafficking, a law was enforced in almost every country in the world (except Egypt and Iran); vi) yet, the organ trade continues through legal loopholes, Internet and newspaper advertisements, and vested interest groups; and vii) the organ hub is shifting from one country to another as the transplant act is variedly being adopted in different countries at different points in time: e.g. Pakistan was one of the major organ hubs until the transplant act was enacted in 2007, while Egypt is now becoming the major organ hub due to the absence of a transplant act in effect there.

Significantly, almost all of the news coverage and reports focus mainly on the global organ trafficking between the developed and the developing worlds (from domestic seller to overseas recipient), rather than exposing the domestic organ trade at national and regional levels (from domestic seller to domestic or regional recipient). Yet, the domestic organ trade perhaps comprises the majority of organs being trafficked worldwide. For example, most Bangladeshi organs are being commodified to domestic wealthy recipients, not to foreign nationals. This is also the case in today’s India, China, Philippines, and Columbia (this claim is based on the data obtained from the local transplant registry). The domestic organ trade is widespread, mostly among those countries where a transplant act was implemented much earlier. For example, India passed the transplant act in 1994; as a result, organs of poor locals are being commodified
mostly to Indian wealthy recipients, except in some cases, where they are sold to foreign nationals. The domestic organ trade is also increasing in those countries where a transplant law was passed only recently. For example, since the Philippines enacted the law in 2008, and China, Pakistan, and Moldova did so in 2007, transplant tourists cannot participate in the organ trade there as they did before. In the next several years, domestic or local organ bazaars could be the only active trend, since the World Health Organization is currently trying to implement a transplant law to prevent organ trade worldwide. To my surprise, the focus of current scholarship has yet to shift from global organ trafficking to the domestic organ trade.

Review of Resolutions

At present, all major organizations, including the World Health Organization, World Medical Association, Transplant Society, and Council of Europe, as well as key summits, such as the Declaration of Istanbul, Asian Task Force, Bellagio Task Force, and Nuffield Council of Bioethics, have adopted resolutions to condemn organ trafficking worldwide, considering this practice to be a form of exploitation of the poor, as well as a violation of cultural practices about the human body.

The World Health Organization (WHO) adopted a Guiding Principle in 1991 (slightly modified in 2003) for preventing the purchase and sale of human organs. Some fundamental precepts of this Guiding Principle include the following: (1) cadaveric organ donation is preferable; (2) living donation is acceptable when donors’ informed and voluntary consent is obtained, surgery is safe and follow-up care is assured, and the consequence of donation does not disadvantage their life; (3) the human body and its
parts cannot be the subject of commercial transactions, so organs should be altruistically (without monetary payment or any fungible gift or reward) and freely (without deception or coercion) donated. The prohibition of the organ trade does not affect covering the costs for reasonable and verifiable expenses incurred by the donor, including loss of income or the payment of other expenses relating to the costs of recovering, processing, preserving, and supplying human organs; (4) advertisements for organs, with a view to offering or seeking payment as well as brokering, should be prohibited (WHO 1991: 1-8; WHO 2003: 1-58). The World Health Assembly eventually adopted this Guiding Principle and called on its member states to “protect the poorest and vulnerable groups from transplant tourism” (WHO 2004a: 57).

The World Medical Association (WMA) similarly declares that payment for organs and tissues for donation or transplantation should be banned, as economic incentives compromise the voluntary nature of decision-making and the altruistic basis of the donation. The WMA therefore urges that all physicians refuse to perform transplantation if the organ has been obtained through a commercial transaction, since the organ seller risks his or her future health for financial rather than altruistic motives. However, the WMA permits reasonable reimbursement of expenses, such as those incurred in procurement, transport, processing, preservation, and implantation (World Medical Association 2006: 1). It adopts that physicians have responsibilities to society to allocate the fair use of resources, prevent harm, and promote health benefits for all. The WMA contends that commercial transactions in the allocation of organs in transplantation, as well as access to needed medical treatment based on ability to pay, are contrary to the principles of justice (World Medical Association 4).
The Transplantation Society also addressed and opposed organ commercialization more than two decades ago, noting that “if the organ donation process were to be relegated to the laws of the market place, the less privileged might be exploited to improve the health of the more privileged, and the established safeguards surrounding altruistic donation would be compromised” (Council of Transplantation Society 1986: 2). This guideline continues to be sustained today, as the Society states: “No Transplant surgeon/team shall be involved directly or indirectly in the buying or selling of organs/tissues or in any transplant activity aimed at commercial gain” (Council of Transplantation Society 2). This position is reiterated in the Society’s current policy, which says: “Organs and tissues should be freely given without commercial consideration or financial profit” (Sheil 1995: 3). The Society opposes the practices of transplant tourism, arguing that this activity exploits donors and recipients, violates ethical principles of care, and has no transparency or professional oversight (The Transplantation Society 2010: 1).

The Council of Europe prohibits organ trafficking, stating that the human body and its parts shall not give rise to financial gain: “A human organ must not be offered for profit by any organ exchange organization, organ banking centre or by any other organization or individual whatsoever” (Council of Europe 1987 in Rothman et. al. 1997: 2740). The Council also espouses the position that advertising the need for or availability of an organ with financial gain or comparable advantage shall be prohibited. This resolution recognizes that there is a need to prevent the commercialization of the human body in facilitating organ transplantation in the interests of European patients. It also advocates that taking such measures are necessary to protect the dignity and identity of
all human beings, and guarantees everyone, without discrimination, respect for their integrity and other rights and fundamental freedoms with regard to procurement, exchange, and allocation activities in organ transplantation (Council of Europe 2003: 2 & 7-8). Consequently, the European Parliament approves the ban on organ trafficking, considering this practice to be a “punishable offence” involving a 10-year prison sentence for those who commit it, even under “aggravating circumstances” (Bosch 2003: 1556; The European Parliament Resolution 2008: 8).

Recently, the Declaration of Istanbul came to the consensus that organ trafficking and transplant tourism target impoverished and otherwise vulnerable donors, lead inexorably to inequity and injustice, and violate respect for human dignity; the practice, it states, should be banned. The prohibition includes all types of advertising (including electronic and print media), soliciting, or brokering for the purpose of transplant commercialization. This prohibition also contains penalties for acts – such as medically screening donors or organs, or transplanting organs – that aid, encourage, or use the products of organ trafficking. The Declaration promotes that all countries need a legal and professional framework to govern organ donation and transplant activities, as well as a regulatory oversight system that ensures donor and recipient safety and the enforcement of standards and prohibitions on unethical practices (The Declaration of Istanbul 2008: 1-5).

The members of the Asian Task Force note that the trafficking of human organs is a continuing and expanding practice that has been carried out with impunity. This group advises that organ trafficking facilitates the exploitation of the poor; although the poor donors carry disproportionate risks to their physical and psychological health, they are
not provided with sufficient information, are coerced by financial offers or other material considerations to provide organs, and cannot make a decision using their better judgment due to deception. The Task Force considers that the involvement of unscrupulous agents in transplant transactions promotes commercial rather than beneficent or altruistic aspects of donation (Taipei Recommendations 2008: 3-5).

The Bellagio Task Force concurs that the ban on the sale of solid organs from live unrelated donors should be continued. Some Task Force members have a principled objection to commercialization, believing that a progression from sale of blood to sale of solid organs is inimical to human dignity, while the entire Task Force agrees that abuses of commercial arrangements as they exist today supply the underpinning for its recommendation against organ sale from living donors (Kass 1992 in Rothman et al. 1997: 2740). According to the Task Force, present abuses are so grave that the self-determination of would-be sellers of organs must be curtailed to protect the most vulnerable (Rothman et al. 2741).

The Nuffield Council of Bioethics enforces respect for human lives and the human body, arguing that a market for organs and tissues may undermine altruistic desires to give tissues, and may reduce the quality of tissue available. Those who are most eager to sell body parts may not be the most suitable, but rather the most desperate, suppliers, who may have infected or damaged tissue. The Council considers that the organ market might encourage criminally or morally reprehensible methods of procuring human tissue, and would certainly have to be hedged with many restrictions to prevent unacceptable use being made of the tissue collected. In addition, the organ market may provide large payments to some whose tissue happens to play a prominent part in
profitable scientific or technological advance, while ignoring the contribution of many others whose tissue is also collected and studied. Due to such strong reasons, the Council rebuts the procuring of human organs and tissue along commercial lines. It concludes that the altruistic motivation of patients, donors, and relatives should be respected and encouraged rather than eroded (Nuffield Council 1995: 50-52).

In sum, all of the above-mentioned resolutions unequivocally argue against the organ trade, since it exploits the poor and turns their body parts into market commodities. These resolutions also consider that an organ market brings many detrimental outcomes: for example, it compromises sellers’ decisions, jeopardizes altruistic donation, and augments criminally coerced exchange. They therefore prohibit the organ trade and the publication of any advertisement seeking organs through commercial transactions. The resolutions urge state officials and physicians to establish a legal framework to prevent organ commercialization.

Again, these resolutions, like most of the scholarship outlined earlier, focus mainly on global organ trafficking, rather than the domestic organ trade. These resolutions are put forward in one or two terse sentences with no supporting arguments (Rothman et al. 1997: 2739). Most of the resolutions do not explicitly indicate, while a few of them simply introduce with discretionary language, the penalty for vested interest groups such as sellers, recipients, brokers, doctors, and state officials engaged in this trade. For example, the Transplant Society declares that violating its guidelines for commercialization “may be cause for expulsion from the society” (Rothman et al. 2739). Some of these resolutions – mainly the recent ones – propose various compensations or remunerations to kidney sellers, but do not clarify the exact boundary between gift,
rewarded gifting, payment, and market transaction. Some recent resolutions urge each
country to enforce legal action against the organ trade, but do not direct how to enforce
these global policies and provisions at a local level. None of these resolutions clearly
state their position on those countries where a paid donor program already exists (e.g.
Iran) or is proposed (e.g. Saudi Arabia). Still, these resolutions take timely, relevant, and
essential steps to combat organ trafficking.

The following section outlines how anthropology offers rich ethnographic insights
on organ commodification, as well as on transplantation in general.

_Ethnographies of Organs_

In comparison to other disciplines, anthropology has contributed modestly but
centrally to the discussion of organ commodification, but ethnographic research on organ
transplantation in general is growing. Here I distinguish between existing ethnographies
of organs, placing them into four categories based on their research focus: i) organ
commodification, ii) organ donation, iii) brain death, and iv) organ transplantation in
various settings.

b, 2002a-c, 2001a-c, 2000, 1998a-b, 1996) is mapping out the global context of organ
trafficking by conducting multi-sited ethnographic fieldwork in several countries,
including Brazil, South Africa, the Philippines, Israel, Turkey, Moldova, and
Mozambique. Scheper-Hughes eloquently examines how organ transplant shapes “new
relations between capital and labor, bodies and the state, belonging and extra-
territoriality, and between medical and biotechnological inclusions and exclusions,”
which now take place in a transnational space, with both donors and recipients following new paths of capital and medical technology in the global economy (Scheper-Hughes 2003a: 197). She argues, “Whether bought, donated or stolen, a kidney is never just a kidney, rather it is always a blend of commodified, reified, personalized, and spiritualized matter” (Scheper-Hughes 2003c: 1). By understanding fetishized kidneys, she shows that the ultimate fetish is the idea of life itself as an object of endless manipulation in this global capitalist economy (Scheper-Hughes 2003a: 198). Scheper-Hughes eventually explores how “a grotesque niche market for solid organs and other body parts has exacerbated other divisions between North and South, haves and have-nots, organ donors and organ recipients” (Scheper-Hughes 2006b: 1700). According to her, these divisions are a kind of “medical apartheid” that has “divided the world into organ buyers and organ sellers,” and created “a medical, social, and moral tragedy of immense and not yet fully recognized proportions” (Scheper-Hughes 2003b: 1648).

Anthropologist Lawrence Cohen (2002 & 1999) examines organ commodification within the context of a neo-liberal economy in India. Exploring ethnographic data from the four major sites – Chennai, Bangalore, Delhi, and Mumbai – in India, and outlining the ethical dilemmas in organ commodification, Cohen asked: “How do we steer between a flexible ethics that reduces reality to dyadic transactions and a purgatorial ethics that collapses real and imaginary exploitation in the service of complex interests?” (Cohen 1999: 149). Cohen illustrates how flexible ethics argues for allowing the exchange of one man’s surplus money for another man’s surplus kidney by positing that it is a win-win dyadic transaction, achievable as a matter of “life for life,” in which buyers can save a life and sellers can pay off their debt. Meanwhile, purgatorial ethics (adopted by British
philosopher Janet Radcliffe-Richards and her followers) are concerned with a small minority of wealthy recipients who can afford the cost of dialysis or transplantation. In both of these ethical viewpoints, advancement of expensive biotechnology and commercialization of health care become increasingly synonymous, while options for life-saving treatment for the poor become unimaginable. In a later article, Cohen (2002) analyzes the biopolitics of kidney transplant, in which he argues that the suppression of viable donors, not recognition, turned transplantation into a major industry (Cohen 2002: 11). He exemplifies how the development of the powerful and expensive anti-rejection drug cyclosporine has led to the expansion of the population of potential organ donors and the growth of the illegal organ trade. By analyzing a popular Indian film on organ transplantation, he concludes that the narratives constitute forms of ethical publicity that posit the limits of human connectedness as a surgical problem; however, they entail transfers from the wrong kinds of bodies, according to the traditional Indian conceptions of class, caste, and racial difference (Cohen 9).

Meanwhile, Aslihan Sanal (2004) analyzes the complex set of relationships within the Turkish transplant hospitals, particularly among doctors, patients, and brokers, in an attempt to illuminate the conditions of trafficking body parts. Sanal examines how Turkish doctors are encountering ethical dilemmas, “balancing ‘ethics’ as defined by law, ‘ethics’ as defined by their values of saving life, and the ‘ethics’ of their personal conscience” (Sanal 2004: 284). Based on personal interviews and media reports, she offers ethnographic narratives of a so-called mafia doctor, who arranges transplantation overseas for local wealthy recipients, some of whom found ways – what they called companies – to go abroad to have a transplant. Sanal shows how privatization becomes
intertwined with private investors’ desires to make a profitable business of body parts, and physicians and patients create a complex set of relationships in the “crime in medicine” (Sanal 285).

A second set of anthropologists examines cadaveric and living organ donations, as well as setting them in the context of bioethics. Notable scholar Lesley Sharp (2007, 2006a-b, 2001, 2000, & 1994) examines how new forms of “embodied intimacy” arise between organ recipients and donors’ families through cadaveric organ donation. In an award-winning book, Sharp explores how both organ recipients and donors’ families think about death, loss, and mourning, and celebrate rebirth, rites, and myth, as well as experience a new kind of kinship, reciprocity, and self through a life-saving cadaveric organ transfer. She demonstrates how medical professionals, donors’ families, and organ recipients struggle with the irresolvable contradiction of the human body being simultaneously a thing and a living entity through this “strange harvest” from dead to living (Sharp 2006; see also Sharp 2001 & 1994). In an earlier article, Sharp (2000) underscores the importance of looking at the social and historical processes of body commodification and suggests that an anthropology of organ transplant requires integrated theoretical approaches and the inclusion of bioethics (Sharp 2002: 317, see also 2007).

Sharon Kaufman (2006 & 2005) examines the “live kidney donation” to older recipients (over age 70) from younger donor kin, mostly spouses, siblings, and adult children. In this kidney transfer, as she notes, “new dimensions of intergenerational relationship and medical responsibility are opened up,” in which the kinship matters enormously, in terms of “one’s sense of duty and responsibility for the health and
longevity of a family member with end-stage renal disease” (Kaufman et al. 2006: 82). She depicts “how the clinic, patient, and family together shape a particular kind of bond between biological identity and human worth, a demand for an old age marked by somatic pliability and renewability, and a claim of responsibility that merges and organizes the [bodily] obligations of self and other,” and “a claim of responsibility that merges the ‘right to live’ and ‘making live’” (Kaufman et al. 81). She concludes that live kidney transplant is one of the medicoethical experimentations, which is linking ethics to intervention and understanding of the arc of human life to clinical opportunity and consumption (Kaufman et al. 81).

Integrating anthropology with bioethics, Patricia Marshall (1992, 1996, 1998 & 2000) focuses on (i) the availability of resources and technologies of organ transplantation, (ii) the cultural construction of the beliefs about the body and personhood, and (iii) the articulation of biomedical authority and the negotiation of power relationships in particular social and political contexts for understanding the ethical dilemmas of organ transplantation (Marshall et al. 1996: 2). She concludes that the cultural dimensions are important in constructing and resolving these ethical dilemmas.

A third pool of anthropologists examines the brain death criteria in the development of organ transplantation. In groundbreaking research, eminent scholar Margaret Lock (2007, 2002a-b, 2000a-b, 1999a-b, 1997 & 1996a-b) looks at the relationship between brain death and new biomedical technologies. By contextualizing the ontologies of death and cultures of dying, particularly in Japan, where brain death diagnosis is impossible because of the belief that the soul remains in the body as long as
the heart is beating, Lock argues that death is a biological and social construction. In contrast to Robert Taylor, a neurologist, who claims that death is a biological phenomenon, Lock underscores that brain death is a social construct, as it “permits individuals, although living, to become organ donors, provided that prior consent has been established” (Lock 2002a: 359). By contrasting and comparing North American and Japanese death, Lock illustrates how cultural context shapes the construction of death in modernity/postmodernity dichotomies in Japan, where transplant from brain-dead bodies has been permitted since only June 1997. In North America, however, the criteria of death is focused on “saving lives,” “making death meaningful,” “remaking death yet again,” and “assumed as technology to be culturally and politically autonomous” through organ transplantation (Lock 1997: 227). Lock concludes that death, dying, and organ transplantation are not a physical totality, but rather are socially situated (Lock 2002a: 194).

Emiko Ohnuki-Tierney (1994) also explores Japanese resistance to the normalization of transplant technology: in particular, the issue of brain death. She shows that the introduction of this new technology has profound implications, especially when it is “gift wrapped” as “the gift of life.” Based on the analysis of Marcel Mauss on the gift, Ohnuki-Tierney argues that in organ donation, the giving is one way, because the recipient cannot offer a countergift; thus, this transaction is devoid of social relationship, the major stipulation of gift giving (Ohnuki-Tierney 1994: 241; see also Fox and Swazey 1978 & 1992). She concludes that donated organs from the brain dead can never be gifts (Ohnuki-Tierney 233).
A fourth cluster of anthropologists examines various issues of organ transplant, mainly in non-Western settings. Prominent anthropologist Veena Das (2000) traces “the different and multiple genealogies that go into making the object – the transplant world – as a set of practices” in India (Das 2000: 263). She explores the ethical, legal, and medical issues of organ transplantation, encompassing the highly technical worlds of doctors, hospitals, health and international organizations, national legislative bodies, and the local worlds, such as the everyday life of the individuals and families within which decisions about gifting, selling, and cadaveric donations are made (Das 264). On the basis of ethnographic data, Das is able to generate a critique of bioethics grounded in the ideas of autonomy and individual rights.

Medical surgeon Farhat Moazam (2006) has carried out an ethnographic study on living related kidney donation in Pakistan. Conducting three months of fieldwork in a dialysis and renal transplant unit in Karachi, she offers an engaged and informed perspective on the interactions and relationships among physicians, recipients, donors, and their family members, as well as the decision-making processes regarding who should donate a kidney to kin and why (Moazam 2006: 3). She describes how Pakistani kinship, family-patient interaction, the Islamic moral world, and universal bioethics are weaved together but conflict through organ transplant (Moazam 2). She explores how secular bioethics evolve in a non-Western setting, but shows that health-care professionals fashion a distinctive, and shared, moral world that is deeply suffused by indigenous cultural and religious norms of Pakistani culture (Moazam 16). She also examines the tragic worlds of donors, recipients, and their families, who see the discordance between “scientific knowledge” and their “lay belief” (Moazam 18).
Sherine Hamdy (2008) investigates how poor Egyptian kidney-disease patients understand and experience their illness in terms of Egypt’s larger social, economic, and political ills. She points out that the suffering that end-stage renal failure patients endure extends beyond the pathological kidney and implicates corrupted state services that they deeply mistrust (Hamdy 2008: 553). As Hamdy discovers, these patients understand the breakdown of their kidneys, their need for dialysis machines, and their diseased bodies as a direct outcome of the breakdown of the welfare state (Hamdy 353). She argues that patients’ perceptions of their disease, along with their mistrust of medical treatment and state service provision, reflect that all etiologies are “political etiologies” that inform ethical decisions about kidney transplantation and maintaining life on dialysis (Hamdy 2008: 353). Thus, she brings together two important strands in the growing field of the anthropology of medicine and science: the subjective experience of illness and the ways in which social inequalities disproportionately distribute disease (Hamdy 353).

Megan Crowley Matoka (in press) examines organ transplant in Mexico by addressing three sets of inter-related concerns: i) the access to transplant; ii) the complexities between life and death, self and other, and gift and commodities arising from transplant; and iii) transplant as a window onto both imaginings and experiences of modernity. In tracking the personal dilemmas, media representations, and political debates surrounding this biomedical technology, Matoka argues that “the promise and perils of biomedical technology can be seen as a story of modernity in microcosm, a cautionary tale in which the impossibility of ‘normality’ as it is played out in the bodies and lives of transplanted patients mirrors the impossibility of ‘modernity’ in the nation-state of Mexico” (Matoka, in press, 23) She explores “various facets of transplantation
surrounded in turn by intense fascination, exuberant celebration, deep-seated fear and suggestive silences, which may help us think through some of the larger issues which transplantation as a set of knowledge, practices, institutional arrangements and embodied experiences engages” (Matoka 17).

Meanwhile, Linda Hogle (1995 & 1999) examines the commodification of a medicalized body through the emerging biomedical engineering technologies and regenerative medicine, particularly in the context of Germany. By discussing the alteration of the body into a production site, she illustrates that this process is not a new development that has transformed an ontological organ into a “real” organ through medical techniques of transplantation (Hogle 1999: 152; see also Koenig and Hogle 1995). In a different article (1995), she reveals that the standard protocol of organ procurement or the practice of selecting organ donors is subject to enormous local variations (Hogle 1995: 485).

Eleni Papagaroufali (1999) examines the cultural phenomenology of organ donation in the Greek context. By understanding the experiences of 24 Greek donors who decide to donate their organs or bodies after their death, she argues that “the body as flesh [used as subjectively lived body that one has as a text that one reads; or somehow personally lived/socially informed and experienced/actually sensed, rather than thought/spoken] is itself a somatic image, rather than a primordial material reality, generated in a historically/culturally and politically informed habitus” (Papagaroufali 1999: 284–5). She argues that many societies share an “imagined” sense of “original wholeness … as unique to humans”; thus, organ/xenotransplantation and other related practices are troubling (Papagaroufali 1996: 241).
All of these ethnographies offer compelling accounts of numerous issues surrounding organ transplantation. They focus on various cultural, ethical, and medical issues related to organ transplantation, as well as commodification. Yet, to my surprise, only half a dozen succinct ethnographies and research reports, particularly on kidney sellers have been published to date (Zargooshi 2001a-b; Goyal et al. 2002; Scheper-Hughes 2003a; Budiani-Saberi and Delmonico 2008; Naqvi et al. 2007 & 2008; Moazam et al. 2009); most of them are based on rapid survey data and were carried out mainly in those ethnographic settings where the organ trade was not outlawed. Importantly, this handful of ethnographies, as well as modest research reports, does not include descriptions of the detailed processes of selling kidneys and the severe suffering of kidney sellers. Also, they do not investigate structural violence against kidney sellers that is historically, economically, and politically grounded, as well as culturally situated in a particular ethnographic setting. Most of these studies tend to underscore either a political economy–centred or a cultural meaning–centred approach to examining the ethics of organ transplantation, yet many acknowledge the importance of employing both approaches. Over and over again, most of them tend to focus on global and transnational organ trafficking, rather than examining the domestic organ trade.

An Ethnography of Kidney Sellers

The ethical conundrum surrounding the “extraction” of organs from impoverished bodies is contentious, as several important questions remain: If financial incentives increase living organ donations to save the lives of transplant recipients, should we implement “compensated donation” or an “organ market” despite the ethical concerns
involved? Or, should we continue to promote voluntary and cadaveric donation, both of which are based on sounder ethics but do not yet meet the global need for organs? A detailed ethnography on kidney sellers is therefore imperative to allow us to examine the global ethical concerns through the local, coarse realities of the organ bazaar. My 15 months of challenging fieldwork in an underground organ market in Bangladesh offers a comprehensive length of processual ethnography of 33 kidney sellers who narrate the processes and experiences of selling their organs at the pre-operative, operative, and post-operative stages. This ethnography is elemental in documenting structural violence and labyrinth of exploitation that impoverished kidney sellers experience in the process of selling kidneys, and from which they suffer severely afterwards.

Based on kidney sellers’ deeply moving testimonies, my ethnography analyzes organ selling as a process to document detailed findings of selling body parts in the context of the global arena, the national government, the national media, the health professionals, as well as the buyers (both recipients and brokers). This ethnography also describes the subjectivities of kidney sellers who begin the journey and then find themselves pursuing it despite all the tricks and pressures they experience. Rather than relying on the oft-repeated idea that poverty drives people to sell organs, this ethnography complicates this view with the agency of the sellers, the strategies and manipulations of the brokers, and the changing affect, desperation, and self-centeredness but also morality of the buyers. This ethnography illustrates not only the instrumental purposes of the sellers and the buyers, but also their web of connections with the brokers, their own families, and health providers, as well as the “commodified kinship” that holds the seller and buyer to a vision of connections and emotional ties in life and in death.
Based on this ethnography, my thesis documents widespread deception, manipulation, and misinformed consent, along with medical, economic, and social harms, as well as subjective emotions, individual agency, and the sufferings of kidney sellers, placing them within the wider political economy and analyzing them through the theoretical lens of “structural violence.” Rather than simply stating the association of suffering with structural violence, the thesis illustrates the web of structural violence and analyzes them through the perspectives of individuals, their hopes and strategies, to the lack of public health and environmental regulation, laws and police, and global inequality. It demonstrates that such structural violence is an outcome of historical exploitation, neo-liberal expansion, widespread corruption, and media manipulation. In addition, the thesis examines structural violence not only through the macro-historical, global, and national perspectives, but also through its profound connection with micro-individual, social, and political realities. It situates the sellers’ experience in the wider economic and political context to specify how their suffering is an outcome of structural violence and their subjectivity is constrained by structural processes. Even though the thesis mostly focuses on the micro-level realities of structural violence and suffering, it could have been critical to analyze the close link between structure and subjectivity; i.e., why and at what level and degree is structural violence linked to “constraint of agency” (to borrow a phrase from Amartya Sen)? And, why are structure and subjectivity closely tied to power disparities and economic inequality? Despite these limitations, the thesis takes a bottom-up approach, meaning that it first explores the process and experiences of kidney selling, and then examines the ethical complexities of trafficking human organs.
At the same time, this thesis develops a critically focused and culturally informed analysis to understanding and examining the ethics of organ harvesting, but through the experience and standpoint of the victims. My research is grounded in critical medical anthropology, but imports cultural meaning–centred approaches into a useful theoretical framework. In 1982, Hans A. Baer and Merrill Singer coined the phrase “critical medical anthropology,” largely to incorporate the political economic approach in medical anthropology (Baer and Singer 1982 in Baer, Singer, and Sausser 1997: 37). Through this critical lens, my research examines the following questions: How does historically rooted and economically driven structural violence facilitate organ commodification from the bodies of the poor? How is organ commodification sustained by widespread poverty, inequality, and corruption in a particular ethnographic setting? How are poor kidney sellers being seriously harmed, deceived, manipulated, and misinformed in this trade? Based on socio-ethical principles, this research exemplifies how organ harvesting results in a serious exploitation of the poor and injustice against them, especially those living in less developed countries.

Even though some anthropological theories tend to oppose structural processes versus cultural perspectives (see also Appardurai 1986), the scope and diversity of critical medical anthropology is wider than including only the political economy approach (Kleinman 1997; Kleinman et. al. 1997; Scheper-Hughes 1992; Bourgois 2003). In addition to outlining the macro/institutional aspects of economic and political forces that shape organ commodification in a particular context, this research also includes the micro/individual perspective, without losing sight of the cultural dimensions of organ commodification. My research explores the possibility of the following working
synthesis: Social inequality and power disparity are inextricably linked to lived experiences and cultural meanings of commodification. This synthesis is in contrast to research that tends to focus on one aspect, to the exclusion of the other.

My research examines how individual experiences of suffering, as well as a cultural understanding of body and self – the principles upon which universal human rights are based – are called into question. It exposes these questions: How does organ commodification destroy kidney sellers’ homeostatic balance of body and self? Is commodification a serious invasion of their self? How does organ commodification violate kidney sellers’ body integrity, which is existentially grounded in many cultures? How does organ commodification dehumanize sellers’ dignity and self-respect? Do these sellers have ownership of their bodies and the right to trade their organs like they would trade other personal property? These questions help me to analyze what it means to be poor in the 21st century.

This research project is therefore theoretically experimental because it allows me to integrate structural processes and cultural dimensions of organ commodification. This amalgamation is important, since organ commodification is currently being carried out mostly in Third World countries, where the rate of maternal and infant mortality, lack of nutrition, and rapid spread of communicable diseases is alarming. Although this unethical practice is not necessarily or widely considered to be a major problem in the Third World, it is a deeply disturbing, highly exploitative, and culturally contested phenomenon. In order to critically understand this issue, we cannot afford to employ structural and cultural approaches separately. As Scheper-Hughes and Lock illuminate, we cannot examine the individual body without considering the social body and the body
politic (Scheper-Hughes and Lock 1987). This, it appears, is the time to blend these two approaches.

Moreover, organ commodification should not be seen only from a critical distance. It is also linked to human rights abuses. Keeping this point in mind, the thesis reveals the ethics of organ commodification through the eyes of the deprived kidney sellers, rather than looking through the lens of organ recipients, brokers, or doctors, who are often beneficiaries of this trade. Here lies one of the strengths of anthropology as a discipline to include the excluded. The thesis essentially situates the subaltern voices and standpoints, as well as challenges against the dominant exploitative discourses. In contrast to the common assertion that both recipients and sellers are victims of transplant tourism, the thesis demonstrates how brokers, as well as most recipients, brutally exploit kidney sellers – a stark example of structural violence. To address and analyze these kidney sellers’ exploitation and resistance, we need a politically and morally engaged anthropology – “an anthropology-with-one’s-feet-on-the-ground” (Scheper-Hughes 1992: 4). Organ commodification is an area where anthropologists can pursue resolutions to the tension between “objectivity” and “militancy,” or “white-coat” and “barefoot” anthropology (D’Andrade 1995; Scheper-Hughes 1995; Nader 1995; Singer 1995; Farmer 1999 & 2003). The theoretical synthesis that this thesis proposes is therefore part of an effort to establish a critically focused, culturally exposed, and actively engaged anthropology.

Furthermore, organ commodification has predominantly been explored by Western anthropologists. Most of them travel to Third World countries, perhaps carrying their Western “knapsacks,” to understand the ethics of commodifying organs, particularly
those being trafficked from the South to the North. Being a “halfy” (adopted from Abu-Lughod 1991),[^4] I was fortunate enough to be able to explore the underground organ bazaar though rigorous fieldwork, and then expose its global ethical concerns through local ethnographic details. Even though existing studies on transnational/tourist medicine reflect that it is much easier to gain access to buyers, who often speak English, and health professionals, who are more accessible, than to find sellers, the researcher has to speak the local language and find a way to trace people who would rather not be found and to whom the health professionals and the health buyers often do not pay attention beyond the access to organs. Unlike other ethnographies on organ trafficking that are primarily being conducted in multi-sided research settings, the thesis examines the detailed processes and experiences of selling organs through the eyes of local kidney sellers, rather than analyzing the fleeting glimpses of organ trafficking in a vast number of research settings.

Finally, the thesis examines domestic organ trafficking, which operates at national, regional, and international levels. As I noted earlier (see Shimazono’s discussion on page 6) the existing studies tend to focus on international organ trafficking as such:

[^4]: I adopted the term “halfy” from the writing of Lila Abu-Lughod. She coined the term to distinguish among Western, halfy, and native anthropologists (Abu-Lughod 1991). Even though Kirin Narayan and some scholars do not see this distinction between Western and native anthropologists (Narayan 1993), I consider myself a halfy, since I spent most of my life in Bangladesh and currently reside in North America. My local roots and cultural familiarity helped me to conduct ethnographic fieldwork on this challenging issue and obtain valuable data on the underground trade of human organs.
In Bangladesh, as my ethnography reveals, there are distinct and diverse forms of organ trafficking. See the following diagram:
The common scenario of organ trafficking in this country is that local recipients (mostly wealthy people) find organ sellers within their own country and travel abroad to undergo organ transplant (i.e. both recipients and sellers are Bangladeshis who travel abroad, mostly to India, for transplantation). In some cases, both recipients (mostly middle-class people) and sellers are from Bangladesh and the transplant takes place within that country (i.e. Bangladeshis sell to Bangladeshi recipients, and their transplants are performed in Bangladesh). In a few cases, Bangladeshi recipients (mostly wealthy people) travel abroad for organ transplant and buy organs from the host country (i.e. Bangladeshi recipients receive organs from Pakistani sellers in Pakistan). In other cases, international recipients (mostly Bangladeshi-born foreign nationals) find sellers in Bangladesh and travel abroad to undergo organ transplant (i.e. North American, European, or Middle Eastern recipients and Bangladeshi sellers travel abroad, mostly to India for transplantation). Thus, different forms of organ trafficking are exposed in the course of my thesis; in turn, the ethics of the organ bazaar are critically examined as holistic phenomena where structures, cultures, and activism intersect with each other.

Outline of the Chapters

This is a multidimensional study that examines the ethics of organ commodification. My thesis consists of ten chapters that are clustered into three sections. Section One sets the study in context through the global comparison, the local realities, the literature, the method, and the media. The second section is the thick description of process and experience of selling kidneys that offers rich ethnography and detailed accounts for the development of theoretical analysis. The third section addresses global
ethical questions and concludes by linking the fieldwork and theory to an operational
decision.

Chapter one situates my research in the broad spectrum of global organ
trafficking, exposes existing ethnographies of organ transplantation, and reviews major
resolutions adopted against this practice. This chapter emphasizes that local ethnographic
exploration is imperative to examine the global ethical disputes of organ
commodification. Chapter One urges that a critical, cultural, and actively engaged
anthropological framework is useful for analyzing the current ethical concerns and
complexities of organ commodification.

Chapter Two turns to exploring my 15 months of challenging and risky fieldwork
in Bangladesh. In particular, it illustrates how I gained access to the underground organ
bazaar and successfully interviewed 33 kidney sellers who had already sold one of their
kidneys and were now living in various parts of the country. This chapter not only
contextualizes my research methodology, but also compares other ethnographic
approaches to studying “hidden populations.” It also proposes formulating mainstream
ethnographic methods that are appropriate for conducting fieldwork in black markets.

Chapter Three delves into the context and condition of the organ trade in
Bangladesh. It outlines how historical and structural processes have resulted in
widespread poverty and poor health conditions in Bangladesh. This chapter illustrates
why the poor have the greatest risk of organ failure, yet they cannot save their lives
through organ transplantation, let alone dialysis. Depicting the existing kidney bazaar in
Bangladesh, this chapter raises this question: Why is the organ trade thriving in this
country despite the fact that an organ transplant act was enacted there?
Chapter Four examines the fact that more than a thousand organ classified ads that are regularly being published in major Bengali newspapers. I separate these advertisements into three categories based on their source of publication: recipients, sellers, and brokers. Through content analysis, this chapter examines the impact of these newspaper advertisements on Bangladeshis, and the question of why Bengali newspapers openly publish these outlawed classifieds. This chapter reflects that not only human kidneys but also liver lobes and single corneas are for sale in Bangladesh.

Chapter Five situates the background information for the entire Section Two, which offers rich ethnographic narratives of kidney sellers who outline in detail the processes and experiences they went through during organ selling. This chapter illuminates how grinding poverty, severe corruption, and intensive inequality are intertwined together, facilitating organ commodification from the bodies of the poor. It illustrates the poor conditions and socio-economic contexts under which my interviewed sellers sold their kidneys.

The following three chapters offer a composite story of the kidney sellers in order to depict their pre-operative, operative, and post-operative journey of organ selling—a deeply moving trilogy.

Chapter Six turns to the pre-operative journey of kidney sellers. It outlines how sellers contact their prospective recipients, meet with a broker, successfully match tissues, and then arrange for false documents, cover essential dealings, and initiate their life-altering journey of organ selling. During this initial stage, sellers hope for a better life, but at the same time worry about the risks involved in having a vital organ removed;
their journey is a constant battle between hope and fear. This chapter reveals how a domestic black market of organs is expanding through brokers and sellers.

Chapter Seven discusses the operative journey, which tends to be carried out abroad. It outlines how sellers relocate temporarily to a new place, meet with their recipients, undergo repeat medical tests, and pass a review by an authorization committee, as well as experience the daunting operation and return to Bangladesh with a massive scar from the surgery. Sellers, knowing they cannot renege on their agreement, enter the operating room hoping for a better future, but it is the saddest moment of their lives. This chapter discloses how sellers are manipulated, oppressed, and even coerced in this trade.

Chapter Eight continues the depiction of the post-operative experiences of kidney sellers. It highlights sellers’ reintegration into society, financial dealings, health conditions, and the new commodified kinship they have established with recipients. Sellers have sold their kidneys hoping for a better life, yet, in the end, they experience excruciating physical, psychological, economic, and social harm and suffering. This chapter illustrates how these sellers are brutally deceived and deprived by both recipients and brokers.

Chapter Nine exemplifies the ethically contested platforms on the current organ trade and investigates these global disputes through local ethnographic realities to draw a conclusion. This chapter reviews the major literature, arguments, and concerns that either support or rebut the organ trade. Based on the narratives of my interviewed kidney sellers and their detailed experiences of selling their kidneys, this chapter examines why the organ trade is ethically reprehensible and reveal why the Bangladeshi kidney sellers I
interviewed similarly oppose this trade. This chapter illustrates how organ commodification is a form of structural violence against the poor, causes them serious harm and suffering, and results in many detrimental outcomes.

Chapter Ten argues that there are alternative ways to resolve the organ shortage that should be promoted. It concludes that the organ trade is a serious exploitation of the poor and should cease. My ethnography offers a glimpse into violence and injustice against Bangladeshi kidney sellers. More importantly, it warns us to move beyond the academic ivory tower to ensure justice for the poor, who have the right to keep their body parts intact.

This study offers rich ethnographic realities, methodological novelties, and engaged theoretical synthesis into understanding and perhaps resolving ethical disputes on the current practice of organ commodification. Unlike Foucault’s, my research focus is not about the biopolitics of technology that deals with the production and political discourses of technology, but rather exposes the impact of technology on the bodies of impoverished people living in other cultures. It documents the commodification of bodies within global inequality and the suffering engendered by unequal power in the market for those who sell their body parts. The thesis helps to clarify the ethical dilemmas in the field – not only of organ extraction, but also of medical tourism, with respect to other issues, such as surrogate mothers and the trafficking in bodies that characterizes widening inequality and structural violence. With its contemporary relevance, this research supports equal rights to health care across the socio-economic spectrum. The research aims to broaden the discussion, intervention, and development of global and national regulations. My thesis challenges the assumptions driven by neo-liberal bioethics that
rationalize utilitarian principles on saving lives, through the exploitation and suffering of impoverished sellers. In response, it offers an alternative humanitarian ethics grounded in principles of equity and justice.
CHAPTER TWO

Conducting Fieldwork in a Black Market

I did not tell the story to anybody, not even to my wife. How could I? Selling a kidney is the most humiliating thing a person can do. You are the only person whom I trusted. It took enormous courage to come and talk with you. I was worried, however very relieved after sharing it with you. – Nozrul, a 27-year-old kidney seller, following the interview

Conducting fieldwork in the context of black markets is challenging because the research populations are often entirely hidden and involved in illegal activities. Issues of access and methods are particularly complicated in conducting this kind of fieldwork. This chapter outlines how I gained access to a black market of human organs and conducted interviews of a “hidden population,” namely 33 kidney sellers. It also explores how I employed a novel but effective and ethical methodology for researching organ commodification. By briefly outlining the current fieldwork on hidden populations, this chapter not only contextualizes but also proposes to expand methodological approaches to ethnographic fieldwork in black markets.

I faced tremendous difficulties in accessing people involved in organ commodification in Bangladesh. Very few participants wanted to disclose their identities and share their stories, largely because the organ trade is illegal there, just as it is in every other country in the world. The sellers’ experiences were so humiliating that most of them did not disclose their actions to family members, not even to spouses or parents. Yet, I was able to interview 33 sellers who had already sold one of their kidneys. I also collected data from recipients, brokers, and health personnel to examine their experiences of the trade. This chapter outlines in detail how I gained access to a black market of
organs and formulated my fieldwork among kidney sellers. Relevant methodological issues, such as interview techniques, participant observation, data recording, as well as risks, payments, and insider/outsider viewpoints are also discussed. This detailed sketch of my methodology is part of a larger goal: to compare, examine, and formulate ethnographic approaches to conducting fieldwork in black markets.

Studies of Hidden Populations

Studies in black markets can be traced back many years. Several terminologies have been used to study unseen groups of people in black markets, such as “underground,” “subterranean,” “informal,” “clandestine,” “concealed,” “unofficial,” “submerged,” and, most commonly, “hidden.” Hidden populations are defined as groups that reside outside of institutional and clinical settings and whose “activities are clandestine and therefore concealed from the view of mainstream society and agencies of social control” (Watters and Biernacki 1989: 417). Their activities frequently go unrecorded and remain concealed due to illegality. It is therefore challenging to contact and conduct research with these populations.

Hidden populations can include drug users, unseen sex workers, certain groups of gays and lesbians, people with HIV/AIDS, carriers of infectious diseases (e.g., sexually transmitted infections or tuberculosis), illegal migrants, alcoholics, school dropouts, unmarried pregnant teens, runaways, abused women and children, sexual abusers and pedophiles, street youths, gang members, criminals, and organ traders (Singer 1999: 128). Among these hidden groups, some are more invisible than others. For example, organ traders are often more concealed than sex workers, and criminals are more concealed than
alcoholics. Even within a particular hidden group, some subgroups are more hidden than others. For example, men who receive money for having sex with men are frequently more invisible than paid female prostitutes. The invisibility of groups varies depending on the illegality, stigmatization, and concealment of their action. Therefore, Merrill Singer points out four types of hidden populations: highly accessible, semi-hidden, hidden, and quite invisible in terms of research accessibility (Singer 130). Each of these groups presents different challenges for researchers wishing to study hidden populations.

The research on hidden populations is an emerging field of social science research because it reveals a deeper understanding of a particular population with its diverse subgroups and provides an opportunity to access concealed information about various enclaves of a society. Beginning in the 1970s, social science research on hidden populations was on the rise, but tended to focus mainly on health issues such as drug addiction and HIV infection. Different methodological models have been developed to gain access, select the sample, and obtain information from such groups. For example, Watters and Biernacki (1989) developed a model of target sampling by mixing qualitative and quantitative research methods to study the spread of HIV among injecting drug users and their partners. This research demonstrated that hidden populations are more visible in social science research when such groups enter institutional and carceral settings, such as outreach programs, hospitals, prisons, or courts. By comparison, studies of such groups in non-institutional settings are rare, because of the difficulties in gaining access to them. Therefore, Watters and Biernacki’s research concentrated on collecting survey data from the streets (non-institutional settings) of San Francisco’s Tenderloin district. By employing a “modified chain referral” technique in which “the drug users know the
research team would serve as an initial link in the chain and be asked to introduce the person they knew to be injecting drug users to the study,” as well as developing controlled lists with detailed plans, Watters and Biernacki recruited adequate samples within each of the target groups (Watters and Biernacki 1989). Although such target sampling is criticized for its limitations and biases, many researchers have adopted this method in gaining access to and recruiting research samples of hidden populations. Nevertheless, target sampling is not considered a substitute for ethnographic methods for studying hidden populations.

Ethnography – in particular, “street ethnography” – is especially important in studying hidden populations (Weppner 1979: 21). Ethnographers have unique tools to unearth hidden populations, as well as collect first-hand and in-depth information through fieldwork. Ethnographers’ natural inquisitiveness, wandering around, casual approach, techniques of rapport building, and grounded knowledge through participant observation, as well as their long-standing fieldwork experience in non-institutional settings, offer a unique perspective to study hidden populations. As Merrill Singer notes,

Ethnography takes the researcher out of the academia or institute suite and into the street (or other settings) where members of the target population live out their lives. Through rapport building, concern with the subject’s point of view, and long-term presence in the field, ethnographers often are able to gain access to places, events, and information that might be hard for other methodologies to achieve. (Singer 1999: 150)

Ethnographic fieldwork is an effective and important means to explore the unseen lives of hidden populations.

One of the classic pieces of ethnographic fieldwork among hidden populations was carried out by William F. Whyte in 1937. In Street Corner Society, Whyte noted how a social worker in a local settlement house introduced him to Doc, a street gang leader.
When Whyte explained his research and established a rapport with Doc, Doc agreed to take Whyte around and give him access to his community. Through this support, Whyte was able to carry out interviews with Doc and his corner-boy gang, as well as with the members of a community of impoverished inner-city Italian immigrants who were otherwise “unseen” to the researchers (Whyte 1981). In a similar fashion, Phillippe Bourgois gained access to and the trust of street-level drug dealers through Primo, a key informant, as well as by conducting several years of intensive fieldwork in one of New York City’s most dangerous neighborhoods – East Harlem (Bourgois 2003). Likewise, Merrill Singer conducted research on polygamists in Utah, which would have been impossible without the help of a key informant (Singer 1999: 152). The common thread of these studies is, as they underscore, that a key information technique can be essential for the ethnographer to gain access to and obtain unidentified layers of information from hidden populations.

Laud Humphreys used a different, rather intrusive, approach that is usually called “going native”. In *Tearoom Trade*, Humphreys describes how he “hung out” in public washrooms and studied the men who were engaged in sex with other men. At these public places, he served as a lookout by warning men if someone was about to come in. By being voyeur, Humphreys was able to observe hidden activities without disturbing the men. Since most of the men entered and left the tearoom quickly, Humphreys was not able to interview them. Unconventionally, Humphreys recorded the men’s car license plate numbers and successfully obtained their home address from the Department of Motor Vehicles with the support of friendly policemen. Changing his hairstyle and manner of dress, Humphreys visited these men’s homes, introduced himself as a
researcher on community health and sexual practice, and obtained his data (Humphreys 1975). Although Humphreys offers invaluable information, his research is seriously challenged, both methodologically and ethically. As research ethicists note, Humphreys “snooped around,” “spied on,” violated privacy and freedom, and took advantage of some powerless people to pursue his research (Hoffman 1975: 179; Warwick 1975: 211). One of these ethicists concludes, “This is one of the few social scientific studies which would have lent itself directly to a grand jury investigation” (Humphreys 1975: 229).

In an even greater level of “going native,” Ralph Bolton participated in casual sex with gay men in order to study their private sexual practices in bars, saunas, parks, streets, and private rooms in Brussels (Bolton 1992: 133-35). Bolton’s “sexual ethnography” (a term that he coined, see Bolton 1995: 140) is subject to criticism, as he used sex as a technique to diminish the distance between himself and his field subjects (Beusch 2007: 3). The research methods of both Bolton and Humphreys raise serious ethical concerns, especially in terms of employing participant observation for studying hidden populations.

All of the above-noted ethnographic works examine various avenues and diverse methodological directions to gain access to and collect data from hidden populations. They underscore two distinct challenges that are critical to the successful study of hidden populations: a) gaining access, and b) employing methods ethically. During my fieldwork in the black market of human organs, I confronted these two issues. The Bangladeshi kidney sellers are extremely inaccessible because of their invisibility, their concealment for highly stigmatized behavior, and their participation in criminal activities. Additionally, this fieldwork was exceptionally challenging because organ
commodification is fairly new, mostly unrecorded, highly deceptive, and often dangerous. Although I could not foresee all of these hurdles before going into the field, I anticipated that the fieldwork would be demanding. Therefore, I concentrated on exploring research methodology, particularly on the black market of organs, beforehand.

Since the mid-1990s, a growing number of studies have been conducted on organ commodification. These provide an opportunity to add new methodological insights and approaches to this kind of fieldwork. With the exceptions of Nancy Scheper-Hughes and Lawrence Cohen, however, researchers did not provide detailed elaborations of their methodologies. Scheper-Hughes (2004) addresses how she investigated covert and criminal behavior and conducted “undercover” research in numerous sites – from the impoverished shantytowns of the Third World to the privileged and technologically sophisticated medical centers of the First World. Her research team included graduate students, field assistants, human rights workers, documentary filmmakers, private detectives, political journalists, and “fixers,” a class of paid research “intermediaries” long used by documentary journalists. Her primary fieldwork method was open-ended key informant interviews (often with the aid of local research assistants), followed by structured questionnaires (Scheper-Hughes 2004b: 32–33, 64–65, 67–68). The essential methodology of Scheper-Hughes’s ethnography was “to follow the bodies” – what George Marcus formerly described as “follow the things” (Scheper-Hughes 2004b: 32; Marcus 1995: 107). In a critique of this approach, Andrew Walsh noted that following things leads followers away from the unique perspectives of the locals who experience things removed from them (Walsh 2004: 226). How, then, can we understand detailed local meanings of bodies when we are presented with fleeting glimpses of a vast number
of research settings? Although Schep-Hughes’s research gives an overview of the organ trade globally, it does not delve deeply into how the localized practices are played out in particular cultural contexts. For this reason, I did not follow her methods of a large-scale, multi-sited ethnography, but chose to focus on in-depth interviews with 33 kidney sellers.

Some additional methodological issues in Schep-Hughes’ research are worth exploring. For example, she posed as a medical doctor in some field sites, and as a potential kidney buyer in others (Interlandi 2009: 1). These latter approaches are controversial and raise a serious ethical question: Should researchers conceal their identities and introduce themselves as potential end users to conduct this difficult kind of fieldwork? Moreover, Schep-Hughes collected data from organ brokers and other intermediaries via phone conversations using a pseudonym, but she left unclear how informed consent was attained and how her ethics protocol was approved. Furthermore, she did not outline the detailed methodology employed by her research assistants, or address issues such as the limitations of her distance fieldwork methods, the collaboration on the wide range of data, and the transactions such as those between “fixers” and herself. Additionally, she delayed outlining her methodology until 2004, about ten years after her initial writings on organ commodification (Scheper-Hughes 1996 – 2004). Unfortunately, I was already in the field by this time, and was therefore unable to assess her detailed methodology for organ commodification and consider it in relation to my own research.

Lawrence Cohen (1999) has also provided a brief outline of the methodology he employed in the slums of Chennai in India. He briefly introduced and described interview subjects, kidney sellers, and his research assistant, as well as translator Felix Coutinho,
formerly an organ broker but currently a social worker (Cohen 1999: 136). Cohen, however, did not outline why the kidney sellers contacted him and told their stories or why Coutinho, the key informant, decided to support the research. Cohen also did not address how the sellers contacted the patients and how their trade agreements were conducted. Despite these questions, both Scheper-Hughes and Cohen have provided the most influential ethnographic fieldwork methodology for studies of organ commodification to date.

Outside of anthropology, urologist Javaad Zargooshi (2001) conducted interviews among 100 kidney donors (94% were living unrelated) in Iran. When Zargooshi noticed that 95% of kidney sellers whose transplant was performed in the public renal transplant unit in Kermanshah had provided a false address to hide their identity, he relied on other sources to locate the sellers, but did not name these sources. By conducting a focus group discussion and pilot study among kidney sellers, Zargooshi formulated a 13-page, 69-item questionnaire and successfully conducted his interview. He obtained informed consent by guaranteeing confidentiality on his participants’ statements (Zargooshi 2001a: 386–87). That same year, Zargooshi published another research result of 300 kidney vendors from the same transplant center, yet again he did not mention how he gained access to these vendors. In this study, the vendors completed independently a 40-item, mostly multiple-choice questionnaire (which was developed from the previous questionnaire). These questions focused on the vendors’ “perceived quality of life rather than the objective measurement of health and functional status” (Zargooshi 2001b: 1790–91). In both studies, Zargooshi recorded the respondents’ interviews and living conditions on videotape. Although Zargooshi was a pioneer in conducting the research on kidney
sellers, his methodology is undeveloped, as well as being based on survey interviews. Most importantly, it is not applicable to my ethnographic context because Bangladesh outlawed organ transplant from living unrelated donors. Iran is the only country in the world that regulated this trade in 1988, which was before Zargooshi’s research was conducted.

A year later, medical specialist Madhav Goyal and three other doctors (2002) conducted a survey among 305 kidney sellers in Chennai, India. The researchers relied primarily on newspaper articles and transplant professionals to identify neighborhoods in Chennai where kidney sellers primarily resided. Eight research assistants identified kidney sellers by going door to door in these neighborhoods. The research assistants conducted snowball sampling and recorded each face-to-face interview on a questionnaire (Goyal et al. 2002: 1589–93). However, the researchers did not delineate how the research assistants approached kidney sellers, why they conducted interviews for only 20 minutes, what particular difficulties they experienced while collecting data, or why they verified the nephrectomy scars. In other words, their methodology was not explained in detail. Even if it had been explained, their knocking-on-doors approach to finding kidney sellers would not have been useful for my research, because Bangladeshi sellers reside in very different parts of the country and would not disclose their activities in this way.

In Pakistan, urologist Naqvi and other medical doctors (2006) conducted a rapid four-day survey among 239 kidney vendors residing in the district of Sargodha, a province of Punjab. In collaboration with a crew of a local television company that was filming a documentary on kidney sale in Pakistan, the doctors conducted interviews
through questioning, such as reasons for vending, objectives of vending, prospects of future vending in the family, and qualitative health status post-vending. The surveyors obtained verbal informed consent. Wherever possible, they verified the nephrectomy scar of the kidney vendors, and did not offer any financial incentives to the vendors (Naqvi et al. 2007: 935). In 2007, these researchers conducted a five-day survey among 104 vendors in the same region. The local Nazim, an elected government representative, facilitated contact between the surveyors/doctors and the vendors. With informed consent, the surveyors examined the vendors in a special mobile ambulance used for disaster management that was equipped with a generator, refrigerator, ECG facilities, oxygen masks, and separate beds. The blood samples from vendors were collected, stored, and later transported to Karachi. The surveyors evaluated the vendors’ general health status, and their renal and liver functions. They recorded the vendors’ past history of diseases and date of nephrectomy, as well as carried out a systematic health examination by monitoring the vendors’ blood pressure, recording their hypertension, and undertaking ultrasound examination of their abdomen, kidney, uterus, and bladder. The surveyors provided the vendors with some test results on the following day, and other results after two weeks (Naqvi et al. 2008: 1445). Clearly, Naqvi et al.’s methodology is limited, as it was a rapid survey and mostly medical based. Because they conducted their research before the organ trade was outlawed in Pakistan in September 2007, it is not useful for my research context, especially since they gained access through elected government representatives.

All of the above-mentioned methodologies on organ commodification, however, have some applicability to my fieldwork. In particular, the ethnographic methods were
either ethically questionable or limited, while the surveys were hastily carried out in contexts where the organ trade had yet to be outlawed (except in India). The questions surrounding these methodologies suggest that conducting fieldwork on organ commodification is extremely demanding, both methodologically and ethically. How should researchers gain access to hidden populations, especially if a key informant is involved – often one who is engaged in criminal activities and exploiting others? Should ethnographers employ participant observation and depend mostly on interview techniques in such fieldwork? What are the risks involved in conducting this fieldwork? How should one provide financial incentives (if any) for arranging and conducting interviews with hidden populations? How can one uphold informed consent and guarantee anonymity, since the research populations are vulnerable and are engaging in black market activities?

Since there was no formal set of procedures to follow, I could not formulate a codified methodological approach to organ commodification before going into the field. Based on previous field trips in Bangladesh (preliminary fieldwork in August 2003, and distance fieldwork between December 2001 and March 2002), I realized that it would be extremely difficult to locate research subjects, particularly kidney sellers. Yet, I managed to gain access to 33 kidney sellers and create a novel but effective approach to studying a black market for kidneys. The following section of this chapter outlines a detailed account of how I contacted hidden populations (similarly outlined by Whyte in 1981) and my methods of conducting fieldwork on organ commodification.
Access to Kidney Sellers

Locating kidney sellers was the most arduous task in undertaking this research. In the first three months of a year of fieldwork, all of my initial attempts were in vain. The turning point of my research occurred when I met a buyer and he arranged for me to interview his kidney seller. Following this interview, I did not find any other sellers for some time. After trying all feasible means of locating sellers, I finally employed a broker as a key informant and a seller as a research assistant. With their help, I contacted and interviewed a total of 33 kidney sellers.

Going Nowhere

At the beginning of my fieldwork, I asked various Bangladeshi professionals for advice on locating kidney sellers. Suggestions included i) contacting doctors and recipients in hospitals, ii) searching Bangladeshi newspapers for kidney advertisers, iii) locating potential kidney sellers whose stories are exposed in popular media, iv) meeting journalists and lawyers who investigate medical crime, and v) finding slum dwellers and drug addicts who might serve as kidney sellers. All of these approaches turned out to be unsuccessful.

First, I attempted to uncover kidney sellers through health personnel involved in major kidney transplant centers in Bangladesh. In order to make contact with medical specialists, I attended a conference on “The End State Renal Disease: A Global Issue,” on October 9, 2004, at Dhaka. This event gave me the opportunity to observe how Bangladeshi medical specialists approach issues of organ commodification. Local nephrologists and urologists used this occasion to point out how the lack of infrastructure
hinders the establishment of a successful kidney transplant program in the country. They claimed that kidney transplants from unrelated sellers are performed in other countries, but not in Bangladesh.

Through connections I made at the conference, during the following week I was able to meet with the head of the Department of Nephrology at Bangabandhu Sheikh Mujib Medical University Hospital (BSMMUH), the major kidney transplant center in Bangladesh. When I asked him if he could put me in touch with kidney sellers, he provided me with a copy of the Organ Transplant Act and stated that trading kidneys is “strictly illegal” and not performed in Bangladesh. At the end of the meeting, I asked permission to conduct interviews within the hospital; he asked for a formal application outlining my research questions, methods of data collection, and institutional affiliation.

After several bureaucratic encounters, I finally obtained permission to conduct research at BSMMUH. However, the verbal consent did not give me access to kidney specialists, including nephrologists, urologists, and post-graduate trainees at BSMMUH. In most cases, their lack of availability was attributed to their apparent busy schedule and aloofness. Upon brief discussions, they denied the existence of illegal organ transplant in Bangladesh. Surprisingly, I then noticed two posted advertisements in the Department of Nephrology and Urology at BSMMUH for selling kidney (one advertisement was on a wall next to the elevator, and the other was on the doctor’s reading room door).  

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5 During the fieldwork, several advertisements for selling kidneys were posted in this hospital. All of the advertisements were soon removed because of my physical presence.
The kidney specialists declared that advertisements for selling kidneys are frequent in Bangladesh, but that all unrelated (and therefore illegal) transplants are performed outside the country. A nephrologist told me that many of his patients were kidney recipients who have purchased kidneys from other Bangladeshis, had their surgeries in India, and then returned for post-operative care to Bangladesh. I asked him if he could put me in touch with these recipients, but no meetings ever materialized. I suspected that Bangladeshi health professionals were reluctant to disclose the illegal kidney trade because many of them are beneficiaries of this trade.

With a fellow Bangladeshi anthropologist, I also visited the only private dialysis center in Dhaka. He was acquainted with several employees there, as his father-in-law had kidney failure. We tried to locate a clerk who had previously offered to arrange the purchase of a kidney from a poor villager. Neither the clerk in question nor any further information regarding this matter was found at the dialysis center. People in health-care settings were generally not enthusiastic about discussing organ commodification with an outside researcher due to its illegality in Bangladesh.

Additionally, I directly approached recipients in further attempts to locate kidney sellers. I interviewed a few recipients currently admitted to BSMMUH for post-operative
transplant complications. These recipients spoke of inadequate organ establishments, poor health-care services, high costs of dialysis and transplantation, and post-operative complexities. When asked where the donated kidney came from, recipients claimed to have obtained kidneys from family members, yet avoided revealing the donors’ identities. After I gained the trust of one particular recipient, he disclosed that he had purchased a kidney from an undergraduate student enrolled in a college close to Dhaka. Although the recipient agreed to introduce me to the seller during their next meeting, he never called me back. I later visited the college but could not identify the seller, because I had too little information and I was concerned about revealing his actions to authorities.

I also contacted kidney patients who were in the process of arranging transplantation. These potential recipients claimed that they were considering only related donors. One patient and her donor seemed unrelated but both of them claimed that they were family members. The patient enthusiastically produced official certificates verifying their relationship. I approached additional family members of both kidney recipients and those needing kidney transplants. Most often, they revealed their donors’ identities only vaguely. A father of a kidney recipient mentioned that during his son’s transplant at BSMMUH, he met another recipient who had purchased the kidney from a seller. I phoned the recipient in question after getting his contact number from the father. The recipient did not want to disclose the kidney seller’s identity to an unknown researcher, and then claimed to have obtained the kidney from a family member. Furthermore, he declared that he was no longer in touch with the donor and refused my request to meet

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6 Although the father promised to provide contact information for the kidney buyer over the phone, he never called me. My research assistant, Sudipta, went to Sylhet, about seven hours by train from Dhaka, to collect the phone number of the buyer in question.
with him. All of my efforts at contacting kidney sellers via health personnel and recipients thus failed.

Second, in order to locate sellers, I searched advertisements regularly posted in major Bengali newspapers. As I had previously experienced in the hospital setting, recipients were not keen to connect me with their donors/sellers; therefore I focused on the few advertisements from potential sellers. I initially attempted to contact potential sellers over the phone as most of them resided throughout Bangladesh. Only six telephone numbers were in service, and I did not successfully communicate with any of the sellers. In one instance, a schoolteacher explained that his neighbor, a 29-year-old female village dweller who was in debt, had used his phone number for the newspaper postings on the sale of her kidney. He added that she had received phone calls from three potential buyers. Two of them had inquired about her blood group (which did not match their requirements); the other buyer did not call her back, even though she borrowed money and went to Dhaka for tissue typing. In another instance, the sister of the advertiser answered the phone and told me that her brother had not been in touch with the family for the last two months. She worriedly asked how I had obtained his phone number. I did not want to mention the advertisement, so I abruptly ended the call. On the third attempt, the person who answered the phone told me that he had purchased the phone from a second-hand store. In a fourth effort, the person did not answer or return my numerous phone calls. Lastly, two people who answered the phone declared that they

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7 I discuss newspaper ads in Chapter Four.
8 Currently, mobile phones are widely used in Bangladesh. The SIM card (usually known as chip) for connecting mobile phone was as cheap as $1. The potential sellers often change their SIMs, so their numbers are usually changed a few months after posting the advertisements.
did not know the persons I was calling. Thus, I was also unable to access any potential sellers by contacting them by phone.

I also attempted to locate potential sellers through the addresses some sellers provided in their ads. Unfortunately, I could not locate any of them, as most addresses were not valid. Some sellers used their friends’ addresses, but their friends refused to put me in touch with the sellers since I was a researcher and not a potential buyer. I did not attempt to locate advertisers who used post office box numbers, because I could not access their information from newspaper offices.

Third, I collected newspaper coverage of potential kidney sellers whose stories were sensational and widely publicized. I thought these stories could lead to kidney-selling networks in Bangladesh. The newspaper coverage indicated interview locations, reasons for selling, and a brief context for commodification. Therefore, in Comilla, an eastern town close to Dhaka, my research assistant contacted Minu Begum, a potential kidney seller whose story was widely covered in the daily newspaper Prothom Alo in August 2003. Minu became aware of the kidney-selling trade through one of her villagers, and decided to post a newspaper ad because of her debts. She was not familiar with any particular brokers, sellers, or buyers who were currently involved in the organ trade. I decided not to contact any of these potential sellers because they often do not sell their kidneys; rather, they sometimes receive donations from government officials after a wide circulation of newspaper coverage.

Fourth, in order to find kidney sellers, I contacted journalists and lawyers who specialized in medical crime. I visited newspaper offices, talked to medical reporters, and

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9 I asked family and friends to contact the advertisers because they were in every corner of Bangladesh. For example, my father attempted to contact a potential seller who resided in my hometown. My father was informed that the person in question did not rent there any longer.
searched library resources. This process did not prove successful in obtaining any useful information for locating kidney sellers. I also communicated with a lawyer who was conducting research on child trafficking for a non-governmental organization. He referred to newspaper coverage that reported that Bangladeshi children are smuggled to other countries for prostitution, camel jockeying, and organ harvesting (Khayer and Badal 2004). The lawyer could not validate his claim, and the newspaper coverage seemed sensationalistic. Another lawyer was also solicited for information on locating kidney sellers. When I mentioned that a Bangladeshi court had tried to penalize an alleged gang for trafficking organs, he advised me to visit the court record room for archival research. Researching court records proved to be extremely time consuming, as they are seldom coherently organized in Bangladesh. I made one trip to the Dhaka Magistrate court anyway. A record room clerk informed me that no cases related to the organ trade had been filed. Clearly, going through numerous court records case by case would not have been a good use of my limited time.

Lastly, I chose not to contact slum dwellers and drug addicts who may have been likely to be involved in selling kidneys. I realized that finding kidney sellers within this very broad group would be difficult and time consuming.

In conclusion, it was very frustrating not to be able to locate a kidney seller in three months, despite my efforts to follow the “leads” I had been given.

*The Turning Point*

The turning point in my fieldwork occurred when a fellow anthropologist introduced me to Kamal Chowdhury, a transplant recipient. Kamal had purchased a
kidney from Manik Miah, a 32-year-old slum dweller who had sold his kidney in order to pay high business debts. The operation was successfully performed in a renowned and expensive hospital in India in January 2004. After the operation, Kamal flew to Australia to obtain better health care, and Manik traveled back to Dhaka to pay off his debt.

In the faculty lounge of Dhaka University, Kamal agreed to facilitate my research largely because he had strong opinions on the topic. For over three hours, he discussed the inadequacies of kidney transplant infrastructure and the poor provision of health-care service in Bangladesh. He also described his transplant experience in India. At Kamal’s request, we met again in a coffee shop the following week. In the seven hours that followed, he depicted the details of his pre-operative, operative, and post-operative experience. Kamal described how he began his search for a kidney by posting advertisements in three national Bengali newspapers. As a result, he was connected with approximately 90 potential sellers. Based on blood group and an initial conversation, he selected about 30 sellers for a tissue typing examination. Of that number, only six were selected, based on their matching tissues. As tissue typing is not always accurate in Bangladesh, Kamal, along with these six potential sellers went to Calcutta, India, to re-examine and verify the tissue typing results yet again. Kamal finally selected Manik Miah, as their tissues matched well and Manik had demanded less money for the

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10 To conceal the respondents’ identities, all the names used in this text are pseudonyms. I am also careful to avoid describing the interview location, relevant details about the person, and any other factors in such a way that might reveal their identities.

11 Kamal, as well as other kidney recipients, mentioned that the HLA tissue typing examination in Bangladesh is often not accurate. Most recipients prefer to re-examine the result of the HLA test in India, but cannot afford the expenses.
exchange than the other sellers had.\textsuperscript{12} On the basis of this single encounter, I was able to gain access to a kidney seller, as Kamal finally agreed to connect me with Manik.

Arranging to meet with Manik was relatively “easy,” as Kamal had already informed him about my research. Manik wished to discuss the issue in a concealed setting, so we chose to carry out the interview in my apartment in Dhaka. In a conversation lasting over eight hours, Manik related his experiences of selling his kidney. He emphasized that finding a buyer is the most difficult job for a kidney seller, as the tissues seldom match. Manik sought a buyer for eight months, competed with other sellers, and finally managed to sell his kidney to Kamal. He received 120,000 Taka ($1,700 USD) for the kidney, plus three months’ living cost of 5,000 Taka ($70) per month.\textsuperscript{13} Almost all the money he received from Kamal was spent paying off his debt, which he had accumulated due to high and compound interest rates. He also managed to purchase a television and some clothing for his family. Kamal arranged a clerical job for Manik in a medical college, with the salary of 3,500 Taka ($50) per month. However, he was eventually fired and became a vendor, earning as little as 1,500 Taka ($22) per month. Compared to other sellers, Manik was very fortunate, as Kamal kept his promises. Currently, Manik is living without debt, but with only one kidney.

I tried to locate other sellers by applying the snowball sampling method through Manik, but this approach did not prove to be productive. The sellers usually tried to conceal their identities. In addition, their buyers often discouraged them from discussing their transaction in order to avoid ending up in jail. Manik, however, did advise me to ask

\textsuperscript{12}During the interview, Kamal mentioned that Johra was “greedy” because she asked for a large amount of money for the kidney. It was difficult for him to select Manik over Johra, but he opted for “needy” over “greedy, as he mentioned.

\textsuperscript{13}All monetary values are presented in US Dollars as $1 US, equivalent to 70 Taka.
Kamal, as he might have had addresses of other sellers who contacted him through the newspaper advertisements, Unfortunately, Kamal stated that he no longer possessed the addresses of these potential sellers, and that many sellers did not disclose their addresses. He also mentioned that the sellers did not have a telephone, and that they had used pay phones to contact him. Since I was eager to find additional informants, Kamal insisted that I contact kidney brokers in order to locate kidney sellers. He provided the telephone number of Dalal Islam, a 34-year-old kidney broker, from whom he had received the names of three prospective sellers before his own transplant.

*Crossroads and a New Approach*

Contacting sellers through a broker can be ethically problematic. This approach raised numerous questions for me. Should Dalal be my key informant when he was involved in illegal activities and potentially exploiting others? To what extent should he be involved in my research? Yet I had unsuccessfully examined all other possible ways of finding kidney sellers and was even considering changing the focus of my research. My research seemed possible only if I could employ a broker as a key informant, as Whyte had done to some extent in his research. After much soul searching, I decided to contact Dalal Islam.

Over the phone, I informed Dalal that I was a Bangladeshi citizen currently residing in Canada. When Dalal asked how I had obtained his phone number, I referred to his client, kidney recipient Kamal. Initially, I did not mention my study to Dalal, as my previous research had taught me that he might not be interested in discussing his business with a researcher. Instead, I said that I wanted to meet in person to discuss kidneys in
general. Dalal asked for my residence address and said that he would visit my apartment when he was in the neighborhood. Eventually, late one morning, Dalal called me. Our conversation that morning was the major turning point in my research.

Both my insider and outsider perspectives influenced by dealings with Dalal. My identity as *half* (half-Bangladeshi half-Canadian) (Abu Lugod 1991) and my wife’s distinctiveness as *bedeshi* (foreigner) played an essential role in gaining his trust. My familiarity with local culture aided me in determining my initial approach, and my fluency in Bengali provided an easy medium for sharing our thoughts without any confusion. My wife’s foreignness reassured Dalal that I was not an undercover police officer or journalist but a “harmless” researcher. As my parents and Dalal are from the same part of Bangladesh, our regional affiliation may have been another important factor connection in acquiring his trust. My family and friends’ reputations, as well as my profession as a university lecturer in Bangladesh, may also have influenced his support of the research. During our first conversation, I informed Dalal about my research and its progress since its initiation. At the end of our short meeting, Dalal said that he would be able to contact numerous kidney sellers, but chose to ponder the entire issue and notify me of his decision.

Dalal contacted me more than a week later, and agreed to facilitate the research. Exploring why Dalal chose to facilitate this research is an important question. It may have been that he considered his broker business secure because his clients included police officers, lawyers, and doctors who could help him resolve any potential legal troubles. He may also have thought that this research would help to expand his business outside of Bangladesh, as he insisted that I use his photo and name in publications. Dalal
assumed that he would receive lofty monetary benefits, even though I paid only for transportation and communication costs (on average $7) to locate kidney sellers. I was in constant negotiations with Dalal, as he would contact sellers in Dhaka but fabricate stories about their origins to exaggerate the transportation costs.

Dalal’s entry into the kidney trade began when he became a potential seller after he lost his job in the mid 1990s. After enduring economic hardship, he collected newspaper advertisements of kidney buyers. After several attempts, his tissues matched with a potential recipient, and he eventually went to India for the surgery. In the end, he returned to Bangladesh without selling his kidney, because the potential recipient did not want to pay him in advance. Within a month of visiting a renowned hospital in South India, Dalal met other Bangladeshi recipients and sellers who had gathered at the hospital for kidney transplants. Before departing, Dalal realized that if he could start a business collecting tissue-typing reports from them, it would be “handy for everybody,” as he expressed it. Dalal approached Bangladeshi organ recipients in the hospital and shared his idea. Five months after commencing his business, Dalal was able to match the tissues of his first clients, and their operations were successfully performed in India. Dalal mentioned that he received 10,000 ($143) from the recipient, and did not ask any money from the seller, which is the typical “business policy” he continued to follow. At the time of the interview, Dalal claimed to have collected more than 500 tissue-typing reports from both recipients and sellers, and to have arranged 97 kidney transplants that were performed in Bangladesh, India, Pakistan, Singapore, and Thailand.

At the end of the interview, Dalal and I outlined three possible approaches to locating kidney sellers: first, making phone calls to the sellers who were still linked with
Dalal; second, seeking the sellers whose permanent addresses were accessible to Dalal; and finally, contacting Dalal’s recipients who were currently connected with their sellers. We decided that Dalal should approach the kidney sellers, as they might not disclose their activities to an unknown researcher.

Dalal immediately made arrangements for me to meet Shamsu, a 30-year-old kidney seller who lived in Natore, a northwestern town in Bangladesh. Shamsu had sold his kidney to a Bangladeshi-born US citizen living in New York. The operation was performed in South India in July 2003. By the end of December 2004, four months after I began my research, I had interviewed four more kidney sellers via Dalal. All of them were male, and their ages ranged from 27 to 41 years. Their professions varied, from barbers to street vendors to commercial artists. All of the kidney recipients resided in Bangladesh, except a female Bangladeshi immigrant who was living in Italy. Three transplants were performed in India and the other in Bangladesh, between November 2000 and March 2003.

The Final Cut

My fieldwork encountered new difficulties when Dalal decided to go on a business trip to India for two months. Due to the limited time allocated for fieldwork, I insisted that he provide me with some kidney sellers’ contact information. After several attempts, I collected from him about 30 contact addresses of recipients and sellers. Dalal asked to be paid for arranging interviews as well as for providing contact addresses. He demanded a huge amount of money for transportation, telecommunications, and time

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14 Dalal accompanies recipients who pay the fee, transportation, accommodation, and compensation for his time during the operation in India. He called them “special clients”; there are on average two per year.
allocation. I carefully examined his bill and reduced it to about $25 for fixing interviews with five kidney sellers. I refused to offer any payment for providing contact addresses.

I eventually realized that Dalal provided me with only those addresses that were difficult to contact. I initially attempted to contact the sellers, even though they lived in remote parts of Bangladesh (thus, areas that would have been difficult to get to due to poor transportation). Some sellers’ addresses were incomplete, incorrect, or no longer in use. In addition, some of the telephone numbers were no longer in service. Nevertheless, I was successful in contacting one seller, and scheduled an interview with him. Unfortunately, this seller did not appear at my apartment despite several attempts to reschedule. Based on Dalal’s list of addresses, I also contacted some recipients by phone. These recipients expressed concern about my call and asked how I had obtained their phone numbers. Using Dalal’s name as a reference was not enough for them to trust me.

I was stuck again! When I realized that a kidney seller might facilitate the trust between recipients, sellers, and me, I employed Shamsu (the first interviewed seller from Dalal) as a research assistant. Shamsu had extensive knowledge of the kidney trade, as he had traveled to India twice: once to sell his kidney, and once to accompany his brother, who was also selling his kidney. Shamsu and I discussed ethical guidelines, upcoming workloads, and possible remuneration. Shamsu was also informed that his contribution would be gratefully acknowledged in the publication. With the support of Shamsu, I was able to interview seven more kidney sellers by the end of February 2005. Of these seven interviewees, only one seller was female: a 37-year-old divorced woman (living with one son and one daughter) who earned her livelihood selling fruit on the
streets of Mymensingh. The other sellers were all male, between ages 25 and 42, with diverse professional backgrounds, from farmers to butchers.

Based on Dalal’s list, Shamsu and I deduced that most sellers lived in the northern part of Bangladesh. To locate sellers, Shamsu agreed to travel to Mymensingh, Natore, Dinajpur, Rajshahi, and Ishwardi, some of the northern towns in Bangladesh (see Map 2.1 on the next page). When Shamsu met sellers in their homes, he invited them to go to a tea stall. At the beginning, Shamsu introduced himself as a kidney seller, then outlined the research to them, and finally asked for an interview. He successfully gained most of the sellers’ trust because he was a seller as well. At every meeting, Shamsu called me from his cellphone and I talked with the sellers. I explained the research project, outlined ethical principles, obtained their trust, and scheduled their interviews. Two sellers refused to meet with me: one seller scheduled an interview but did not appear on the day. Shamsu also approached several organ recipients residing in Dhaka, but they did not reveal their sellers’ identities. Only one recipient agreed to introduce his seller and was given my phone number. He eventually contacted me and I was able to conduct an interview with his seller.

Interviews with 13 kidney sellers revealed that a man named Batpar Azam (a pseudonym) was the main broker for kidney trading in Bangladesh. Many Bangladeshi sellers went to Batpar and concurrently kept in touch with Dalal to maximize their chances of matching tissues with potential buyers. I obtained Batpar’s telephone number from these interviewed sellers and called him in mid-February 2005. I mentioned to Batpar that I would like to meet with him instead of talking over the phone in order to discuss kidneys.
The number represents how many interviewed sellers came from that region.

Figure 2.2. Map of Bangladesh.
Source: www.dcdhaka.gov.bd/bangladesh_map.jpg
I still remember that early afternoon, walking through dark alleys in old Dhaka with my wife. She accompanied me, as meeting with Batpar was very dangerous. I also wanted to make it clear to Batpar that I was not a local journalist hiding my identity in an attempt to reveal his illegal business. My wife and I introduced ourselves, outlined the research, and guaranteed confidentiality. Batpar was accompanied by several men. He completely denied being involved in the illegal kidney trade. He warned us that by contacting him we were “playing with fire.” Since we didn’t have any power to challenge him, we requested that he call my cellphone or come to my home address if he could support the research in any way. When we left his office, we felt very relieved to return to Dhaka’s city life.

Batpar never did contact me, but I was constantly worried and felt on numerous occasions that somebody was following me. Despite this threat to my safety, I realized that it was important to interview Batpar’s clients in order to obtain different insights on the kidney trade. I asked both Shamsu and Dalal about the possibility of contacting some of Batpar’s clients. Shamsu had met a few sellers who had sold their kidneys through Batpar during his own and his brother’s transplants in India, and Dalal had come across some of Batpar’s clients through business. Based on Dalal’s information, Shamsu tried to contact a client of Batpar’s who lived in Dhaka. After several attempts, Shamsu was able to contact the seller, but the man refused to discuss his selling experience with a researcher. It was a long time before I met some of the sellers who had sold their kidneys through Batpar.

Dalal arrived back in town in early March 2005. He arranged for me to meet with nine more kidney sellers, all of whom were his clients. All the sellers interviewed were
men who lived in various parts of Bangladesh, including Dhaka, Barisal, Khulna, Bagerhat, and Rajbari. Six sellers went to India for the surgery, while three had the surgery performed at BSMMUH in Dhaka. Dalal was not satisfied with receiving his previous payment to fix the interviews, and so we agreed to raise his fee from $5 to $8.

The research gained momentum when Shamsu bumped into Sodrul Hossain, a 22-year-old undergraduate student at Dhaka College who had sold his kidney through Batpar. When I received Shamsu’s phone call I met with Sodrul right away in front of the Dhaka public library. The three of us sat down in a tea stall, and Shamsu and I convinced Sodrul to meet with us again for an interview. In an interview lasting over nine hours, Sodrul revealed how Batpar, an evasive kidney broker, often brutally exploited the kidney sellers. According to Sodrul, Batpar usually transported four or five sellers at a time to India, where they lived in a bachelor apartment, which he continually rented for that purpose. He charged kidney recipients huge amounts of money and paid as little as possible to the sellers. Like other sellers, Sodrul did not receive the entire payment that Batpar had promised. The sellers could not challenge Batpar, as he was a rich businessman who was well connected with powerful Bangladeshis. At the end of our meeting, Sodrul mentioned that he might have the contact addresses of some sellers who went to India with him. Although Sodrul agreed to provide their contact information, he never picked up or returned my phone calls. Perhaps he was afraid to talk about Batpar.

The other major turning point in my research came when Dalal introduced me to a 48-year-old man who had purchased a kidney through Batpar. I called the recipient, who revealed that he was still in touch with the seller, a 32-year-old rickshaw puller and day laborer named Dildar who lived in Bhairabbazar. Less than two weeks later, Dildar called
me while visiting Dhaka. Over the phone, I outlined the research and convinced him to proceed with an interview. During the interview, he described in detail his experience of selling his kidney through Batpar. Dildar was frustrated since he did not receive full payment from Batpar even after he called more than 30 times and visited his office about 10 times. Both Dildar and Sodrul, who had sold their kidneys through Batpar, told similar stories. Dildar also provided me with the contact information of four other kidney sellers with whom he had become friends while staying in Batpar’s apartment in India. I arranged interviews with three of these sellers. These three sellers also mentioned Batpar’s murky business practices and the exploitative context of the kidney trade in Bangladesh. Thus, I was able to apply the snowball sampling to Batpar’s sellers, as they had stayed together in the tiny bachelor apartment in India.

After several failed attempts, I finally located and interviewed two female kidney sellers, Hena Begum and Nergis Begum, sisters-in-law who lived in Pirozpur. They told me that their husbands had asked them to sell their kidneys in order to give their family better economic stability. In all, I was able to interview 29 kidney sellers by May 2005.

I wished to interview other sellers in subsequent months, but I realized that my fieldwork was coming to an end. Nevertheless, I interviewed three more sellers as arranged by Dalal, since these sellers went to Pakistan, Singapore, and Thailand for the operations. I thought that their experiences might be different from the others, and therefore informative for the research. These interviews revealed how wealthy Bangladeshis obtained kidney transplants and care in various nations. During one interview, a seller compared his experiences in India and Thailand. He initially went to
India for the operation, but his recipient died, so the seller went to Thailand with another recipient.

Lastly, through the brother of one of my research assistants, I interviewed a seller who had managed to sell his kidney without a broker. All in all, I was exceptionally privileged to collect rich narratives from 33 kidney sellers.

During the fieldwork, I also collected data from other relevant research populations, including recipients and their family members; potential organ buyers; possible sellers; kidney brokers; health personnel, including nephrologists, urologists, post-graduate trainees, nurses and laboratory technicians; the president of the Kidney Patient Welfare Association; a member of Bangladeshi Private Body Donation Group; journalists; documentary filmmakers; lawyers; social workers; university faculty; and students. These interviews provided insights and helped to situate the research collected from the sellers. Access to these research populations was relatively simple, though there were a few exceptions especially among organ buyers. I was fearful, for example, when I went to interview a potential liver buyer in a hotel in downtown Dhaka. This potential buyer had posted a newspaper ad in the daily *Prothom Alo* on April 25, 2005; after many calls, I finally arranged his interview by mentioning my desire to discuss the issue in person. He told me to meet him in the late evening at a major intersection in Dhaka. Before leaving, I informed my family and friends of our meeting place. As I was waiting, I called the buyer on his cellphone frequently, but nobody picked up. I then received a phone call on my cellphone, but when I answered, the person on the other end hung up. It turned out to be a trick so that the person could observe and identify me. He eventually came forward and told me to come to the hotel for our discussion. In other situations, I
successfully obtained data from a Bangladeshi woman who posted a newspaper advertisement to sell her cornea, a Bangladeshi recipient who had collected money through art exhibitions and charities in order to purchase a kidney in Islamabad, a Canadian recipient who traveled from Ottawa to Dhaka to purchase the kidney of a poor rickshaw puller, and another Canadian who traveled to Islamabad to purchase a kidney for her mother. Through these various interviews with kidney sellers, buyers, brokers, and those involved with organ trafficking, I managed to gain access to this hidden population for conducting fieldwork in a black market for organs.

Conducting the Interviews

My fieldwork was based in Dhaka, the capital and the largest metropolis of Bangladesh (see Map 2.1). Dhaka is the only city in the country where kidney transplants are performed and where organ commodification is concentrated. Bangladeshis travel from different parts of the country to Dhaka in order to obtain organ care in two established public and private kidney transplant units, in public and private dialysis facilities, and in many laboratory examination centers. Dhaka therefore became the epicenter of my research; my research assistants and I traveled to various parts of Bangladesh to locate kidney sellers and collect data. My fieldwork data, however, is nevertheless circumscribed in its scope, considering that interviews were held with a very small subset of the population. My research therefore cannot be taken as representative of the rich social and cultural diversity of Bangladesh, and the results of my study are in some respects both tentative and preliminary.
Nevertheless, the interviews I was able to conduct produced about 1,500 pages of interview transcripts and diverse supporting documents. Interviews, participant observation, and case studies therefore provided rich ethnographic data to explore and examine organ commodification in Bangladesh.

Library research provided me with newspaper advertisements published in five Bengali dailies from 2000 to 2004. These advertisements were later used to analyze public discourses surrounding organ selling. Supporting documents such as forged passports, notary certificates, government documents, laboratory examination reports, a personal diary of a kidney seller, letters from recipients to sellers, written trade agreements, a copy of the Organ Transplant Act, a Bengali film on kidney selling (Shaheb) and a novel (Ruper Palanka), and photographs of 33 kidney sellers also formed part of my data.

Though various research methods were employed, conducting interviews remained the key method of collecting data. In order to interview kidney sellers, it was imperative that I create a safe environment in which they felt comfortable. The location of interviews was significant, especially given that people wished to have their confidentiality ensured. The sellers preferred to meet with me away from their neighborhoods in order to conceal their actions. Thus, I arranged to conduct all interviews in the living room of my apartment in Dhaka. Many sellers resided in different parts of Bangladesh, and therefore must travel on average seven hours to Dhaka by bus or train. Sellers often would start their journeys late at night; Dalal, Shamsu, or I would pick them up the following morning. Since I had not met the sellers before, it was difficult for me to find them at their destination. For this reason, upon arriving, sellers called me from
a pay phone so we could exchange descriptions of our clothing and appearance. Our encounter often resembled scenes from movies in which illegal goods are being exchanged.

These “interview” mornings typically started by having breakfast with the sellers. Most sellers then took a shower to feel refreshed after their long journey. My main goal at this point was to create a relaxed zone for the interview. On average, interviews lasted 10 hours, though they ranged from six to 14 hours, and typically lasted until the evening. Usually my wife prepared both lunch, which gave us a half-hour break, and dinner. The seller, my wife, and I shared the food together, which was a pleasant way of interacting and ending the interview. I then dropped the sellers off at a bus or train station, and compensated them with one day’s salary plus the cost of transportation, which ranged between $10 and $15.

At the beginning of each interview, I informed the research participants of the ethical guidelines from the Ethics Review Board at the University of Toronto. I clearly outlined to participants the nature and scope of the research in writing or orally. As mentioned earlier, confidentiality, one of the key issues in conducting research with hidden populations, is especially important given that some participants may be involved in activities that are legally ambiguous or prohibited. Before conducting any interview, I discussed and evaluated with them the possible consequences of using their true identities. Later, I disguised features in my field notes, transcripts, and publications that could be used to identify individuals.

Before the interview, I also informed participants that their participation was voluntary and they were free at any time to withdraw their consent to be included in the
study. They also could request that any part of the interview not be used. I then asked participants to sign and date an informed consent form to indicate their willingness to be included in this research. Each interviewee was given a copy of this form to keep for his or her own records. Despite following the procedures required by the ethics protocol, I found that written and signed informed consent forms are of limited value in Bangladesh, especially with kidney sellers, recipients, and brokers who must remain anonymous. Consent forms therefore aroused suspicion. At times, these forms were inappropriate, since most of the participants in this research were illiterate. As a result, I often read an alternative informed consent script to such respondents in order to provide them with information outlining the details of the research and the nature of their participation. I then asked for a verbal indication of their willingness or lack of willingness to participate. In all cases, the informed consent form and script were provided and communicated in Bengali.

Unstructured, narrative-based interviews allowed me to establish a casual relationship with kidney sellers, and gave them the opportunity to talk. Most sellers would openly ask me questions related to kidney selling. My responsibility was to guide the conversation according to the purpose of the study. I attempted to develop an informal way of exchanging ideas in which we were interviewing each other. Although no structured questionnaire was followed, a thematic arrangement was considered for the interviews. The thematic focus of the interviews can be divided into three sections.

First, the socio-economic conditions of the seller – including name, age, educational qualification, occupation, monthly income, gender, religion, marital status, and family size – were used to initiate conversation and to generate a preliminary rapport.
Second, the experiences of the kidney sellers were discussed in detail. This phase of the interviews started with my asking how and when they became aware of kidney selling. The discussion was then expanded to other issues, such as the reason for selling kidneys; how they dealt with their family; how they connected with the network of commodifying kidneys; how much money they were promised and how much they actually received for the kidney; how the money was spent; how they evaluate the financial and other benefits versus the losses of selling a kidney; the health consequences of pre-operative, operative and post-operative kidney exchange they experienced; what kind of relationship the sellers presently maintained with the recipient; and whether they were familiar with legal aspects of kidney commodification. The sellers shared their stories and described their experiences in rich and moving narratives.

Finally, the last stage of the interview commenced with a discussion on how and why human organs, especially kidneys, are widely exchanged in Bangladesh. This discussion was followed by other ethical, political, and cultural topics, such as who benefits from commodifying organs, whether organ exchange should be regulated or banned, the ethical dilemmas of organ commodification, and the role of the government of Bangladesh regarding this issue. In some cases, we discussed why a cadaveric organ donation program does not exist in Bangladesh, and how religious ideas and beliefs come into play in the exchanging of organs. Finally, we explored how the body is generally perceived before and after the transplant surgery. In this stage, the sellers engaged in exploring of critical and theoretical issues related to organ commodification in Bangladesh.
At the end of the interviews, I asked the sellers’ permission to take their photographs. Most sellers were hesitant about posing for pictures, but I guaranteed that no photograph that could possibly identify them would be published without their consent. I also informed them that the purpose of these photographs was to recall, support, and validate the data. Some sellers did give their permission to publish outside of Bangladesh pictures that showed their faces. In all, I took six or seven different shots of each seller.

I interviewed every seller individually, except for three, who were accompanied by either a husband, cousin or friend. I conducted only one interview per day, except in one case, where I had to interview two sellers who visited Dhaka on the same day. (In this case, the first interview was conducted from 7:30 a.m. to 2 p.m. and the second from 2 p.m. to 8 p.m.) Except for one seller, I was able to complete the interviews without any interruption. (The one seller had to leave for an appointment during the middle of our discussion, but he came back again the following week to complete the interview.)

In addition, recipients, their family members, doctors, and brokers (see Table 2.1) provided important data on kidney commodification.

<table>
<thead>
<tr>
<th>Interviewees</th>
<th>Totals</th>
</tr>
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<tbody>
<tr>
<td>Sellers</td>
<td>33</td>
</tr>
<tr>
<td>Recipients</td>
<td>7</td>
</tr>
<tr>
<td>Recipients’ Family Members</td>
<td>11</td>
</tr>
<tr>
<td>Doctors and Postgraduate Trainees</td>
<td>14</td>
</tr>
<tr>
<td>Organ Brokers</td>
<td>4</td>
</tr>
</tbody>
</table>
These relevant research populations were selected at random. I carried out their interviews in different locations, such as public and private transplant hospitals, dialysis centers, intensive care units, kidney wards, newspaper offices, universities, libraries, legal chambers, residential hotels, private offices, and personal dwellings where illegal kidney exchanges are performed, discussed, and debated. The length of these interviews varied widely between one and 10 hours.

In addition to interviews, I also used participant observation, a hallmark of ethnographic research, to collect data for this research. I spent a considerable amount of time conducting participant observation in transplant units and dialysis centers when doctors were on rounds, nurses were on duty, and post-graduate trainees were on lunch breaks. I “hung out” in the nephrology departments when donors were lounging in the waiting room, patients were being prepared for surgery, and their family members were cooking in the hospital kitchen. I was also able to observe activities in variety stores, where recipients photocopied fake documents, and on street corners, where brokers approached potential recipients and made promises to find sellers. My participation and observations were recorded in field notes and later analyzed, and subsequently provided a valuable source of ethnographic data.

I also used case study methods to support the research and cross-check the data. Three cases (including the recipient Kamal and the seller Manik) were examined for a deeper understanding of the interactions between recipients and sellers. For these studies, the recipient and seller interviews were carried out and followed up separately.

As a final comment on the interviews and the interview process, I note that using a tape recorder, a common technique of documenting data, was not suitable for this
research as the respondents were not comfortable with my recording their experiences in this fashion. I did use a tape recorder during one interview with a seller, but this technique proved detrimental, as he was not spontaneous and it took me a long time to establish a rapport between us. Instead, all interviews were recorded in the form of written scripts.

**Conclusion**

Every fieldwork experience is distinctive, but most researchers strive to fully engage and participate with the population they study. This is not always possible, especially when the research subjects are vulnerable and involved in criminal activities. The major drawback of my fieldwork was that I could not do participant observation of the organ trade as I had originally planned, but rather collected interview data from 33 sellers who recalled their experiences within Bangladesh’s organ trade. It would have been remarkable had I been able to “follow” a kidney seller and observe his or her actions during every stage of the selling process, but this was not possible.

The level of difficulty in accessing data on the kidney trade may partly explain why the study of kidney sellers is extremely rare, except for short journalistic reports. My study begins to draw a fuller and more detailed portrait of this black market, but it is limited in terms of gender representation, as I interviewed 30 male sellers but only three women. (Being a man in the predominantly Muslim society, I was certainly fortunate to have been able to interview these female sellers.) Despite the limitations that I have outlined above, this research is insightful, as I did not apply a top-down approach; in other words, I did not follow Western recipients to find their sellers. Rather, I
successfully employed a bottom-up approach in order to understand the local and ethical complexities of this global issue. I am therefore pleased to record here the detailed experiences and the voices of 33 kidney sellers, which until now have been silent in the literature. This chapter has outlined how I contacted hidden groups and has detailed the ethnographic methodology I utilized in an underground setting. Given that work in hidden populations is expanding, it is hoped that my discussion here can also contribute to more generalized debates on methodologies that are respectful of hidden populations and appropriate for studying black markets.\textsuperscript{15}

\textsuperscript{15} The ethnographic fieldwork in black markets and among hidden populations is on the rise. Currently, Kaveh Khoshnood, Merrill Singer, Kevin Irwin, and Craig Fry are editing a book provisionally entitled \textit{Ethics in the Shadows: Moral Challenges in the Study of Illicit and Stigmatized Behaviors}, with publication planned for 2010.
CHAPTER THREE

Kidney Bazaar in Bangladesh

_The recipient_ – How much do you want?
_The seller_ – I need 200,000 Taka ($3,000).
_The recipient_ – Many others have come to me to sell their kidneys. They asked for only 50,000 Taka ($700). Why are you asking this much? Is the quality of your kidney better? But it should not be that good. Yours is also made in Bangladesh. Generally, the products made in Bangladesh are not good. – Humayan Ahmed, a prominent Bangladeshi novelist writing on the bargain between a potential kidney recipient and a seller (Ahmed 2003: 19)

Six centuries ago, Ibne Battuta, a Moroccan medieval traveler whose extensive voyages took him to Persia, China, Sumatra, and Timbuktu, was so captivated by the prosperity of Bengal that he wrote: “This is a country of great extent, and one in which rice is extremely abundant. Indeed, I have seen no region of the earth in which provisions are so plentiful” (Hartmann and Boyce 1983: 11). Today, Bangladesh is one of the poorest countries in the world. The roots of its poverty are derived from colonialism and have been exacerbated by neo-liberal reforms, as well as by population growth and natural disaster. Acute poverty often forces many poor people to turn to organ trade in the People’s Republic of Bangladesh.

Bangladesh, as a part of the Indian subcontinent, served as a British colony for nearly two centuries. The East India Company defeated Nawab Siraj-ud-Daulah, the last Mughal emperor, in 1757, and plundered the Bengal until 1947. The British rulers extracted Bengal’s wealth mostly through deindustrialization, land reform, and high taxation. They destroyed Bengal’s textile industry and employed Bengali workers in indigo cultivation, which helped to finance Britain’s industrial revolution (Hartmann and
Boyce 13). Ultimately, the development of Britain was the underdevelopment of Bengal. Historian Romesh Chunder Dutt (1906) outlines this underdevelopment:

The people of Bengal had been used to tyranny, but had never lived under an oppression so far reaching in its effects, extending to every village market and every manufacturer’s loom. They had been used to arbitrary acts from men in power, but had never suffered from a system which touched their trades, their occupations, their lives so closely. The springs of their industry were stopped, the sources of their wealth dried up. (Dutt 1906: 27)

At the end of British colonization, Bengal, the so-called Manchester of England, had turned into a land of poverty.

In the dying days of its rule, British divided Bengal based on religion into two halves – the East belonged to Pakistan and the West belonged to India. Sir Herbert Risley, then the Health Minister, expressed frankly his motive behind this separation. Arguing that a united Bengal was a power, he wrote: “Bengal divided will pull in different ways … One of our main objectives is to split up and thereby weaken a solid body of opponents to our rule” (Tripathi 1967 in Hartmann and Boyce 1983: 15). Under this political ploy, East Bengal returned to another colony of Pakistan for almost two and a half decades. Bengal’s exploitation continued through the expansion of Pakistani neo-colonialism. East Bengal/Pakistan was forced to serve as a satellite of West Pakistan. Raw industrial materials from the East were extracted to the West, but the East was used as a market for selling finished products of the West (Virtual Bangladesh 2005: 2). Consequently, many industries were destroyed in the East but flourished in the West. Further, the East’s revenue earnings, mostly from jute and tea export, were used to build up Western cities. During this neo-colonial regime, a calculated net transfer of resources from East to West Pakistan was approximately $2.6 billion based on the exchange rate of

16 Andre Gunder Frank, an eminent dependency school scholar, theorizes similar processes in the context of Latin America, in particular, in his writing on Capitalism and Underdevelopment in Latin America (1969).
the time (*Virtual Bangladesh* 2). Due to such economic exploitation and political devolution, as well as cultural and language differences (East and West are geographically separated by 1,000 miles of a huge foreign territory, and their languages are Urdu and Bengali respectively), the East Bengalis asked for the secession of their own land from Pakistan. After a nine-month brutal war, Bangladesh became independent and a sovereign state on December 16, 1971. Its national flag represents a circle of 300,000 Bengali freedom fighters’ blood on its green land.

Bangabandhu Sheikh Mujibur Rahman, the “father” of the nation as well as its founding president, started the journey of the Republic of Bangladesh with four key goals: nationalism, democracy, socialism, and secularism. His cabinets nationalized all major manufacturing companies and put regulations on the state economy. However, the country faced economic deterioration after returning from a war and long colonial exploitation, as well as being impeded by the growing political lawlessness. After the notorious 1974 famine, the country experienced another catastrophic event. In 1975, Bangabandhu and his family were assassinated in Dhaka by a group of army officials. Martial law was put in place and Major General Ziaur Rahman became the new president, bringing with him his 19-point program of neo-liberal economic reform.

On this historical turn, Bangladesh became one of the very first countries to open up the former nationally regulated economy to foreign investment (*Zora* 2005: 2). In 1981, Zia was also assassinated. He was replaced by Lieutenant General Hossain Mohammad Ershad through a second military coup. In a similar fashion, Ershad implemented a “new industrial policy” that fostered further privatization, deregulation,

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17 Samir Amin, a dependency school thinker, eloquently explains these processes in his writing on “blocked economic underdevelopment”. See in particular *Neocolonialism in West Africa* (1973) and *Unequal Development: An Essay of the Social Formations of Peripheral Capitalism* (1976).
and flow of foreign investment into newly created export processing zones (Zora 2). After a decade of military and authoritarian rule, Ershad was forced to resign due to massive public protests, but the country was already in major economic crisis. During these two military regimes, the structural adjustment policies under the auspices of the World Bank and the International Monetary Fund were seeded in Bangladesh but the economic reforms were not effective.

The economic situation from that time onwards did not improve steadily, but democratic voting rights improved somewhat. In a reasonably “fair” election in 1991, the Bangladesh Nationalist Party, led by Khaleda Zia, the widow of Major Zia, took power with the support of the Islamic fundamentalist party. Prime Minister Khaleda, however, intensified the neo-liberal policies that were carried out by her military predecessors. In 1996, in another democratic election, the Bangladesh Awami League, led by Sheikh Hasina, daughter of Bangabandhu, formed the government. This time, Bangladeshis dreamed of seeing Bangabandhu’s Bangladesh restored, but Hasina also adopted the free market economy and executed the structural adjustment policies. Based on their economic resemblance, both Khaleda and Hasina were re-elected in 2001 and 2009 respectively, but within escalating political turmoil and with the support of caretaker governments. Both of them have massively privatized public enterprises, such as the state banks, power generation, and telecommunications. With the people’s mandate, these leaders ironically closed the Adamji Jute Mills, the 51-year-old state-run industry that employed 26,000 workers at its height and created a new industrial zone there. These leaders greatly reduced customs taxes and tariffs to attract foreign capital; the garment
industries flourished because of very cheap labor (the wage is now half that of China), but at the cost of the workers’ severe exploitation.

The neo-liberal economic reforms and their counterpart, the lack of policies of distributional justice, have resulted in widening social inequality, displacement of the poor, and massive unemployment, all of which exacerbated the overall poverty situation in Bangladesh (Nuruzzaman 2004: 37; Vogl 2007: 3). One of the consequences of these economic reforms was the formation of a small group of a dominant class that effectively controls the total industrial and financial assets of this poor nation (Nuruzzaman 2004: 33; Navarro 2006: 7). By depriving the poor majority, these 3% of privileged Bangladeshis currently own 97% of the nation’s total wealth. It is for them, that the showrooms of expensive cars such as Mercedes, BMW, and Volvo have recently appeared in Dhaka.

The vast majority of Bangladeshis were left out of these economic reforms. Although nearly two thirds of Bangladeshis are primarily occupied with agriculture and the country possesses the most fertile lands in the world, Bangladesh is experiencing food shortages every year. The pro-business agenda of the state did not prioritize the agricultural sector, but rather cut subsidies to it. Currently, the Bangladeshi mode of production is transforming from feudalist to capitalist. Consequently, many rural dwellers and small holders are selling their lands and becoming landless (Akanda and Ito 2008: 23; see also Ahmad 2005). A popular primary school textbook written by the Bengali poet Jasimuddin outlines the suffering of the poor villagers in this way:

Gani Miah, a poor farmer with no land of his own, cultivates paddy and jute in the land of others. He gets two-thirds of the produce of that land. His daughter got married in last March. To pay for his daughter’s dowry, he had to borrow a large
sum of money and incur debt that he is still not able to repay. Now his sorrows have no bounds. (The Bangladesh Observer 2006: 1)

To a great extent the farmer of this textbook is representative of rural Bangladeshis. Many such landless farmers (62% of the total number of Bangladeshi farmers) are migrating to cities in search of a better future. Consequently, the typical poor small farmer becomes a poor rickshaw puller, while his wife becomes a maid.

Overall, due to the colonial economic underdevelopment and neo-liberal reforms, the urban city landscapes are crammed with *bostis* or slums, while the countryside is filled with frail houses made of mud, bamboo, and straw. 81.3% of Bangladeshis live on less than $2 a day (*UNDP* 2009: 189). The annual per capita income of Bangladesh is around $380 (*ICDDRB* 2009: 1). About 40% of the entire population does not have any employment opportunities (*Index Mundi* 2009; 1). “We cannot eat and wear, we are poor” – this is the chorus of most Bangladeshis in the land of the highest levels of poverty in South Asia.

Neo-liberal economic policies contribute to an immense social and economic inequality and the exploitation of the poor that turns Bangladesh to a land of hunger. But “the neo-liberal era,” as Paul Farmer explains, “has been a time of looking away, a time of averting our gaze from the causes and effects of structural violence” (Farmer 2005: 16). The extreme poverty of Bangladesh is an outcome of “structural violence” (borrowing from Paul Farmer 1999; 2005) that is expanded in the black shadow of colonial exploitation, political voracity, and neo-liberal reforms. It is a human-made disaster manifested through certain structural and historical processes (Sen 1982; Rahman

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18 In 2008, 27% of Bangladeshis lived in urban settings. The current annual rate of urbanization is 3.5% (*CIA*, The 2009 World Fact Book). In addition, 62% of farmers in Bangladesh are landless (*World Vision* 2007).
1986; Arens and Beurden 1980; Griffīn 1989; Jansen 1986). It is also intensified by demographic factors and natural disaster (Maloney 1988). Although there are some non-governmental initiatives, such as the Grameen Bank’s micro-credit financing (for which Dr. Mohammad Yunus was the first Bangladeshi to win the Noble Prize), the scheme is criticized for being unable to reach out to the poorest and to resolve poverty (Wood and Sharif 1997; Milner 2000).

At present, the total area of Bangladesh is 55,599 sq. miles (147,570 sq. km). The country lies in the northeastern part of South Asia: it is bordered by India to the west, north and northeast, Burma to the southeast, and the Bay of Bengal to the south. Bangladesh is known as river based, with almost 700 rivers spread throughout the country. Due to its deltaic location, Bangladesh is vulnerable to severe natural disasters, such as floods, tropical cyclones, tornadoes, and tidal bores; consequently, about one third of the country is flooded during the monsoon season each year (CIA 2009: 1). In addition, it is the most densely populated country in the world. Approximately 140 million Bangladeshis live in an area one twentieth the size of India (about the same size as the state of Iowa in the United States). The capital, Dhaka, alone has a population of more than 14 million. Thus, rapid population growth is a serious concern. Although in the last five years the population growth rate has declined, it is still outpacing the capacity of the economy to provide even basic human needs. The condition of poverty is excruciating in Bangladesh.

Consequently, as a result of the poor conditions, the health situation of Bangladesh has become alarming. A staggering 77% of Bangladeshis lack the minimal requirements for a healthy human existence (Zora 2005: 2). The average lifespan of its
citizens is 60 years: 57 years for male and 63 years for females (CIA 2009: 1). The nutritional status of Bangladeshis is among the world’s most substandard; about one-quarter of all households are hungry (United Nations 2009b: 1). According to United Nations (2009), malnutrition is a major cause of death and debility in children in Bangladesh; about two million children are suffering from acute malnutrition (United Nations 1). 54% of preschool-age children, equivalent to more than 9.5 million children, manifest stunted growth, 56% are underweight, and more than 17% are “wasted” (United Nations 1999: 3). Additionally, many people have anemia due to lack of nutrition; about 50% of Bangladeshi women have chronic energy deficiency (United Nation 3). Clearly, the country is suffering from harrowing health conditions.

In addition, communicable diseases such as dengue fever, malaria, tuberculosis, leprosy, and filariasis spread rapidly. Every year, due to massive floods, the lands and waters of Bangladesh are contaminated by both disease pathogens, such as cholera and dysentery, and chemical toxins, such as arsenic. Hot and humid weather also fosters the spread of many diseases. Overall, according to government statistics, over 2.2 million Bangladeshis were affected by diarrhea and 393 people of them died from it in 2008 alone (Xinhua News 2009: 1). Malaria is a major public health problem in Bangladesh, as about 26 million people are at risk and a total of 598 deaths were reported from malaria in 2002 (World Health Organization 2009b: 73). Tuberculosis continues to be another significant public health problem; every year, more than 300,000 new cases occur in Bangladesh (World Health Organization 2004b: 32). Other communicable diseases, such as measles, tetanus, polio, and kala azar (visceral leishmaniasis) are major silent killers. In addition, many non-communicable diseases, such as rheumatic heart disease,
pneumonia, tobacco-related illness, and physical disability are rarely diagnosed and treated, thus contributing to the high death rate, which is 8 deaths per 1,000 people, while infant mortality is 57 deaths per 1,000 live births in Bangladesh (CIA 2009: 1).

The health care infrastructure is extremely poor in Bangladesh, with very few hospitals to provide health care for all Bangladeshis. For example, in 2006, there were only 589 public and 2271 private hospitals in Bangladesh (Directorate General of Health Services 2009: 14). Most private hospitals are located in cities, and the poor cannot afford to pay for health care. Overall, the public hospitals are poorly equipped, have few beds and have limited medical personnel: there were only three hospital beds, three physicians, and one nurse for 10,000 people in 2005 (World Health Organization 2007a: 19). Basic medical and diagnostic equipment is also in drastic short supply. After visiting an operating room in Bangladesh, Christine Cameron, a palliative care nurse from Canada, noted that there is nothing wasted; items that are considered disposable in North America are reused many times (Williams 1996: 3). Less than 40 % of the population has access to basic health services beyond immunization and family planning (United Nations Economic and Social Commission for Asia and the Pacific 2002: 1). In spite of the high maternal and infant morality rate, only 24% of pregnant women receive antenatal care, and only 13% of births are attended by someone with formal training (Ahmed and Jakaria 2009: 46). This portrayal illustrates the very limited public health care infrastructure for the number of people who need such services in Bangladesh. Although some high-rise private hospitals, such as Apollo and Square, were recently established in the country, only a very few Bangladeshis can afford to obtain health care there.19

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19 Lawrence Cohen (2002) observes that Apollo is not only a hospital that looks like a five-star hotel, it is a five-star hotel that looks like a hospital (Cohen 2002: 16).
Additionally, the public health care service (as well as most private services) is remarkably poor in Bangladesh. Many doctors live with their families in cities and work in private hospitals to earn extra money, even though their job postings are in rural public hospitals. As a result, about one third of the jobs for public doctors in thana, the local constituencies’ health complex, are vacant for years since the doctors refuse to go there, preferring to arrange alternative posts in the capital, Dhaka (Amadershomoy 2009a: 1). Moreover, nurses avoid nursing because of the colonial heritage in healthcare, poor salary, as well as Bangladeshi societal stigma towards nurses for their night duty, contact with strangers, and involvement in “dirty” work that is often associated with commercial sex work (Hadley et al. 2007: 1166). Further, the hygiene system in Bangladeshi public hospitals is very unsatisfactory; patients often sleep on grubby hospital floors in open spaces, their blood-soaked bandages lying all around them. The filthy toilets have inadequate sewage systems (Ahmed 2008: 2). The environment is so unsanitary that many people believe the public hospital to be one of the worst places in Bangladesh. In addition, public health service, which should be provided free of charge by the state, is mostly unavailable. Transparency International, an international non-governmental organization, conducted a study in Bangladesh revealing that 84% of the respondents to its survey mentioned the high rate of corruption in the supply of medicine (Transparency International 2005: 2). Similarly, Community Information Empowerment Transparency, an international NGO in Ottawa, Canada, collected data from a national survey in Bangladesh pointing out that one in every five people admitted “unofficial” payment to health workers in order to get public health services that are supposed to be free
(Community Information and Epidemiological Technologies 2001: 6; see also Rahman 2006: 10).

Overall, Bangladeshis suffer from the poor health conditions in their country. Many NGOs are working to improve this dire situation by providing basic health care services, but their effects are hardly enough to resolve this shocking health scenario. To make matters worse, socio-environmental factors contribute to many organ-related diseases, and corruption plays a central role in health care delivery – circumstance that are not unrelated to the flourishing black market in organs in Bangladesh.

Organ-related Diseases: Causes and Conditions

Although there is no reliable data, the general health conditions do not indicate low rates of organ-related diseases. Many factors, such as arsenic poisoning, air pollution, pesticide use, and smoking tobacco contribute to organ failure in Bangladesh. The country currently faces a major health catastrophe because most of the groundwater used for drinking has been contaminated with naturally occurring arsenic. Frequent and massive flooding has been cited as the reason for arsenic contamination (Pearce 2002: 3). The scale of this environmental disaster is enormous. The World Health Organization called that this could be the “largest mass poisoning of a population in history” (World Health Organization 2000a: 1). Among the 64 districts of Bangladesh, 59 districts have arsenic levels above the maximum permissible limit (SOS-arsenic 2002a: 9). It is estimated that between 35 million and 77 million Bangladeshi people are at risk of
drinking contaminated water (Smith et al. 2000: 1093). Arsenic poisoning thus poses a major health hazard in Bangladesh, given that people who ingest arsenic-contaminated water risk major diseases such as skin cancer and gangrene. Smith et al. have predicted that arsenic poisoning will lead to a further increase in cancers of the liver, kidney, lung, and bladder, as well as cardiovascular problems (Smith et al. 2000 in SOS-arsenic 2002a: 14; Unicef 2000: 6). Additional studies of the effects of arsenic in West Bengal, India, also indicate that ischemic heart diseases are associated with arsenic (Tsuda et al. 1995 in SOS-Arsenic 2002b: 3). In another study, restrictive lung diseases were found among 53% of a small sample of severely affected arsenic patients in West Bengal (Mazumder et al. 1997 in SOS-Arsenic 2002b: 3). Importantly, other research on those suffering from arsenic contamination reveals a relationship between exposure to arsenic and high incidences of diabetes, one of the major causes of kidney and pancreatic diseases (Rahman et al. 1998 in SOS-Arsenic 2002b: 3). Arsenic poisoning therefore contributes significantly to the number of organ-related diseases and failures in Bangladesh.

Air pollution is another major cause of organ malfunction. Dhaka, the capital of Bangladesh, is considered one of the most polluted cities in the world (Ayesha 2001: 1). The major sources of air pollution in Bangladesh are motor vehicle emissions, industrial emissions, and poor municipal cleanup services for sewage sludge. Air pollution contains lead, cadmium, mercury, copper, zinc, chromium, and carbon monoxide (Mahmood 2002: 1). The inhalation of such polluted air has direct effects on health. The lead level in Bangladesh is three times the acceptable level established by the World Health Organization air quality standard, and is the cause of extensive brain and bone damage

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20 While arsenic contamination of water occurs elsewhere, the problem in Bangladesh is drastic. In Argentina, for example, 10,000 people, in Mexico 20,000 people, and in Taiwan 20,000 people have been affected by arsenic contamination (SOS-arsenic 2002a: 17).
A publication by the World Bank reports that as many as 15,000 deaths, 100 million cases of sickness requiring medical treatment, and 850 million cases of minor illness could be avoided annually if air pollution levels in Bangladesh’s major cities were reduced to the levels in developed countries (Jian 1). Many people, primarily children and seniors, suffer from respiratory diseases caused by inhaling the polluted air (Ahmed 2000: 1). A three-year study in Bangladesh revealed that five children out of every 100 below the age of 14 who attended the country’s major hospital for outpatient treatment had cancer (Ahmed 1). Air pollution–related heart and lung diseases claim nearly 25,000 lives in Dhaka city alone every year (Ayesha 2001: 1; Hashmi 2001: 1). Thus, air pollution is yet another cause of the disproportionately high number of organ-related diseases in Bangladesh.

The excessive and unregulated use of pesticides in Bangladesh is another major contributing factor to poor organ health. This is of particular concern since two thirds of the population is employed in agriculture. A common belief among Bangladeshi farmers is that excessive pesticide use leads to higher yield (Heijnen 2001: 2). Thus, despite its relatively small land mass, Bangladesh used more than 11 million kilograms of pesticides in 1996, resulting in a threefold increase in pesticide use over the past decade (Heijnen 3). In addition, Bangladesh uses many banned, unsafe, and even smuggled pesticides, many of which do not meet safety standards (Heijnen 4; Fadinap 1999: 1). Much of this problem stems from pesticide dumping, where Western countries send large stocks of banned pesticides to Southeast Asia (Toxics Press Release 1998: 1). Also, many small local companies compound the pesticide problem by making “lookalike” copies of illegal pesticides.

In comparison, Bangladesh uses only one third of the amount of pesticides that Canada uses, but the total area of Bangladesh is one seventieth than that of Canada (Food Watch 2002: 1). Bangladeshi agriculture therefore relies much more heavily on the use of pesticides than Canada does.
well-known brands and selling these generic versions for profit (New Internationalist 2000: 1). Bangladeshi farmers often use these newly labeled pesticides because they are an inexpensive alternative to the standard regulated pesticides. The excessive and unregulated use of pesticides therefore creates an ecological problem that affects every living organism. Dangerous chemicals seep into the ground, into the water, and into human bodies. Given that pesticides are easily absorbed through the skin, lungs, and stomach (Macfarlane 1999: 1), the large population of Bangladeshi farmers, many of whom are professional sprayers, suffer from chronic health problems. In 1997, for example, poisoning related to the improper use of pesticides totaled 309,409 cases in Bangladesh (Heijnen 2001: 5). Other detrimental effects of pesticide use include cancer of the liver, pancreas, kidney, and lung.

Smoking is yet another cause of organ-related problems. Almost half of the male population of Bangladesh smokes tobacco (Uddin et al. 2009: 48). It is estimated that smoking-related trauma claims six victims every minute, or one death every ten seconds worldwide, and that the majority of these deaths occur in developing countries (Chopra 1997: 1). Particularly high incidences of smoking-related deaths occur in Bangladesh, India, and Pakistan (Chopra 1). The World Health Organization notes that about 102,000 deaths and 382,000 disabilities were caused by tobacco related illness (World Health Organization 2007b: 38). Smoking tobacco for as long as five years has a permanent effect on the lungs, heart, liver, kidney, and other organs (Brodish 1998: 3), and contributes to coronary artery disease, strokes, chronic pulmonary disease, and peripheral vascular diseases that in turn lead to heart attacks, bronchitis, and lung cancer (Brodish 5). High blood pressure is another outcome of smoking, and is the cause of 15% of
kidney disease cases in Bangladesh (Xinhua News 2008: 1). Passive smoking also contributes to poor health. As Bangladeshi people smoke almost everywhere, it is inferred that passive smokers are nearly five times more likely to develop asthma and twice as likely to develop respiratory problems (BBC News 2001: 1). These irreversible effects of smoking contribute to poor organ health in Bangladesh.

Further, extreme poverty also contributes to major organ maladies in Bangladesh. The high prevalence of pregnancy complications and anemia causes many renal failures in Bangladesh (Kidney Foundation 2005a: 2; see also Black Health Care 2000: 1). Diarrhea outbreaks due to seasonal flooding in Bangladesh are another key cause of acute renal failure (Kidney Foundation 3). Sanitation is poor and access to it scarce, which leads to urinary infections and kidney diseases. Villagers also frequently buy unprescribed and unnecessary drugs from village pharmacists, which is especially detrimental for kidneys (The New Nation 2009: 2). Further, poor Bangladeshis are forced to eat old and expired foods, such as betel nuts, rice, and pitha (small sweet or spicy homemade cake), that are covered by a specific kind of fungus that releases a toxin causing liver and pancreatic diseases (Ali 2002: 1).

The ultimate result of these socio-environmental factors outlined above is that approximately 12 million people are suffering from kidney-related diseases in Bangladesh, according to research carried out by a group of nephrologists at BIRDEM hospital in Dhaka (Amin 2009: 1). This figure translates into almost one out of every 10 people in Bangladesh. This study also reports that approximately 50,000 people die of kidney diseases every year, and there are 30,000 patients in renal failure in Bangladesh
annually (Amin 1; see also *Kidney Foundation* 2005: 3). Kidney failure is therefore one of the major health problems facing Bangladesh today.

Liver disease is also a common health concern in Bangladesh. Dr. Mohammad Ali (2002), a liver transplant surgeon in Bangladesh, notes that about 10% of the population of Bangladesh are chronic carriers of Hepatitis B, and 4% are chronic carriers of Hepatitis C. He reports that these two liver viruses alone affect about 18 million people in Bangladesh. Ali also notes that liver cancer is the second leading cause of cancer deaths in Bangladeshi men. He adds that about 80% to 90% of liver cancers are related to liver cirrhosis, which is often caused by Hepatitis B and C. Ali further notes that many Bangladeshis suffer from double or triple simultaneous liver viral infections (Ali 2002: 1). In addition, ulcers, which are directly related to liver problems, are very common. Almost 7% of people die from ulcers in Bangladesh (Streatfield et al. 2001 in *Center for Policy Dialogue* 2001: 15). Liver failure, therefore, is another major organ health problem in Bangladesh.

Lung disease is also very common in this country (Brundtland 1998). In 1997, the leading causes of death in Bangladesh were, respectively, pneumonia/lung cancer (15.7%), respiratory failure (9.4%), and upper respiratory tract infections (5.9%) (Streatfield et al. 2001 in *Center for Policy Dialogue* 2001: 15; Karim et al. 2000: 1). Bangladesh is also the country with the fifth highest rate of tuberculosis (*World Health Organization* 2002a: 55). There is one-tuberculosis caused death every 10 minutes; this disease claims 70,000 lives annually in the country (WHO in Ullah et al. 2006: 149; *Bangla2000a* 2000: 1). On top of all this, asthma is a major cause of death in Bangladesh (Streatfield et al. 2001 in *Center for Policy Dialogue* 2001: 15). The Asthma Association,
along with the Chest and Heart Association of Bangladesh, revealed that seven million people suffer from asthma throughout the country (Bangla2000b 2000: 1). The combination of frequent pneumonia, cancer, tuberculosis, and asthma leads to a high rate of lung failure in Bangladesh.

Heart disease is also very prevalent. Cardiovascular diseases are one of the major leading causes of morbidity and mortality in Bangladesh (World Health Organization 2002b: 66). Currently, it is estimated that approximately 500,000 Bangladeshis suffer from rheumatic heart disease, for which about 75,000 patients will need heart surgery within the next 10 to 15 years (The Daily Star 1998: 1). Many Bangladeshi children have congenital heart diseases as well (Kabir 2001: 1). The frequency of heart failure in Bangladesh is alarming.

Despite the lack of solid data on pancreatic diseases in Bangladesh, the prevalence of diabetes, arsenic exposure, and communicable diseases, along with the general health conditions of this country, make it likely that pancreatic diseases are very common in Bangladesh. Six million Bangladeshis have diabetes; it can be assumed that many of them also have pancreatic tumors and cancers (Kidney Foundation 2005b: 2). Diabetes mellitus – a chronic form of diabetes often associated with arsenic exposure (Sommer 2000: 1) – is the second leading cause of the end state renal failure in Bangladesh (Kidney Foundation 2008: 3). In the following Figure 3.1, I summarize organ health conditions in Bangladesh:
<table>
<thead>
<tr>
<th>Organ</th>
<th>Affected Population in Bangladesh</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kidney</td>
<td>12 million suffering from kidney diseases: of them, 50,000 die each year from kidney failure.</td>
</tr>
<tr>
<td>Liver</td>
<td>18 million suffering from Hepatitis B and C, the leading cause of liver cancer and failure.</td>
</tr>
<tr>
<td>Lung</td>
<td>70,000 die from tuberculosis each year, and 7 million suffer from asthma, two major causes of lung cancer. Lung cancer is one of the leading causes of death (15.7% of overall deaths).</td>
</tr>
<tr>
<td>Heart</td>
<td>500,000 suffering from rheumatic heart disease. Heart failure is the leading cause of death.</td>
</tr>
<tr>
<td>Pancreas</td>
<td>5 million suffering from diabetes: many of them may suffer from pancreatic tumors and cancers.</td>
</tr>
</tbody>
</table>

Figure 3.1. Organ health in Bangladesh

In spite of a disproportionately high number of organ failures, the Ministry of Health and Family Welfare of Bangladesh does not prioritize taking preventative measures for organ health outbreaks. As the public health literatures often indicate, the Bangladeshi Ministry should give priority from bottom to top as such: primary prevention, secondary or tertiary prevention, chronic care, and acute care. See the following pyramid.

Figure 3.2. The Pyramid of Prevention
If the state of Bangladesh allocates most of its health funding to *primary prevention* – i.e. avoiding environmental exposures, educating citizens to diminish risk-taking behaviors, and maintaining a safe water and food supply – organ disease would not obtain such a foothold in the body. The state should also emphasize *secondary and tertiary prevention* – that is, management of diseases that are already present and have progressed somewhat in the body. This includes periodic testing of blood pressure and blood cholesterol levels, and screening for high lead levels in the blood for people with high environmental exposures, as well as routine screening for and management of early renal problems among diabetics. The third stage of this scheme is *chronic care* of those diseases that have a prolonged course, do not resolve spontaneously, and rarely are completely cured. Typical examples include cancer, heart disease and diabetes. Knowing that diabetes is the leading cause of end-stage renal disease, the state needs to give priority to prevention and cure of this disease. Early detection, aggressive blood pressure control, and treatment with enzyme inhibitors can reduce the progression of diabetic nephropathy by about 60% (Herman and Ilag 2002: 6). The final state is the *acute care* of self-limiting diseases that have abrupt onset and usually short duration but may impair normal functioning or have severe life-threatening outcomes. For example, organ failure can lead to death; a transplant is required to save lives.

Since the Bangladeshi state has scarce resources, transplantation cannot be its first approach to dealing with organ diseases. Primary and secondary prevention of diseases, including organ-related diseases, should remain the state’s top priority. This approach has yet to become a reality in Bangladesh, given that organ disease can be greatly reduced through proper primary and secondary prevention.
Kidney Care: Context and Conditions

In spite of a high degree of organ failures, the organ health care infrastructure is extremely inadequate and poorly equipped. As I mentioned earlier, almost 40,000 patients die each year of kidney diseases, even though 70% of these dying kidney patients could return to an almost normal life with the aid of dialysis or transplantation (Xinhua News 2001: 1).

The establishment of kidney transplantation programs in Bangladesh is a fairly new development. The first Department of Nephrology was created in 1973, while the first Department of Urology was established as recently as 1981 (Bangladesh Renal Association and International Society of Nephrology 1999: 2). However, kidney transplantation became a regular procedure in Bangabandhu Sheikh Mujib Medical University Hospital (BSMMUH) only in 1988 (Bangladesh Renal Association and International Society of Nephrology 2; Harun 2009: 117). Currently, BSMMUH is the major public hospital that performs most of the kidney transplants in Bangladesh. In addition, the National Institute of Kidney Diseases and Urology (NIKDU), another public hospital, initiated the first kidney transplant in 2008; it performs very few transplants – usually one per month (Amin 2009: 2). As the private health sector is rapidly growing in Southeast Asia, some private hospitals also initiated transplantation in Bangladesh. Bangladesh Institute of Research and Rehabilitation in Diabetes, Endocrine and Metabolic Disorders (BIRDEM), a World Health Organization–collaborating unit and semi-public semi-private center, has initiated kidney transplant service for Bangladeshis since 2004 (Uzzal 2004: 1). Similarly, the Kidney Foundation, a non-governmental
organization, conducted the first kidney transplant on September 3, 2006 and has performed 95 operations till October 2008 (Kidney Foundation 2008: 1). The Indian Apollo hospital also established a unit in Bangladesh that facilitates kidney transplant (Apollo Hospitals 2010: 2). Thus, in total, only five hospitals (most of them established in the last few years) provide kidney transplantation for the entire country. However, all of these hospitals are located in Dhaka, a city that is inaccessible for many Bangladeshis who die prematurely because they were unable to receive kidney transplantation in a timely manner.

To date, there are only 70 nephrologists and 20 transplant surgeons available in the whole country (Rashid 2009: 117; see also Bangladesh Renal Association and International Society of Nephrology 1999: 2). This means that Bangladesh has in total only one kidney specialist, as well as 40 post-graduate trainees for every 3.5 million people (see also The Independent 2002: 1). Additionally, there are only two tissue typing centers, BIRDEM and Lab Aid, operating for all Bangladeshis. Further, pediatric kidney transplants have yet to be performed in Bangladesh. Clearly, the state of kidney care is remarkably inadequate for the increasing demands of kidney patients.

Twenty years after kidney transplantation first began in Bangladesh, only about 500 transplants in total have been performed there (Rashid 2009: 118). 22 In the United States, by comparison, more than 250,000 kidney transplants were performed in the last two decades: 16,625 were done in 2007 alone (United Network for Organ Sharing 2008: 1). Due to extremely inadequate access to kidney transplantation in Bangladesh, only two to three per million patients in this country remain alive on renal replacement therapy

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22 By 2007, 366 transplants in total have been performed in Bangladesh: BSMMUH had done 306, BIRDEM had done 30, and Kidney Foundation had done 30 (Medical Voice 2007: 1)
(Rashid et al. 1995: 1461). These figures reflect an overwhelmingly insufficient kidney transplant infrastructure in Bangladesh.

Dialysis facilities are also limited to a few major cities and treatments are highly expensive. At present, there are in total 42 dialysis centers in Bangladesh, of which, only 5 of them are in public hospitals (Rashid 2009: 117). Among public hospitals, only 30 to 40 patients undergo daily dialysis at BSMMUH, despite the high demand (Xinhua News 2001: 1). Dhaka Medical College Hospital (DMCH), one of the leading public centers, has only two hemodialysis machines, which provide dialysis for 10 to 12 people a week. A typical example of the shortage of dialysis treatment at DMCH is offered by the story of a patient who underwent dialysis on June 13, 2002, and then had to wait 17 days to get on the schedule for the next treatment, although an end-state renal failure patient needs three hemodialysis treatments per week for normal function (Huq and Barman 2002: 1).

In comparison, the private dialysis centers, such as Lab Aid Dialysis Unit, Kidney Hospital, Jahan Ara Clinic, Renal Hope, and Ibne Sina Clinic, are less crowded and somewhat better equipped. The unfortunate fact, however, is that although there are 260 hemodialysis machines in private clinics (in comparison to 40 machines in public centers) throughout the country (Kidney Foundation 2008: 1), less than 10% of kidney patients can afford this expensive service (Rashid 2004: 185). Although there are a few non-governmental dialysis facilities, such as the Kidney Foundation and the Khan Family Foundation, which are offering dialysis care with lower cost, they are extremely inadequate compared to the high demand (Kidney Foundation 2008: 1; The Imdad-Sitara 2008: 1).

As the public dialysis centers are overcrowded in Bangladesh, a patient needs about $5,500 for a year of standard (three times per week) dialysis in a private center (Rashid 2004: 188). However, the per capita GDP (on a purchasing power parity basis divided by population as of July 1st for the same year) of Bangladesh is $1600 (CIA 2009: 5), which is less than one third of the cost of dialysis.
Many kidney patients are thus compelled to compromise on the number of dialysis treatments they receive, and many Bangladeshis are unable to meet the high cost of the treatment.

Transplantation is a better economic option than dialysis for Bangladeshi kidney patients. In a public hospital, dialysis costs start at 100,000 Taka ($1,500) a year, whereas the cost of transplant surgery and post-operative care for two weeks starts at about 225,000 Taka ($3,200) (Kidney Foundation 2008: 1; Medical Voice 2007: 1). Bangladeshi kidney patients also prefer the option of transplantation instead of the pain and discomfort of dialysis. However, most people cannot afford this astronomical sum for transplantation and post-operative medication. They can neither obtain a free transplant from the public hospital nor obtain a lifesaving loan from the state. As a result, about 5 kidney patients are dying each hour without receiving an organ care (Amadershomoy 2009b: 8). Overall, the service of kidney transplantation fulfills the needs of only a relatively small group of wealthy Bangladeshis.

The situation is even worse with respect to the failure of other organs as, with the exception of kidney, there is no other transplant program currently available in Bangladesh. These organ transplant programs are far from being implemented. It was only in 1999 that a committee was proposed to work on the possibilities of bone marrow and liver transplantation in Bangladesh (The Daily Star 1999a: 1). Programs for heart, lung, and pancreas transplantation have still not been addressed at all. This situation is exasperating in light of the catastrophic organ health conditions in Bangladesh. Such dreadful conditions beg the question: Why does the Bangladeshi state not prioritize organ

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24 The quoted price is for the public hospitals BSMMUH and NIKDU; the rate is much higher in private settings, ranging between 250,000 Taka ($3,500) and 700,000 Taka ($10,000).
transplantation? There are two opposing views for the underdevelopment of organ health care (Moniruzzaman 2003: 53-56). As outlined in my previous research, while some respondents emphasized the lack of resources, others pointed to the corruption, lack of precedence, and poor regulation of the Bangladeshi state as key barriers to establishing satisfactory organ transplantation practices.

Due to a lack of resources, transplantation in fact does not rank high on the list of priorities for the state of Bangladesh. State priorities remain, instead, basic medical needs, such as immunization, family planning, and the control of infectious diseases. The per capita public health and family planning expenditure was only 182 Taka (about $2.50) in 2006 (Directorate General of Health Services 2009: 181). Most of this budget allocation was used to support the primary health care system. Thus, a lack of resources makes the relatively smaller population that is suffering from organ diseases a secondary concern for the state. Currently, the inadequate transplant program is inextricably linked to Bangladesh’s poverty as a Third World country.

In any case, the state cannot come closer to establishing an acceptable transplant program due to severe corruption. Transparency International, an international NGO, reported that Bangladesh was the most corrupt country in the past five consecutive years (Transparency International 2001-2005). The government of Bangladesh lost about $1.5 billion in unpaid taxes in 1998 alone, almost as much as the total received in foreign aid (Ahmed 2004: 37). The state of Bangladesh is unable to stop corruption because law enforcement agencies, including the police and the judiciary are the most corrupt sector. The health sector is identified as the second most corrupt sector in Bangladesh, as Transparency International notes (Transparency International 2005: 1). Resources
allocated for public expenditures, including the health sector, simply fill pockets of corrupt bureaucrats, politicians, and elites in the form of bribery. Thus, the state fails to distribute its limited resources towards establishing an effective transplant program.

In addition, transplantation is virtually ignored by the state of Bangladesh. The recently launched website of the Ministry of Health and Family Welfare has very little to say on the topic, and the Ministry of Health’s annual report contains no reference whatsoever to the word “transplantation.” The public budget allocation for the health sector is historically extremely inadequate. In the 2009–2010 fiscal year, the public expenditure of health was only 4.4% of the total revenue expenditure in the budget compared to 7.1% for military (The Ministry of Finance 2010: 31). The state does not allocate larger revenues to the health sector and establish an ample transplant program despite dire conditions.

Poor regulation is another reason why the transplant program remains unsatisfactory in Bangladesh. Although there are bylaws, such as the 1980 Medical and Dental Council Act, which make any kind of unethical health practice legally unacceptable in Bangladesh, many immoral practices in both the public and private sector leave the citizens of Bangladesh without quality organ care (Khan and Zahidul 2002: 1). One illustration of this inadequacy is the case of Asma Begum, a 17-year-old girl whose only functioning kidney was “mistakenly” removed by gynecologists during an operation at Dhaka Medical College Hospital on August 11, 1998. The state is in some ways complicit in these unethical practices because there is still no public report of their acts (The Daily Star 1999b: 1; Bangla2000c: 2000: 1). In another case, the state ignored allegations of negligence and improper treatment when Raushanara, a 48-year-old
woman, died from a fatal liver injury she received while undergoing a gall bladder operation in a private clinic in Dhaka. Raushanara’s family collected signatures to enlist support from others but could not ensure that justice was done in her case (e-Mela 2002: 1). Due to state negligence and poor management, many Bangladeshis do not have confidence in the organ transplantation and health care currently operating in the country.

As a consequence, a vast majority of rich and middle-class organ patients go abroad, largely to India, to buy a transplant. According to a research report by the Center for Policy Dialogue, a non-governmental organization in Bangladesh, each year about 50,000 Bangladeshis travel to India to obtain better medical services, including organ transplant. The report also indicates that these patients spend in total an average of $30 million per year for healthcare (Rahman 2000: 14; see also Amadershomoy 2007: 1), which means that the state of Bangladesh is losing a large portion of that money. With this money it could, theoretically, establish standard health care practices, including its own transplant program.

It is notable that there are also very few non-governmental initiatives for kidney care in Bangladesh. Only recently, the Kidney Foundation has begun trying to establish a modern transplant and dialysis center equipped with 200 beds; it has initiated a lottery to raise funds (Bangladesh Sangbad Sangstha 2008: 1). In some ways, the Bangladesh Kidney Patient Welfare Organization is operating: while it could not secure its demands to the state (such as tax-free medication, expansion of local transplant facilities, and arranging free follow-up care), it is able to ensure a discount of 10% from major pharmaceutical companies for its members (Bangladesh Kidney Patient Welfare Organization, personal communication). With international support (mostly from Saudia
Arabia), BIRDEM hospital also initiated an organ transplant and care program. Ironically, BSMMUH received an expensive tissue-typing machine as a donation, but it has been just sitting in the veranda of the Nephrology Department for several years due to the “lack” of an operator – a typical outcome of the technology transfer. The non-governmental initiatives are beneficial, but the existing activities have yet to gain confidence among Bangladeshis. In sum, currently, wealthy Bangladeshis procure transplantation from other countries (mostly India) and a few middle-class citizens buy transplantation within the country (mostly from private hospitals), while the poor majority, who are at the greatest risk of organ failure, die prematurely without benefitting from this new technology.

*Kidney Bazaar*

Bangladesh largely serves as an organ bazaar for “wealthy bodies.” In the underground market, not only human kidneys but also livers and corneas are for sale. Both recipients and sellers regularly post newspaper advertisements looking for clients. Organ brokers have already expanded their network and run the business for a hefty fee. Health personnel are also profiteers, engaging in the illegal dealing. The advancement of transplant technology create a demand for kidneys, while extreme poverty facilitates the supply; thus, a black market of organs is flourishing in Bangladesh. This section outlines how the organ bazaar functions through the contribution of the various actors involved, as well as examines how this market is openly thriving even though it is outlawed in Bangladesh.
To this day, there is no cadaveric organ transplant performed in Bangladesh.\textsuperscript{25} Although a handful of private cadaveric body donations exist in this country, they are intended for medical research.\textsuperscript{26} Only cadaveric cornea donation and blood donation programs are currently functioning.\textsuperscript{27} The former president of Bangladesh, Dr. Badruddoza Chowdhury, inaugurated the first Kidney Donation Bank, a public initiative to collect kidneys from cadaveric donors, in April 2002; however, it is not yet in operation (\textit{The Independent} 2002: 1). Cadaveric organ donation, therefore, is virtually absent in the country.

Bangladesh is one of only a few countries in the world where the only way to obtain a kidney is through living donors (Chung and Jha 1995: 1184; Turcotte et al. 1990: 906). As there is no transplant registry in Bangladesh, it is difficult to know exactly how many recipients have obtained kidneys from living related donors (altruistic donation from family members) and unrelated sellers (purchased organs from an unknown person). Rashid and others (2003) noted that 280 patients out of 458 recipients who underwent post-operative care in Bangladesh between 1988 and 2000 obtained kidneys from living related donors; the other 178 patients obtained kidneys from living unrelated sellers (Rashid et al. 2003: 158). In other words, 64\% of those who gave a kidney were donors and 36\% were sellers. The authors also noted that all living unrelated renal

\textsuperscript{25} When I refer to organ, this means solid organ, such as kidney, liver, lung, heart, and pancreas, but not including the eye.

\textsuperscript{26} Aroz Ali Matubbar, Ahmed Sharif, and Wahidul Haque were among the first pioneers to donate their bodies for medical education, to Barisal Medical College, Bangladesh Medical College, and Bangabandhu Sheikh Mujib Medical University Hospital respectively (Roy 2001: 1; Karim 2000: 1; \textit{Unheard Voice} 2007: 1). The prominent Bangladeshi magician Jewel Aich also runs a private body donation program that has only 17 signed donors so far. These bodies are also donated for research purposes.

\textsuperscript{27} In 1983, Sandhani National Eye Donation Society, a non-governmental organization, launched programs for the procurement, processing, and preservation of human corneas collected posthumously from eye donors. Although it was pledged 33,577 donor eyes in the last 18 years, it has collected in total only 1,543 corneas, of which 1,424 have been grafted; the rest have been used for educational purposes (\textit{Sandhani National Eye Donation Society} 2009: 1). Sandhani has the most successful cornea donation program within the country, but it cannot meet Bangladeshis’ high demand for corneas.
transplantations (except from spousal donors) were performed outside the country (Rashid et al. 158; see also Rashid et al. 1999: 3112; Rashid et al. 1995: 1461; Rashid et al. 1992: 1831). During my fieldwork, Bangladeshi nephrologists mentioned to me that they “strictly maintained” the Bangladesh Organ Transplantation Act that was enacted by parliamentary act in 1999 to outlaw purchasing kidneys from living unrelated sellers, often called the kidney trade. Therefore, organ transplantation from the living unrelated donor/seller is not performed within Bangladesh, as local nephrologists claimed.

An illegal kidney bazaar nevertheless thrives in Bangladesh. As there are no cadaveric donations, and living donations are the only means of transplantations, it can be assumed that many Bangladeshis participate in the kidney bazaar. In fact, as the demand for kidneys continues to rise and growing numbers of poverty-stricken people seek to survive, the kidney trade in Bangladesh is probably on the verge of expansion. The demand has escalated as most Bangladeshi recipients buy kidneys from the market if they can afford it, while poor recipients seek kidneys from family members. The reasons for these approaches are: i) kidneys are very available in the market; ii) the price of a kidney is cheap; iii) family members do not want to put their health at risk; and iv) the recipient does not want to carry the burden of the family’s gift. 28 My cross-checking with recipients, sellers, and brokers provided clarification that families do not want to donate because of the health risks, even though many recipients prefer to obtain a donated kidney from a family member due to a better match and survival rate. Although some families step forward out of emotional obligation, many of them are relieved when their tissues do not match. Two potential Bangladeshi kidney recipients (who contacted me to

28 Sociologists Fox and Swazey (1978; 1992) eloquently discussed the tyranny of the gift. They noted that the family member feels emotional pressure and obligation to donate, and the recipient feels a burden for not being able to repay the gift.
find out the details of the black market over the last three years) told me that their families did not consider donation. Instead of giving them the broker’s contact information, I challenged, informing them that buying kidneys is unethical and illegal, and the recipient’s survival rate is lower if a kidney is obtained from a stranger. However, the family members refused to donate; one of the potential recipients even responded, “Who would like to see their family without body parts if there is a market out there?”

Kidney supplies are higher than the demand for trading them, as there is an abundance of kidney sellers in Bangladesh. Immense poverty increasingly drives many poor to sell their own body parts; these poor are the victims of structural violence. In addition, northern Bengal is affected by *monga*, the state of extreme penury. As a result, there is a kidney gram, or village, where many people had already sold their kidneys due to hunger, as one broker told me. The people located in the south are also battling seasonal flooding – thus, many become homeless and in debt, adding to their extreme level of poverty. Consequently, a post-graduate trainee at BSMMUH noted that at least one potential seller visits the outpatient unit at BSMMUH every day to trade a kidney. Because of the high supply, the average price of a kidney is only $1,500 in Bangladesh, which is low for a buyer who has money but a fortune for the many potential sellers who are unable to save this amount of money in their lifetime. For them, selling a kidney offers hope of getting out of poverty and resolving their hardship. Bangladesh is clearly a country where the kidney bazaar is already saturated by impoverished sellers.

On the axis of this demand and supply curve, there are kidney brokers who facilitate this trade for a hefty fee. The brokers play a vital role for both recipients and sellers to find a suitable match. The prevalent presence of the broker in almost every
sector, including in the kidney trade in Bangladesh, can be traced back to British colonialism in the Indian subcontinent. Evidently, organ brokers compete over clients in major transplant and dialysis centers in Dhaka; I even witnessed one of my interviewed kidney sellers brokering in the dialysis unit at BIRDEM hospital. Bangladeshi kidney brokers have already established a wide network from village to regional to national to international levels. Brokers hire kidney sellers to find poor villagers with various blood groups, and have strong connections with rural areas due to their extended family. These brokers approach the poor villagers and slum dwellers, saying that kidney donation is a noble act, a simple procedure, and extremely profitable; they lure the sellers with false hopes. The sellers, however, cannot take action against the brokers, who are well connected and protected by their powerful recipients. The major Bangladeshi brokers, Batpar Azam and Dalal Islam, have already accumulated huge profits from trading kidneys: Batpar has several businesses, Dalal uses his profits to gamble. When I asked some of the brokers about their reasons for brokering kidneys, they argued that their action is ethical because they are saving recipients’ lives and resolving sellers’ financial problems. As Dalal stated, “What is more important between life and money? For the rich it is life, but for the poor it is money. So, why not help each other out?”

The current form of the kidney trade in Bangladesh is a blend of “rewarded gifting” and the commercial sale of organs in the market. The equation of this trade among its core actors is simple: the recipients prolong lives, the brokers ensure profits, and the sellers hope to get out of poverty. The kidney follows the market rule: the recipients are bidders, the sellers are suppliers, and the brokers are agents. The product, an organ, is for sale even though the trade is outlawed in this country.
The Pirates of Kidney Bazaar

The state of Bangladesh passed the Human Body Parts and Organs Transplant Act on April 13, 1999. This law imposes a ban on the sale of body parts and organs for transplantation, except for donations from close kin in a manner that causes no harm to the donor. “Close kin” refers to blood-related kin – in particular, children, parents, siblings, blood-related maternal and paternal uncles and aunts – as well as emotionally related kin, which includes spouses only. According to the law, anyone violating it could be imprisoned for a minimum of three years to a maximum of seven years, and/or penalized with a minimum fine of 300,000 Taka ($4,300) (Bangladesh Gazette 1999: 1819). Yet, in spite of the law, the kidney trade is extensively practiced in the country. The central question is why the state turns a blind eye to this outlawed trade. To answer this question, I look at the role of powerful elites in the following section.

The neo-liberal state is complicit with the organ trade because local elites, who are in power, are often beneficiaries of this trade. The Bangladeshi state is dominated by a group of elites, particularly bureaucrats, politicians, businessmen, and professionals, who control, maneuver, and exploit the public institutions for their private gain. Theoretically, the role of the state is to ensure equity and justice for its citizens. However, in practice, these elite groups turn this state into a profit-making enterprise – I call it the Bangladeshi State Inc. (BSI). The elites deprive the poor, and the state somehow legitimizes the elites’ conduct, a typical scenario of the neo-liberal government in Bangladesh and elsewhere. This approach reflects the “pathologies of power,” as Paul Farmer wrote:
The liberal political agenda has rarely included the powerless, the destitute, the truly disadvantaged. It has never concerned itself with those popularly classified as the “undeserving” poor: drug addicts, sex workers, illegal “aliens,” welfare recipients, or the homeless, to name a few. And yet the poor … are struggling, and often failing, to survive. (Farmer 2005: 6)

The Bangladeshi elites ensure massive profits through bribery, corruption, and nepotism, and the state lends them both hands.

In spite of the country’s extreme poverty, the elites create their own economic chain system, from which they collect bribes from local citizens and plunder public assets that they distribute according to their official ranks. One of my interviewed respondents experienced how the elites’ chain system works. As he outlined, each month he needed to buy a pass from the local police to run his illegal business. Typically, local police officers collect various monthly bribes from local residents and deposit the money to the local police station. Each month, the local police officer in charge first transfers a fixed amount of money to his district boss, then distributes the rest of the money among local police officers according to their rank. In this system, local police officers are under pressure: to avoid losing their jobs or being transferred by the immediate district chief, they collect the fixed amount at the expense of local residents. The district police chief then similarly pays a fixed amount to his divisional boss, and the divisional chief pays the highest-ranked chief of police. The police chief then must pay a certain amount of bribe money each month where he is obliged to do so. My respondent suspected that the police chief pays certain shares to Bangladeshi elites – in particular, to elected politicians. In the chain system, if a police officer is ever accused of collecting bribes, he is protected by the upper police officials and politicians. This chain system is operating in every public sector in Bangladesh, including health, education, land, and the judiciary, to name a few.
The elites’ role within the Bangladeshi state is highly disciplined, and the punishment of its actors is strictly maintained. Bangladeshi elites have become, in effect, the “pirates” of the state; currently they deposit their money in Swiss banks, maintain a lavish lifestyle, and send their children abroad for higher studies. The elites are well connected to each other and to the international communities. These elites are vested, and, if challenged, typically blame other groups for the underdevelopment of Bangladesh.

Under the greedy eyes of Bangladeshi elites, the black market of human organs thrives. The elites are the direct and indirect beneficiaries of this trade. They are the recipients of both kidneys and bribes. Such elite groups not only conceal the organ bazaar, but also collaborate quite closely with transplant entrepreneurs, health personnel, pharmaceutical executives, media reporters, and even organ brokers. The elites do not take any initiative to eliminate the kidney market, although the transplant law is openly defied. They abuse their power and use the Bangladesh state as a means of collecting bribes, issuing permits, and arranging deals for expanding transplantation. No wonder the Bangladeshi state has been identified as the most corrupt country in the world for the past five consecutive years (Transparency International Report 2001–2005). Consequently, the state of Bangladesh is ineffective in protecting the poor whose bodies are being fragmented and whose kidneys are being removed for “hungry” elites. Additionally, the state remains largely silent when the elites victimize the Bangladeshi poor through physical violence as well as structural violence.

Profit-oriented, neo-liberal capitalism has turned this land of 140 million Bangladeshis into a haven for private entrepreneurs, while the commercialization of health care makes transplantation a lucrative industry. Transplant centers are flourishing

29 See also discussion on the state and illegal activities by Heyman and Smart 1999.
in this country as the number of kidney patients increases. When I conducted my fieldwork in 2005, there were only two transplant centers (one public and the other semi-public/semi-private) in Bangladesh; now, nearly every six months a new transplant center is being opened there. These private transplant centers attract the upper middle-class Bangladeshis; the wealthy usually participate in transplant tourism abroad. In this market economy, the critical question arises: Why is the rate of transplants increasing so rapidly in this country?

To understand this situation, we need to look at the historical and current context as well as the national and international status of kidney commodification. Before the Indian transplant act was implemented in 1994, Bangladeshi recipients used to purchase kidneys from Indian sellers. Now it is far more difficult and expensive, particularly for foreign nationals, to buy a kidney on the black market in India. Bangladeshis find prospective sellers “at home” and fly to India to ensure better transplant care. Indian doctors report that more transplant patients are coming from Bangladesh and bringing their “donors” with them (Frontline 1997: 16). In addition, Bangladeshis can no longer buy kidneys from any neighboring countries, as Pakistan and China implemented organ transplant acts in 2007. On a global scale, transplant tourism is entirely prohibited, so a significant number of Bangladesh-born foreign citizens are coming to the country to purchase kidneys. Currently, Bangladeshis purchase kidneys largely from their own poor countrymen.

Although there is no shortage of kidneys in Bangladesh, recipients face difficulties in arranging transplantation abroad. Most recipients do not have familiarity and links with foreign hospitals, and all of them need to provide false passports and visas
to the sellers (to prove “legally” that the recipient and seller are blood related and that the kidney is given as a form of donation). Due to these difficulties, a transplant war eventually began in Bangladesh: the private centers are competing with each other over the potential recipients. Now Bangladeshis can arrange organ transplants and participate in the kidney trade in their own land.

Consequently, the kidney trade has expanded here more than ever, as one of my interviewed sellers recently told me over the phone. However, a rationalization of this outlawed trade is currently taking shape in various ways – the typical scheme of accumulating neo-liberal profit. For example, Bangladeshi vested interest groups are suggesting that kidney donors are scarce in the country. A doctor from the National Institute of Kidney Diseases and Urology has therefore argued to expand the donation pool by including donors beyond blood relatives in the Transplantation Act (The New Nation 2008: 2). Similarly, the president of the Bangladeshi Kidney Patient Welfare Association notified me that the association has already demanded that the state revoke the transplant act because it limits the potential recipients to purchasing organs from sellers. Such an alteration or withdrawal of the existing organ transplantation act would entail more business for private entrepreneurs, but also more exploitation of poor Bangladeshis.

Further, the global flow of kidneys indicates that the poor Bangladeshi kidney sellers are already serving as commodities in the international organ market, in addition to in their homeland market. For example, I collected a newspaper ad from a broker residing in Germany who was looking for prospective Bangladeshi sellers. I have also collected some Internet ads from poor Bangladeshi sellers seeking foreign recipients.
Awaya, a renowned Japanese sociologist, further noted that Japanese patients seek kidney sellers in Bangladesh (Awaya 1998: 50). It seems, then, that the private transplant centers in Bangladesh, which are lucrative draws for foreign markets, can easily manage to transplant the “fresh” kidneys from poor Bangladeshis. All of these factors reflect why transplantation is rapidly thriving in this kidney hub.

Due to this transplant boom, the Bangladeshi kidney trade is extended by criminally coerced exchange. There have been a few cases reported in the national newspaper of Bangladesh where children have been smuggled to other countries, mostly to India and Middle East, for their organs (Khayer and Badal 2004: 1; Yasmin 2007: 1). The United Nations estimates that about 5,000 Bangladeshi women and children are trafficked each year, mostly for prostitution and camel racing (Tutul 2008: 1). A number of gangs are possibly involved in selling trafficked people into servitude or for organ harvesting to those who can pay large amounts of money (Miko and Park 2002: 7-8). The residents are also worried about cheledhora, “the children catcher,” to use the literal translation, and believe that their children’s organs will be tapped for removal. Whether based in fact or fantasy, their fear reflects the concern that organ commodification is on the rise.

A good question at this point might be: why did the Bangladeshi government pass an organ transplantation act? During my fieldwork, one recipient explained that the state had to implement the law because of pressure from international bodies. Another recipient argued that it was nephrologists, not the government, who implemented the law because they were losing a huge amount of money, as Bangladeshi recipients usually went to India for transplantation. Whatever the reason is, one nephrologist contextualized
that the transplantation act was proposed by a few nephrologists who belonged to the political party that was then in power, and the act was passed by the government without any change or debate. The resultant law is vague and narrow; it is only five pages and most of its discussion is on brain death (even though organ transplant from brain-dead donors is not currently performed in Bangladesh). Only two sentences are about the organ trade. Yet, the state did not inform or create awareness among the citizens about the law; Bangladeshis are generally not aware that the kidney trade is illegal. Despite the law, the recipients, sellers, and brokers create an organ bazaar where high demand is surpassed by a plentiful supply of organs, and Bangladeshi elites accumulate profit as the kidney trade thrives in the country.

Given this association between neo-liberal capital and Bangladeshi elites, what is mostly troubling to me is the role of Bangladeshi health specialists. Frequently, the medical doctors in this country become state elites. As one respondent reflected: “Nowadays there is little difference between a businessman, bureaucrat, and doctor – they are often three in one.” The Bangladeshi kidney specialists directly profit from the expansion of organ transplantation; as a result, they “turn their backs” to the outlawed kidney trade.

Many nephrologists, for example, are allied with new private transplant and dialysis centers. Although these nephrologists are affiliated with major public hospitals, they do not provide care until the patients visit their private chambers and pay high visiting fees. These nephrologists fight over clients to ensure profits and expand their business. A member of the Kidney Patient Welfare Association, a non-governmental organization in Bangladesh, told me that some influential nephrologists in the country
ignore this association because they lose business when the association invites an Indian doctor each year for post-operative checkups of its members. Moreover, such nephrologists also benefit from major pharmaceutical companies, such as Novartis and Roche, which are key manufacturers of Cyclosporine and Cellcept, the major post-transplant medications. One nephrologist accidentally stated to me that these companies often provide his conference travel and accommodation costs; in exchange, he prescribes only their medication to patients, a common scenario in many countries. Strangely, the Renal Journal of Bangladesh is funded by the advertisements of these companies, and is controlled by a small group of nephrologists. Further, these nephrologists assigned extra medical tests in exchange for an astronomical commission from the diagnostic centers, as many respondents complained (a common complaint of Bangladeshis against their doctors). For many Bangladeshi nephrologists, transplantation is very much a profit industry. This is why a post-graduate trainee at BSMMUH told me that gaining admission to the nephrology unit is now very competitive.

The Bangladeshi nephrologists do not generally endorse or enforce the transplant act, as it would reduce their profits. Recipients, sellers, and brokers repeatedly mentioned to me that nephrologists are aware of this trade, but they simply overlook it and just follow their routine procedures. These specialists follow the general rule: examining more patients means more profits. The broker, Dalal, claims that he brings potential kidney sellers to his nephrologists, who condone the entire situation for their visiting fees.

Most of the Bangladeshi specialists, however, are not directly engaged in illegal organ dealings, but neither do they attempt to eliminate this trade. During the fieldwork, I
discovered that the nephrologists at BSMMUH did not widely circulate the organ transplantation act. For example, a social work officer, who must verify the recipient’s and donor’s relationship and whose approval is required for transplantation in this hospital, was not aware that a transplantation act was already enacted in Bangladesh; this officer eventually asked me for a copy of the act. I also noticed that the BIRDEM tissue typing center was full of sellers and brokers, but that health personnel did not take any steps to verify the relationships between the clients for Human Leukocyte Antigen (HLA) tests, and some clerks were suspected of being involved in this trade. As the kidney specialists do not strictly implement the ethical guidelines, and take minimal steps to prevent the buying and selling of kidneys, the kidney trade has expanded in Bangladesh.

What surprises me most is the Bangladeshi kidney specialists’ discreetness about this unethical and outlawed trade. I discovered that many of these specialists even claimed in their publications that they do not perform kidney transplants from unrelated donors. To this date, they have not published a single article on kidney trade in their country. The *Renal Journal of Bangladesh* does not even acknowledge this trade at all. During my fieldwork, many nephrologists frequently claimed to me that organ transplantation from unrelated donors is not performed in Bangladesh. After collecting evidence from some of my interviewed sellers (as their transplants were done by Bangladeshi nephrologists), I confronted one of the senior nephrologists. He replied, “We always maintain ethical protocol, but sometimes there could be very few cases that we are unaware of.” When I challenged him again, he argued that nephrologists are not the police and their role does not constitute spying on their recipients. Nephrologists’ roles
are indeed limited, but perhaps I should have asked him why they turn a blind eye to this outlawed trade.

The neo-liberal economy and its counterparts—the vested interest groups, including the wealthy recipients, medical specialists, and organ brokers—therefore victimize the poor sellers and take advantage of their poverty through physical and structural violence. These conditions also turn the “Bangladesh State Inc.” into an institution of double-dealing for profit gain through kidney removal. The ambiguity of the state’s role is captured in a Bangladeshi proverb: *upore fitfat kintu bhitore shodorghat*—“everything is lawfully arranged on the surface, but muddled inside.” The dominant groups benefitting from the trade rationalizes it in various ways. For example, it persuades people that newspaper advertisements for commodifying organs are just to encourage donation—an ethical act for saving human lives. (I explore the widespread newspaper classifieds in Bangladesh in the following chapter.)

On the first day of my fieldwork at BSMMUH, the major transplant center in Bangladesh, I saw a police officer standing with a rifle in front of the Department of Nephrology. The metal gate was opened only about a foot, and was hooked by a solid chain so no unauthorized personnel could trespass. The security guard asked me whether I had permission to enter. During the rest of my fieldwork, he got to know me a little and we often smiled and chatted with each other. Once I asked a nephrologist about the reason for guarding the department with a police officer. He replied that in this way, the Bangladeshi nephrologists ensure that no one can illegally trade a kidney on the premises. I still do not know whether this was a joke. Despite the presence of the police officer, I found that the golden Bengal had turned into a kidney bazaar.
CHAPTER FOUR

Organ Classifieds – Buy or Sell

Are you [Monir] certain that organ trade is illegal? And if it is, why are so many organ advertisements published in Bangladeshi newspapers? – Dildar, a 32-year-old kidney seller

Commercial advertisements for human organs are flourishing worldwide. Both recipients and brokers currently seek organ “donors” through Internet websites, newspaper advertisements, and even highway billboards. Meanwhile, organ sellers are looking for clients through street posters, hospital visits, and personal contacts. This chapter explores a wide range of organ classifieds published regularly in major Bengali newspapers and examines how recipients, sellers, and brokers publish these advertisements even though they are outlawed in Bangladesh.

The media play a crucial role in representing scientific knowledge to the social world. Recent scientific innovations, such as organ transplantation, offer plenty of news coverage that provides an opportunity to examine how the media shape and represent this “miracle of life.” Yet, very little research focusing on the media in relation to organ transplants has been carried out to date. For example, Morgan, Harrison, Chewning, and Habib (2006) examine the narratives of Jesica Santillan, a 17-year-old Mexican illegal immigrant who died from a “botched” heart transplant following medical error at Duke University Medical Center in North Carolina in February 2003. Collecting 162 stories (97 in print and 65 on television) that were reported by the media during Jesica’s two transplants, the authors elucidate how her story emerged into the media, how it changed over time, and how authors and commentators articulated the meaning of this case.
Exploring wide contradictions and variations in her story, as well as a number of people who appeared repeatedly in coverage of her case, the authors conclude that media produce a profound ambivalence and mixed message about organ transplant; Santillan’s case added to this corpus (Morgan et. al. 2006).

Moloney and Walker (2000) also systematically analyzed the social construction of organ transplantation by the mass media. They investigated how organ transplants have been historically and gradually portrayed in the West Australian newspaper, which published 672 articles related to this issue from 1954 to 1995. The authors conclude that newspaper represents organ transplantation as a “conflicting” core, crisscrossed between scientific advancement of the “spare-part surgery” and lay image of the “gift of life.” As they note,

The social representation of organ donation and transplantation emerges as a representational field organized as a dialectically opposed conflicting core. One aspect of the representation field is medically oriented, which is organized around an iconic image of spare-part surgery and which emphasizes the recipient at the expense of the donor. The other aspect of the representational field is situated in the lay world and is organized around the image of organ transplantation as a “gift of life.” (Moloney and Walker 2000: 222—223).

The research done by both sets of authors highlights the fact that the media offer opposing views on organ transplantation (see also Morgan 2009: 32).

Instead of focusing on organ transplant, Feeley and Vincent (2007) examine how major newspaper articles represent organ donation. The authors collected 715 stories on organ and tissue donation from 20 US newspapers published in 2002 or 2003. By analyzing the content of these stories, Feeley and Vincent point out that the majority of these articles were either positive (57%) or neutral (29%) regarding organ donation, while few of them were negative (14%). They also note that the four most common topics
covered in these news articles included: (a) post-transplantation health and welfare, (b) organ donor shortage, (c) living donation, and (d) transplantation procedure (Feeley and Vincent 2007: 125). The authors suggest that the content of news stories significantly influences and shapes public opinion on organ donation; however, they did not examine how citizens perceive these media representations.

All of the above studies focus on organ transplant and donation as presented in the media. Yet there is a dearth of knowledge on how the media represent organ commodification in general. Seale, Cavers, and Dixon-Woods (2006) examine the role of mass media in contributing to the commodification of body parts. By looking at media language, the authors argue that not only is biomedicine responsible for the commodification of the body, but also mass media commodifies human material for commercial interests through a form of entertainment (Seale et al. 2006: 25-42). The authors emphasize the discourse analysis of the media and their commercial representation of the commodification of body parts.

All of the above-mentioned studies examine organ transplant, donation, and body parts commodification as presented in the mass media. However, a scholarly article, or even a media report on organ classifieds published for organ commodification, is still absent from public discourse. In this chapter, I explore various organ classifieds printed in major newspapers in Bangladesh. Unlike the above-mentioned studies, which focus solely on the social representation, I explore how the media are being used for the outlawed practice of organ commodification. As newspaper advertisements for illegal activities are an unusual phenomenon, my “process of anchoring” (that is, finding language to describe a new phenomenon – see Morgan et al. 2006: 21; Morgan 2009: 34-
is primarily based on content analysis followed by a brief discourse analysis. I sketch how organ commodification is exposed in the media in a non-Western setting.

In Europe and North America, both recipients and sellers advertise for organs mostly online (BBC News 2007: 1). Such advertisements are so widespread that the Google search engine yields thousands of websites purporting to sell various body parts (Vaknin 2007: 1). MatchingDonors.com and JoeNeedsALiver.com have become the new marketplaces for organs. An auction for a kidney on eBay in February 2000 reached $100,000 before the company was forced to prohibit this trade (Vaknin 3). Some medical tourism companies, including the Calgary-based Overseas Medical Services, are assisting North American recipients in purchasing organs from India, Pakistan, Egypt, China, the Philippines, and Eastern Europe (www.overseasmedicalservices.com). The demand for organs, mostly in these wealthy nations, is growing; so, too, the numbers of advertisements is increasing in the online bazaar.

In the developing worlds, organ harvesting is expanded mostly through newspaper advertisements, street posters, and personal contacts. In China, poor villagers hold signs in public places, major roadsides and railway stations, offering to sell their kidneys (Goldkorn 2005: 1). In Egypt, kidney sellers regularly hang advertisements in the streets, as a transplant act has yet to be enacted there (El-Bahr 2007: 1). In Brazil, a major newspaper ran an organ advertisement where a seller stated: “Offering to sell any organ of my body that is not vital to my survival and which could help save another person’s life in exchange for an amount of money that will allow me to feed my family” (Schepers-Hughes 2002c: 275). Newspaper advertisements for organs are commonly published in
South Asia. However, Bangladesh could be the leading country in the world where organ classified ads are widely in print.

In Bangladesh, would-be recipients regularly publish organ advertisements in local newspapers. They also post kidney advertisements on local television channels. Further, one respondent noted that a wealthy recipient in his hometown searched for a kidney by announcing his search with a microphone and sitting on a rickshaw, a common way of advertising Bengali movies in local towns. In comparison, although Bangladeshi sellers publish far fewer newspaper advertisements, these are, however, evidently increasing. Some sellers also post handwritten advertisements in major hospitals, hostels, and intersections in Dhaka. In addition, a few of them also offer their organs over the Internet. Human organs, it seems, are part of a “blowout sale” in Bangladesh.

I collected organ classifieds published in major Bengali newspapers between 2000 and 2007. During my fieldwork, I covered the newspapers from 2000 to 2004 with the support of three research assistants: Sudipta Chowdhury, Mohitush Sami, and Abduallah Sumon. Under my online supervision, another research assistant, Sania Tanzin, covered newspapers from 2005 to 2008. The other research assistant, Mohammad Babu, aided me in scanning organ classifieds from 2000 to 2004; the remaining years have yet to be scanned, and thus are not included in this chapter.

After six months of intensive research and several bureaucratic encounters, I collected newspaper advertisements, reports, and articles related to organ

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30 Chowdhury, Sami, and Sumon completed their Master’s degrees in anthropology from Shahjalal University of Science and Technology (where I taught for almost three years), located in Sylhet, Bangladesh.
31 Tanzin completed her Master’s degree in anthropology from Jahangirnagar University (where I obtained my undergraduate and graduate training), located in Savar, Dhaka, Bangladesh.
32 Babu received his Master’s degree in computer science from Khulna University, Bangladesh.
commodification in Bangladesh. Our library research was situated mostly in Dhaka University Library, as well as Shahbag Public Library, Agargaon National Library, and Jahangirnagar University Library.

Collecting such advertisements by hand is a laborious task: it is not only complicated to find a small advertisement (usually 2 by 2 inches) in a voluminous daily paper (usually more than 20 pages), but also newspapers are often inaccessible, not to mention dusty and missing pages in the archives of Bangladesh. No wonder manual research of newspapers, where the researcher goes to the library and turns page after page, is rare in our modern age of online databases.

Five national dailies, namely Ittefaq, Jugantor, Prothom Alo, Janakantha, and Inqilab were examined, as commercial advertisements for organs are more frequently published in these newspapers. However, many other national, regional, and local newspapers also publish such advertisements. After examining The Daily Star, the leading English newspaper in Bangladesh, from 2000 to 2002, and not finding organ advertisements there, I concentrated solely on Bengali newspapers instead. In total, I collected 1,139 advertisements from would-be recipients, compared to 149 advertisements from sellers, in the above-mentioned five newspapers between 2000 and 2008.

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33 Some sellers mentioned that they regularly looked for newspaper advertisements in Dainik Korotoa, a local newspaper published in Bogura, a northern town in Bangladesh.
34 Some recipients post more than one advertisement but in different newspapers. Sometimes the language construction of these repetitive ads is different but the phone numbers are the same. I tried to eliminate these repeat ads and count them as one in the above table.
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<td><strong>Ittefaq</strong></td>
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<td>85</td>
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<td><strong>Jugantor</strong></td>
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<td>18</td>
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<tr>
<td><strong>Prothom Alo</strong></td>
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<td>6</td>
<td>0</td>
<td>18</td>
<td>0</td>
<td>13</td>
<td>1</td>
<td>21</td>
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<tr>
<td><strong>Janakantha</strong></td>
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<td>0</td>
<td>26</td>
<td>0</td>
<td>21</td>
<td>0</td>
<td>9</td>
<td>0</td>
<td>23</td>
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<tr>
<td><strong>Inqilab</strong></td>
<td>15</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>12</td>
<td>0</td>
<td>19</td>
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<td><strong>TOTAL</strong></td>
<td>106</td>
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<td>115</td>
<td>13</td>
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R = Recipients  
S = Sellers

**Figure 4.1. Newspaper classifieds in Bengali newspapers**

From this table, it can be seen that most of the organ classifieds (in total 604) are published in *Ittefaq*, which is renowned as the commercial newspaper with the highest circulation in Bangladesh. *Jugantor*, another major newspaper, published 245 organ advertisements, while *Prothom Alo*, the leading newspaper in the country, published 223 such advertisements. Organ classifieds in *Janakantha*, as well as *Inqilab*, the Islamic newspaper, gradually declined, perhaps due to their lesser circulation. At present, three major newspapers – *Ittefaq*, *Jugantor*, and *Prothom Alo* – publish the majority of organ advertisements in this country.

Bangladeshi recipients publish most of the organ classifieds – approximately one advertisement each day. Recipients regularly post these ads because matching tissues is very challenging, and printing costs are affordable: that is, about 700 Taka ($10) for a 2x2-inch space. In comparison, sellers publish fewer and smaller advertisements because they cannot afford the cost and are often unfamiliar with this procedure. It is difficult for me to calculate exactly how many advertisements are published by the brokers. The
number could be approximately ten per year (for example, brokers posted six advertisements in *Prothom Alo* and three in *Ittefaq* in 2006). I was able to identify some of these ads because the telephone numbers used for contacting the advertisers were the same numbers I dialed to locate the brokers. The general rule, however, was: if a newspaper advertisement mentioned two blood groups, but one of them is not O+, it was a broker’s advertisement (O+ is a universal donor). As it appeared that most brokers may have been posing as recipients, I included all the brokers’ classifieds in the recipients’ columns in the above table.

As mentioned earlier, newspaper advertisements are the key means of promoting the extensive practice of organ trade in Bangladesh. Kamal Chowdhury, a university professor at Dhaka, posted advertisements in three national Bengali newspapers and received more than 90 phone calls from different sellers. Another person, Rafiq-un-Nabi, who posted an advertisement in a daily newspaper for a kidney for his wife stated: “I was astonished at the response I had got after the advertisement was published.” Clearly, newspaper advertisements have an enormous impact on expanding the organ trade. The content of newspaper classifieds posted from recipients, sellers, and brokers is distinctive for each group.

*Classifieds from Recipients*

Recipients typically include in their advertisements a brief sketch of personal data, blood group, tissue type, seller’s precondition, reward proposition, and contact number. In the following discussion, I present some newspaper advertisements with corresponding size and translated text.
To outline their personal features, recipients commonly include name, age, gender, occupation, education, and even a photograph. From the observed data, I discovered that all of the recipients live in Bangladesh, except six, who are in Canada, Germany, Italy, and the United States. From their names, it is evident that most of them are Muslim. The recipients’ ages, however, differ: only the youngest, between ages 10 and 40 tend to be identified, because their advertisements often stress that saving a younger life is especially imperative (see Figure 4.2 below).

![Figure 4.2. Kidney wanted for a student](The Daily Inquilab, 11 April 2000)

**Translation:**

**KIDNEY WANTED**

*Kidney wanted for Shaheda Akther Pinki, a talented student in grade 10. Pinki’s Blood group is O+. Interested persons please contact the following telephone numbers: 8153075 and 0189207156 (mobile).*

The recipients’ characteristics vary; generally, only the socially respectable professions, such as doctors, engineers, lawyers, and professors, or “decent” identities, such as freedom fighters and reputed *Moulana* or *Alem* (Muslim religious persons), are mentioned. Most of the recipients are male, although a few of them are “pious females”
or mothers. A few recipients include their photos; they are portrayed as helpless to address their vulnerability. For example, in the following advertisement, the recipient appears religious, which is considered socially respectable.

![Image of the advertisement](image_url)

**Figure 4.3. Kidney needed for an Islamic educator**
*The Daily Inqilab, 14 February 2002*

**Translation:**

**Kidney Needed to Save the Life of Maulana Samsuddin**

Two kidneys are damaged of Maulana A.K.M Samsuddin, Father – Dead Mohammad Shafiguddin Sajjad, Village – South Gajipur, Police Station and District – Pirojpur, currently residing at Darul Islam Trust, North Ouchpara, Tongi, Gajipur. The life of this distinguish Islamic educator can be terminated at any time. Doctor advised Maulana Samsuddin to transplant a kidney. It is possible to save his life, if somebody comes forward with a kidney. The blood group of Maulana Samsuddin is ‘A Positive.” Contact Address: Advocate Abu Syed Molla. 89/C/1, Gopibagh 7th Lane (4th Floor), Mr. Rofique’s House, Dhaka. Telephone: 017-144928.

In this way, recipients outline only particular information in their advertisements in order to stress that saving a socially acceptable and seriously ill life is particularly significant.

Most recipients indicate blood group as the foremost criterion for matching with a donor. The most common blood group of recipients is O+, followed by A+ and B+. Few seek sellers of O- or AB+. However, it is not only the blood group but also the Human Leukocyte Antigen (HLA) tissue typing that must be matched between recipient and seller for organ transplantation to be successful. Recipients therefore include their HLA
results so potential sellers can match the tissues before making contact with recipients. There are six tissue types (A, B, and C, with two numerical types each) that must be suitably matched between the donor and the recipient by at least a standard percentage. In the advertisements, recipients ask that if total tissues, or even one tissue from A and one tissue from B, match with the HLA report they give, to please contact them immediately. In one unusual advertisement, a recipient requests Ayub Masum, a resident in Mirpur, Dhaka, to contact him quickly as their tissues matched well. See the following advertisement.

![Figure 4.4](image)

**Figure 4.4. A kidney from AB positive or O positive wanted**
*The Daily Ittefaq, 21 January 2002*

**Translation:**

**Kidney Wanted**

*Blood group AB positive or O Positive, HLA TYPING: AW24 (A9) B35+53 A-Dg: B42 C: CW6, CW. Ayub Masum, a resident of Mirpur – my HLA is matched with you, so please contact me at the following address: House 24/D, Azimpur, Dhaka, Phone-9665803.*

In their advertisements, recipients occasionally outline some preconditions for the sellers. Some ads indicate that the seller must be healthy, meaning free of diabetes, asthma, high blood pressure, and drug addiction. For example, see the following advertisement.
Figure 4.5. Kidney from A positive blood group needed
The Daily Ittefaq, 7 April 2000

Translation:

Kidney Needed
Blood group “A” Positive. The donor has to be free of high blood pressure, diabetes, asthma, HBS-Ag and drug addiction. The age should be between 23 and 32 years. The donor will be amply rewarded. To contact: Galib, Well Trade, City Heart Building, 12th Floor, 67 Noyapolton, VIP Road, Dhaka-1000. Phone: 8317145, 8316780, 414453, Mobile: 017534139.

Some ads specify that the age of the seller should be between 20 and 40 years, assuming that a younger person’s kidney is “fresher.” Several advertisements demand a kidney from a male, assuming that a male person’s kidney is “stronger.” A few advertisements, however, prefer a kidney from a female, assuming that a female seller cannot cause trouble. Some advertisements are strictly for sellers who have HLA reports available. Many advertisements outline that the donors should contact the recipient directly to avoid the involvement of middlemen.

Recipients periodically mention the amount of money that will be rewarded, the promise of job opportunities to follow, or some other form of compensation for the kidney. For example, one advertisement indicates that the recipient, who is currently under healthcare in the United States, will bear the seller’s expenses of traveling and living in the US. This advertisement also points out that the seller must travel to Washington DC, as the transplant will be performed at Georgetown University Medical Center.
Translation:

Request for Kidney Donation

Both kidneys are damaged of a USA resident, Kulsum Begum. Kidney specialists advise her to transplant a kidney immediately. A heartfelt request is placed to the good persons who can donate a kidney with the following criteria.

1. The interested donor’s blood group and the tissue must be matched with those of Kulsum Begum. Blood group O+.

2. The donor (male or female) has to travel to Washington DC, USA, for the donation. The transplant will be performed at George Town University Medical Center.

3. The donor has to be in good health and aged between 19 and 40 years. All the relevant expenses will be covered by Kulsum Begum. To discuss in details, contact urgently the following address.


Another recipient mentions that he will arrange citizenship and a job in Italy for the seller.
Figure 4.7. Kidney wanted for an Italian resident
The Daily Ittefaq, 25 June 2000

Translation:
Kidney Wanted
A kidney is needed for a seriously ill patient. Blood group B+. The patient is living in Italy. If a good-hearted person donates a kidney, s/he will be amply rewarded or offered a job and citizenship in Italy. Contact within three days to Dr. ABM Eyahia, between 10 a.m. and 12 p.m. or 5 p.m. and 8:30 p.m. Telephone: 8116010 (Chamber).

Similarly, two advertisements indicate that the seller can travel to Canada or Germany. See the following advertisement from a recipient living in Canada.

Figure 4.8. Kidney needed for a Canadian resident
The Daily Prothom Alo, 2 November 2004

Translation:
Kidney Needed
Two kidneys of Engineer Syed Moniruzzaman (Ripon) are damaged. Currently he is under health care in a hospital in Canada. If a nice-hearted man can donate a kidney, please contact the following address. The recipient’s blood group is B+ and tissue typing is = A2, B-52, 60. All kinds of support will be given to the interested person. Contact: Dhaka – 0171837110 and 9120159-134, Chittagong – 011702356, Natore – 0171900849, and Dinajpur – 64357.

In the above samples, these recipients are very likely making false promises, as they cannot guarantee the sellers’ visas for Europe or North America.

Recipients include telephone numbers, mailing addresses, or post office box numbers where they can be contacted. Most recipients include their home address as the
mailing address. Others use contact locations, such as police hospitals, medical clinics, or government quarters, while the rest provide only a post office box number to hide their identity. A number of advertisements offer a timeframe for contact, such as between the 8\textsuperscript{th} and 14\textsuperscript{th} of August, or three days between 5 p.m. and 11 a.m., or after 3 p.m.

Many of the newspaper advertisements posted were for kidneys; however, one for a liver was placed in Prothom Alo on April 25, 2005. The headline of the advertisement states that the liver is needed to save a critically ill patient, and lists the patient’s blood group (O+) and cellphone number. See the advertisement below.

![Liver Needed to Save a Seriously Ill Patient](image)

Translation:

**Liver Needed to Save a Seriously Ill Patient**

*The patient’s blood group is O+. Contact address 0173105615.*

After calling the advertiser several times, I was finally able to conduct a brief interview with him in a hotel in Dhaka. He was a 42-year-old patient living in a southeastern town, visiting Dhaka for a checkup with his liver specialist. When he learned that I was a researcher and not a potential seller, he became agitated and claimed that his friend advised him to post this advertisement. He mentioned that four potential sellers (including an undergraduate college student) had contacted him so far. However, he
declared that he refused to purchase any of these livers because none of the potential
sellers’ families were aware of their actions. He claimed that it was not beneficial posting
a liver advertisement and in fact found it rather disturbing, because he had to deal with
many people, including me.

Classifieds from Sellers

Unlike recipients, sellers include very little personal information in their postings.
For example, one seller mentions only that a kidney of a healthy person would be sold.

![Figure 4.10. A kidney is on sale](The Daily Ittefaq, 30 April 2004)

Translation:
**One Kidney will be Sold**

Unlike the above advertisement, many sellers conceal their identities. For example, see
the following advertisement.

![Figure 4.11. Selling a kidney](The Daily Ittefaq, 13 January 2003)

Translation:
**Kidney Sale**
*A 20-year-old boy will sell a kidney to save his parents. Blood group B+. Contact immediately with your address and phone number The Daily Ittefaq, Box Number 000905.*
However, the sellers tend to mention their names, revealing that most of them are male, with the exception of one female. Moreover, in my sample they were all Muslim. Only two sellers indicated their age (20 and 32 respectively). Most sellers have the B+ blood type followed by O+, and A+. Some advertisements indicate that the sellers’ HLA tissue typing has already been done, while a few advertisements include the result:

![Image of a kidney advertisement](Figure 4.12. Kidney sale
The Daily Ittefaq, 27 April 2005)

**Translation:**

**Kidney Sale**

*Because of money, I will sell a kidney. Blood group: AB+. Tissue test is done.*

*Contact Mobile: 0172908308.*

In my sample, one seller directly indicated that 100% discretion is required. No sellers named their asking price, but stated that the recipients should provide a considerable reward. Sellers mostly offer a phone number as a contact addresses, but a few use a mailing address and P.O. Box instead. None of the advertisements studied contain photographs of the sellers.

All of these advertisements posted were for kidneys, except one, which was for a cornea. Shefali Begum, a 26-year-old single mother of a two-and-a-half-year-old daughter, posted a newspaper advertisement for a cornea in the *Ittefaq* on April 17, 2005:

![Image of a cornea advertisement](Figure 4.13. Cornea sale)
Translation:
**Cornea Sale:** Cornea is for sale due to shortage of money. Serious buyers only. Contact – Shefali Begum, Father: Dead Khoibar Munshi, Village: Talukderpara, Police Station: Kalai, Joipurhat. Mobile No: 0175-084483, 0188-138172 (on request).

The ad drew global media attention and many national and international news media covered Shefali’s advertisement. Below is the front page of a Bengali newspaper that told her story.

Figure 4.14. Newspaper coverage on the cornea seller

The Daily Janakantha, 24 April 2005

Translation:
**Facing Difficulties for Posting an Advertisement for Selling a Cornea**
Shefali Begum, an ill-fated mother in Dhaka has been facing difficulties since she posted an advertisement for selling one of her corneas. Local police and political thugs have warned her not to speak with the media, as doing so would do great harm to the image of the Bangladeshi government. Shefali said, “I do not have
any property to sell, so I decided to sell an eye. But I am so ill-fated that no buyer has contacted me yet.”

After several attempts, I was able to talk with Shefali over the phone. Shefali told me that her husband had left her and she did not have any other income to pay rent for six months and buy food for her daughter. She tried to find a job but was not successful because she had no education; nobody would hire her, even as a maid. Ultimately, she decided to sell one of her corneas, as she believed this was the only way to escape from poverty. She borrowed some money to post the small newspaper ad. She did not set a price in the ad she placed, but hoped to get enough money to set up business as a street vendor or a toy seller (Reuters 2005: 1). Fortunately, Shefali received a job and 50,000 Taka ($700) from the government of Bangladesh after much press coverage. This rare burst of charity does not happen to other sellers who regularly post kidney advertisements, even though some of their stories are also covered in newspapers.

The above advertisements indicate that the organ trade has grown by leaps and bounds among impoverished Bangladeshis.

**Classifieds from Brokers**

Brokers usually publish newspaper advertisements by seeking donors of more than one blood type. For example, see the following advertisement.

*Figure 4.15. Kidney from various blood groups wanted*
*The Daily Ittefaq, 26 September 2003*
**Translation:**

**Kidney Wanted**

Kidney for the blood group of AB+, AB-, O+, and O- are needed urgently. Interested donors are requested to contact 8316858 and 0171-549015.

In their advertisements, brokers pose mostly as recipients, or even as doctors. For example, one advertisement mentions that a kidney is needed to save a seriously ill patient; another advertisement indicates that the advertiser would look over the file of a seller who has already had HLA typing. See the following advertisement.

![Figure 4.16. Kidney wanted from A or O positive donors](The Daily Ittefaq, 11 April 2001)

**Translation:**

**Kidney Wanted**

Persons with “A” or “O” positive blood group and whose HLA typing is matched with A, A-11, B44 (12) or B-15 or B44 (12) and B-15, contact immediately. (The patient’s file will be examined) Mohsin – 019354906.

Another advertisement mentioned that a kidney must be sold urgently; readers are invited to contact Renal Hope, a private dialysis center in Dhaka, which indicates that staff of this clinic might be involved in the trade.

Some of the brokers’ advertisements also mention that sellers with HLA results will be given priority. All of their advertisements use local telephone numbers, except one, which gives a German number (a possible indicator of the expansion of the organ trade abroad). This latter advertisement appears below.
Figure 4.17. Kidney Wanted for German residents
The Daily Ittefaq, 7 March 2003

Translation:

Kidney Wanted: Blood Group B+, O+, and O- (female preferable). Contact phone: 00492203358922 in Germany (can be called through the Internet) between 2 p.m. and 1 a.m. Bangladeshi time.

All of the above advertisements – published by recipients, sellers, and brokers – suggest that the human organ bazaar is growing in Bangladesh.

Organ Classifieds: A Few Questions

According to the Human Body Parts and Organs Transplant Act of 1999, newspaper classifieds for organs are prohibited in Bangladesh. A few questions therefore arise around why such classifieds are being published in newspapers. How are newspapers rationalizing the publication of organ classifieds? What effects do newspaper classifieds have on people’s attitudes and beliefs towards organ commodification? These issues are discussed below.

In organ classifieds, the buyers’ (both recipients and brokers) discourse of commodification is shifted to organ donation. Thus, outlawed organ classifieds are widely published in Bangladesh. The buyers apparently seek organ “donation,” which is legally and morally acceptable. They construct language in such a way that what they are doing, which is illegal, is rationalized and portrayed as “gift giving” to save lives. However, the buyers’ advertisements are morally and emotionally manipulative. They emphasize saving lives, desperate situations, and urgent needs in order to endorse their
actions. They also use photographs, social position, and religious affiliation to solicit social empathy. These deceptive and manipulative actions can be described as “hidden in plain sight” (Newhouse et al. 2005). Nevertheless, the underlying quintessence of commodification is exposed in some ways; at times, for example, the headlines of the buyers’ advertisements are bolder and bigger, such as “Wanted to Buy.”

In contrast, the sellers’ advertisements are mostly explicit about commodification. However, they have little impact because they are usually smaller and placed under the general classified section, thus becoming lost in the sale of apartments, automobiles, and animals.

An obvious question here is this: Why do Bangladeshi newspapers openly publish these outlawed classifieds? A main reason perhaps is that organ advertisements are profitable for the media, not only for gaining revenue but also for increasing circulation, as vested interest groups involved in the organ trade regularly buy these newspapers. Bangladeshi media in particular court wealthy and middle-class citizens, who are the principal buyers of organs (the poor often cannot afford to buy newspapers, let alone organs). Also, these higher classes of citizens run the media and might in some way feel compassionate towards their fellow bhai (brother) or bone (sister) who are suffering from organ failure. Thus, newspapers avoid challenging organ commodification, which might cause local dilemmas or have a negative effect on circulation for the newspapers in question. Consequently, Bangladeshi newspapers as well as other media are either oblivious or silent on the organ transplant trade.  

35 I spoke with a senior assistant editor of Ittefaq, who claimed that he and his staff were unaware of the Organs Transplant Act of 1999 in Bangladesh.
During my library research, I was surprised that I could not find a single critical report on organ commodification, nationally or internationally. Yet there were a few commercial newspaper reports on kidney sellers, reinforcing how “ill-fated” the Bangladeshi poor are. However, there is plenty of reporting (especially on World Kidney Day) about the number of organ failures and the transplant success rate within the limited infrastructure of the country. Thus, organ commodification virtually does not exist in Bangladeshi newspapers, apart from the classifieds.

This ambivalent position of Bangladeshi media (that is, publishing few reports on organ commodification, but publishing numerous organ classifieds) is an outcome of a lack of familiarity with global bioethics, of adopting neo-liberal policies, and of promoting conflicting viewpoints. Media are generally unaware of the wider bioethical debates and complexities surrounding organ commodification. For bioethical perspectives, they depend solely on local nephrologists, who play an ambiguous and distant role in relation to this issue. As a result, local media personnel have opposing views on commodifying organs (i.e. legalizing vs. banning the organ trade). In addition, the media cannot practice independently without state influence, even though they are legally recognized as the free press. Hence, they adopt a neo-liberal structure of a patron-client relationship that supports the benefits of local elites. Also, the media are predominantly run by the private sector; a reporter usually does not have the power to challenge organ commodification alone. Further, Bangladeshi media are one step removed from the process. They do not see themselves as promoting organ commodification; rather, it is the recipients and sellers who post advertisements for their

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36 Bangladeshi media, surprisingly, did not cover the story of Amit Kumar, the Indian doctor and so-called kidney kingpin who was arrested with the support of Interpol in February 2008.
desperation. The media thus adopt a deliberately ambiguous position, as do the Bangladeshi doctors.

Bangladeshi newspapers also publish organ classifieds widely because ethical regulations are very limited. Since 1993, the Press Council has adopted 22 ethical rules for Bangladeshi newspapers, as one of the rules indicates: “The editor has the right to publish any advertisement in his/her newspaper, even if it is apparently against some individual interest, although it can be neither slanderous nor against public interest. However, if a protest is being made about such an advertisement, the editor shall print and publish it at no cost” (The Press Club 2009: 2). The newspapers can easily bypass such a brief Press Council Act, as well as the Organs Transplant Act and so far, there are no legal repercussions for publishing organ advertisements in Bangladesh. The ultimate outcome is that so-called outlawed organ classifieds are widely published in this country.

The critical question then becomes this: What is the impact of these newspaper advertisements? Per Stahlberg (2002) examines the cultural production of mass media in his book Lucknow Daily: How a Hindi Newspaper Constructs Society. Stahlberg examines two basic questions: Does the mass media have the potential to construct locality? Or are the mass media and locality mutually exclusive? Through participant observation, supplemented by content and discourse analysis, he demonstrates that a newspaper is not an object or cultural artifact, but a practice, organization, and group of people involved in social relations and shaped by local and global forces. He argues that the local newspaper structures and offers the news to the readers, rather than readers themselves doing the selection and construction of meaning (Stahlberg 2002; see also Gupta 1995: 385). His research challenges Appadurai’s notion of individual choices and
the accessibility of information as one of the primary factors allowing the construction of one’s own meaning of culture (Horolets 2005: 588). Organ classifieds are thus structured and diffused by the media, powerfully shaping people’s attitude and beliefs towards organ commodification.

The impact of these organ classifieds in national newspapers is enormous. According to government data, there were 286 daily newspapers and 1,522 periodicals published in 1997–98 (Ahsan and Mahmud 2008: 11). The five newspapers covered in this research have extensive circulations. As of January 2001, their total circulation is more than one million copies per day (based on the circulation records they claim). In addition, these newspapers have Internet editions. Thus, organ classifieds are widely circulated among Bangladeshis.

Newspaper classifieds therefore normalize the “illegal” organ trade as it is practiced. During my fieldwork, I found that most Bangladeshis were unaware of the Organs Transplant Act. Dildar, a 32-year-old kidney seller quoted at the beginning of this chapter, asked me if I was sure that the organ trade was illegal, and, if it is illegal, why then are there so many organ advertisements in the newspapers. Some Bangladeshis I interviewed who were aware of organ laws, were sympathetic to both recipients and sellers, believing that organ trade was the last remaining option for the survival of both. These individuals perceived recipients as victims of disease, and sellers as victims of poverty; and that the media help both through advertising the organ trade. Accordingly, organ trade becomes normalized within a system of diverse practices of rationalization, exploitation, and deception becomes a mundane practice, in part through these newspaper advertisements.
Thus due to the normalization of the organ trade, many poor Bangladeshis who have not previously thought about selling body parts step forward believing that they are “donating” organs in exchange of gifts. Most sellers told me that they were unaware of the Transplant Act when they initially decided to sell their kidneys. Many recipients were also unaware of the regulations, while some were vaguely aware that there is a Transplant Act in Bangladesh. As the classifieds for selling livers and other body parts are increasingly published in Bangladeshi newspapers, local people gradually accept the commodifying of body parts.

The common presence of organ classifieds in major newspapers is likely an outcome of widespread neo-liberal practices in Bangladesh. A well-known saying among today’s Bangladeshis is that if someone has money, he can buy the eyeball of a royal Bengal tiger. In comparison, human body parts are much easier and cheaper to find.
There are colors on the street: red, white, and blue
People shufflin’ their feet, people sleepin’ in their shoes …
Keep on rockin’ in the free world. – Neil Young

This chapter (and the subsequent three chapters) provides in-depth accounts of 33 Bangladeshi kidney sellers and reveals the labyrinth of exploitation that took place through the “miracle” of transplant technology. In the following three chapters, the kidney sellers offer detailed narratives of the processes and experiences of the pre-operative, operative, and post-operative stages of selling their organs. Chapter Six outlines the pre-operative stage, where sellers contact the prospective buyers, successfully match tissues, examine medical tests, arrange false documents, and initiate their life-altering journey. Chapter Seven exposes the operative phase, including sellers’ travel to a new place, medical re-examination, the daunting operation, and the physical outcomes (such as scars) incurred. Chapter Eight explores the post-operative part: the return home, financial dealings, health conditions, and “commodified kinship.” For the sellers, selling a kidney begins as a journey of hope, but towards the end they experience it as a journey of deception.

Poverty, Corruption, and Inequality

The earth provides enough to satisfy every man’s need, but not every man’s greed. – Mahatma Gandhi
Before delving into the sellers’ odyssey, let me briefly outline the context of poverty in which poor Bangladeshis live, illustrating that their poverty is not the result of personal failure; rather, it is a form of structural violence against the poor (Farmer 1999; 2005). The majority of Bangladeshis live amid crushing poverty; they not only suffer from chronic hunger and malnutrition (Hartmann and Boyce 1983), but must also deal with a scarcity of land and limited work opportunities (Jansen 1986). Many cannot afford basic daily expenses, the minimum cost of education, or proper water and sanitation facilities. To escape from poverty, many poor live with other families or migrate to overpopulated cities, yet they are still unable to meet such basic human needs as sufficient food, shelter, and health care. Bangladeshi poor live with the bare margin of subsistence; they are surviving on an “hour to hour basis.”

During my fieldwork, I saw the body of a poor Bangladeshi who died of hunger and disease on a street in Dhaka.

![A man lying dead on a street in Dhaka.](image)

*Figure 5.1  A man lying dead on a street in Dhaka.*

*Photo by Md Moniruzzaman, October 2004.*

The state provided no assistance, although the person had been dead for several hours. The local people told me that their state officials and political leaders do not shed even
crocodile tears for the poor, as these authorities are busy maximizing their own profits. As the family of this deceased person likely lived in a village and was thus unaware of his death, it was the locals who were collecting money from pedestrians to wrap his body in white cloths and bury him in a grave.

Ironically, the dead body was lying next to two poignant symbols – a bread roll that held burning incense, and some Bangladeshi Taka, collected from pedestrians. The deceased person had not obtained enough of either of these things, food or money, to prolong his life. In many respects, the posters behind the cadaver represent the current political economy of Bangladesh – the top poster is linked to the economy and the lower one is linked to politics. The top row of posters signifies how the neo-liberal economy is expanding in the country, where profit-making business is considered the priority. The muscular body and the gym culture epitomize how new Western concepts are deliberately penetrating this impoverished country where only wealthy citizens can afford them. The lower row of posters contains photographs of Sheikh Hasina (then the opposition leader and daughter of Bangabandhu, the father of this nation), protesting an assassination attempt during her political assembly. The country is facing tremendous political problems, which are intensified by frightening bomb blasts. The blasts are attributed to Islamic fundamentalist groups, although they were in league with the coalition of Prime Minister Khaleda Zia, the leader of the ruling party at the time.

Fakir Mia, a 47-year-old Bangladeshi villager, described to me his living conditions amid this extreme poverty. When Fakir’s father settled down in Kochua, a village on the south bank of the river Atai in the district of Jessore, there were few people but many orchard trees. However, due to population growth and new settlement patterns,
people cut down the trees and built houses there. Resources became scarcer, a situation that was intensified by various natural disasters. Fakir’s father had a moderate amount of land, but he had to sell it to pay off the money he borrowed to arrange dowry for his daughter’s wedding.

The poverty of the landless Fakir was pervasive. He started cultivating *amôn*, *aush*, and *boro* paddies in land leased from a wealthy landowner, but in return, he had to give the owner two thirds of his total cultivated crops, even though Fakir had to pay all his own expenses as well. Fakir could not usually afford to pay for proper irrigation and pesticides; thus, as he expressed it, he could never smile during his harvest. During the off-season of cultivation, he often worked pulling a rickshaw or at a construction job, however, now that he was older, he did not get these jobs regularly. Fakir did not send his three daughters to school, arguing that education for girls is not beneficial. In contrast, his two sons went to school, but quit after a few years to help their father cultivate the land. Fakir was somewhat fortunate as his wife received a microcredit loan from the Grameen Bank, a local non-governmental organization. With this fund, the family bought a cow, yet the earnings from selling the cow’s milk were often insufficient to repay the loan. Fakir’s wife, therefore, went to the closest bazaar to break brickbats with her hands. Most days, however, there was no work, so she did *nakshi katha*, or hand embroidery. Their family expenses were always higher than their earnings, which were on average 150 Taka ($2) per day. They felt fortunate if they had thrashed rice and molasses to eat, but usually could not arrange two meals a day. Fakir told me, “We can stay without food,

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37 *Amon, Aush, and Boro* are three crops of Bangladesh harvested in every alternative four months of a year.

38 In Bangladesh, local workers commonly gather in the centre of town at dawn. Employers come and pick workers mostly based on their age, as well as their knowledge and the tools they bring. A typical worker’s salary is 100 Taka ($1.50) for eight hours’ labor.
but it is pathetic not to feed our children.” The family’s biggest worry was that their poverty was not static but rather was deepening.

Fakir’s family was virtually shut out of medical facilities. Buying health care and medicine were luxuries for them when they could not even afford enough food. They depended on panipara, or holy water, that they obtained free from the local mosque, to cure common illnesses. Last year, their son had surgery to remove a tumor; they had to pay a bribe to obtain access to the public health-care facilities. Fakir fumed when he told me that Hamid Bepari, one of his wealthy neighbors, went to the same hospital but did not have to pay any money to treat his injured hand. Ultimately, Fakir’s family had to sell the cow to pay for their son’s medical treatment. Fakir was vulnerable when he said that now he had no money to repay his microcredit loan, nor had he any savings for future medical treatments. On rainy days, water poured into his house, but Fakir could not afford to repair it. He smiled sadly when he said that in the dry season, poor farmers suffer from a lack of irrigation, but in the rainy season, they suffer from unemployment. Such sorrows are almost insurmountable for poor Bangladeshis (Moniruzzaman 1995: 126-30).

Yet Fakir and his family are better off than many of the 35 million Bangladeshi poor (around a quarter of the total population) who face acute poverty and hunger. The University of Bath–based researcher Peter Davis (2008) finds that dowry payment (which is usually 200 times the daily wage) and costly medical expenses are two major causes of chronic poverty in Bangladesh. The study notes that some families face a “double whammy”: paying dowry and wedding expenses for their daughters while at the same time bearing medical expenses for elderly relatives. Based on collected life histories, the
study also indicates that the lives of many poor people decline in a “saw-tooth” pattern, meaning that the slow improvements of their poverty conditions are reversed by sharp declines caused by unexpected events, such as illness, high medical costs, wedding expenses, and legal disputes (Davis 2008: 1-2). In these ongoing situations, the poor need to borrow money, but eventually must sell their land to pay off their loans. Thus, many poor people are becoming landless, without assets. Having many family members to support perpetuates their poverty. The vicious circle of poverty of the Bangladeshi poor is intensifying on a daily basis.

Although poverty is extreme in Bangladesh, the poor are living under the “regime of disappearance,” particularly in relation to neo-liberal capitalism (Goode and Maskovsky 2001). As usual, the poor are individually blamed for their lack of funds (Susser 2001) or idle habits. Yet, the fact is that the neo-liberal Bangladeshi state has failed to create employment opportunities, let alone reduce poverty, inequality, illiteracy, malnutrition, and diseases so that poor citizens can ensure their basic needs for survival. Although more than 20,000 non-governmental organizations, including the world’s largest NGO, the Bangladesh Rural Advancement Committee, are currently operating in this country (Ullah and Routray 2007: 240), the development policies of the past were mainly a failure, measuring in terms of alleviating poverty, ensuring justice, and creating employment (in contrast, they are somewhat successful in terms of aggregated growth rates) (Islam 2007: 7). The Grameen Bank, the Nobel Prize–winning microcredit system, is strongly criticized for reinforcing the neo-liberal view that the poor can change their fate by themselves with the support of credit, entrepreneurship, and hard work. The bank does not offer any direction in terms of job opportunities, equitable distribution, and
structural change (Karim 2008: 10; Mahmud 2008: 127; Feiner and Barker 2006: 2). Overall, despite inflows of huge amounts of foreign aid, the Bangladeshi state has failed to rebuild the socio-economic infrastructure of the country or to uplift the socio-economic condition of the masses living below the poverty line (Islam 2007: 7).

Unlike affluent societies, in Bangladesh today “a quieter violence also stalks with the violence of needless hunger” – a direct outgrowth of an uneven capitalist state (Hartman and Boyce 1983: 282). Poverty in this country and elsewhere has been closely allied with inequality in the distribution of income and wealth (Sen 1984; Streefland et al. 1986; Griffin 1989). A small group of Bangladeshis is reaping huge profits from the misery of the majority, so poverty of the poor is deprivation of the many and affluence for the few (Kurine 1978). This poverty is “not fortuitous, a result of divine dispensation or individual failings of character,” but rather “the outcome of a long history of exploitation, culminating in a social order that benefits a few at the expense of many” (George in Hartman and Boyce 1983, back cover).

Following Marx’s writing of the *Eighteenth Brumaire*, Hamza Alavi, a Pakistani scholar, views the post-colonial state as an instrument for accumulating sufficient power within the state apparatus to be able to both influence and indeed to contribute to the growth of certain classes (Alavi 1972; see also Sobhan 2002). The poverty of Bangladesh is closely related to class structure perpetrated through low wages and through patronage systems, but also because of kinship and social groupings that cut across class lines controlled by the rich (Abecassis 1990). It could be argued, in contrast to Mahatma Gandhi statement, that there are limited resources in Bangladesh; however, the reality is the wealthy class secures its huge share of means at the expense of the poor (Jansen
Large landowners, big merchants, government officials, and political leaders are prime forces responsible for the majority’s poverty (Arens and Buerden 1977). Increasingly, the rich are getting richer and the poor are getting poorer in this country.

The link between extreme poverty and severe corruption is explicit in Bangladesh, since corruption is perhaps the major disease of the neo-liberal regimes. However, it is believed by many that “the free market is the most efficient means for achieving economic growth and guaranteeing social welfare” (Sanchez-Otero 1993 and Bourdieu 1998 in Goode and Maskovsky 2001: 7; see also Haller and Shore 2005: 9). Privatization and globalization appear to have “enlarged the scope and opportunities for corruption, not only by enlarging the rewards of fraud and chicanery, but by eroding public ethics, reducing the state’s legitimate interest, and diluting the general interest through the pursuit of profit and the defense of selfish private interests” (Meny 1996; Rose-Ackerman 1996 in Haller and Shore 2005: 9). The structural violence against the Bangladeshi poor persists due to widespread poverty and corruption, which are two sides of the same Taka.

Although limited research has been done on the exact extent of corruption, many are aware that corruption is pervasive in Bangladesh and South Asia (Gupta 2005 & 1995; Srivastava 2001; Halayya 1985). As mentioned earlier, corruption in Bangladesh is among the highest in the world. Based on a survey conducted in 2005, Transparency International (TI), a Berlin-based non-governmental organization shows that corruption is prevalent in almost every sector in Bangladesh, including land administration, police and judiciary, health, education, power supply, taxation, and the distribution of aid (presented from higher to lower corrupt sector). To capture the extent of Bangladeshi corruption, I highlight some of TI’s survey findings:
92% of households that lodged FIR (First Information Report) to the police station had to pay a bribe, as did 66% of plaintiffs to the lower judiciary. 97% of Bangladeshis who purchased land had to pay a bribe for land registration. 46% of citizens had to pay a bribe to doctors for receiving medical treatment from public hospitals. 40% of Bangladeshi students at the primary level had to pay admission fees even though primary education is supposed to be free. 70% of people pay bribes to obtain an electricity connection. 49% of households who paid income tax had to pay bribes (Transparency International 2006).

In this country, political leaders, police officers, and members of the civil and military bureaucracy are assuming huge proportions of the wealth as a result of widespread bribery, extortion, and theft (Pavarala 1996). Public servants, especially the police, know “every dirty trick” to extort money from both criminals and innocent people alike (Islam 2000: 1). Evidently, Bangladesh has lost to corruption an estimated $27 billion received as foreign aid since its independence, by which it could raise its GDP growth by 3% each year (The World Bank 2000 in Zaman 2009a: 5-6).

Corruption breeds and increases poverty, deprivation, and injustice (Zaman 2009b: 5). It invariably channels public resources to the rich while the poor suffer. The poor are mostly affected and directly vulnerable to corruption; for example, their access to health, education, security, and justice is lessened (Knox 2009: 118). Their access to various services is also reduced, while “drugs and textbooks are stolen from public facilities and sold privately, and while doctors and teachers have high rates of absenteeism from their public jobs and sell their services privately” (Mollah and Uddin 2007: 1). The estimated bribe to receive public service per person is 485 Taka ($7) on average in 2004 (Transparency International 2008: 4). Many of the poor, including Fakir Mia in the above-presented case study, lack funds to pay such a bribe, and thus are unable to obtain many services that are supposed to be free of charge. The poor are also deprived
of their legal rights, entitlements, and many other services due to corruption. Evidently, corruption is anti-poor (Vittal 2003: 56), as well as an anti-economic development that impede Bangladeshis’ fight against extreme poverty.

The corruption in Bangladesh is often identified by *ghoosh*, or bribes, but corruption is also executed in the form of misusing political and social power against the poor (Zaman 2006: 4; see also Zafarullah and Siddiquee 2001). Of billions of dollars that Bangladesh received from foreign aid since its independence, barely 25% was used to benefit its people (Barakat 2001 in Chowdhury 2006: 2). Many Bangladeshis, living in 68,000 villages, commonly talk about *gom chor*, or wheat thieves: local political leaders and government officials who grab most of the foreign aid allocated for the poor. Fakir Mia told me that his Union Parishad (the local government) once received camel meat as aid from Saudi Arabia during Ramadan (the month of fasting among Muslims), but the meat was stolen by public officials and local politicians. Fakir claimed that in his entire life, he had not received any foreign aid, except a blanket during Bangabandhu’s presidency.

Like the public sectors, the widespread non-governmental organizations currently working in Bangladesh are not free of corruption. These NGOs benefit the privileged minority by ignoring the poor majority, a typical outcome of the Western modernization approach (Harrison 1987). Transparency International has termed the Bangladeshi NGOs a mid-level corrupt sector, as they commonly have lack of transparency, lack of accountability, and serious irregularities (Transparency International 2007 in *The Daily Star* 2007: 1). Some NGOs are alleged to be involved in political manoeuvring, even in
expanding Islamic fundamentalism. The massive expansion of NGOs thus has not significantly change the poverty situation in Bangladesh.

In summary, extreme poverty, severe corruption, and extensive inequality are intertwined in Bangladesh. By focusing on the narratives of the poor, anthropologists must examine how these relationships intersect and are facilitated through the neo-liberal state (Haller and Shore 2005; Gupta 2005 & 1995; Nuijten 2003; Sen 1982). As Fakir Mia said, “The rich always dominate us and cunningly take away food from our mouth; they are increasing their wealth from stealing our assets.” The suffering of the poor is not merely a tragedy, but a crime.

*The Poverty of the Poor*

The impacts of poverty, corruption, and inequality are often unexamined, particularly in the underground bazaar where body parts are for sale. In the following three chapters, I outline how wealthy Bangladeshis exploit the poor, to the point of enticing them to sell vital organs to prolong their own lives. By generating the discourse of disillusion – in which kidney sellers are apparently donating their organs, a lawful and noble life-saving act, in return for which they receive gifts – Bangladeshi buyers (both recipients and brokers) deliberately use fraud for their personal gain. The buyers’ fraudulent fabrication of the concepts of donation and gift giving when it comes to organ commodification are, as I have shown, institutionalized through their widespread newspaper advertisements. Poor Bangladeshis believe that selling a kidney is their only hope for changing their “wheel of fate.” Cunningly, buyers lure them and eventually
procure their organs through deception, manipulation, and misinformed consent – common fraudulent hoaxes perpetrated by organ buyers in Bangladesh.

Poverty is the core reason for selling kidneys in Bangladesh and in many other countries in the world. Among the 33 sellers I interviewed, most were compelled to sell their kidneys to pay off debts and dowries, while others decided to sell in order to have a better life, at least in material terms. It is difficult to distinguish between the forced and the aspired causes of selling a kidney, as they are interconnected by the vicious cycle of poverty. However, more and more Bangladeshis are considering selling their kidneys because of an illusion that doing so is an easy means of getting out of poverty.

Most poor Bangladeshis need to borrow money when faced with unexpected events in their lives, such as health crises, legal disputes, and dowries. The majority, however, cannot get a loan from the bank; the very few fortunate ones who do qualify for a loan must go through an extremely bureaucratic process to get it. Transparency International notes that an average Bangladeshi who does manage to get a bank loan must usually pay a bribe, and even then needs to wait on average 108 days for the public banks and 30 days for the private banks (Transparency International 2005: 2). For this reason, poor Bangladeshis depend on obtaining loans from two accessible sources: the local lender, or shudkhor (literally, “interest eater”) and the microcredit program offered by non-governmental organizations. The problem in both systems is the high interest rates charged: shudkhrs charge cumulative interest as high as 10% per month, while NGOs charge about 20% per year. The ultimate outcome is, as Brett Williams shows in her study in the United States, since the poor cannot receive bank loans, they borrow money
at high rates from various sources, such as through a credit card, all of which eventually perpetuate their poverty (Williams 2001).

Among the interviewed sellers, debt was the number one reason for selling a kidney. After borrowing money at high interest rates to support a growing business, my research population fell into onerous debt mostly due to unexpected circumstances. For example, a peasant started a poultry farm after borrowing money, but later was ruined by *ranikhet*, an epidemic; a small businessman opened a variety store, but was unsuccessful due to a colossal amount of unrecovered credit; a contractor borrowed money to start a business, but had to bribe the police to keep quiet when one of his workers died on the job. These types of business loss force many Bangladeshis to sell a kidney in order to pay off their debt. Some sellers are in debt for other reasons. For instance, three sellers borrowed money and sold their land to get a job abroad, only to be deceived by the middleman. Also, two sellers arranged bribes to get a job, but it was later revealed that the job was only a temporary position. Two other sellers got loans to pay for health care for family members: one seller’s father was ill; another’s wife was giving birth. Sadly, both of them died.

In still other cases, some sellers sell a kidney to arrange dowries. One widow, who had been struggling financially since her husband’s death in 1990, sold her kidney in order to arrange dowries and weddings for her four daughters. Another seller borrowed money from his parents to run a business, but when the business was unsuccessful, he had to arrange his sister’s dowry by obtaining loans. Selling a kidney for dowry appears to be common in Bangladesh.
Furthermore, a number of sellers choose to sell their kidneys to pay off debts they accumulated due to their addiction to fencidil, alcohol, and heroin. However, these sellers did not disclose their addiction to me. I cross-checked their statements and found out that very few sellers thus addicted engage in selling their organs. Still, living in poor conditions with high unemployment rates perpetuates drug addiction and contributes to the increase in the trend of selling kidneys in Bangladesh.

Living with debt results in excruciating suffering for sellers, as both *shudkhors* and NGOs pressure the poor to recover the loan. The *shudkhors* often come to the seller’s house and create constant pressure by using vulgar language, seizing valuable things, even using physical force or taking legal action to recover the money the person has borrowed. It is a typical scenario in Bangladesh for the *shudkhors* to seize the borrower’s house or land; the poor cannot afford to pay for legal disputes to be resolved and are unable to fight against the powerful. Many NGOs also threaten the borrower with jail; some borrowers obtain further microcredit loans to pay off the interest of the first loan, thus creating huge debts. Not surprisingly, a few sellers told me that they sold their kidney to pay off a microcredit loan generated by the program implemented by Nobel Prize–winning Bangladeshi economist Muhammad Yunus. Even though the interviewed sellers were unemployed, they left their homes early in the morning and came back at midnight to avoid the unrelenting pressure from lenders. A few sellers left their village

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39 Fencidil, a cough syrup smuggled from India to Bangladesh, is widely used in Bangladesh. The effects are ultimately fatal as this mixture slowly destroys almost every organ in the body.
40 Many sellers said that borrowing money from different NGOs is simple. The microcredit program is set up in such a way that the local NGO officials are pressured from the higher authority to form a group (the standard is about 40 members) to facilitate the loan. The officials often fight over clients, thus accepting many of those who are already members and have borrowed money from other NGOs.
and started a new, harsh life in Dhaka, but many could not run away. As Hiru, a 38-year-old seller, described:

I was under constant pressure for being in debt. I am Hindu, so I could easily cross the Indian border for not paying off the loan. However, I did not want to contribute to the claim that Hindus always run away from Bangladesh. If I were in India I could be religiously secure, but I preferred living in Bangladesh because, like my father, I was born in this place. This is my home. My family does not need the burden of living with my worry.

Selling kidneys thus is often a last resort for poor Bangladeshis needing to pay off rapidly accumulating debt.

Other poor Bangladeshis sell their kidneys because they aspire to a better life. They believe that in return for their kidney they will receive a lot of money, a good job offer, and/or an overseas visa that will change their lives for the better. In Bangladesh, rapid industrialization and urbanization dislocate many people, and have pushed the unemployment rate as high as 35.2%. Therefore, some people choose to sell their kidneys in order to get some cash quickly. As Motlob, a 27-year-old seller, said:

I was weaving sari at Mirpur, Dhaka. Like many other handlooms, my factory was closed due to rapid industrialization. I tried but was not able to get any satisfactory job without high school education and other expertise. On the other hand, I could not live as a rickshaw puller or a garment worker due to my social status. So, I decided to sell my kidney, which helped me arrange a bribe to get a job.

Four sellers also mentioned that they had been unemployed for years, so they brokered a deal to open a small business. Thus, some sellers have poor jobs with limited income and they sell a kidney in the hopes of changing their fate.

It is difficult to identify which reason as the foremost one for selling kidneys. Clearly, sellers decide to sell for numerous reasons derived from poverty. As Jobbar, a 28-year-old seller, described:
I borrowed money to open a video store. The interest rate was so high that I had to sell almost everything in the store, but could not get out of debt. I then started a commercial painting job, but there were not enough working days, so I switched to another job as a bus helper. I could not live this dwindling life and decided to sell my kidney hoping for a better future.

The Backdrop

The following three chapters explore the processes and experiences of 33 Bangladeshi kidney sellers as they trade their kidneys. A composite odyssey is drawn from the predominant themes that emerged from rich narratives collected during my fieldwork. The focus of the narratives is on kidney sellers; these provide a collective account of what might be called a typical journey. However, not all sellers follow the exact same route or decisions. Because they face different obstacles, their actions vary. Yet, despite their differences, the journey of kidney sellers has many standard aspects. For example, selling a kidney is a process that takes about a year to complete.

A composite journey could be methodologically significant, as it unfolds the collectiveness of a typical course of action. However, a composite journey/account/story is not usual in social science research (exceptions include Max Weber’s discussion on ideal types), even though it is typical in literary genres. My composite journey of kidney sellers is noteworthy as it offers detailed descriptions and includes the rich personal narratives of the processes and experiences of kidney sellers’ combined action. I focus primarily on the sellers’ narratives rather than the buyers’, as the former offer subaltern voices grounded in the perspectives of exploitees rather than exploiters. However, I cross-check sellers’ accounts with other research populations when necessary.

Before narrating the detailed accounts of kidney selling, some key issues need to be discussed. I label the person who sold his/her kidney as a seller rather than a donor or
vendor. However, it is important to note that identifying kidney sellers as mere sellers might lessen their worth, as buyers fraudulently treat them as “donors,” who are apparently saving lives and getting gifts in return. Additionally, I often place the recipient and the broker in one category, labeling them as buyers because there is no significant difference between them. Nonetheless, I have separated them when necessary. Furthermore, I do not evenly distinguish between the two types of brokering as exhibited by two leading brokers: Dalal (my key informant and the second most prominent broker in Bangladesh), who matches the tissues for a commission, then deals directly with the recipient; and Batpar (the major broker), who operates a package deal so that sellers do not meet with recipients before the operation. Moreover, it is worth mentioning that the popular analogy of the good, the bad, and the ugly (the sellers are good, the recipients are bad, and the brokers are ugly) is not always effective: some recipients deal with sellers reasonably, a few sellers trick the recipients,41 and some brokers are worse than others.42

Before setting up the following three chapters, it is also important to gain some background knowledge of the 33 sellers, the source of my narratives. These sellers came from diverse backgrounds in terms of geography, education, marital status, religion, gender, age, and economic status. They resided in different parts of Bangladesh, mostly in rural towns (see map 2.1 in Chapter Two). Eleven of them lived in North Bangladesh (mainly from the districts of Natore and Dinajpur), four in South Bangladesh (Barisal), two in East Bangladesh (Faridpur and Magura), and three in West Bangladesh

41 Recipients mentioned that some sellers cheat them. In some cases, sellers did not show up for the trip to India after recipients spent a lot of money on them for medical tests, passport, and tickets. Also, recipients noted that many prospective sellers contacted them initially but did not come back after receiving hundreds of Taka ($3 to $7) at the first meeting. However, in general, sellers do not have the power to deceive recipients; it is mostly the other way around.

42 Undoubtedly, Batpar is the worst type of dealer in Bangladesh, while Dalal largely cheats recipients as well as sellers whenever possible.
(Bhairabbazar, Bramhanbaria, and Chittagong). Nine lived in Dhaka (the capital of Bangladesh), and the final four came from central Bangladesh (mainly in Mymensingh). Thirteen of the sellers were 21 to 25 years old, seven were 31 to 35 years old, and four were 41 to 45 years old.

To my surprise, many sellers were educated; one seller had even obtained a Master of Science degree. Five had completed high school (grade XI and XII), eight had passed grade X, nine finished grade VIII, eight completed up to grade V, and the last two were able only to sign their names. The sellers had varying occupations, from rickshaw puller, hawker, barber, electrician, daily worker, and farmer to teacher and student. Some were religious activists, commercial artists, and housewives. Most of the sellers were poor: 10 sellers (including three females and one student) had no income or an insignificant income of 500 Taka (US $7)\textsuperscript{43} per month; five earned a monthly income of about 3,500 Taka (US $50); another five made about 5,000 Taka (US $75) per month; while only one had an income of about 7,000 Taka (US $100) per month.

The sellers’ marital status also varied: 21 were married, 11 were single, and one was divorced. On average, sellers had three and four family members, while most single sellers lived in a joint family home with five or six relatives. Representing the Bangladeshi religious landscape, all of these sellers were Muslim, except one, who was Hindu. Only three sellers were female, while 30 were male. To guarantee anonymity, all sellers are identified by pseudonyms.

Sellers sold their kidneys to various recipients, whose age ranged from 30 to 75 years of age. Nineteen of the recipients were female; 14 were male. All the recipients were Muslim, except one. Most of their transplantations were performed in India, with

\footnote{The dollar sign here represents to US currency, and $1 is equivalent to approximately 70 Taka.}
the exception of six: three were done in Bangladesh, one in Pakistan, one in Thailand, and one in Singapore.

*A Trilogy*

The common picture of the kidney trade in Bangladesh is that of a wealthy recipient posting newspaper advertisements to find prospective sellers. The seller contacts the recipient, who then arranges the HLA typing examination to match their tissues with each other. Usually, the tissues do not match in the first attempt, so the seller keeps on trying on average five or six would-be recipients. Finding someone with matching tissue is extremely difficult, which partly explains the role of a broker in the process. Most of the time, sellers turn to a broker to find successful tissue matches. Upon matching, the buyer (recipient or broker) forges the necessary documents (including passport and notary certificate) so that the seller becomes “commodified kin,” donating the organ to save a life. Finally, both recipient and seller travel to India or an overseas country for the transplant surgery. After the operation, the wealthy recipient may fly to another country for better health care, while the seller travels back to Bangladesh to pay off debts. Among the 33 kidney sellers interviewed, most of them followed this path. Some sold their kidney through other sellers who usually work as brokers’ agents on commission, while a few sold their kidney directly to the recipient without a broker’s involvement.

The sellers’ odyssey is a trilogy. I have divided it into three sections: pre-operative, operative, and post-operative. How sellers arrange the deal, enter the operating room, and suffer as a result of selling a vital organ is revealed in the next three chapters.
Remarkably, these stages are parallel to three colours: white – a symbol of hope; red – a symbol of sacrifice; and blue – a symbol of suffering.
CHAPTER SIX

White: Hope

Selling a kidney is like running for a *sonar horin* or golden deer – an illusion. – Hiru, a 38-year-old kidney seller

This chapter explores the pre-operative journey of 33 Bangladeshi kidney sellers. It specifically outlines their initial undertakings, efforts towards tissue matching, meeting with a broker, and covers the essential dealings before the operation which tends to be performed abroad. The pre-operative is the most expensive stage for kidney sellers, as arrangements typically take about seven months, and include constantly phoning buyers and meeting with them with the aim of finding a match. During this period, sellers hope for a better life, but at the same time worry about the risks involved in having a vital organ removed; their journey is a constant battle between hope and fear. When they hesitate before making the decision to proceed, buyers entrap them by saying that a kidney transplant is a routine procedure in which the seller is saving a life and in return receiving gifts. Buyers manipulate sellers by providing misleading information, false promises, and moral fabrication to persist in the fantasy that the process is a donation. Sellers, meanwhile, like gamblers everywhere, convince themselves that they are the winners in the deal. At the end, they experience unexpected health, economic, social, and moral sufferings.

*Entrapment*

While trying to overcome poverty in their everyday lives, poor Bangladeshis regularly check newspaper classifieds for possible job prospects. When they come across
an advertisement for organ “donation” (such as those explored in Chapter Four) they are attracted by the lucrative offers made, including a monetary reward, a job offer, or an overseas visa. Some believe that selling a kidney can resolve their economic hardships and drastically change their social condition; their hopes are often as high as the sky. However, due to high social stigma against selling body parts in Bangladesh and many other countries (Schep-Hughes 2003a; Zargooshi 2001b; Chengappa 1990), those who are interested choose not to disclose their disgraceful and humiliating action to anyone. They might cut the advertisement out of the newspaper with a shaving blade and hide it under a mattress. Although these potential sellers are intrigued, they are also frightened that having a kidney removed might threaten their lives and lower their social position. They therefore hide their interest and the ad, and are ambivalent about contacting the advertiser (usually a potential recipient).

Most potential sellers have very limited or no knowledge about kidneys or their function in human health. Rahmat (28) had heard about a boy donating a kidney to his father in a distant village; Motlob (27) knew that his grandmother died because of a kidney stone. On the other hand, Mofiz, a 41-year-old seller, said in an interview:

I saw an ad looking for a kidney posted in the daily Ittefaq in 2000. I asked one of my friends, what is a kidney? Where is it located? What does one need to do when it is damaged? How can you donate your kidney? How much money can I get? I did not know that a kidney could be sold for money.

Likewise, Sokhina (37) stated, “I only knew that people snatch kidneys from others; it was like a fairy tale.” Generally, sellers do not know the location, function, and

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44 This bracketed number represents the age of the seller. This number indicates the person’s age when the interviews were conducted, not when the seller sold a kidney. However, most sellers sold their kidney within two or three years of the interview.
importance of a kidney. To them, donating a kidney is like donating blood; they believe people can easily trade a kidney if their blood group matches that of the recipient.

Sellers repeatedly read the newspaper advertisement they have cut out to gain more knowledge about selling a kidney, but obtain very little information. Some therefore decide to visit a village pharmacist to learn about kidney donation. Local practitioners offer vague advice, telling sellers that kidney donation is a good act. As one of them declared, “People can live without a kidney; it is like everyone needs two legs to live well, but one leg is enough to survive.”

A few sellers also visit regional doctors, even though access to these doctors is limited. The doctors usually encourage them to donate, as the transplant discussion promotes organ donation and saving lives, and tell them that a healthy person can donate a kidney to a family member. These physicians brush off the negative health consequences of selling, saying merely that the donor needs to rest for only a few months after the surgery and cannot lift heavy loads during this time. Doctors charge a service fee for these appointments, but do not attempt to find out the underlying motivation of the person’s visit. Some are fully aware that the people consulting them are not planning to donate but rather to sell their kidney; these doctors overlook this point in order to increase their own profits. As Mofiz (41) outlined:

I asked a doctor: Sir, is there any problem for giving my kidney to my sister, who has two damaged kidneys? He replied that kidney donation is a moral act. I asked whether I would encounter any sexual or other problems after the donation. He replied that if the operation is done properly, there would be no physical problems. The doctor then asked whether I was donating to my real sister. I could not lie. He asked me why I was selling my kidney. I indicated my poor conditions to him. He replied that these were my personal problems anyway. Kidney donation is straightforward; the donor has to match his blood and tissues. I asked him: Sir, can you please check my blood group? He informed me that I have O+. He gave me a certificate and took 150 Taka ($2).
Due to the commercialization of health care in Bangladesh, doctors usually do not closely scrutinize sellers or pursue an in-depth discussion about the physical risks and moral questions around selling a kidney. Sellers are also unable to obtain proper information about the consequences of selling, since they introduce themselves as donors and discuss donation in general terms. What is more, the practice of informed consent is nominal among Bangladeshi health-care personnel (World Health Organization 2000b: 5-12), and in fact most citizens do not comprehend the need for informed consent (Lynoe et al. 2001: 460). Sellers thus obtain from health-care personnel vague or insufficient information on the details of kidney selling. Indeed, sellers are typically encouraged to sell their kidneys, because doctors predict that no physical harm will result from the donation and sellers believe that the recipient will compensate them well. As Rahmat (28) noted:

> When I talked with a doctor, I realized that I have two kidneys but the potential recipient has none. I can easily save a person’s life without facing any health difficulties. So, I decided to donate my kidney in order to live a far better life, even though I did not have any debts and had a job with a salary of 4,500 Taka ($65) per month. I was living sufficiently, as my monthly expenditure was 2,000 Taka ($30) for living in Dhaka, and I sent 2,500 Taka ($35) every month to support my extended family.

Because sellers do not fully understand the health consequences of selling a kidney, they become confused when they realize that replacing a kidney cannot be as simple as it sounds. As Dildar (32) noted, “Although the doctor told me that due to a recent medical success they could just cut off my kidney and set it up in the recipient’s body, he did not explain how I would survive. Or how my kidney would adjust to another body.” Sellers also fear the risk of death or health complications associated with kidney transplant. Oscillating between hope and fear, they decide to contact a recipient to find
out more about the deal for a better life that is on offer. They rationalize that they are just curious, and will step back anytime if the consequences seem dire.

As most do not have a telephone, sellers call the recipient from a phone store. Usually, they are so frightened and uneasy that their tone of voice changes. As Sodrul (22) recounted, “I made such a big decision in life, so I am slightly shaking. I am worried: what will happen if somebody finds out that I am trying to sell my kidney?” Some sellers dial the recipient’s number but hang up before anyone answers, while others lose their nerve before dialing and wait a couple of months before calling the recipient. Sellers realize that they must be brave to approach the recipient/broker. They talk with the recipient as little as possible, partly because it is difficult to discuss such a sensitive issue in front of a phone man.45

Over the phone, sellers indicate that they are calling because of the newspaper advertisement and would like to help out the recipient. The recipient in turn gradually asks for the seller’s personal information, such as name, address, and age. As recipients usually receive many phone calls, they tend to screen out potential sellers based on blood group. If the blood group matches, they ask sellers to meet immediately. If sellers do not know their blood group, most recipients ask them to call back once they have their report. (Some wealthy recipients, on the other hand, ask potential sellers to meet immediately even if they do not know their blood group.) Even when the blood group matches, some recipients dislike meeting sellers without the tissue typing report. Recipients who wish to meet immediately (often within a day) will ask sellers to come to Dhaka for a detailed

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45 There are next to no public phones in Bangladesh. People usually go to private stores, which create extra business by offering phone service. In this setting, there is no privacy, as the store owner dials the number and the client must talk in front of him.
discussion. Recipients do not forget to mention that sellers will be compensated for the cost of their trip.

Before meeting with a recipient, sellers think constantly about their decision, when they are walking, working, or even sleeping. Many are sad about the situation and stay home all day before traveling to Dhaka. Some are curious to meet with the recipient to whom they plan to give a kidney. A few sellers are worried, believing that the recipient will reject them for being too young. Overall, sellers are concerned about taking such a big risk in life, as Mokhles (41) expressed:

In my village, a rich man was looking for a kidney for a while. Only one man came forward to save his life. The rich man offered three acres of land, but died before the operation. Every kidney recipient is now in big trouble. Who will come forward to save his/her life? People are afraid for their own lives, as was apparent when nobody came forward to help the Bangladeshi movie star Zafar Iqbal when he needed a kidney. People do not donate their kidneys, because they feel like they could die.

Despite this fear, some sellers feel they have no choice but to sell their kidney. As Gofur (41) noted, “I realize if I can sell my kidney, I would be free of debt. If I die, it will be in peace. People cannot say I died with my debt.” Likewise, Joinal (37) said, “There were only two options in front of me – suicide or selling my kidney. I could not commit suicide because I am a man with a wife and two children. Selling a kidney is relatively better in my situation.” Some sellers consider selling in hopes of a better life. As Hasmat (32) said, “Selling a kidney was my last resort. I could not sell anything on the street because of social honour. But I can sell my kidney secretly and perhaps live longer and better off. And if die, at least my family will live better off.”

In addition to having perturbing thoughts, sellers hide their decisions from their families and friends, believing that those close to them would prevent them from carrying
out this life-threatening and stigmatized act. The sellers I interviewed told their families that they were going to Dhaka for a job interview. They asked for the family’s blessing, and borrowed money from family or moneylenders to arrange the trip.46

After arriving in Dhaka, sellers are baffled but somehow manage to find the client at a certain house, office, hospital, or major intersection. Recipients themselves typically do not meet with sellers; rather, their proxies (usually family or friends) come forward to discuss the deal.

As my interviewees revealed, sellers exchange salams, or greetings, with the proxies at the beginning of their meeting. The proxies introduce themselves and offer tea and biscuits as a sign of hospitality. Some proxies falsely inform sellers that the recipient is unable to be at the meeting due to severe illness.47 Noticing their nervousness, proxies treat sellers as invaluable donors. As the doctors had done earlier in the process, proxies inform sellers that kidney donation is a noble act that saves lives and does not harm the donor. In return, recipients bear all the expenses related to the transplant and compensate the donor well. Proxies also entice sellers by saying that the operation will be performed abroad, meaning that sellers will have better care and the risk of health complications will be low. Additionally, proxies advise sellers to speak with others who recently donated a kidney to confirm that the experience is a positive one. Sellers find these arguments convincing because proxies are often learned professionals who work for a pharmaceutical company, for a diagnostic center, as a newspaper reporter, in law enforcement, or even in the ministry of health.

46 Some sellers could not arrange to pay for the cost of the trip, so they waited until they had saved some money.
47 Usually the recipient did not engage in dealing because it is illicit.
This is a typical example of the balance of power between the rich (powerful) and the poor (powerless), particularly in the context of Bangladesh (see also Jansen 1986; Kochanek 1993). In this power dynamic, proxies are at the top of the ladder and sellers are at the bottom (in the overall power composition, doctors are at the top, then recipients, then brokers; sellers are at the bottom). Proxies create a patron-client relationship with sellers, where proxies are dominant actors and manipulators, while sellers are dependent and vulnerable. Proxies provide insufficient, even misleading information on organ “donation” to bring about the deal. Sellers do not have any bargaining power to negotiate the deal; they become passive subjects of the wealthy recipients.

Due to the uneven power dynamics, the proxy plays the dominant role in the meeting with the seller. First, the proxy verifies how the seller got information about the recipient who is looking for a kidney. The proxy then verifies the seller’s blood group and inquires about health status, such as whether the person has a drug addiction or a history of major diseases. For their part, proxies provide minimal information; because sellers do not comprehend the complex medical procedure, proxies simply say that matching blood groups is not the only criterion, and that tissue typing is a vital factor in the process. When the sellers do not understand the blood group or tissue typing process, proxies vaguely inform them that certain numbers that define human blood and tissue must match those of the recipient if the operation is to be possible. For this testing, proxies say, the doctor draws a little blood for analysis; this is necessary to match the size and condition of the donor’s kidney with the recipient’s. Proxies tell the seller not to worry, as the test will be done at the Bangladesh Institute of Research and Rehabilitation.
in Diabetes, Endocrine and Metabolic Disorders (BIRDEM), a renowned hospital in Dhaka.

Because it is extremely difficult to find a match when it comes to tissue typing, most proxies do not discuss the financial deal at this point. Instead, they like to find out more about the seller. They ask why the seller has decided to donate a kidney. In response, sellers say that debt, dowry, and poverty led them to choose this path. Some proxies also ask sellers about how much they will ask for their kidney. Sellers, who do not know the monetary value of a kidney, give a vague response. Many of them do not attempt to bargain for a better price, but depend on the proxies to set the terms – another example of the uneven power relationship. As Hiru (38) recounted in his interview:

Sir, you are a very well-educated big officer. So I am going to do you a favour of selling my kidney to you. However, I also ask for a favour in return. If my kidney matches with your brother, please look after me so that I can run my future smoothly. Whatever comes to your mind and is appropriate is fine for me.

Some proxies seek to discover the seller’s price because many other potential sellers have also contacted them. These proxies, therefore, push further, as one of them claims:

A kidney is not a commodity. No one can buy or sell a kidney, so we are simply exchanging it. You are donating a kidney to my brother on humanitarian grounds, and we are helping you to improve your life. My brother will get his life back and we will be grateful to you for the rest of our lives. So, frankly tell us about your problem and we will try to match your needs.

Sellers, arguing that they need to get out of debt and secure a better life, might ask for approximately 300,000 Taka ($4,300). Proxies usually decline this “high demand,” stating that the average market price of a kidney in Bangladesh is 100,000 Taka ($1,430). As one proxy (a recipient’s brother) stated, “We are not rich, so we sold our land and mortgaged the house for transplantation. Many other potential sellers came forward and asked for 100,000 Taka ($1,430). We could give you only 10,000 Taka ($143) more.”
Sellers find it hard to believe that a kidney can sell for such a small amount; most of them decide to verify this price with other recipients and sellers whenever possible, however some of them desperately ask for a higher price. Proxies refuse to bargain. In the end, sellers realize that since their high-interest debts are accumulating and they are living in dire conditions, it is in their best interests to accept the offer.

Proxies want to keep the deal secret; when the seller pledges confidentiality about the sale, the proxy is relieved. They caution the seller not to disclose the deal to anyone, arguing that others who might be jealous or vindictive could advise sellers not to proceed.

The first meeting between proxy and seller lasts for an hour or two. At the end, the proxy compensates the seller for the transportation costs – roughly 350 Taka ($5). The seller returns home the same day to save the expense of lodging in Dhaka. As sellers do not have a telephone number where they can be reached, proxies repeatedly ask sellers to call frequently.

After the meeting, sellers reach the conclusion that their kidney will save someone’s life, but they themselves will get very little in return: they wonder if what is offered is the actual worth of their kidney. In addition, some sellers are puzzled because the recipient does not view it as a donation but instead directly discusses the logistics of payment. They ask themselves: Has the recipient properly evaluated such a valuable thing? Will the recipient assist them if they are in trouble? Not knowing the answers to these questions, some sellers take a loan to start a business and tell the recipient they are terminating the deal. Yet most sellers feel they have accomplished nothing in their lives, so they find satisfaction in knowing that they are saving someone’s life – an act that will make them a hero, even just for one day. Many sellers are forced into the decision by
poverty: even though they do not want to get involved in illegal activities, what choice do they have? Most decide that they have nothing to lose, as recipients pay not only for transportation, but also for the HLA test. As sellers have high hopes that this deal will lift them out of poverty, some become thankful that the recipient has selected them for a tissue typing examination, which could be a sign of good luck. Sellers strongly believe that if their tissue matches the recipient’s, their financial problems will be immediately resolved.

Sellers keep calling the proxy/recipient, as requested, but the appointment for tissue typing takes longer than they were told to expect. Often, recipients examine tissue typing only one seller at a time to save money; if the tissues of one seller do not match, they then ask for another seller. However, some wealthy recipients examine HLA typing of up to five sellers in one appointment. The recipient or proxy informs sellers of their appointment for tissue typing or an HLA examination within an average of 10 days. Meanwhile, sellers spend every waking hour waiting for the day of the HLA examination. As Moyna (43) described:

Every moment seemed like a decade. I looked at my watch a thousand times a day. When night arrived, I thought about when the day would come. I kept looking at the calendar, anxiously waiting for my appointment day. I wondered how I could get through the week.

Because of the long wait, Hiru (38) even went to BIRDEM in person, but the officials there refused to discuss anything without the consent of his recipient. Mojnu (35), who had been unable to reach the proxy (the recipient’s business manager) despite calling many times over a period of a month, made a surprise visit to the proxy only to learn that the recipient’s tissue had already been matched with that of another seller. When the proxy informed Mojnu that they did not need him anymore, he frantically replied: “Why
did you not tell me before? I waited for you and did not contact many others who posted classifieds in newspapers.” Sometimes the long waiting period forces sellers to switch to new potential recipients, while other sellers, like Mojnu, end up waiting for nothing.

Following the proxy’s instructions, sellers come to BIRDEM with an empty stomach for the tissue typing examination. When they reach the third floor of the hospital, typically around 8 a.m., they experience another world. At times, they are not able to find the proxy, so they just sit in the waiting room. The room is full of various people, but sellers can distinguish between the rich recipients and the poor donors. When the proxy arrives, he calls the seller’s name loudly. Some proxies call two or three names at a time, so sellers realize that they have competition. Proxies pay about 1,500 Taka ($25) for each seller’s test, and then wait for their number to be called. In the meantime, proxies prepare sellers by telling them that if the doctor or lab attendant asks about the relationship between the seller and the recipient, the seller must not disclose the deal, but rather say that they are donating the kidney to a close family member (such as a brother, sister, uncle, or aunt). Proxies do not inform sellers that kidney selling is illegal.

When sellers enter the examination room, they become anxious. As Tofail (27) noted, “When they took my blood, my knee was shaking. I started reciting the holy Koran in silence. I thought, what are they going to do with my blood? Why do I need to give blood to sell my kidney? What am I doing in such a place where I do not belong?” Apparently, sellers are relieved when they discover that the HLA test is very simple; they must only give a syringe of blood. After the test, the proxy invites the seller for breakfast at a restaurant in front of BIRDEM. The seller is told that the proxy will pick up the test results in one week, so the seller should call them then. This time, the proxy pays the

48 Some sellers come to BIRDEM for the initial discussion and to conduct the HLA test at the same time.
seller a higher transportation cost: about 500 Taka ($7). When the seller says that the transportation cost is less than this amount, the proxy advises using the extra money to buy food to restore the blood.

As they return home, sellers wonder why so many people are exchanging their kidneys at BIRDEM. The sellers have accepted the proxies’ explanation that kidney donation is clearly not very risky, as many people are involved in it. Still, sellers are not convinced that the price they have been offered is correct, so some decide to verify this value while they wait for the next step. Most are unable to obtain more information due to their very limited access to the underworld. Hiru (38) is an exception. He found out more at BIRDEM, as he described:

I came back to BIRDEM as requested by the recipient and realized that it was the only center for HLA testing in the country. I waited in the corridor and conversed with some sellers. Nobody admitted their actions and did not disclose the exact amount of their transaction. However, one person admitted when I asked him as a brother, were you a donor? He said yes. I asked him how much he was getting for the donation. He looked at me and asked whether I was new in this line. I replied, yes. He told me that he was receiving 100,000 Taka ($1,450). My heartbeat increased; the value of a kidney is truly that little. I could not believe it, though. So, I went to the HLA lab and asked the assistants about the market price of a kidney. Nobody talked with me except one, who said, “People who are standing in here are the most vulnerable in our society. They would die without a kidney transplant. They cannot get involved in kidney business, as it is legally prohibited.” I desperately asked him about the worth of a kidney. He felt sorry for me and advised that if I managed to find a party from the old Dhaka or Chittagong district, I might collect 200,000 Taka ($3,000), but if I got a party from other places, I would acquire a maximum of 150,000 Taka ($2,150).

Although the price was lower than he wanted, Hiru was still considering selling in the hope that he could pay off his loan, start a business, and obtain other forms of support from his recipient. At this point, sellers still have high hopes, and their fear is decreasing slightly.
Sellers eagerly await the HLA results. Some, unable to wait another day, call the proxy or recipient before the due date. Sellers strongly believe that their tissue will match the recipient’s because they are totally healthy, but they want to make sure, so they pray to Allah for a match. Some of their family members and friends ask them what they are thinking about all the time.

When the HLA results are ready, the recipient picks them up from BIRDEM and consults with a nephrologist about the match. If luck is with them, there is a match. But most of the time, this is not the case.

One gloomy day, the seller receives the bad news: the tissues do not match. It feels as if the sky is falling. These sellers have taken such a risky step, embarking on something they had never thought of doing before, but all of their hard work is now wasted. Many sellers cannot hold back their tears. Jobbar (28) felt that receiving news about a death would have been better than this news; he lay down all alone in a playground and looked at the stars all night long. But life must go on. Within a few days, the search in the classified ads begins anew. This time, sellers are experienced: they make sure their blood group matches before calling the advertiser. In addition, as advertisers usually ask about a seller’s tissue typing report, sellers try to obtain this report from the previous client. Most sellers get the report easily, but others are unsuccessful, as the proxy paid for it. To collect the report, sellers must pay for their transportation, while the advertiser pays for photocopying of the original HLA results. Looking at the report, sellers are unable to comprehend how to match these numbers, but are confident that this time they are a little farther ahead in the process.

49 The sellers meet with the proxies in their offices, at major intersections, and in hospitals. Gofur (41) came to a dialysis center and picked up the report from an employee, with whom the proxy had left it.
Tissue matching is an extremely difficult process. On average, sellers make five or six failed attempts before finding a match. They feel as if they are in the middle of a game and cannot solve its puzzle. But because they are hooked on this game, they decide to see it through to the end. Many become so distressed that they search newspaper classifieds on a regular basis to find a tissue match. As Jobbar (28) said: “I went to the newspaper stand and looked for advertisements after my fazor namaz (morning prayer) almost every day. It became my addiction to write kidney buyers’ addresses in my notebook.” Some days are better than others: one day, Jobbar managed to match his blood group with three advertisements; he bought tea for his friends to celebrate. Most of the time, however, sellers need to wait longer to find an advertisement that matches their blood group. They worry constantly. When their families ask about their mental state, they lie, saying that they are trying for a big job.

When sellers find a matching advertisement, they act on solving the puzzle quickly. Some ads sound better because of the tone used (see examples of newspaper advertisements in Chapter Four). For instance, one advertisement highlights saving a university professor’s life; another advertisement expresses urgency to save a mother’s life. Some advertisements also include HLA tissue typing numbers, but the seller cannot read how to match these with their own. Some advertisements are specific: they give a certain age limit. If sellers have choices, they select the most suitable ads and call one

\[50\] Fazor namaz is usually prayed at early dawn. The call to prayer, azan, is announced around 4:30 a.m., and the prayer is performed around 5 a.m.
advertiser at a time to minimize their phone costs. However, this time, sellers’ hopes are not as high as they were the first time.

Once they have connected with another recipient, sellers need to travel to Dhaka again, as they are unable to translate their tissue numbers to the recipient over the phone. In addition, many recipients ask sellers to redo HLA typing, as Bangladeshis believe that medical test results are often inaccurate. Sellers worry about retaking the tissue test in the same place, fearing that their true identities will be revealed. But they do not have a choice: if the buyer demands it, they must obey. As Jobbar (28) described, “I felt scared because I came to BIRDEM to examine my tissue with a different buyer a week ago. I felt scared when the same lady who took my blood before entered the room. I started praying to Allah. Fortunately, she did not ask me any questions.” Sellers are smarter this time around: when they need to talk with the recipient, they dial “missed call” to minimize their own phone costs.51

Even with a second attempt, sellers rarely find a tissue match with a recipient. To ensure a good result, they rely on their faith. As Jobbar said, “In my early childhood my mom taught me that if somebody recited SobanAllah, his wishes would be successful; I recited it all the time to match my tissue with a recipient.52 Malek (28), meanwhile, came to Dhaka to meet with the recipient buyer out of superstition, believing that he received bad news the last time because it was over the phone. He explained:

When I came to the proxy’s (recipient’s sister’s) place, she told me to sit down. I was trying to read her face, but there was no smile on her face. She emphatically stated that my tissue did not match with her brother’s. She added that the tissue is biological and nobody can match it without the desire of Allah. She noted that

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51 To minimize costs, the “missed call” is very common in Bangladesh. Callers dial the number and then hang up quickly. Receivers notice the number on their mobile phone screen and call back. This way, the original caller saves money on the per unit telephone service.

52 SobanAllah is an Arabic phrase that is commonly used for good luck.
many people attempt several times but could not match, while some try once and match it successfully. She advised me to keep trying and wished me luck for the future.

Sokhina (37) even went with the recipient to pick up the report, and to a nephrologist to determine the result. As she described,

The head specialist looked at the report and declared by shaking his head that the tissues did not match because the donor had 32 but the recipient had 30. I thought the size of my kidney was 32 inches and the recipient’s was 30 inches because I was bigger than her.

Once again, these sellers did not escape their bad luck.

Sellers attempt many more times, but still fail to get a match. When they receive the bad news, they often cry and can barely speak of it. As Jobbar (28) said, “I felt like the person who is in the middle of the ocean trying to save his life but does not know to swim. My feeling was even worse because that person would die but I cannot.” Sellers are overwhelmed as they try over and over again. In Jobbar’s words: “My situation was like when a cat runs for its life and jumps from a tree.” Dildar (32) was devastated:

When the proxy (recipient’s husband) said sorry to me, I thought there was a problem with my kidney and it would not match with anybody. I started crying in the hall of BIRDEM. I even told him to take both of my kidneys in exchange for the recipient’s damaged ones. The proxy held me and said it is not possible in such a way. He advised me not to cry like a fool, and promised to help me match my tissue with someone. He bought my lunch and gave me 300 Taka ($5). I left a copy of my HLA report and contact information with him. Before leaving, I touched his feet to show my respect.

Sellers are frustrated and even lose weight after several unsuccessful matching attempts. At the same time, they realize that tissue matching is a complicated matter. It is like winning the lottery; everything depends on “fate.”

So far, sellers are caught in the poverty trap. Like those who buy lottery tickets week after week, kidney sellers are trapped in the cycle. The poor buy more lottery
tickets than the rich, which begs a question: Why are the poor susceptible to the lottery
dynamic, which offers low returns? Haisley and Mostafa reveal in a psychological survey
“the hope of getting out of poverty encourages people to continue to buy tickets, even
though their chances of stumbling upon a life-changing windfall are nearly impossibly
slim and buying lottery tickets in fact exacerbates the very poverty that purchasers are
hoping to escape” (Haisley et al. 2008: 283).

The kidney sellers I interviewed live under a similar belief: that selling a kidney
will take away their financial suffering. That is why they repeatedly try to match their
tissues, believing that it is their best, and perhaps their only, opportunity to improve their
social condition. Yet, this entrapment eventually reinforces their poverty: they cannot
work the usual number of hours, as they spend so much time checking newspaper
advertisements, meeting with recipients, and examining HLA tests. Some even quit their
jobs entirely to focus on selling their kidney. These sellers believe that the chance for
improving their situation is very high, as they are saving the lives of the wealthy, who in
return will support them for the rest of their days. The desire of poor sellers to escape
poverty creates a vicious cycle that is multiplied by the buyers’ deception, manipulation,
and exploitation.

A few desperate sellers take a more active role in their search, even posting their
own newspaper advertisements to maximize their chances. Hasmat (32) described his
experience of posting an ad in the daily Ittefaq in 2003:

I came to the newspaper office and asked the gatekeeper whom I should talk to
regarding posting an ad. I went to the third floor, called the ad section. An agent
asked me what kind of ad I wanted to post. I replied, a small one. He asked me,
how many words? I wrote the text down. He looked at me with surprise and asked
me why I was selling my kidney. I told him I could not answer his question. It
would be great if you can post it, I said. If not, I will leave. I paid him 400 Taka ($7) and immediately left the place.

Hasmat saw his ad the next day, but he did not buy the newspaper; he said that his ad was ineffectual, probably because the buyers were worried there was a catch. Conversely, some sellers receive three or four phone calls after posting an ad. These sellers could not communicate easily with buyers, who used their friends’ phone numbers, and often resided in various parts of Bangladesh. Most sellers, however, do not post newspaper ads because of the expense involved and the risk of being identified and humiliated by the community.

A number of sellers visit BIRDEM to find recipients, but this approach is not effective. As Hiru (38) mentioned:

I came to BIRDEM at 8 a.m. and saw a decent family waiting for an HLA test. I sat on a chair, stood up, walked back and forth to the same chair. I finally came forward, and called the man, who looked like a patient to me, “sir.” I told him that since he often goes to dialysis and sees other recipients, if somebody needs a kidney, could he please have him or her contact me? I gave him my HLA report and we exchanged our contact information. One and half months later, I came to his house but he did not invite me inside. He informed me that he failed to match my tissues.

Similarly, Tofail (27) noted:

I came to Dhaka and stayed in my relative’s house so I could visit BIRDEM early in the morning. I approached a man who was going here and there with some papers. I asked, brother, what is your problem? He told me that his wife needed a kidney, so he was examining her tissue with a donor. I asked for his wife’s blood group. I was glad that her blood group matched with mine. I asked whether she had her HLA report ready. He said yes and he had been looking for more donors to match. When I told him that my HLA report was with me, he held my hand and took me to a quieter place. He photocopied the report and told me to wait two days in Dhaka. In the meantime, he consulted with a specialist and notified me after that my HLA did not match with his wife.

Sellers thus attempt to match their tissues in various ways, but are often unsuccessful.
Some sellers suggest that selling a kidney is like running for a *sonar horin*, or golden deer – an illusion. They lose money, time, and energy trying to find a tissue match, yet fail to escape from poverty. Sellers and the poor overall are trying to get out of their individual poverty, but fail due to structural injustice and the uneven distribution of resources. That is why sellers see with frustration that no matter how much they strive, they cannot escape poverty; their attempts are nothing but an illusion. Yet, most sellers decide to keep trying as long as they have strength in their bodies; only a few give up the attempt.

During their unsuccessful efforts, sellers experience the kidney trade as competitive, as many other sellers are involved in it. When Nazrul (27) came to a recipient’s house, he met five other potential sellers from different parts of Bangladesh waiting in the room. A proxy (recipient’s sister) gave each person a pen and a piece of paper and told them to write down their name, address, and contact number. She then asked them to write their blood group, availability of HLA test, and price they would charge for their kidney. She finally collected all the papers and discussed with each potential seller individually his or her reason for selling. Informing Nazrul that his price placed him third on the list, she then bargained with him. Similarly, Jobbar (28), in a half-hour meeting, found that a proxy received four phone calls from potential sellers; he knew that his chances in this deal were slim. So, too, Hiru (38) and his wife (also a potential seller) competed with fifteen other sellers, including a university student. Bangladeshi sellers know all too well that due to extreme poverty, the poor are selling their organs, which means kidneys are readily available in Bangladesh. Recipients have
an abundant choice, making it possible for them to pick up the healthiest kidneys with the closest match and maximize their chances of prolonging their lives.

Nowadays, the price of a kidney is often as low as 70,000 Taka ($1,000) because kidneys are widely available; sellers thus must bargain to get a decent price. Some sellers, on the other hand, consider asking for less than the market price in the belief that recipients will be more likely to choose them. Sellers who had thought they would have little competition soon realize that, as one person noted, “they are not a hero, but only a zero.”

During their numerous attempts at tissue matching, a few sellers are deceived. For example, Dildar (32), a poor rickshaw puller, borrowed money and traveled to Dhaka to contact an advertiser about selling a kidney. The advertiser took all his money, 1,750 Taka ($25), and told him to come back in two weeks, after he had made an appointment for the HLA test. When Dildar returned, he discovered that the advertiser was a fraud and no longer lived at that address.

At this stage, unsuccessful sellers are often unable to concentrate on their work or other aspects of their lives. While working, Manik (32) broke the glass of a picture frame, so his employer did not pay three days of his salary. A distracted Hasmat (32) was hit by a rickshaw on his way home from meeting with a proxy (recipient’s son), who cheerfully offered him sweets after matching tissues with a different seller. Sellers are physically and mentally tired; their energy is drained going from one place to another to match their tissues. As Jobbar (28) noted, “My friends cannot recognize me anymore. Two days ago I looked sad as I heard the bad news and now I am cheerful after finding a new buyer. My mood keeps drastically changing; it was cloudy, then rainy, but suddenly sunny.”
Sellers also reveal the importance of a broker in matching tissues and arranging the trade. They realize that selling a kidney is not possible merely because one desires it; they may be unable to find a tissue match even if they search continuously for a year. Consequently, the next avenue they try is contacting a broker to accomplish their mission.

Shaking Hands with the Broker

All but five of the sellers I interviewed contacted a broker to match tissues; the rest found their matches through newspaper advertisements or approached the recipient directly at BIRDEM. Sixteen sellers (the majority) sold their kidneys through Dalal, my key informant and the second most important kidney broker in Bangladesh, while 11 sold their kidneys through Batpar, the major kidney broker in Bangladesh. The two brokers use different tactics.

Batpar contacts kidney sellers mostly through newspaper advertisements, as well as through his regional agents. Typically, he poses as a recipient in these newspaper advertisements to attract the seller. Sellers who try to contact Batpar often find him hard to reach. His manager apparently dislikes talking with sellers over the phone, so he asks for a meeting in the office located in old Dhaka. The manager approaches sellers by saying that his boss, who is busy trying to arrange transplantation for his brother abroad, is seeking a donor. He tries to attract sellers by suggesting that his boss will provide them

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53 Surprisingly, two sellers (one of them had tried once and the other, twice) were able to match tissues with the recipient through newspaper ads; a third tried twice and sold to a recipient whom he approached spontaneously at BIRDEM; a fourth also tried twice and finally sold to a recipient introduced by the previous buyer; and the fifth sold on the first try, to his friend’s sister.

54 Batpar is a busy man dealing with many businesses, including the kidney trade, a garment factory, and a printing press. He often travels to India to arrange transplants, so his manager looks after the kidney business during this time.
with monetary rewards for donating. The manager asks for the seller’s name, address, blood group, and HLA test results. If the seller’s HLA test has already been done, the manager photocopies the report. If testing has not been done, he advises the seller to arrange the test with his boss.

Batpar follows the market rule: if demand is low, he does not meet with the seller immediately. Batpar trades illegal kidneys, so he often plays nasty tricks. Hiru (38) travelled six hours from Rajbari, a northern city, calling Batpar at three in the afternoon on the day the meeting was to take place. Batpar told him to call back in two hours. After sitting in a park for this time, Hiru called again; Batpar said he could not meet because of his busy schedule. Dildar (32), after waiting two days, also failed to meet with Batpar, as he described:

I came from Bhairabbazar according to the appointment. However, Batpar’s manager told me that his boss could not come to the office today. I went back there the next day and waited for two hours. His manager called and Batpar promised to come back as soon as he had completed his work. I waited the whole day but he did not show up. It was the middle of winter and I was cold. His manager called again in the evening and Batpar said he had already gone home. He told his manager to put me up in a hostel. The next morning I finally met with this busy man.

On the other hand, if market demand is high, and supply, especially responses to advertisements, is low, some sellers meet with Batpar immediately.
Meeting with Batpar is a unique experience. The following is a composite account of the encounter. Sellers are often shocked at how competitive it is to sell a kidney. Mojnu (35) recalled:

After taking the night coach and traveling eight hours, I came to Batpar’s office very early in the morning. The room was full of people whose age ranged from 20 to 40 years old. I did not know that they were potential sellers. I thought they were the recipient’s family members. The boy sitting next to me asked whether I was a donor. I replied and asked him why he was asking me this question. He told me that he was a donor and came here after seeing a newspaper ad. We started the conversation. He asked my blood group. I replied, O+. He mentioned that he is B+. He asked me how long I had been trying for a match. I said, about two months. He asked me why I had been trying for a match. I told him that I had tried to but did not know how to get a match. He told me that O+ is a universal donor, and if he had O+, he would not just sit there like I was doing. I thought I had made a wrong decision. I should have contacted other recipients whose blood groups were different, too. I then talked with some other people in the room. Everybody told me that they were donors. I felt scared when I realized that I was completely in the hands of the broker. I could not believe that 15 or 16 of us came here to sell a kidney. Many of them looked experienced and smarter than me. I would be lost in this big crowd. Could I make it?

Upon arriving at the office, Batpar instructs all sellers to leave the room and wait in the corridor. They become sad looking at children studying in a madrasa, or Islamic school, located in the next building, while they are selling their own body parts. Batpar calls in one seller at a time by name.

The seller enters the room, sits down in front of Batpar, and exchanges salam, a greeting. The boss is busy with business files, so the seller must take the lead and say, “Sir, over the phone you told me to come to Dhaka.” Batpar asks their blood group without looking at their face. He suddenly closes the file and asks directly what they will charge. Sellers, overwhelmed, want to discuss payment later. But Batpar warns them that
he needs to fix the deal to initiate the case. Sellers are speechless, so Batpar offers 80,000 Taka ($1,150) for the kidney. Sellers insist on a higher price, even up to triple that amount. Batpar does not want to negotiate, so he presses for a very low amount. Sellers are powerless; they can bargain only a little over the deal. Some sellers do not agree with the offer and decide to leave. The manager steps forward and haggles with them, arguing that the market value of their kidney is low because their blood groups are in ready supply. After further negotiations, the boss finally raises the price to between 90,000 Taka ($1,300) and 100,000 Taka ($1,450). Sellers agree on this price range after accepting that they will not be able to match the tissue with a potential recipient by themselves. Batpar informs them that once he finds a matching recipient, he brokers everything. He tells them that the operation will be performed abroad. Sellers will thus be in the hands of world-renowned specialists, so the operation is 100% safe. He adds that going abroad is fun, as sellers can visit new places, try different foods, shop, and watch Indian movies. According to Batpar, this is an exclusive deal offered only to his clients, but he warns them not to disclose it to other sellers.

When a seller expresses anxiety about living with only one kidney, Batpar tells the story of the “sleeping kidney,” a fictional tale about how kidneys work that rationalizes why everybody can donate and live a healthy life with only one kidney. As the story goes, each person has two kidneys: one works and the other sleeps. If one kidney is infected, the other kidney starts working. But if one kidney is damaged, the other one will also be injured because of the polluted blood. Therefore, there is no point in having two kidneys. During transplantation, the doctor uses medicine to wake up the donor’s sleeping kidney. The newly awakened kidney stays in the donor’s body; the
“old” kidney is removed and given to the transplant recipient. This story circulates extensively in Bangladesh; many sellers repeatedly mentioned to me that Batpar, Dalal, and other brokers use it to lure poor Bangladeshis into becoming kidney sellers.

At the end of the meeting, Batpar verifies whether sellers have definitely decided to trade their kidney. As Mojnu (35) said in our interview, “When somebody’s back is to the wall, the person cannot move. In my condition, even the back wall is broken and I did not have any other choice.” As my interviewees put it, the boss is glad to deal with such desperate sellers. The kingpin invites them to stay at his hostel at no charge whenever necessary.\(^5\)

Batpar also gathers potential sellers through his agents. These agents have already sold a kidney through him and now work for him on commission. Keramat (25) explained how one of Batpar’s agents approached him:

I used to purchase groceries from Shafie’s store using credit. One day, Shafie advised that I could easily solve my money problems by donating a kidney. He told me the story of the sleeping kidney and described his own experience of selling. He confirmed that selling his kidney did make his life better without any health complications. Shafie rolled up his shirt partway. He tricked me by showing just a small scar, but in reality the scar was bigger. He also mentioned that the trip to Bangalore was enjoyable. He went to parks, lakes, movie theatres, and shopping centers all the time. Everybody, especially Batpar, supported him by preparing food, offering accommodation, and providing a television, a refrigerator, clothing, and other necessities. Furthermore, he said that all medical expenses related to examining whether his body was free of disease were covered. He persuaded and guaranteed me that he would ask Batpar to take personal care of me if I would like to donate. Shafie also promised that he would travel with me to India and lend money to my family when I was away for the operation. One day, he took me to a clinic and paid for my blood group examination. He then arranged the meeting with Batpar. Before the meeting, Shafie warned me not to discuss the deal directly with the boss. Batpar treated us with Coca-Cola and asked me my personal information and reasons for selling. After fifteen minutes, Shafie told me to leave the room so he could put my request to Batpar personally. On our way back, Shafie told me that he had made a special request for Batpar to match my tissue with a good and wealthy recipient immediately. Batpar had

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\(^{55}\) Batpar usually sends sellers to stay in a hostel, which costs about 50 Taka (75 cents) per night.
kindly agreed to reject other sellers and consider my case instead, and generously offered to pay me 50,000 Taka ($700). The price seemed low to me, so I asked Shafie to ask for a higher price. Shafie told me that he had already done so, but agreed to that price as Batpar mentioned that A+ blood group donors were in abundant supply. Shafie warned that he should not push Batpar, who could refuse the case anytime. I agreed to the price, believing that selling a kidney is an easy way to get quick money.

For a long time, Keramat did not realize that Shafie worked for the broker. How could he? He trusted the religious Shafie, who had a big black spot on his forehead from touching it to the floor so often during his daily namaz, or prayers. Like Keramat, some sellers are exploited more than once, by brokers, their agents, or both.

Dalal, another key broker mentioned earlier, has a distinct business technique. He collects sellers mostly through recipients as well as agents. Typically, when recipients visit BIRDEM or various dialysis centers, Dalal approaches them to say he could find a potential seller. At this point, recipients have already posted advertisements in the newspapers and contacted many sellers to find a tissue match, but without success. Dalal expands his business through a key business trick: he collects sellers’ information (mostly HLA reports and addresses) from recipients, who provide this information to get extra care in the deal, as well as to help out desperate sellers. Dalal then often goes to these sellers’ houses or offices or contacts them by phone when they are in the stage of finding a tissue match or are about to renounce a deal. Hearing from him gives sellers new hope and a chance to improve their lives.
Initially, Dalal verifies sellers’ names and addresses, and asks whether they have contacted particular recipients. He then tells them that he got their HLA results and contact information from recipients they had contacted earlier but did not match. He introduces himself as a medium to help his clients with tissue matching. He boasts that his business has flourished based on successful tissue matching, smooth transactions, and successful transplantations. He tells them that his business is also based on the moral principle that he works for the poor and that his objective is to save people’s lives. He clarifies that it is not he, but the recipient, who settles the entire deal directly with the seller. As a medium, he simply introduces the seller to the recipient with a friendly and free service. However, if sellers willingly offer something, he will accept their gifts.

Dalal finally calls the potential recipient from his cellphone and asks the seller to speak directly with this person. Over the phone, the recipient greets the seller and asks to discuss details in person, usually at BIRDEM. Dalal arranges a meeting and informs the seller not to miss this “golden opportunity.” He tells the seller not to be worried, as their
tissue will be easily match plenty of his recipient clients, whose HLA reports are already in his hands.

When sellers arrive at BIRDEM, they discuss the deal directly with recipients. Sellers who trade their kidneys through Dalal, therefore, have a slightly better deal than those who trade through Batpar. On average, Dalal’s sellers are promised 120,000 Taka ($1,700), compared to 100,000 ($1,450) from Batpar. However, some sellers also bargain with their recipient; Dalal mediates between seller and recipient to broker the deal. As Suruj (25) described:

I came to BIRDEM to discuss the financial deal with the recipient’s brother. The proxy asked for my demand and I realized that I had to bargain to maximize the return, so I asked for 200,000 Taka ($3,300). The proxy laughed and indicated my demand was as high as the sky, so he proposed 100,000 Taka ($1,450), similar to the average market price. After some more bargaining, I slowly lowered the asking price to 150,000 Taka ($2,500). The deal, however, was fixed at 120,000 Taka ($2,000), as Dalal became disgruntled and asked the recipient to pay a little bit more, saying that I might not be able to lift heavy loads for the rest of my life.

The sellers ultimately get caught up in “the game” through Dalal.

Dalal also contacts sellers through his assistants (working in Dhaka) and agents (working outside Dhaka). Both groups had sold their kidneys through Dalal and now work for him on commission – a similar setup to Batpar’s. Both agents and assistants advertise Dalal’s business and exchange contact information with “looming clients” (those who are not able to match their tissues by themselves and have been referred by Dalal) at BIRDEM. Monu (27) offered an example of how Dalal’s assistant approached him:

When the proxy and I were leaving after the HLA test, a broker’s agent came forward and walked with us. He told us if our HLA did not match, we should contact his boss, a genuine tissue matchmaker. When we came out of BIRDEM, the agent introduced the broker, who showed us many HLA papers in his hand. He gave his contact information to both the proxy and the seller.
Dalal’s agents, who usually reside in villages, approach their families and friends to sell a kidney to Dalal. During the fieldwork, I discovered that a few agents were working with Dalal: one was trying to match his wife’s tissues; another had already traded his sister-in-law’s kidney; one was in the process of trading his brother’s kidney; and the last had posted an advertisement in the local newspaper and provided Dalal with the names of some potential sellers. Both Dalal and Batpar often cannot match the sellers’ tissues immediately; a number of sellers therefore contact both brokers to maximize their chances. For example, Nergis (23) first connected with Dalal, but due to delays, contacted Batpar through a newspaper advertisement and successfully matched her tissue.

Besides Batpar and Dalal, many other kidney brokers currently work in Bangladesh. In fact, the country is full of brokers. As Dildar (32) claimed, “There were at least 50 kidney brokers in Dhaka.” He insisted, “You could encounter at least 10 kidney brokers if you visit BIRDEM any Saturday and Tuesday” (the only days tissue typing is done there). Many interviewees similarly noted that they were approached by a number of brokers, such as Khoka bhai, Nuru bhai, and Harun bhai (brother) during their tissue test at BIRDEM; these brokers or their agents literally snatch clients at this hospital and use them to expand their business. Brokers approached sellers by asking sellers to contact them if they could not match their tissues or if they found a potential seller, which would earn them commission. Manik (32) claimed that a broker even approached him with a business card:

While I was waiting at the HLA test center at BIRDEM, a broker came to me and asked me who the recipient was. I lied to him, saying that I was donating to a family member. He asked whether I would like to donate my kidney to someone else if my tissue did not match with my family. Upon receiving a positive response, he gave me his business card and asked me to call him whenever
necessary. On the card, his name and telephone number were in the upper right corner, and in the middle it was printed that transplantation and tissue matching were arranged carefully.

During our interview, even though some sellers tried to hide from me that they were working as a broker, I cross-checked and proved that they were indeed brokers; I even saw one seller I had interviewed dealing with potential recipients in the dialysis room at BIRDEM.

Organ brokering is so prevalent in this country that it has even expanded in institutional settings. My interviewees stated that certain employees at the BIRDEM and BSMMUH hospitals also work as kidney brokers. Moyna (43) reported that a staff member of the HLA center matched his HLA report with a recipient. As he noted:

When I was waiting for the test on the third floor of BIRDEM, one lab personnel came forward and asked whether I would donate my kidney to others if my tissue did not match with the current recipient. I gave my contact information to him. Two months later, he called. The next day I went to BIRDEM again. He introduced me to a potential recipient. He photocopied my HLA report and matched it with this client. He charged the service fee only to the recipient and not to me.

Shofi (25) told me he provided his HLA report to the secretary of a renowned nephrologist at BSMMUH, as well as to an office clerk at BIRDEM, to find a tissue match.

The expansion of brokers and sellers in Bangladesh can be shown through the following diagram (Figure 6.3).
S = Seller
B = Broker
A = Agent of a Broker

Figure 6.3. Expansion of organ brokers and sellers in Bangladesh

As the diagram represents, initially, there were only a few sellers who had sold their kidney (mostly through recipients) in Bangladesh. Among them, just two became kidney brokers (literally corresponding to Batpar and Dalal). These brokers then lured more poor Bangladeshis, who became kidney sellers. Some of these sellers then started working as a broker’s agents in hospitals or villages to find prospective sellers for a commission. Only a few of them eventually started their own independent brokering –
others continue to work as brokers’ agents. Both brokers and agents lure numerous poor villagers and turn them into kidney sellers. On the whole, the diagram indicates that the number of brokers increases, as does the number of sellers, some of whom also become brokers’ agents to independent brokers. Thus, the number of kidney sellers also increases.

This system can be summarized as follows:

Some Sellers $\Rightarrow$ A Few Brokers $\Rightarrow$ More Sellers $\Rightarrow$ A Few Brokers’ Agents $\Rightarrow$ More Brokers $\Rightarrow$ Many Sellers $\Rightarrow$ More Agents $\Rightarrow$ Many Brokers $\Rightarrow$ Numerous Sellers.

The supply end of this process is controlled by brokers, while the demand end is controlled by recipients and doctors, the most powerful actors in this game.

The diagram, however, does not include various important factors: for example, the number of sellers can rise without the number of brokers or agents rising incrementally, since most mid-level to small brokers’ agents never become independent brokers, and some independent brokers depend entirely on the top brokers if unable to compete in this business. Other brokers, such as members of hospital staffs and kidney recipients, both of whom work as independent brokers or agents, can also be included in this diagram. Additionally, the number of sellers, brokers, and their agents in the diagram do not correspond to the exact figure in Bangladesh. Finally, not every seller follows the same route; a few sold their kidney directly to a recipient without a broker’s involvement.

As we have seen, sellers contact major brokers directly through newspaper advertisements or through potential recipients with whom their tissues did not match. In addition, some poor villagers and slum dwellers are lured by brokers’ agents and introduced to brokers, who then turn them into sellers. As the above diagram indicates, the latter trend is increasing. Even if the Bangladeshi state decided to ban newspaper
advertisements on organ “donation,” an alternative chain system is already developing: it
is controlled by the major brokers from Dhaka and penetrates downwards to Bangladeshi
gram, or villages, to facilitate the kidney supply to wealthy recipients. In this way, the
organ trade is not only functioning but expanding in Bangladesh.

The obvious question is why some sellers are becoming brokers. It could be
because of the easy money. Sokhina (37) described her experiences of being involved in
the business:

When I stepped forward and examined my tissue with the recipient, four
neighbours, Genda, Kalam, Jorina, and Hazera, came to me within a week. First,
Genda came and asked me to find a recipient for him. When I asked him why, he
replied that he had nothing in life, so he wanted to earn some money to live better.
Then Kalam came and asked me to do something for him, too. He said that he had
sold his land and was unemployed. It would be great if he could arrange a job by
selling his kidney. Mafi also came and told me that she had a huge burden of debt.
The moneylender was always forcing her to pay. If she could sell a kidney, she
could save her pride. Finally, Zorina came. She was of an age to marry but was
working as a maid and sleeping in people’s verandas. She told me that her life
was valueless, so she decided to sell her kidney in hopes of a better future. I told
each of them that since they came here to donate willingly, I would ask the
recipient to examine the tissue. The recipient provided me with adequate
expenses, so the four potential sellers and I traveled from Mymensingh to Dhaka
for the HLA test. The recipient’s husband picked up the reports, consulted with a
specialist, and found out that none of their tissues matched. In the end, I did not
lose anything but rather made some money from dealing this way.

There is a saying that kidney failure is a king’s disease, meaning that only the rich can
afford treatment. Sellers also commonly tell me that when the life of a wealthy person is
at stake, their money is flying in the air. Thus, it is tempting for some sellers to be
involved in brokering. One seller jokingly told me that he wants to be rich like Batpar or
Dalal, as he put it: “If they can do it, why not me? I know all the ins and outs of this
business.” The other reason that some sellers are becoming brokers is that their income
declines after the operation, as they had lost their job or could no longer engage in hard
work, heavy lifting, or longer hours; they are trying to selling the kidneys of their wives, families, and friends to solve their economic problems (this aspect is outlined in Chapter Nine).

Sellers worry about dealing with a broker. Some sellers think people who broker with body parts cannot be good. Others fear the broker will entrap them. Some also envision the broker cutting out their kidney and even killing them in India for not paying their dues. Therefore, some sellers choose to step back from the deal and try to match their tissue directly with a recipient. Others, meanwhile, think that going through a broker could be their only hope for matching their tissue. Due to wariness, some sellers verify the broker’s reputation, mostly from recipients they had contacted earlier. But as sellers have no alternatives to immediately match their tissues, most remain in the hands of the broker.

As requested by the brokers, some sellers return to BIRDEM to have their tissue re-examined. Brokers lie to them, saying that the tissue report can change within a few months, so it is wise to verify it again. As some brokers are well connected to hospitals, sellers obtain an earlier appointment for the test than someone without this connection. However, sellers worry about going back to the same room at BIRDEM, especially with a kidney broker; the lab assistants evidently ask no questions though. Sellers claim that everybody, including lab assistants, office clerks, nurses, and doctors, know about the kidney business but pretend that people are donating rather than trading.

Sellers connect with a broker hoping to match tissues immediately from his wide network, but many of them often need to wait longer. Dildar (32) kept in touch with the broker, Batpar, for almost a year and a half. He called nearly 100 times and made 15 trips
to Dhaka, which cost about 10,000 Taka ($145) altogether. He pedaled his rickshaw to earn this money. Many times, Batpar and his assistants hung up on him and told him not to call. He did not argue with them but rather kept calling with the hope that his turn would come. Like other sellers, Dildar was frustrated, as he told me: “Nobody understands the problem of the poor while they are struggling in poverty in their everyday lives.”

Each time sellers go to a broker to find out their matching results, the broker holds two reports in his hands, as if he is a health specialist matching the numbers. While he shakes his head, sellers continue to look at him with hope. The news, however, is not good: the broker claims that all the numbers except one are matched. When sellers become discouraged, the broker reassures them that he will provide faster matching with better and wealthier clients. Sellers cling to this hope.

During the endless waiting, sellers are subject to the despicable business practices of the brokers. The major brokers, Batpar and Dalal, have both created a system of forgery, and many times trick their clients in more ways than one. Batpar usually charges the recipient 400,000 Taka ($6,500) as a package deal. His package includes finding a matching seller, providing fake documents, paying for transportation, arranging accommodation, and paying for the kidney itself. However, the actual cost for these items is approximately 105,000 Taka ($1,500). In this deal, recipients are in charge of other expenses, including the operation and all medical tests for the seller and themselves. Thus, Batpar usually makes a profit of 350,000 Taka ($5,000) on each deal. He arranges about 25 transplants per year, mostly in Bangalore, and makes more profit from the

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56 Batpar roughly pays 80,000 Taka ($1,130) for a kidney and spends 25,000 Taka ($357) for other necessities on each seller.
kidney business in Bangladesh than any other broker. Deception is the key means of ensuring his profit. He asks recipients to pay for a deposit, noting the cost of the sellers’ HLA examinations, transportation, and accommodations, and falsely portrays the sellers as pressuring him for their money. Recipients usually pay him 50,000 Taka ($700) in advance, and thus are trapped in his net.

Although generally deceptive, Batpar is straightforward about one thing: sellers cannot meet with their potential recipients before going to India or talk about the deal with them at any time. He negotiates with each client himself and does not introduce sellers to recipients. A few sellers meet with the recipients’ proxies during the tissue examination process, but do not speak for fear that Batpar will reject them. Only Sodrul (22) successfully exchanged his contact information with a recipient’s husband and later met with him in secret. After knowing the facts about the deal, Sodrul asked Batpar for a reasonable share of the profits; Batpar promised to pay much more than he had originally offered, but later went back on his word. Sellers realize that Batpar does everything for his own profit. He even offers jobs to some potential sellers, but only those who have O blood: they are a lucrative group as they are universal blood donors and therefore their tissues are more likely to match. Batpar invests the profit he makes from the kidney trade into other businesses, which has made him a wealthy Bangladeshi.

Dalal maximizes his profit in a different way. He charges recipients a minimum amount, 10,000 Taka ($145), for tissue matching, and the same amount after a successful

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57 Batpar strictly avoided letting recipients and sellers meet each other for fear they will exchange contact addresses and trade the kidney without paying his commission. He often told sellers that the recipients were giving him only a minimal amount for transportation, accommodation, and test fees, but that he was negotiating with the recipient to obtain more for the seller.

58 O blood group of donors can donate to any blood group of recipients, while A can only donate to A and AB, and B can only donate to B and AB, and AB can only to AB. The Rh factor (+ or -) in blood type is not important in compatibility (UNOS 2009: 4).
operation. But he deceives his clients in other ways. He introduces each seller to many recipients, all of whom must pay his service fee of about 1,000 Taka ($14). He lies to recipients, saying that sellers are coming from distant places and therefore require recipients to pay transportation, accommodation, and communication costs. This is the reason Dalal warns sellers not to talk with recipients: he is afraid that sellers will tell recipients the truth. When a recipient offers a few hundred Takas ($7) directly to the seller, Dalal takes away the entire amount from the seller in absence of the recipient and then he pays the seller for transportation, usually 150 Taka ($2), and keeps the rest of it in his pocket. Dalal is not as wealthy as Batpar, but he lives comfortably in a Dhaka suburb even though he spends a huge amount of money on gambling.

Sellers found that both Batpar and Dalal deal with many clients at a time. They bargain over sellers’ transportation costs. They do not care about their clients but only about their profit. Other brokers are also involved in fraud, as Mojnu (35) discovered:

One day, when Mahidul told me that he was not a small person and his network was big, I started believing him. I came to Dhaka and stayed with him for a week. He asked for my picture and I gave it to him. One day he suddenly stated that he had successfully matched my tissue and we had to go to India the next morning. He had already prepared my passport and we went to Calcutta. After dinner, Mahidul made a phone call to the potential recipient. He looked fretful. I did not know what was happening. He just mentioned to me that he had to return by tomorrow due to an emergency. He directed me to stay in Calcutta until his return. He gave me 1,500 Indian Rupees and promised to complete the deal. He also said that people in Calcutta communicate in Bengali, so I could stay there without any difficulties. He advised me to call his phone right away if necessary. I was left alone, so I called Mahidul the next day. I became worried as his phone was switched off. When Mahidul did not pick up the phone for five days and the money had almost run out, I crossed the border. When I could not find Mahidul, I went to Batpar, who was able to match my tissue.

Mojnu, still hopeful about finding a match and securing a better future, believed that the major broker would be better than the petty broker.
Finally, the bittersweet moment arrives. The sellers have waited for this moment like a *thirther kak*, a hungry crow. This time, brokers are frantically looking for sellers, instead of the other way around. Brokers are eagerly waiting for them, even in the evening. The brokers smile and say how difficult it is to match the tissue, how much effort it requires. They exaggerate, saying that the tissues are matched perfectly, much better than usual. They also give positive images of the potential recipients, indicating their religion, wealth, education, and affiliation to please sellers. But when sellers want to meet with recipients, Batpar reminds them of his business policy, whereby sellers do not meet with recipients before the trip. At the end of the meeting, brokers always tell sellers that they are very fortunate; they do not have to wait any longer to fly to India.

This time, sellers feel something unique, “like an earthquake in their heart.” They cry with joy, considering this to be one of the happiest moments of their lives. It is like enjoying the *Eid*, a feast. Some sellers are so happy that they bring the broker some local paddy and fish as a gift. They buy sweets for their own families, but lie and say the treats are because they have finally got a good job. Nevertheless, the sellers are worried: selling their kidney is dangerous. They feel as if they are receiving money in exchange for their own death. Suddenly, they become sad, believing their lives are at an end. Yet, they hope that their sleepless nights are over and a better life is now ahead of them. What most sellers do not know at this point is that matching tissues alone does not ensure that sellers are in the game.

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59 Brokers always overstate the percentage of tissue matching to the sellers. The sellers I interviewed told me the brokers informed them that their tissues matched with the recipients’ almost 100%, as if they were actual kin.
Additional Medical Tests

Sellers are required to take other medical tests to verify that they are healthy and able to perform the donation. Medical diagnostics are often expensive, so some potential recipients re-examine the HLA results before these tests. As Bangladeshi medical results are often inaccurate, one recipient took five sellers to India to verify their Bangladeshi HLA reports. The seller Manik (32) described his experience:

When I was impatient to know the matching result, the recipient mentioned that it is difficult to match the tissue, thus he could not make a decision until the last moment. He declared that my chance was very good based on BIRDEM’s report. However, he warned me that there were four other competitors whose tissues were also matched with him. The recipient decided to re-examine all the sellers’ tissues in India and select the best one among us. We stayed in a hotel in Calcutta. The test had been done in two days in a renowned diagnostic center. While we were all waiting in the diagnostic center, the receptionist first called my name for the test. For this, one of my competitors believed that I would be the fortunate one to match the tissue. All of us were wondering who would be the winner. We returned to Bangladesh by bus, and the recipient flew back later with the results. I could not sleep that day and was anxious to meet him the next day. The recipient’s tissue was better matched with another seller, but he refused to purchase his kidney because of his greedy demand. The recipient asked me whether I would donate my kidney with a reasonable demand. He was a decent man, so I said, I do not have any demand; whatever you would offer, it is fine by me.

Another recipient faxed some potential sellers’ HLA reports to an Indian nephrologist to verify the Bangladeshi doctors’ choice of matching. Thus, recipients maximize the chance of tissue matching before conducting other medical tests.

Buyers (recipients and brokers) then arrange about 30 medical tests, such as a physical, X-ray, ECG, BDRL, and ultrasound, plus tests for hepatitis, diabetes, and HIV

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60 Many recipients re-examine the sellers and their own HLA result to verify accuracy. Buyers often call this step cross matching. Dalal told me that BIRDEM reports are often inconsistent. He noticed that sellers who went for the HLA tests a few times had varying results. When he confronted the lab personnel, they argued that the errors were due to inaccuracy in the machine. In addition, Dalal claimed that there are 3 tissue groups (A, B and C) to match between recipient and donor; however, BIRDEM has facilities to examine only groups A and B. This means that the HLA result is not trustworthy in Bangladesh.
to confirm that sellers are fit to offer their kidney. Unlike recipients, brokers have fixed
diagnostic centers from which they receive commissions (usually 30%) for these tests.
Dalal is well connected with the owner of a renowned diagnostic center in Dhaka, a
former client who offers him a good commission for these tests. In one seller’s medical
report that I saw from this diagnostic center, Dalal is referred to as “Dr. Dalal.” Dalal
avoids the specialist’s fee because these tests are often standard. Many sellers reported
that both Dalal and Batpar arrange only a few tests in order to make a bigger profit. For
this reason, some recipients prefer to arrange the sellers’ tests themselves. To minimize
costs, they do one test at a time; if one test is satisfactory, they proceed to the remaining
ones. Buyers thus ensure their profits in diverse ways.

Although buyers pay for these tests, sellers are economically compromised for
trying longer for a match as they receive limited transportation costs, have difficulties
supporting their families, are available to work fewer hours, and must pay daily expenses
during the tests. As Mofiz (41) said:

After some tests, I asked permission from the recipient’s proxy to return to my
village. I could not open my tea stall for three days; I was worried about how my
family was buying food. The proxy told me to stay two more days and instructed
me to store my urine and stool in two containers. He promised to give me some
money after the tests.

Mofiz felt that he would receive money only as long as he had blood in his body and the
buyer could squeeze it out.

The tests are inconvenient because they sometimes take over a month. Sellers
must come early in the morning with an empty stomach and fulfill the recipient’s
demands. Sellers negotiate between family and workplace. They lie to their families
about why they store urine in containers and offer various excuses for taking frequent
time off from their jobs. In addition, the tests are often painful. As Salam (32) stated, “My arms were swallowed from giving blood. I had restrictions for taking food. I had to make a long trip from my village, manage various schedules, and locate different hospitals. It was not fun at all.” Further, sellers feel nervous about the tests. During the ECG, Mofiz (41) felt that “when they put clips all over my body, I thought they would cut my body.” Forid (28) also felt terrified during his examination:

When the recipient informed me that the doctor might make a tiny hole in my thigh, I felt scared. He persuaded me that it would be a mini operation and thus I needed to stay overnight in the hospital. I was terrified, believing that they might take meat from my kidney. Before the test, I cried as none of my close kin were by my side. After the test, I went back to my workplace and started working for fear of losing my job.

Whenever sellers go for a test, they worry that they might have hidden health problems they cannot afford to cure. Recipients, meanwhile, argue that sellers are fortunate to get a health checkup without having to pay for it. Sellers, for their part, are content that the buyers are spending “big” money on the tests, which indicates that their tissues match well. Sellers, hoping to win this game, thus put up with the inconveniences that come along with it.

Regardless of their efforts, not all sellers pass these medical tests. Mofiz (41) was screened out because he had jaundice. As he mentioned:

I made such a big decision in life, but the recipient’s proxy did not accept me because I had jaundice. I held the hand of Dalal and desperately requested to convince the recipient. It did not work out. What an unfortunate person I am! I wanted to jump in front of a car.

Likewise, Monu (27) was devastated when he had to redo the test due to errors in the results:

After picking up the test result, the proxy asked me to come to the doctor’s office. The doctor looked at the reports. He was not convinced. Everybody was silent; I
thought my kidney was damaged. The doctor suggested we go for another test in a different clinic. In the end, everything was all right.

Sellers must overcome many obstacles when selling their kidneys.

**Other Provisions**

After successfully completing these medical tests, sellers discuss other details, such as payment and promises of the deal, and arrange fake documents to identify themselves as “donors” for the operation, which is usually performed in India.

As mentioned earlier, sellers are usually not pleased with the price offered for their kidney, but do not have power to bargain with brokers, and most do not want to haggle with recipients. At this stage, they ask buyers how they will receive payment. Buyers promise that the entire amount will be given to them just before they enter the operating room, saying that this is the way everyone else in Bangladesh closes the deal. Sellers, unconvinced, ask for half the money in advance. Buyers refuse this demand, claiming that many people have run away with the money and not donated their kidney. Sellers are not content with this response; some propose opening a joint account and depositing the money there, so they can withdraw the money as per the agreement. Buyers, meanwhile, disagree, arguing that nobody would deposit money in advance because the seller can change their mind at the last moment. Sellers are confused; they ask how they will receive payment in the operating room. Buyers suggest various ways, such as paying them in cash, or transferring money to the sellers’ account electronically, or delivering money to the seller’s family in Bangladesh. Sellers become increasingly puzzled and worried about receiving payment as the conversation goes on, so buyers give

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61 Sellers do not have bank accounts, so buyers promise to open an account for them, but never do. Also, money transfers are not possible through a bank or computer between India and Bangladesh.
them hope by arguing that their proposed way is better because sellers will receive the entire amount at once and can then use it efficiently. Sellers eventually agree to the buyer’s offer, believing that nobody would deceive anyone over payment for a kidney and saving a life.

The deal is still not satisfying to sellers, so recipients promise them lucrative offers. Mofiz (41) revealed what his recipient promised him:

When I contested the price, the recipient’s husband promised to arrange a job in his bookstore at Dhaka and provide all books and expenses for my children’s education. He promised to bring my family to Dhaka and to help settle us on his vacant land. He also told me that he would give his old furniture for our new home. I finally appealed to arrange a wedding for my daughter and a job for my son-in-law. He said that I was giving the whole world, and therefore willingly promised to fulfill my small demand.

Most recipients promise jobs to sellers. When a few sellers ask about the type of jobs being offered, recipients promise to arrange a desk job rather than heavy lifting indicating that the seller will need a comfortable job after the operation. Some recipients, especially those living abroad, also promise to arrange visas, work permits, and citizenship for sellers. Recipients verbally guarantee to support or fulfill the sellers’ demands.

Sellers also discuss with buyers the other financial details of this deal. Buyers promise that they are in charge of all transportation, accommodation, and health-care expenditures for transplantation. Sellers worry about how their family will get by while they are away for weeks or months for the operation. Buyers are not interested in paying anything more than what they had promised, but sellers try to persuade them, saying that they are the only breadwinners in their family. Although sellers demand 10,000 Taka
($145) for this purpose, buyers agree to give only 3,000 Taka ($45). They tell sellers that they do not need more money than this to keep the family for one month.\footnote{The buyers said that sellers need to stay only one month abroad for the operation, but in reality it was much longer.}

When buyers pay this amount, they verify the seller’s address; some proxies even visit the seller’s house. However, buyers approach sellers as if they are establishing a new kinship. If the sellers are sad, buyers say that the money they paid for family expenses is a gift, and they will not deduct it from the principal amount. They also pledge to provide extra money over the phone to the sellers’ families whenever necessary. They promise not to deduct any other payment they have already made, and do not disburse the daily allowance they had promised for India.

Some sellers substantiated buyers’ promises, so they asked recipients to write down the deal. None of the recipients agreed to do so, as Mofiz (41) indicated:

Whatever I asked, the recipient’s proxy agreed to give. So, I wanted to confirm, and therefore asked him to write down his promises on a piece of paper. He told me he had done his pilgrimage to Mecca twice, and thus assured me not to worry about the written agreement. He argued that it is his responsibility to keep the promises, as I am not only saving the recipient’s life, but also an entire family.

Some sellers are doubtful about this arrangement, so they verify their recipient’s reputation through neighbours. Eventually, sellers strongly believe that the recipients cannot deceive them, especially once they get healthier through receiving the seller’s body part.

When everything is settled, it is the brokers who sometimes play an underhanded game. If brokers find new recipients whose tissues also match with the sellers, they trick these sellers in various ways. This is profitable for brokers, as they had already received a lump sum from their old clients. So, they promise these sellers that they will obtain better
deals from the new clients. Some sellers told me that brokers pressured them into changing their mind. Monu (27) said:

When everything was fixed and the recipient was arranging my trip to India, one day Dalal told me that my tissues also matched with another potential recipient. He advised me that the previous client is taking longer and I am in a rush, so I should consider the new client. I asked Dalal how I could do this as the previous client was waiting for so long, and had already invested a huge amount in me. Dalal replied that the recipient always leaves a seller if their tissues match better with others, so why should I not consider this better offer? He continued that the new client was a wealthy person residing in Canada, so I had an opportunity to get citizenship there. I was not able to resist so I accepted Dalal’s lucrative offer, although it was unethical. When I was perturbed at this news, Dalal introduced me to another wealthy potential recipient whose operation would be performed in Singapore. I examined the HLA test again, received 500 Taka ($8) but had to pay 200 Taka ($3) to Dalal. A few days later, Dalal told me that my English was not good enough to complete the deal in Singapore. So, he asked me to save a housewife who was dying without a healthy kidney. What a coincidence that my tissues matched with hers, too. Then both of my previous and current clients were asking to fix the deal. It was a two-way fight for my kidney; I could not easily make up my mind. Dalal argued that the current deal would be better. He also indicated that the previous client could live on dialysis, but the current one was almost dying! He further promised to arrange another seller for my previous client within a few weeks. I thought, everyone is selling to everyone else in this world. So, I decided to sell myself in this deal.

It is hard to say exactly how many sellers who have an agreement with one buyer are manipulated by Dalal to sell their kidneys to new clients. But it can be a typical scenario, as both Dalal and Batpar would not miss an opportunity to make more profit, especially since they absolutely control their sellers. Sellers, who participate in this unethical dealing, are powerless; they are also manipulated and tempted, and thus cannot refuse the brokers’ demands of lucrative offers.

Finally, buyers arrange all the required documents, such as passports, legal certificates, and travel visas for the trip to undergo the transplant in a foreign land. These travel documents ensure that the buyer and seller are close kin, so that one is “donating”
to save a relative’s life. First, buyers arrange the sellers’ passports, using false information. I have copies of sellers’ passports that contain the seller’s name, the parent’s name, as well as permanent and present addresses – all of which are entirely false, but their photographs are real. In this way, a seller becomes a new person who is going to “donate” a kidney to his new family. Passport fraud is so widespread in Bangladesh that there is a common saying that every citizen of this country holds two passports: one real and one fake.

Sellers told me how buyers arrange fake passports. First, they ask sellers for their photographs. Sellers take a black-and-white photo to minimize the cost, but buyers do not accept them. Then sellers then come to Dhaka to pose for a colour photograph and sign the passport application form. Following buyers’ instructions, many sellers grow a moustache to look older, wear studio coats and ties, and try to look wealthy in the photos. Due to widespread corruption, as outlined above, buyers bribe the passport officers so sellers do not need to apply in person. Sometimes government regulations become stricter, so only a few sellers go to the passport office, wait in line, and submit their applications with fake documents prepared by the buyers. In normal times, buyers directly obtain the sellers’ passport, but under strict conditions, sellers pick up their passports themselves then give them to the buyers right away. When the sellers I interviewed first received their passport, they could not believe how their identity was entirely changed. They worried that their true identity might be revealed during the trip abroad.

Similarly, buyers easily obtain clearance from the Ministry of Foreign Affairs that is required for the exchange of organs outside of Bangladesh. Buyers submit fake notary
affidavits; the Ministry certifies them for the apparent act of “donation.” I have collected a set of four fake notary affidavits of this kind: in the first, a seller’s wife signed to certify that her husband was donating a kidney to save his elder brother’s life out of love and affection only; another is from the seller’s mother, who signed to withdraw any objection as her younger son was donating a kidney to his brother without any transaction; a third was from both the recipient and the seller, who signed to certify that they were brothers, that one was donating and the other was grateful for it; the last was from a local municipality where an elected ward commissioner outlined a fake family tree indicating that the recipient and seller were brothers with eight siblings. All of these fake documents were witnessed by a lawyer and signed for testimony by a notary public. In the affidavits, the pictures of both the recipient and the seller are placed next to each other. Sellers do not disclose the document to their families, and as they cannot obtain their wife’s or parents’ pictures, buyers place another picture there and easily obtain the notary certificate of the fake kinship. Buyers manage this process easily, as the entire system is based on corruption. As seller Abdul (30) noted, “If you have money, you can get any fake documents in Bangladesh.” The sellers sign these legal documents without comprehending the written text, which is mostly in English. Some sellers also sign blank documents when their recipient asks them to. After signing, sellers realize they have entirely lost all control in this game, as buyers become legally dominant players.

Sellers also receive their visas without any trouble. If the operations are performed in India, sellers do not need to visit the Indian embassy because buyers arrange the three-month medical visa through an agent. If sellers need other visas (which are relatively difficult to obtain), they must attend a personal interview. Sellers are
nervous, but the interview is just a formality. The visa officers usually ask questions to recipients or proxies, because sellers are unable to communicate in English.

Due to high levels of corruption, buyers easily establish this newly commodified kin relationship without any difficulties. However, recipients (unlike brokers) are not particularly informed about the state of corruption in India and other countries. To avoid trouble from Indian officials, one recipient even asked his sellers to get circumcised. One seller, Hiru (38), referred to this moment as an “unbelievable crisis”:

We were finalizing our trip to India. One day, the recipient asked me to come to Dhaka. I was tense and worried. The recipient told me that we were going to India as brothers. He stated, “But brother, you are Hindu, and I am Muslim. We could not complete the deal if Indian doctors reveal our fake identities, especially during the operation.” He proposed that the only solution was to cut off the foreskin from my sonar matha (the head of the penis). What an unbelievable crisis I faced! The recipient mentioned that he could neither ask me to be circumcised nor could I say no, since it was the only option I had. I felt awfully bad, as I was going to circumcise in spite of my Hindu religious decree. However, I could not step back from the deal at this point. I therefore asked the recipient to arrange the circumcision at Dhaka, but he told me to handle it in my village. I had to disclose everything to my wife, a very simple woman, who fortunately did not fight with me but just cried for the whole night. The next morning, I went to a doctor and lied that the skin of my sonar matha was sensitive due to an allergic reaction and I could not pass urine. Therefore, I had to rub it so much that some of it was dissolved and generated unpleasant smells. The doctor looked at me and said if I wanted a circumcision, it would cost 4,000 Taka ($57). It was too expensive, so I came to a hazam (the local surgeon). He told me that circumcision is an easy matter; I would just need to take few medications for healing. He charged only 1,500 Taka ($21), so I decided to be his client. The hazam came to my house at 5 p.m. and closed the door. He injected a medicine [local anaesthesia] in the skin of my sonar matha. I was not worried for this little pain, as so many injections were pushed in my body in last several months. He rubbed the surrounding injected skin and asked whether I was feeling any pain. He then told me to look up at the roof. After a few minutes everything was done. He put a bandage there. I did not feel any pain, so I went to the market. When I called the recipient, he was deeply relieved. When I was coming back home, the anaesthesia stopped working. That night, I felt so much pain that I felt like it was a nightmare.

This story reveals that sellers place all their hopes on being successful in this game: Hiru ignored his religious decree and the future outcome of his choice to focus solely on
completing the deal. Sellers try for such a long time and are certain they will have better lives at the end of the game. After all, they believe in a local saying: if you work harder, you will get return indeed.

**The Final Countdown**

At this stage, sellers prepare for the trip that will finally lead to the operation. Many visit their families to say goodbye, but others cannot; buyers cunningly tell sellers to stay with the recipient’s family to establish a stronger relationship. Buyers are so worried that sellers will change their minds that one proxy even visited the seller’s family and managed to convince them that he should go on his trip. This seller, Shofi (25), described what happened:

> The recipient’s brother came to my grandmother and identified himself as my new employer. He said he was taking me to Malaysia. He said he offered me a job in his business there. He was buying my ticket because I am a good person and would return it by working for him. He also promised that he would arrange a job for my younger brother in the near future. My grandmother cried and told him that my father was not alive, so she decided to give him her grandchild. She asked him to take care of me.

Most buyers give sellers a travel date that is earlier than the actual one to ensure that they return from their homes and do not step back from the deal.

Sellers have a very unpleasant task to tell their families about their trip. For obvious reasons, sellers do not discuss their disgraceful, risky, and illegal business with their loved ones. They strongly believe that their families would forbid them to sell their kidney. They are ashamed to reveal their actions to the parents who brought them into the world. Instead, they lie to their families, saying that they are temporarily going to work in a distant city for a better opportunity. Two sellers were devastated to leave behind their
pregnant wives without disclosing their actions. Others suffered when their children asked them to bring them back a toy. The few who do reveal their true plans end up arguing with their families, who think it is better to beg on the streets or run away from moneylenders than sell a kidney.

Above all, sellers were terrified about making the trip. Some wished to travel with a family member or friend, but the buyers warned them that this would be at their own expense. But of course sellers cannot afford to spend their kidney-selling money on a trip for a companion. Some sellers give their families the buyer’s (whom they call their new employer’s) address, saying that if they do not return for a long time, the family should contact this address. They tell their families not to be worried if they cannot make phone calls, because they will have limited access while moving around or working in remote places. Sellers cannot spend a longer time with their families or celebrate the forthcoming Eid, as buyers do not want to waste more time when they are ready for the trip. Sellers hand over a few thousand Taka to their spouses to buy groceries during their absence.

Some sellers quit their jobs, as they cannot hold on to them when they are leaving on a trip. Rahmat (28) described how he terminated his job:

I told the recipient’s cousin that I would have to quit my job for the trip to India. He asked why I would not travel on a leave. I replied, saying it was not possible. He told me then that I should quit the job. I asked him how I would survive later on. He guaranteed to offer me a job as a manager in his store. He also promised that if I did not like that job, he would arrange another one immediately. The next day I quit my job, even though it had taken me months to get it. I had been working there for four years, yet I did not think twice about quitting.

Other sellers had already lost their jobs for taking too many breaks and “wandering around” to arrange the trip.
Sellers, realizing that this is their last chance to back away from the deal, nevertheless decide to go ahead as they are just one step away from a better future. They pray namaz and raise their hands to Allah, hoping he will show them the right way. They believe that the tissue is matched because Allah has looked upon their face. Yet some sellers do not comprehend why Allah is giving them such a hard test in life. They do not challenge it, but rather believe strongly that Allah will direct them, take care of them, and even change their fate, although they may be at the end of their lives. Almost all sellers ask for the blessings of Allah for a successful operation. They promise Allah that after a safe return, they will pray regularly and arrange a milad, or special prayer ceremony. Keramat (25) even asked his wife to pray to Allah, especially on Fridays, as he had heard that most operations were performed on that day. Sellers try to convince themselves that Allah had already written their fate, and whatever happened, they could not control it.

Sellers eventually pack their bags, unable to finish their last meal, and wave goodbye to their families. During their visit, sellers do not cry, for this would lead their families to ask many questions, but now that they are alone, they begin the trip with tears. As Moyna (43) described:

When I was leaving, I thought it could be our last meeting. I might not come back, but I kept my trust in Allah. My daughter was crying. I gave her a doll, but she did not take it; she wanted to come with me. My son was sleeping, so I could not say goodbye to him. I told my wife that nobody knows when someone would die. If something happened to me, she should take care of our kids both as a father and a mother. My wife started crying. She had never cried that much – ever! She told me to start my journey with bismillah, initiating something by the name of Allah. As I went to the bus station, so many tears were pouring from my eyes that my rickshaw puller asked if someone in my family had died.
Selling a kidney is probably the most critical situation of a seller’s life. At this point, they cannot back out of the deal, but they are terrified to continue with this risky game. They feel as if their body is leaving, but their soul is staying with their families.

When sellers come to Dhaka, buyers (both recipients and brokers) are deeply relieved. Sellers, however, are not pleased to learn that the buyer told them an earlier travel date to make sure they would get there in time from their village. If questioned on this practice, buyers lie, saying that the recipient’s condition suddenly deteriorated, so they decided to start the trip earlier, but now the person’s health was back to normal. Buyers immediately purchase tickets and arrange the trip. They also buy clothing and travel bags for sellers, so they seem to be actual family members. Dalal’s sellers usually stay with one of the recipient’s family members, while Batpar’s sellers stay in his hostel.

The recipient’s family and the brokers now treat sellers very well, advising them to rest at this stage, so sellers spend their time reading newspapers, watching television, and attending mosque. Also, buyers praise the sellers for saving lives. Salam (32) said:

> When I arrived at the recipient’s house, the recipient’s brother hugged me and his wife cooked whatever I liked. His mother told me that she had four children but from now on she was proud to become a mother of five. She promised to pray regularly for my long life.

Further, buyers try to keep the sellers cheerful, so they do not change their minds. The recipient’s family takes pictures with the seller and introduces themselves to establish this new kinship. Sellers say they receive “VIP treatment” during this time. Some sellers had to hide their identities when the recipient’s neighbours asked about their relationship. For some sellers, staying with the recipient’s family was not a pleasant experience, especially when family members visited and asked the seller too many questions about selling the kidney. As Sodrul (22) described:
The day before the trip, many members of the recipient’s family visited his house. I was sitting in the living room. Everybody looked at me curiously, as if they were watching an animal in the zoo. Nobody entered the room, except a few, who asked me why I was doing this. I did not want to have a conversation, so I just mentioned my financial problem and stared at the television. The recipient’s brother came around 10:30 p.m. and announced that dinner was ready. I ate a small amount of dinner alone. A person then showed me a room and told me to sleep because I had to get up 5 in the morning to catch the bus. I was lying and thinking that they could at least have had dinner with me. Why was I going to give my kidney to this family that was inhumane? Why did I enter into this world? Was this an illusion? No, I told myself; this is just for the money.

Sellers also worried about running into their friends and villagers in Dhaka during this time.

To make matters worse, some sellers must wait awhile at this stage if the recipient fails to arrange the enormous cost for the operation. Nazrul (27) waited for a year: his recipient had to sell his land, a store, and jewellery, and also borrow money from family and his workplace. Jobbar (28) said he had to stay for about four weeks with the broker Batpar because the recipient needed time to arrange the money. During the wait, Jobbar could not visit his family because everybody thought he was in India for health-care reasons.

Some sellers have horrible experiences with the buyer. For example, Mofiz (41) could not attend his sister’s funeral because the recipient’s family did not allow him to go to his village just before the trip. As he described:

The recipient and her husband went to India to arrange the operation, while I was being guarded by three of their family members in their house at Dhaka. The guards tried to convince me that I was a fortunate man, as my tissues were matched with this wealthy recipient. They said I should not be worried about my life. However, I could not go out of their house, so we spent time playing ludo and keram [two popular indoor games in Bangladesh]. I was bored from resting so much. One day, I somehow managed to sneak out of the house and went to a movie theatre. They were so terrified, they came to the theatre to search for me. They were relieved when I told them that I came out to smoke cigarettes and then decided to watch a movie. In a few days, a bodyguard accidentally told me that
my family had phoned me. I felt he was hiding something, so I kept asking him the reason for the call. He then told me that my 15-year-old sister had died of a heart attack after hearing that I was selling my kidney. My cousin (who eventually told me about my late sister) had made the phone call, so I could come to the funeral. I was devastated and decided to go and view her body. The bodyguards and a military officer (the recipient’s relative) did not give me permission to go to the village, even though I promised to come back to Dhaka the next day. They argued that if I went to the village, I could not save my late sister, so was wiser to save another sister of mine who was about to die in India. The trip was arranged and we were leaving the following day, so the recipient’s family did not let me visit my home. I started crying and shouting. I asked them what kind of values they were taught that they would not allow a brother to attend his sister’s funeral. I could neither fight with them nor run away. That night I was so irritated that I punched a bodyguard in the face, and then went to my room and locked the door. The three bodyguards did not sleep the whole night; they waited in front of my door. They knocked on my door, but I did not open it. They constantly watched me through the window. I could not sleep so I got out of bed when I heard the *azan*, the call to prayer, at dawn. I thought of my sister who had died, and of how I was not there to bury her and pay my last respects. This was my punishment for selling my kidney. I wondered: where is Allah for the poor?

In the morning, Mofiz went to India by bus accompanied by three bodyguards. Other sellers were also guarded until they crossed the border. These sellers felt overwhelmed and extremely frustrated as they had no control over their own movements and were not allowed to go anywhere without the buyer’s consent.

Some sellers are also devastated to discover that their recipient is taking additional sellers for transplantation as standbys. These recipients argue that they must maximize their chances, as the Indian doctor might not accept the tissue matching. Sellers are told about these competitors just before the trip. Mohabbat (27) explained:

When the recipient’s brother told me that they were talking to three other potential sellers and would select only the one whose tissue matched the best with the recipient, I felt like I was in the middle of nowhere. I told the proxy that I came from the northern part of Bangladesh to give my kidney. I came about 15 times to Dhaka and had to close my tea stall. Why did they play with me? I felt stupid. How could I trust them so much? I did not want to give them my kidney but I realized that I had no other choice. I asked the proxy why he didn’t tell me about his plans before. He told me that I was number one on his list and perhaps the fortunate one, as the doctor said that I had a good kidney with an excellent
match. He argued that he needed to take other sellers just in case my tissue did not match in India. He continued that he did not inform me earlier because I would be disappointed. This was not right but what could I do? Two sellers showed up in the morning. One of them told me that our tissues were the same so we were brothers. He also mentioned that we should not be competitive as tissue matching depends on luck, so we became friends. Another seller did not talk with me; he was sad. The fourth one did not show up. The proxy said the seller ran off with 5,000 Taka ($70); however, he showed up just two minutes before the bus left. I realized that my chances were very slim.

In this case, all the competitors traveled together, but Joinal (37) mentioned that his competitor ran away before the trip:

The recipient introduced the other potential seller to me just a few weeks before the trip. My competitor was upset, so he argued that he was nervous and did not want to go. The recipient was angry; he asked the other seller why he did not notify the recipient of this decision in advance. The seller did not fight and agreed to join the trip. He left to say goodbye to his family, but did not come back.

In regards to dealing with competitors at this final stage, sellers who sold their kidneys through Batpar were rather fortunate: Batpar usually does not take additional sellers due to the extra expenses involved in his package deal.

The night before the trip, many sellers again re-evaluate their decision to sell their kidney. Are they taking the right step? They realize that they might die from the surgery. If they survive, they could have major health complications, such as being unable to walk, play, or eat as before. They are worried that the buyers have not given them an accurate picture of kidney transplant and post-operative health complications. As Mofiz (41) said, “Even though the recipient mentioned that only he could die in the operation, I felt like the donor could die, too.” Sellers regret believing the buyers and not consulting a kidney specialist. In addition, sellers worry that they might not receive their payment. They know that if the buyers do not pay them, they will not be able to tell anybody. They are also sad that their families will not be by their side in the final moment of life if they
die. They are frightened at the thought of being alone in a different country where they cannot communicate with local people in another language. Furthermore, sellers expect to feel guilty towards their families for the rest of their lives when their actions are revealed. Thus, sellers are constantly thinking and worrying, as seen through Keramat (25), who had nightmares:

I saw somebody talking me to a dark place. I thought I would never get the money if I were to die. The doctor came and I was feeling scared. He cut off my body and was taking out everything including my intestines until he finally found my kidney. I gripped my bedsheets and repeatedly shouted that I would never give my kidney to anybody. My wife woke up; she gave me a glass of water. I told her it was just a bad dream.

The sellers feel as if this is the toughest decision in their lives; there is no happiness in being “slaughtered.”

As mentioned earlier, the decision to sell a kidney is based on a blend of hope and fear; sellers make up their minds and decide to start their journey. Although they are worried about the uncertainty of the next stage, they take the risk and complete the deal. They believe that a bright future lies ahead; there they can easily resolve their problems and get out of poverty. As Keramat (25) noted:

We live in such difficult conditions that it is better to die. Selling the kidney was my only option to pay off the debt. I knew I might die, but people would not be able to point to my cadaver and criticize that I died in debt. I wanted to live better off and in dignity.

Sellers eventually convince themselves that selling their kidney is not really life threatening, and believe their journey of hope will be a success. They also consider that selling kidneys is a simple course of action, as many other people are involved in this trade. Moreover, they are going to do a noble thing by saving someone’s life. They also believe that Allah will look upon them after they tried for so long to match the tissues,
and thus feel assured that they will win the lottery this time. Most sellers also appreciate that traveling to other countries is exceptionally exciting, particularly if it is the first time they have done so.

Still, they are frightened, as their Bangladeshi life may be at an end. But they cannot back out of the deal, as their commitment and reputation are on the line. Just before the trip, buyers are busy with their families, while sellers are alone. Sodrul (22) was hurt when the recipient’s brother ignored him completely. Sodrul noted, “I had the food, took the bag, and came downstairs alone. The proxy was blessing his daughter and did not look at me even though I was going to save his family.” Most sellers take the bus, although they are initially promised a flight. Recipients’ proxies or employees of the brokers escort the sellers, while buyers take a flight to India. Although some buyers initially say that the operation will be performed in North America or Europe, sellers end up going to India. At this point, they feel they have made a poor decision by trusting the buyer.

When the trip begins, the sellers start to weep. Their companions console them, telling them not to cry and saying that the operation is easy and trouble free. These companions also emphasize that sellers should have rethought their decision before they left, as nobody forced them to come. At this point, sellers feel as if they are standing in front of a noose before being hanged. To them, this is the final moment of their lives; the only thing left is the operation, which will happen soon. As Hena (28) put it, “It is worse than experiencing the death of a loved one.” Sellers imagine that from now on, there is no distinction between living and dying; they are at the border between the two.

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63 Usually, one of Batpar’s employees takes five or six sellers to India at a time. But Batpar comes and waits in no man’s land to ensure that the sellers cross the border.
CHAPTER SEVEN

Red: Sacrifice

When a fox catches a chicken, the little one cries. I was the chicken, and the buyer was the fox. At dawn on the day of the operation, my tears were dropping so frenziedly that even a shower could not wash them away. I felt like kurbanir gori, a sacrificed cow purchased for slaughtering on the day of Eid [the biggest celebration in Bangladesh]. – Dildar, a 32-year-old kidney seller

This chapter discusses the operative stage of the kidney seller’s journey. It outlines how sellers relocate temporarily to a new place, meet with the recipient, repeat medical tests, enter the operating room, and return to Bangladesh with a long scar from the surgery. This process takes on average three months. It takes place in various cities, mostly in Bangalore and Chennai (India), as well as in Dhaka (Bangladesh), Islamabad (Pakistan), Bangkok (Thailand), and Singapore (Singapore). The day of the surgery is often the saddest day for the seller but the happiest for the recipient. Sellers, knowing they cannot renege on their agreement, enter the operating room hoping for a better future. At the same time, they picture their bodies being cut and covered in blood.

Relocation

The sellers that I interviewed easily crossed borders with fake identities, although they initially feared ending up in jail if immigration authorities were to discover their true purpose in traveling.

Buyers (recipients’ proxies or the broker Batpar’s employees) prepare sellers by making them memorize new identities, then bribe the authorities. Sellers are escorted to the border; they are entirely in the buyers’ hands. Just after crossing the border, buyers
seize the passports, ensuring that sellers cannot return to Bangladesh until their kidney is removed. Although sellers are hesitant to give up their passport, buyers assure them that it will be safe. Sellers find that the buyer’s behavior is gradually changing after crossing the border, as Jobbar, a 28-year-old seller, noted: “Batpar’s employee was acting as if I was going to run away with his money without giving away my kidney.” From this point, sellers have lost all bargaining power.

On the road, sellers stop over for a day or two in Calcutta, as buyers do not reserve the train from Calcutta to South India ahead of time. The trip, which takes more than two days, is exhausting. What is worse, buyers often purchase third-class tickets for sellers, but first-class tickets for themselves. The journey is uncomfortable: sellers get insufficient food, sleep, and showers while on the train. They feel disappointed and frustrated by buyers’ change in behavior. As Sodrul (22) mentioned while crying in front of me:

> During the 15-hour bus trip from Dhaka to Calcutta, the proxy bought food at every stop but did not bother to ask even once if I was hungry. I did not have money to buy food. When we reached Calcutta, he bought only a vegetable dish for me but chicken curry for himself. He started treating me like his servant. I was completely at his mercy in India.

Even if sellers receive enough food, they often do not eat it, due to the different taste in India. Instead, they rely solely on tea, fruit, and snacks throughout the entire trip. Sellers try not to enter into conversations with other passengers in order to avoid disclosing their true feelings about the trip. Many do not have proper clothes and therefore suffer from the weather. They are also not familiar with the laws; Mohabbat (27), for example, was fined 50 Rupees ($1.25) for smoking in the train washroom.⁶⁴

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⁶⁴ Rupee is the Indian currency. Approximately 40 Rupees are equivalent to $1 US.
As they gaze at the Indian landscape through the train window, sellers are constantly thinking, while buyers listen to music on their Walkmans. Sellers become sad as they think about how they got into this situation. How are their families managing? How will the operation be performed? How will doctors make the cut in their body? What kind of health complications will they suffer afterwards? Knowing that their kidneys will be removed shortly after their arrival in the hospital, they become anxious, as if in a thunderstorm. They understand that they are not on vacation and worry that they might not come back alive. When buyers notice the sellers’ fearful faces, they try to reassure sellers, saying that the operation will be easy and will go smoothly. They claim that it is such a routine procedure, everyone in their own family wanted to donate, but their tissues did not match. Buyers also emphasize how much better the Indian healthcare system is than Bangladesh’s, how great the Indian cricket is, and how beautiful the Bollywood models are.

Convinced by the buyers’ words, sellers become hopeful once more, forgetting their worries and concentrating on different things. They distract themselves by observing the beautiful Indian towns and villages that they are seeing for the first time in their lives; they survey everything and overlook nothing. They are fascinated to discover how much longer and faster Indian trains are compared to Bangladeshi trains. At dawn, the food vendors start to pass through the compartment, selling their wares; sellers, too, curiously walk from one compartment to another seeing different people in India. Eventually, they reach South India. Their confusion and fear return.

Following the buyers’ instructions, sellers find themselves living in a cramped environment. If sellers come via Batpar, they room with as many as 10 other sellers in a
tiny and dirty bachelor apartment permanently rented by Batpar. Sellers are shocked at these living arrangements, where they must sleep on the floor while the broker sleeps on a bed. If sellers arrive with a proxy, they stay with the recipient, where they must share a small room with the maid, while recipients stay in an air-conditioned space.

On their first day, sellers buy meals from the market and are glad to eat rice and delicious vegetables cooked in the South Indian style. They are astounded by the new city. Dildar (32) noted, “There is no rickshaw traffic there and motorbikes are everywhere, even girls are riding them.” The first night, sellers sleep well, as they are exhausted from the trip. The following morning, they meet with Batpar, who arrives after a short flight.

Batpar warns his sellers that India is a dangerous country, so they must follow some strict rules. First, in order to avoid trouble, they are not allowed to go outside often and talk with others. Second, they must not discuss the deal with other sellers or recipients. Third, they cannot stay with their recipient. Finally, they need to memorize carefully their new identity, or Indian doctors might refuse the case. Upon their agreement, Batpar introduces sellers to their recipients, who are already obtaining dialysis there.

Meeting with the Recipient

Most sellers have not met their recipients yet, as brokers and proxies deal with them on the sellers’ behalf. Some sellers (Dalal’s clients), however, had met with their recipients in Bangladesh; a few had traveled together to India. Sellers are always curious to learn who will receive their kidney. They try to comprehend how the tissues of two
individuals can match when the people involved have never met and even live in different places. Meeting with the recipient is an emotional moment, so sellers try to prepare themselves.

Usually the broker or the proxy makes the introductions. When seller and recipient meet for the first time, they hug each other, clasp hands, and look at each other. Sellers feel compassion when they see that their recipients are severely ill, as Mofiz (41) described:

When I went into the room, I saw a slim woman lying on the bed just like a dead person. I realized then that two damaged kidneys means the end of one’s life. She was helpless, weak and close to death. She had lost so much weight that she might only have 30 kilograms of meat in her body. I felt strange when I went to her side. I had never met this person, but my blood and tissue types matched with hers. I looked at her face. I wondered how we are so similar. Were we related in a previous life? I gave a salam, a greeting, and sat beside her. She referred to me as a brother. I asked her how she was feeling. Okay, she replied. I asked her how her kidneys got damaged. She said that Allah gives disease, and people cannot know how it happens. She started crying and whispered that she might die. She told me that I do not need two kidneys; she can only survive with one of mine. Her husband held my hand and told me that everything depends on my mercy. I came as a messiah to save the lives of her entire family – husband, three children, and herself. I looked at her face again with sympathy. I realized that the children will be able to call her “Mom” because of me. I felt weak but understood that I was making the right decision to save this family.

On the other hand, some sellers are surprised to see that their recipients appear healthy. Jobbar (28) said:

I could not believe that my recipient had both of his kidneys damaged because he was only 20 years old, walking straight and talking like a normal person. In fact, he looked better than me. I nevertheless decided to give my kidney because I knew this young man could not live longer in this world otherwise.

Sellers become sympathetic to their recipient because it is a matter of life and death, and only they have the miracle power to save the life of someone vulnerable.
Recipients wait for so long to meet up with their “donor” that they are extremely happy to see them. When recipients were first informed by their family that they had found a matched donor, it was hard to believe; now they look forward to being relieved of suffering and of dialysis. Recipients treat sellers well and greet them like family members. They praise the sellers’ greatness, generosity, and bravery for traveling so far to save a life. Recipients describe how vulnerable they are, living with the very painful experience of dialysis three times a week. They say that this is the last stage of their lives, as they are often vomiting; they need to be careful in their daily activities and drink bottled water only. They wish that God would not give this extremely painful disease to anyone, even their enemy. Recipients reiterate to sellers that only the transplantation can save their lives. Thus, recipients highlight their vulnerability to get sympathy from sellers. This evening is eventful for sellers; they enjoy a wonderful dinner. Recipients treat sellers so well that Jobbar (28) noted, “In that feast I could not eat anymore, but my recipient did not listen and offered so much food that I felt my stomach would burst.”

Seeing all the hospitality, sellers become more sympathetic to their recipient and try to understand why Allah gave the other person such a disease. They think about how it could have been them who was suffering from this horrible disease. With this in mind, they decide to stick with their decision and do something good with their lives. Of course, they are still afraid of the health risks involved in the operation. Sensing the sellers’ confusion, recipients gently inquire whether sellers are losing weight because they are worried about the operation. Recipients reassure sellers that kidney donation is simple, and causes no harm to the donor. They generously agree to fulfill the sellers’ every demand, saying that even this would not be enough because nothing is greater than
saving a life. Sellers begin to trust the recipient, believing that they will not be treated as porogacha, or supporting trees, but provided with lifelong support to build up their fortunes.

Some sellers, on the other hand, are not pleased with their recipients. A few revealed that their recipient’s first transplantation failed, so they were going for a second one. Some sellers are also unhappy to see that their recipients are over 70 years old, with many serious health problems – some cannot speak properly and look withered. Sellers prefer to save the lives of younger people who can live longer with such an invaluable gift. A few sellers are disappointed to discover that when competitors are present, recipients cordially greet only the best-matched seller, and treat the rest as second-class citizens. In terms of manners, some recipients address them using the pronoun tumi (which in Bengali is less respectful) instead of apni (which shows more respect) and “behave like arrogant wealthy people.” Still, sellers decide to put up with the situation, believing that it is good for the poor to keep in touch with the rich.

At the end of the meeting, recipients who used Batpar as a broker often ask sellers to stay with them. Batpar, who is also present, firmly refuses the offer, pointing out that he is in charge of the seller. Recipients therefore ask sellers to visit regularly, but as they leave the meeting, Batpar warns them that they are not allowed to interact with recipients. Sellers should only answer the recipients’ questions and not make any unnecessary conversation. He argues that if sellers get to know their recipient, they might begin to value them less and treat them as cheap. He therefore advises sellers to avoid visiting their recipients or having any type of communication with them. In keeping sellers and recipients separate so they cannot discuss the financial terms of the trade, he ensures a
bigger profit for himself. Sellers have little choice in the matter: they follow the broker’s instructions in order to complete the deal and fulfill their hopes for a better future.

Medical Re-examination

In the following days, sellers must take all the medical tests again, as Indian doctors do not accept Bangladeshi test results. During the tests, sellers meet with other Bangladeshi donors and recipients, see a few operations being performed, and experience various difficulties.

Bangladeshis usually arrange transplantation in particular Indian hospitals to avoid any hassles in removing kidneys from sellers who are not related to recipients. Batpar regularly brings many clients at a time to a certain hospital in South India. Some recipients, on the other hand, attempt to arrange the operation in a hospital that has good standing, but fail to have the transplantation because of the hospital’s firm rules against organ commodification. Abdul (30) described such a situation:

We came to a big hospital in Velore. The doctor strongly declared that if the donor was from outside the family, he would not accept the case. He warned that he would examine the DNA test to confirm the relationship between the recipient and donor, and he would not perform the operation without the physical presence of the donor’s wife. The recipient was nervous, so he admitted that I was an unrelated donor. The doctor suggested that the recipient’s wife, who was with us, could donate instead. I was glad, hoping that I could be free from this jail. However, the wife decided not to take the risk. It was a very difficult moment for me. I became scared: if the wife did not want to be a donor, it must be dangerous. But I could not run away, as the recipient would die. The recipient told me not to worry and said he would arrange the operation in Bangalore instead.

On the whole, recipients want to have the operation in an established hospital, but cannot take the chance of being rejected or legally punished for illegal organ exchange. Instead, they arrange the operation in a private hospital where the entire procedure is largely a
masquerade based solely on economic profit. All things considered, sellers do not have the choice of having the operation in a reputable hospital to minimize the risk.

When they meet the doctors, sellers get so worried that “their lips and throat become dry.” In these hospitals, however, doctors usually focus on their own business rather than enquiring about the kinship between their clients. In the first meeting, sellers report, doctors speak almost exclusively with buyers (although brokers are sometimes present). They ask for Bangladeshi test results, passports, and legal documents, and are pleased to see that everything has been properly arranged. Doctors then look at sellers, record their personal information, and ask simply whether their relationship with the recipient is real. Sellers, comforted by the relaxed atmosphere of the hospital, lie and say yes. Doctors ask sellers common questions, such as if they have previously taken any medication or why they are so skinny. Finally, doctors direct recipients and sellers to retake all medical tests. As doctors benefit financially from this medical re-examination and transplantation, they smile at the broker.

Many sellers claim that these doctors are connected with Batpar, a regular client who gives them good business. Doctors know that “donors” are not related to recipients, but bypass the law, pretending that everything is happening as a “donation” between family members, which is legal if they truly are related but fraud when false papers have been created to support the story. Mohabbat (27) outlined how doctors are aware of this trade but shut their eyes because they gain financially from it:

I entered the doctor’s room with three other competitors and my recipient. The doctor looked at the reports and said he would examine tissue tests only with me. When the recipient said to examine tests with everyone, the doctor mentioned that the tissues matched with me the most. However, he advised keeping all the sellers until the test results were satisfactory with me. The doctor knew that we were all sellers, but pretended that our genetic makeup was closely related.
Sellers also noted that they are encouraged to donate by doctors who tell them that a kidney transplant is trouble-free, especially for the donor, who is able to stand up in just a week. The doctors also tell sellers of the number of successful transplantations they have performed to date. At times, Batpar lies to the sellers by telling a story of an Indian doctor who donated a kidney in early childhood and is now living a healthy life and has become a transplant specialist.

The medical tests begin with the sellers’ tissue typing. In India, Batpar easily manages earlier appointments for the tests, but recipients sometimes have trouble getting quicker procedures. To avoid suspicion, Batpar does not take his clients all at once for the tests. In general, sellers wait more than a week for the tissue-typing test. Most of the tissues of my interviewed sellers matched as the Bangladeshi results indicated. A few others were devastated to learn that their tissues did not match with their recipients. Sadly, Mostafa Kamal, a recipient, died soon after finding out that his seller’s tissues did not match in the new result. Keramat (25), his seller, described the scenario:

When Mr. Mostafa found out the tissue did not match, he was angry and called Batpar a bastard and son of a broker. He blamed Batpar for forging the paper, thus different results in India. Batpar argued with Mostafa that Bangladeshi test results are often inaccurate and do not match the Indian results. Mostafa did not buy his arguments, but rather blamed the situation on Batpar’s nasty tricks; Mostafa warned that if he were to die, Batpar would be responsible for his death. Unfortunately, Mostafa died in two days from a heart attack while taking a shower.

The situation was definitely Batpar’s fault, because he did not examine Keramat’s tissue in Bangladesh at all, as this seller confirmed with me:

Batpar told me he would do my tissue test in India rather than in Bangladesh. I did not know the entire procedure, so I could not comprehend his action then. He basically forged the HLA paper. He photocopied someone’s result but placed my name. In this way, Batpar made a huge profit. Mr. Mostafa, the late recipient, had
paid about 100,000 Taka ($1,450) as an advance; however, Batpar spent only 10,000 Taka ($145) on me. When the tissue did not match in India, Mostafa could not get the money back. I had to return to Bangladesh; Batpar keenly introduced me to another new recipient. He would do anything if he smells money.

Similarly, Jobbar (28) also mentioned that nobody understood Batpar’s game. As he described his experience:

Batpar told me that my tissue matched with a client. I came to his office and took my passport pictures. When I called him a few days later, he said we were not traveling to India. I was angry and asked whether he had another seller who was charging less than me. Batpar informed me that the doctor made a mistake in matching my tissues. I could not understand then, but later I realized he tried to forge my HLA result, but the recipient revealed it at the last stage and the trip was canceled.

The underhanded business practices of these brokers explain why some recipients take more than one seller to India; the possibility of discrepancies between Indian and Bangladeshi test results make sellers worry even more.

When tissues between sellers and recipients are matched, everybody is thrilled. If they do not match, sellers must return to Bangladesh. It is a sad moment, especially for those sellers who set out as competitors, became friends, and are separated due to these unfortunate circumstances. Mohabbat (27) depicted one such story:

The four of us became a family on our journey to India. Our kinship was based on our matching tissues. We shared our sorrows together. When the doctor said that my tissue matched and advised the recipient not to examine the others, the other sellers almost lost their minds. One of them was angry for quitting his job in Bangladesh. Another could not figure out how to return home without money. I was the fortunate one; the others were losers in the battle. It was easy for me to tell them not to worry. I gave them hope, saying something better was waiting for them. I gave them contact numbers of some buyers. I advised them to contact as many buyers as possible: first recipients, and then brokers. The other sellers were in deep trouble because of this business.

Recipients keep unmatched sellers on hand just in case. They say they like these sellers the most, even though the doctor had already rejected them based on the match.
Recipients also indicate how much they have done for these sellers, even bringing them to India. They falsely promise to pay these sellers 10,000 Taka ($143) after the operation. Recipients further insist that the sellers not try to connect with other recipients until their medical tests and the operation are performed. Most sellers agree to remain as standbys; a few try to find a potential client in the Indian hospital, but all the Bangladeshi recipients have donors with them.

The tissue-matched sellers undergo other medical tests, including physicals, ECGs, X-rays, and ultrasounds. They are not pleased about having to retake all these tests, which they find painful and stressful, as Keramat (25) outlined:

Almost every day there was an appointment for a test. The recipient came to Batpar’s apartment and picked me up. One day, I gave seven syringes of blood and got examined for eighteen tests. My head was spinning like latim, a kid’s toy. The recipient paid about 19,000 Rupees ($475) but dropped me off from the taxi offering nothing, not even a sorbet. I felt almost senseless so I slept all day.

Sellers become angry at having to give syringes of blood for these tests when they are undernourished and underweight. They feel that the buyers are feeding them well just to take more blood out of them. As Hena (28) said, “They were vampires and we were victims.” These tests also restrict sellers, who must follow instructions on what to eat, when to store urine, and how to prepare. Aware of sellers’ dissatisfaction, recipients promise to compensate them in some way. Mofiz (41) explained:

One day I told the recipient that he took lots of my blood, which reduced my weight by about two kilograms, but did not tell me about this. Rather, he misinformed me that everything was ready and the operation would be performed just after our arrival. I said I could not accept it so I would not give my blood again since it was not in our contract. The recipient held my hand and promised to pay a bonus after the operation.

Buyers encourage sellers to take these medical examinations, telling them how fortunate they are to have their health checked in a modern hospital in India at no cost.
During the medical tests, sellers’ days pass slowly; every minute seems like an eternity. They become bored by the daily routine, such as grocery shopping, cooking, eating, and sleeping. They watch TV, play cards, or accompany their recipients to dialysis at the hospital. Many sellers do not go outside, fearing that the Indian police might arrest them. Some spend their time at the lake, park, railway station, or shopping mall. They do not have enough money to see the city. While wandering around, Hasmat (32) saw a bird that had been hit by a truck and rescued by some local people; he was surprised to see the poor Indians taking care of animals while the rich Bangladeshis were harvesting body parts. At their residence, sellers read Islamic books and pray all the time for the operation to be a success. Some sellers pass the time sitting together, gossiping and singing songs by national poet Nazrul Islam or folk musician Mujib Pardeshi in order to forget their unfortunate condition.

Some sellers also meet other Bangladeshis who come for transplantation at the same hospital in India. Although the buyers do not like it, sellers defend themselves by saying that they are not thieves and do not want to live in a jail. In these meetings, sellers are surprised to see many other sellers in the same situation. Abdul (30) noted that he met with 15 other sellers at a party hosted by a wealthy Bangladeshi recipient. Most of these sellers come from North Bengal. They are usually educated men between the ages of 25 and 30. Wanting to hide their actions, most of them do not share their stories but simply introduce themselves as “donors.” Abdul guessed that about 90% of these donors were not related to their recipient. Sellers also meet with many other Bangladeshi recipients. Sodrul (22) mentioned that each week, at least two transplants on Bangladeshis are performed in Bangalore; there were 34 operations done in the three months he was there.
Bangladeshi recipients arrive so frequently, his operation was performed at eight in the morning, and another Bangladeshi’s operation was scheduled two hours later on the same day.

Sellers notice that Bangladeshi brokers such as Batpar and Dalal walk with pride there. Sellers try to avoid other brokers, fearing that they might disclose the sellers’ true identities to the Indian doctors, or ask for money to keep quiet. Sellers who stay with Batpar say that his network is enormous. Batpar tells them that he successfully dealt with 107 cases and has had no medical problems with his clients. However, three of his recipients died – not because of kidney failure, but because they had disregarded the doctor’s advice. Evidently, most of Batpar’s recipient clients belong to the upper class, thus his business is well protected. “Batpar brought his wife to spend holidays in India; once, when his wife saw a donor’s scar, she fainted, but Batpar argued that he was not doing anything wrong, but rather saving lives of the vulnerable,” as Jobbar (28) noted. During medical examinations, brokers walk around Indian hospitals and ask Bangladeshi sellers to find other potential sellers or ask recipients to find prospective clients on commission. The brokers expand their network and business through a large pool of Bangladeshis – so large that there are Bengali interpreters in some Indian hospitals.

While waiting for the operation, some sellers watch a kidney transplant operation being performed, and are very scared when they see the big scar that results. As one seller described:

I saw the operation on donor Jahangir (with whom I spent most of my time). When he came out of the hospital, we both cried together. I saw his scar and got scared like I get scared in thunderstorms. It was longer than my forearm. I asked him, when the doctor cut your body this long, weren’t you scared? He replied that he was sleeping, and noticed the scar only when he felt pain and woke up. I thought I would not survive this operation, or I would be disabled. I pictured
myself unable to stand up, and having to spend the rest of my life sitting on the bed doing my everyday activities. I saw his scar four or five times, and each time I became so scared that I closed my eyes right away.

Sellers, at first puzzled when they see the scar, quickly realize that the buyer lied to them about the length of the scar. They become scared and try to find out what happened to other kidney donors as a result of the surgery. Seeing that the sellers are alarmed, buyers reassure them, saying that these days, a kidney transplant is a routine procedure and nobody has ever died from this simple operation. They point out sellers who are recovering after the operation. Recipients’ families promise to stay with the sellers in the operating room.

During these days leading up to the surgery, sellers experience many other difficulties. Before the trip to India, recipients tell them they will need to stay there for only a month, but they end up staying much longer. They worry about their families’ survival in Bangladesh, especially when they hear bad news, such as Bangladeshi flooding, when they watch television. When sellers ask the buyer to send money to their families, the buyer agrees but it is a false promise. When challenged, buyers act as if they sent the money but do not know why the families did not receive it. Furthermore, sellers are not allowed to make phone calls, even though they had been promised they would be able to do so on a daily basis. Buyers are concerned that if sellers call their families, they might weaken and leave without giving their kidney. Buyers also worry that sellers might leave out of fear, so they give only a small daily allowance, too little to travel back to Bangladesh or buy cigarettes or watch Indian movies.

Sellers are annoyed by Batpar’s repulsive behavior. Batpar is especially displeased with sellers if they demand extra money. He warns them that he will send
them back home if he encounters difficulties. To make sellers docile, he often calls his manager and deceptively asks for different “donors.” During the medical examination, Batpar flies to Bangladesh to recruit new clients, which makes sellers experience additional difficulties. Jobbar (28) noted:

I took care of Batpar when he had a high fever although every seller was scared to let him into the hospital, the place of the kidney operation. However, Batpar was not a human being. When he left for Bangladesh to recruit new clients, I gave him a letter to send to my family but he did not drop it in the mailbox. He did not provide enough money for his employee, Kamrul, to take care of us in India. We had such a difficult time. Kamrul had 18,000 Rupees ($450), but everything was gone in a short time. The landlord wanted to evict us because we could not pay the rent for three months. Whenever Kamrul called, Batpar promised to come, but God knows when. Kamrul borrowed some money from our recipients and told the landlord he would pay the rest soon. At one point, we had to leave the place, so we stayed with our recipients. A few months later, Batpar came with five new sellers and rented a new tiny bachelor apartment. He told us to come back. In total, nine of us stayed with Batpar there.

Sellers become upset when they learn that the deal is different for everybody. They worry constantly about receiving payment. One day, four sellers became united and exchanged their addresses in case Batpar cheated them. One even planned to ask help from a mastan, or thug, whom he knew and who resided in the same area as Batpar.

Sellers who stay with their recipients also mentioned that their recipients gradually start treating them poorly. They are put in charge of buying groceries, preparing meals, cleaning the apartment, and doing laundry. Some have to carry drinking water up five flights of stairs. They feel like they are being treated as servants, while recipients behave as if they belong to a rich class and sellers are too dirty to be touched. These sellers never have the option of eating meals with their recipients, so they eat with maids in a separate room. One seller even had to offer regular massage to his recipient. As this seller, Jobbar (28), described:
One day, the recipient asked me to massage his hands as they were tense after dialysis. His maid always massaged him, but now he asked me. I felt uneasy, but fulfilled his demand. After a few days, he asked me to massage his legs. I was shocked but hoped that this wealthy recipient would look after me, so I thought positively that at least he did not ask me to clean his shoes.

Also, recipients do not permit sellers to go outside; they must stay home all day alone and always do what their recipient demands. There are some exceptions, however: a few sellers saw their recipients as well-behaved men who respected them and did not discriminate. These recipients eat meals with the sellers, walk with them holding hands, and promise to take care of them for the rest of their lives.

Some sellers face additional problems, as the Bengali communities in India often snoop around in their business. These sellers are always being challenged about to whom they are “donating” their kidneys. Although it is revealed in some cases that these “donors” are selling their organs, Bengalis do not argue, as many of them are also bringing sellers with them to India. However, they berated one seller for giving his kidneys to a Hindu rather than a Muslim. This seller, like others, restrained himself from fighting back because he was weak, was in a foreign country, and felt small about being involved in this unethical dealing.

However, Mofiz (41) was frustrated with the entire process; he fought with his recipient. As he told me:

The tests were going on for a long time in India. I was not happy so one day I protested. I told the recipient that it was not in our contract, as he stated in Bangladesh that everything was ready and the operation would happen in India right away. The recipient held my hand and requested me not to behave like this. The time was not passing by; one day seemed a month to me. So I asked the recipient for some money to watch movies and buy tea and cigarettes for myself. I thought if I could see the city and have fun, I would somehow forget my shameful action. But the recipient refused to pay any Paisa (pennies) and promised that he would give me money after the operation. I thought, how could I go to the operating room in sadness? How could I give away my kidney in pain? I
experienced the different face of the recipient in India; he was not taking care of me. However, I did not know what to do, so I chose to seek advice from a Bangladeshi there. This Bengali man suggested not giving my kidney to this foul recipient. As I could not speak English or Hindi, the man informed the doctor that I was a kidney seller, not related to the recipient at all. The doctor called in both the recipient and myself, and declared without explanation that I was unfit for the operation. The recipient’s face became dark; he could not decide what to do. I asked for my passport back for returning to Bangladesh. He told me to wait a few more days. The next day he sent a fax along with all medical reports to another hospital in Bangalore, and asked why the doctor rejected me although I was fit according to Bangladeshi results. The new doctor told him to come to his hospital. I did not want to go to Bangalore but wanted to go home. However, my recipient did not give my passport back and said I could try to cross the border without it. I was angry and warned him that I would inform other Bangladeshis here. The recipient then started crying, became soft, and promised to give me some pocket money from now on. I went to Bangalore based on his words.

In the above case, the manipulation goes both ways; in most cases, it is a one-way process from recipients to sellers. When sellers are discouraged, buyers take them to see historic places, such as Taj Mahal, Nandi Hill, or Emperor Tipu Sultan’s grave. They try to convince sellers that they are having a fun-filled picnic every day. This is how buyers try to balance the deal.

Feeling confused and depressed, some sellers decide to drink alcohol, a banned item in Muslim-dominated Bangladesh. They buy cheap alcohol and usually share it with other sellers, hotel caretakers, or hospital cleaners. As seller Mohabbat (27) indicated, “I saved money from the grocery and daily allowance, so sometimes I had beer or whisky as they were available everywhere in India.” One day, Mohabbat tried to return to Bangladesh after drinking alcohol with some Bangladeshis in a bar. He continued:

While drinking, I expressed to other Bangladeshis (two sellers and a proxy) my frustration and the obstacles for returning to Bangladesh, especially without a passport, which was seized by the recipient. My countrypeople felt bad about me, so they decided to help me out. I drank heavily that night. We left the pub and came to the railway station. One man bought a ticket for me. Another person gave the contact information of an agent who would help me to cross the border illegally. My recipient did not know that I was leaving; I could not even take my
clothes from his apartment. I stepped onto the train. When the train started, suddenly I felt horrible. I asked myself why I was cheating on the recipient, who had already spent a huge amount of money for my medical tests and trip to India. I could not face these questions, so I jumped off the moving train. I walked here and there and came back to the recipient’s apartment at about two in the morning. My recipient and her family were walking along the balcony. I was tense, but the recipient told her husband not to say anything about it.

Like Mohabbat, sellers decide they cannot escape because they feel sorry for the recipient, would feel guilty for leaving, and, most importantly, do not have passports in their hands.

Awwal, a 28-year-old impoverished seller, even fell in love with his recipient. He came to India to give a kidney to his friend’s sister. The recipient’s family could not arrange the money for a while, so both seller and recipient stayed in India for almost a year. As Awwal described:

Nazma (a 22-year-old recipient), her brother, and I went to India for transplantation. When all the medical tests were done there, the recipient’s family did not have enough money for the operation. So, Nazma’s brother left us to collect money from Bangladesh, but did not return for six months. Nazma and I stayed in a hotel. I took care of her and spent all of my time with her. One day she was seriously ill, so I carried her from the fourth floor at 2:30 in the morning to the hospital. The doctor saved her from this serious condition, provided oxygen, and admitted her to the hospital for two weeks. From then on, I did not let Nazma do anything, and I did everything, including cooking and cleaning by myself. Nazma’s brother sent money to my bank account there; whatever we needed, I spent from this account. Sometimes we did not have enough money, so I even borrowed money from other Bangladeshis and paid them back after receiving money from her brother. Other Bangladeshis thought that I was her real brother. We stayed together for six months so we developed some feelings for each other. I solved problems and fulfilled demands, whatever she asked. We fought at times, too. But when things cooled down, she asked me to bring her to the market. One day while I was watching TV, Nazma sat next to me and asked why I came to give my kidney and stay with her, leaving my family behind. I was locked into my obligation; I replied that I came to save her. She stated that I was sacrificing a lot, so she wanted to offer something in return. She promised that if Allah saved her life, she would be with me the rest of our lives. I did not respond, so a few days later she brought up the issue again. I told her, “How can I refuse you?”
Alas, after the operation, Nazma and her family flew back to Bangladesh, while Awwal, alone, took the train. Soon after, Nazma got married to a rich businessman, but died six years after the transplantation.

The reports from the medical examination come one after the other; sellers get scared that these reports might reveal some unknown health problems and they will be eliminated from the deal. Some sellers are devastated after being diagnosed with kidney stones, diabetes, hepatitis, or jaundice. These tests were undiagnosed in Bangladesh because brokers do not request all medical tests, in order to maximize profits. Consequently, a few sellers (particularly those with diabetes and hepatitis) are not candidates to provide a kidney and must return to Bangladesh. Those with kidney stones or jaundice, on the other hand, usually manage to resolve their health problems, but their operations must be delayed. Even these latter crises are difficult to overcome, as Jobbar (28), who had a kidney stone, described:

One day, the doctor informed me about my kidney stone. The recipient became upset and asked how did I get the stone? Broker Batpar argued that anyone could have stones from not drinking enough water. The doctor said that a kidney stone is not a big problem, as current medical procedures do not involve cutting the skin; rather, the ray would easily crush the stone. This doctor offered to provide my health care, but asked for 15,000 Rupees ($375) for the associated costs. Both the recipient and Batpar were very tense; they decided to think about it.

The following day, the recipient and Batpar took me to another specialist. After the examination, the doctor confirmed the stone in my kidney. He informed us that my kidney stone was very small, a little bit bigger than a grain of sand. The recipient was still despondent; he wanted to buy something clean and unmarked. Batpar argued that the stone was so small that the Bangladeshi ultrasound result could not detect it. The recipient was not convinced; he declared that if he had known about the stone earlier, he would not have brought me from Bangladesh. He was angry about spending thousands of Taka on me, so he left me with Batpar and did not visit me for two weeks.

I realized that they would not take my kidney and I did not have the financial means to crush it and secure my health. I could not eat, sleep, or cry. Batpar even
called his manager in Bangladesh and asked for another donor with the AB+ blood group, like mine. I was counting the days until I could return to Bangladesh. I was so miserable; one seller suggested that if each of nine sellers (who were all staying with Batpar) offered me 2,000 Rupees ($50) as a donation from their share, the problem would be resolved. I did not want to be in their debt and return back to Bangladesh with empty hands.

One day, the recipient’s mother came to me; I touched her feet in honor. She called me her son and asked why my face looked so pale. She agreed to pay to crush my stone, saying that Allah gave them enough money. Batpar told me that my recipient would not take my kidney, but his family was taking care of my health because they felt guilty. Batpar claimed that he persuaded the recipient to take care of me. I was glad that at least my health problem would be resolved. He advised me to drink at least 6 liters of water daily; I drank more.

During the operation, when a needle-like thing entered my body, I felt pain. The doctor then stroked the stone about 25 times. He gave me medicine to dissolve the stone. He declared that the color of my stone changed, but it would take time to be removed entirely. Eventually, the doctor recommended that the recipient take my kidney as our tissues matched well.

The recipient paid for my entire treatment; I owed him so much that I was grateful to give my kidney without any hesitation. He revealed that he had already talked with the doctor about taking my right kidney instead of the left one with the stone. But the doctor opposed this idea, arguing that the donor could be sick or face health problems after the operation; he did not agree to put the donor in a vulnerable situation with only a more vulnerable kidney. As the recipient was hesitant to take a kidney with a stone, I promised him that if he could manage the doctor, I would give away the stone-free one.

After the removal of my kidney stone, the recipient’s care of me was way beyond my expectations. I could not comprehend the reason for this amount of care, even though his maid once mentioned that the recipient was doing it to protect his own interests. One day, I found out that the recipient paid for my stone to be crushed to keep me in his hand because I was his standby. He was trying to arrange another AB+ donor with matching tissues from Bangladesh. Batpar also tried to provide him with a stone-free kidney because he wanted to maintain his business reputation. In Dhaka, the recipient’s brother managed to find a seller, but this person became very worried and did not come to India. Batpar lied to the recipient, saying that he had brought a seller to Calcutta, but failed to bring him to Bangalore. I became angry at the recipient for hiding his actions from me. He then promised to take my kidney after all, as it was taking too long to arrange for another seller. Regrettably, he started stalling on me again.

One day the recipient said he would take my kidney, but the next day he told me he would not. He wanted to discuss it with his brother in secret, so he asked me to
leave the room. I was mad at the recipient as he broke my heart. He promised again but kept trying to find a spotless kidney. This time I asked for his final decision. In two days, he arranged a blood test just to make me happy and show me that he was initiating the operation. I could not stand any more of this, so I asked for my passport back so I could return to Bangladesh. Only then did he take me to the doctor to finalize the operation date. However, the doctor was going on holidays, so we got an operation date three weeks later. In the meantime, the recipient, his family, and Batpar tried their best to attain another seller, but failed, so they had to depend on me. The recipient did not consider that it was a bonus for him to survive even for a day, but instead tricked everyone to prolong his life to the maximum level.

Buyers fix sellers’ health problems out of their own interests, but later deduct all of these healthcare costs from the fixed payment, without informing sellers about this deduction. Sellers do not have consent or control over the buyers’ decision.

Sometimes the tests reveal that recipients have other health problems, such as tuberculosis, jaundice, or hepatitis B or C. As a result, sellers suffer as the operation date is delayed until the recipients’ recovery. I discovered three cases in which a recipient with hepatitis C had difficulties going through the operation; one of them later transplanted the kidney at Islamabad in Pakistan, another switched to a new hospital and had the operation performed in India, and the last one needed to return to Bangladesh. Consequently, some sellers could not complete the deal because of their recipients’ health problems.

Five sellers (all of them Batpar’s clients), like Dildar (32), returned together without having the surgery for various reasons. These sellers did not need to pay back the money that the buyer spent on them. Some sellers could not obtain their health reports from the recipients. Consequently, Joinal (37) stole his medical reports and made

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65 Sellers asked recipients to request these health reports for future attempts, but recipients said they were the owners of the reports because they had paid for the exams.
photocopies while his recipient was taking an afternoon nap. These returning sellers feel they have wasted a lot of time and have nothing to show for it.

Finally, buyers and the sellers who have passed all the tests up to this point go to see the doctor, who verifies all medical reports and asks for the last test, the CT scan. All sellers are worried about the CT scan, which they find daunting; buyers, meanwhile, consider it expensive. Gofur (41) described his experience:

I signed a paper for the CT scan and entered the laboratory room. Three machines were there; I was inside one and a corpse was in the one next to me. The machine looked like a coconut tree. It had a very weird sound; I felt somebody was digging my grave. If my feet were not tied up with belts I would run. My whole body was shaking and sweating, so I screamed. A doctor came and relieved my tension by informing me that the corpse was of a young man who had died a week before, and the medical team was identifying the cause of his death through a CT scan. I was still scared, but successfully followed the instruction of breathing in and breathing out. After the exam, Batpar told me that the doctor saw both of my kidneys through the CT scan. The recipient advised me not to move and to rest for at least two days. I felt like I had survived my death.

Going through medical testing is a long and difficult experience. Sellers are glad when the tests are completed and relieved to know that their bodies are free of disease. Although they have mixed feelings about giving up a kidney, they believe themselves to be fortunate after competing with other sellers to win the race; they hope that through boundless support from their recipient, their lives will improve drastically. Even if they do not achieve anything else in life, they think they will be heroes for saving a life. In any case, they realize they cannot turn back at this point. They prepare for their operation with a blend of hope, heroism, frustration, and guilt.
Preparing for the Operation

To finalize the operation date, sellers must meet with an authorization committee and validate that they are donating rather than trading their kidney. (However, some said that they did not come before the medical board at all. They easily pass this step because “it is a set game,” as they called it.) The medical board usually consists of doctors, government officials, and lawyers, and the meeting lasts on average ten minutes. Buyers submit all the false supporting documents, which were prepared in Bangladesh and arranged with the support of a bribed liaison officer in India. Buyers must also submit a certificate, which they easily obtain from the local Bangladeshi High Commissioner, indicating that the recipient and donor are related. Fearing that the medical board might turn them down, recipients make sellers memorize their new identities, while Batpar manages the hospital authorities beforehand.

In the medical board interview, some sellers are asked a few questions. It is an easy procedure, as Dildar (32) described:

When I entered to meet the board, I was worried but was relieved soon after, seeing my recipient and Batpar. The doctor just asked my name, father’s name, and the relationship with the recipient. That’s all. Everybody knew what was going on; we were not real brothers. Anyone can read a face. Our faces were different, and so was our status. If the board members had been strict, I would not have been able to pass the interview with the false identity. In fact, they just maintained the formalities.

Like Dildar, some sellers state that Batpar was with them at the medical board, which reflects how everything is covered up. Nazrul (27) stated that he disclosed to the doctor

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66 Sellers do not need to go to the Bangladeshi High Commission in Calcutta; recipients easily arrange the certificate that indicates kinship between recipient and seller. Most recipients submit the sellers’ passports, notary certificates, and other documents, and pay about 100 Taka ($1.50) to obtain the certified paper. The recipient usually collects the paper during the stopover in Calcutta; a few, however, were unaware of this step so they had to return to Calcutta from South India to obtain the paper. Sellers said that Batpar never collected this certificate.
and nurse that he was Muslim, but he easily passed the board because his passport name was Hindu. He also mentioned that during his stay in India he met 15 other sellers, all of whom passed the medical board with no problem. The sellers claim that the committee members know about the deal, but choose to overlook it because they gain financially from it. This claim proves valid according to a recent article, which indicates that the authorization committee in India could not successfully implement the Organ Transplantation Act because middlemen and service providers cut corners for commercial interests, and authorization committee members overlook fake documents, do not follow a standard procedure, and are being pressured in various ways (Muraleedharan et al. 2006: 47-49).

In Bangladesh, sellers also face a medical board, which is a formality as well. Bangladeshi nephrologists assured me that they are “extra careful” when verifying that the recipient and donor are related: sellers need to obtain signatures from five people, including a nephrologist, an urologist, a psychologist, and a social worker. However, one of the social workers told me that she just followed the order from the chief nephrologist: when she saw his signature, she approved the file. She had not rejected a single case in her entire career. When I guaranteed her anonymity, she disclosed that she was not aware of the Organ Transplant Act existing in this country, and asked me for a copy of it. Bangladeshi recipients also say that the system functions through deceit as it formalizes deals.

However, in Thailand and Singapore, as well as in renowned hospitals in India, sellers are comparatively well interviewed by the medical board, as I learned from the sellers’ comments. Board members ask and verify many facts, such as name, occupation,
income, parents’ and siblings’ names, date of birth, spousal consent, and reasons for donation. They also challenge sellers by informing them about the many risks involved in the operation, the huge length of the scar, and health consequences of donation. When sellers fail to handle the situation wisely and answer questions improperly, board members inquire further. Nonetheless, sellers pass this interview; because they do not understand the questions in English, recipients correct the sellers’ answers while translating.

At the end of the meeting with the medical board, sellers sign some papers in front of the authorization committee. These papers are typed in English; sellers sign them without comprehending them. If they later inquire about what these papers said, buyers reply that they are merely declaration forms stating that “The donor is donating a kidney willingly. If s/he dies in the operation, nobody, not even his/her parents or hospital authorities, is responsible.” Sellers feel sad thinking that they may have just signed their own death warrant.

The Indian government recently implemented DNA testing to verify the recipient’s and donor’s relationship. However, the sellers I interviewed who had the DNA test said that buyers obtain a successful report by bribing hospital authorities, as Dildar (32) recounted:

My recipient was worried about the DNA test, but Batpar managed everything. He knew the doctors and hospital officials. He gives them enough business that they treat him as a client. Everything happened in front of my eyes. Batpar made the deal and told the recipient to pay 42,000 Rupees ($1,000) to the doctor’s clerk. Of this amount, 10,000 Rupees ($250) was doctor’s fee, 10,000 ($250) was for Batpar, and 22,000 ($550) was for the test. The recipient deposited the money and submitted copies of all the fake documents. Then both the recipient and I gave blood at the hospital. The recipient told me not to worry, as the result would be manipulated by the bribe. The hospital sent the test to Bombay; after one month,
the result came back without any concerns. They could easily make you a brother, a sister, a father, a mother, and a wife.

Sellers who deal directly with their recipient also say that there are Indian brokers (mostly female) who negotiate between recipient and doctor to fix the DNA deal. Sellers claim that almost every Bangladeshi brings unrelated sellers and easily obtains successful DNA results with bribes. This situation indicates how people manipulate the system for their own interests, a common practice in South Asia and beyond (see discussion on corruption in this section’s introduction; Gupta 1995 & 2005). When a seller’s DNA is matched, friends want to celebrate this special moment with sweets. Sellers ask buyers for some money, but instead of buying sweets they buy mangoes, which are cheaper. “The mangoes were sweet, unlike the buyers,” as Dildar (32) put it.

Some sellers said that their DNA did not match in the first attempt. The buyer therefore hid the blood sample in a different location and paid extra to manipulate the report in the second try.

In spite of the high levels of corruption, not all sellers can match their DNA to their recipient. Four sellers had to return to Bangladesh, but later managed to sell their kidney to a different recipient. Keramat (25) suffered when he failed the DNA testing. He described his bad experience:

When Batpar told me that my DNA test did not match, my hands were on my forehead the whole time. I was in deep trouble. I lied to my wife that I had been working in a different city, so how could I come back home without money? I was better off before, but now I had lost my job. My wife had not been able to pay rent for a few months and was getting groceries on credit from the variety store. How could I pay back these loans? When I had no way, Batpar fortunately arranged a job for me. I started working as a maid for a Bangladeshi recipient who was waiting for his transplantation. This recipient was a high police official whose wife returned to Bangladesh to secure her job. The recipient agreed to pay me 8,000 Rupees ($200) a month, and promised to offer me a job after I went back to Bangladesh. I was worried about the payment; Batpar claimed that the
recipient was so trustworthy, he himself would disburse if the recipient did not pay my salary. It did not take long to realize what a bad decision this was. A month passed, but the recipient did not allow me to enter his room. He told me to knock on the door and leave the food on the table next to the door. I obeyed his orders. He was inside the room watching TV all the time, while I looked out the window of the other room and watched the cars pass by. I cooked all day and slept in one place. Sometimes the recipient went out, but he locked me in from the outside. Even when he was at home, I could not go out. It was like being in a prison. Each month, when I asked for my salary, he promised to give it all after we returned to Bangladesh. When I went back home after a few months, he forfeited two thirds of my salary. When I complained to Batpar, he denied promising to give me the money if the recipient reneged, but, thankfully, found another recipient for me.

Clearly, sellers face diverse difficulties as they go through the various stages of the deal.

Finally, after months of testing and waiting, the operation date is set. However, it is often delayed for two reasons: i) getting access to transplantation is not easy in India due to the high volume of clients, and ii) the recipient must deposit a large sum of money, and most have trouble arranging and transferring it to India. Sellers remain as positive as they can be, believing that this could be their only hope in their entire lives. As one seller said, “Life is like gambling. All one needs is a hope to win the lottery.”

Still, most are not at peace. Some behave oddly, like Tofail (27), who felt that he was going to die in the operating room so he started laughing loudly during the remaining days of his life; his recipient was worried by this extra but strange happiness.

Out of the 33 sellers I interviewed, only two received full payment before the surgery, even though buyers had promised it. Farid (28) received 90,000 Taka ($1,300) before the operation, which was performed in Bangladesh. He told me that he had not touched the money, because the recipient had deposited it with a friend. Only Sodrul (22) received payment before the operation in India, but he was treated harshly by Batpar in
the process of obtaining it. This college student told me that the broker beat him up, assaulted him, threatened him, and forced him to have the operation:

When the operation date was fixed, I asked Batpar about my payment. He asked me how much we had agreed upon. I told him 120,000 Taka ($1,700). Batpar argued that he could not give me this much because he had received less than expected from the recipient; he agreed to pay me 100,000 Taka ($1,450). He declared that if I would accept the offer, that was good. If not, he could not do anything for me. When I asked for payment, he bit his tongue. He said he would pay the money after the operation, even though he had already received the payment from the recipient.

I thought I might not get any money for selling my kidney, so I did not want to give my kidney. Batpar argued that both of my kidneys were running after the CT scan, so it would be risky not to have the operation. I wanted to return home but Batpar declined to give my passport back. He told me to leave, knowing that I could not go anywhere without my passport. I was helpless because I needed at least 3,000 Rupees ($75) to come to the border and risk crossing it. I was worried about what I should do.

The following morning, I sought advice from another Bangladeshi recipient, who suggested filing a case against Batpar to the Indian police. He added that the Indian government would arrange my trip back to Bangladesh, but if not, he would help me out. I went back to Batpar and asked for my passport back; if he did not give it to me, I would file a case, I warned. Batpar wanted to discuss this with me in the evening. At 11 p.m., he came with two hired local mastans, musclemen. All of them were drunk. They instructed the other sellers to leave the apartment and told me to stay there. Batpar told the musclemen, indicating me, “This piglet was giving me a very hard time; do whatever you want, either lock or slice him.” The bigger man punched my face while the other kicked me when I fell down. I could not understand their Hindi language but realized they were calling me a son of a bitch. Batpar said that if I would not sell my kidney, they would kill me tonight. One muscleman took out his long dagger. Batpar then told me to sign a statement. He wrote on a paper: “I have decided to give away my kidney in exchange for 100,000 Taka ($1,450).” I just signed it. He told me to sign another blank page and I feebly followed his instructions. I started crying after becoming a puppet in Batpar’s hand. I realized that I had to give away my kidney, even if Batpar would not pay the money.

Before leaving, Batpar told me he would give me 75,000 Taka ($1,050) before the operation and 10,000 Taka ($145) after the operation. The rest, 15,000 Taka ($215), would be deducted for my transportation and accommodation costs. He declared that if I told anyone this, he would not let me enter Bangladesh alive: it would be easier for him to kill me here. That night I told two other sellers who had become friends of mine. They were also worried about their payment but
were scared of Batpar, so they did not open their mouths. I realized that we could not do anything against him.

The next day, I opened up to my recipient. He refused to help me fight with Batpar. He said that Batpar is a very powerful man, even in Bangalore. His network is very wide, as he had been dealing with this type of illegal activity for a while. He looks like an ordinary person, but he is very clever and extremely dangerous. He is very familiar with and connected to underground channels. My recipient claimed that Batpar would harm him if he helped me. He also said that Batpar arranged operations for powerful people in the country. If Batpar needed help, these people would cover him out of their own interests. I realized that nobody could do anything against Batpar: whatever he says, everybody must accept it. Above all, I had already signed a blank paper. I could not even file a case against him in Bangladesh, as it would be publicized and my family would know about my shameful action. It would not solve my problem, but rather make me shameful in front of people for selling a body part.

I was completely doomed, so I decided not to fight back with Batpar. However, he did not offer me enough food after this incident. Unexpectedly, two days later Batpar came to me and asked whether I preferred to receive payment in US dollars, Indian Rupees, or Bangladeshi Taka. I asked for US dollars; he gave me $1,000 (about 70,000 Taka) and 5,000 Rupees ($125), even though he received 400,000 Taka ($5,700) from the recipient. I did not know where to keep this money. I could not hide it in the apartment, as anybody could take it. So, I deposited it with the recipient, even though I did not want to. The recipient did not take care of me either and behaved like a rich son of a bitch. However, he was the better of the beasts.

The above case shows how buyers try to maximize their profits at the expense of sellers.

If sellers disagree and decide to return home, buyers refuse to give their passports back. Sellers have no money to travel back and no connections to cross the border illegally; they are trapped like “fish in a net.”

All sellers were skeptical about whether they would receive payment after the operation. When challenged, buyers argue that sellers could neither carry the money into the operating room, nor leave it with somebody, nor open a bank account abroad, so it is safer for them to receive payment after the operation. A few sellers remain unconvinced, so they ask to sign a written document. Buyers do not accept the sellers’ proposal.
Instead, they promise while holding the holy Koran to pay after the operation and repeatedly say how grateful recipients are to the sellers for saving their lives. Sellers, having no bargaining power, must agree to these conditions.

Just before the operation, some sellers are faced with terrible news. Shofi (25)’s 72-year-old recipient died just two days before the operation, which was to be done in Malaysia. He described what happened:

I was sitting next to my recipient when he was having dialysis for the last time before the operation. All of a sudden, he did not feel well and did not want to continue the dialysis. His health deteriorated; he looked pale. I called the proxy (his manager) and told him to come quickly. I came back to the dialysis room. The recipient was hastily moving his body. A nurse took out all the needles and turned off the dialysis machine. She and I took the recipient to the Intensive Care Unit (ICU). I did not know what to do. The proxy arrived right away and we took care of the recipient.

He was in the ICU for three days. We came to see him every day. One day his situation deteriorated, so the hospital authority called us at two in the morning. We rushed to the hospital. However, due to the restriction on visitors, only the proxy was able to go upstairs. I stayed in the waiting room. The proxy came after half an hour and told me the bad news. My heart shattered and I started crying. It was a very sad moment in my life. I went upstairs to see the recipient. I could not believe that he had died. He was better off, but it happened so suddenly that I could not take it in. I saw his pain in dialysis. His death was in front of me. The proxy arranged to bring his body back to Bangladesh. He asked whether I would stay in Malaysia. He could help me to find a job and I would not need to sell my kidney. However, I did not want to settle there because of this painful memory and the uncertainty of living illegally there.

I went back to Bangladesh. At the airport, the proxy took my passport, saying he might need it. After returning, I realized that what I had gone through was the worst incident in my life. I had come so far, but Allah did not let me complete the deal. My recipient died, which was a bad sign for me. So, I decided not to try to sell my kidney anymore.

I faced hardship in those days. I had already lost my previous job and could not find another one for the next two years. I studied only to grade V, so it was difficult to get a job with incomplete schooling. I borrowed money from friends and somehow survived. In this hardship, one day I was in the barbershop and noticed an advertisement with HLA numbers in the Jugantor. I took the newspaper and held my HLA number beside it to match them. The advertiser had
A10, B57, and 58 tissues, and I had A11, B57, and 58. It almost matched. What should I do now? I was passing time without a job. I had borrowed a lot of money but spent it all believing that I could easily pay off the debt by selling my kidney. So, I called the advertiser and sold my kidney to this new client.

This case shows that once a seller is in the game, he or she keeps trying for the dream of a better life from such lucrative offers is hard to resist. Another seller, Tofail (27), who also experienced the death of his recipient, tried for a second kidney transplant in India. He outlined what happened:

Before the operation, the recipient’s health condition was not good and he was vomiting. I asked myself why I was here, when this old man could die anytime; he had already had another kidney transplant before. The doctor did not give us any hope for his survival. Now I started prayed to Allah for his survival and for my benefit. If he stayed alive, I would survive, too. Both of us were tense. Although the recipient became healthier after receiving some blood, it was his last stage; he died within a week. I felt like there was no ground under my feet.

As we can see from this case, many recipients do not disclose their ages and health conditions but attempt to save their lives by obtaining fresh kidneys from younger sellers, usually in their early 20s. In sum, three sellers said that their recipients died after such long attempts and high hopes.

_The Red Theatre_

The “fortunate” sellers – the ones whose recipients are strong enough for transplant and who are healthy enough themselves – eventually enter the operating room. Sellers are terrified about the surgery, as well as concerned about what will happen to their bodies if they die. Knowing that they are worried, buyers encourage sellers in many ways. Still, sellers feel as if they are committing suicide, but at this point they cannot turn back.
The day before the transplantation, both parties are worried about the operation but relieved that the moment has arrived at last. Everyone is emotional at this final stage. Recipients and their families take care of sellers exceptionally well, as Jobbar (28) described:

The recipient’s mother came to meet with me before the operation day. She was delighted that I was saving her son. None of her family members wanted to donate. Therefore, she treated me as a great person, bigger than anyone in her family, as if I am more than her son. I replied that I left my mother in Bangladesh, but now I had got a new one. In my early childhood, I held my mother when I felt scared or ill. My mother held me with her saree’s anchol (the end of the cloth), so I would not be scared. I asked my new mother, would you cover me like the banyan tree? She promised to resolve all of my problems after the operation and asked me not to keep any bad feeling inside.

At this time, recipients encourage sellers by giving them more hope that their demands will be fulfilled and more promises to support them for the rest of their lives after the operation. They also admire the greatness of sellers for saving their lives.

It is extremely difficult for sellers to feel a sense of triumph at this stage. All they can do is try to be strong enough to complete the deal. They rationalize that they are making a sacrifice for a better life, not only for themselves but also for their families. For this reason, they feel that they are doing nothing wrong – rather, they are saving a life. They also believe that in the operating room, Allah will help those who save the lives of the vulnerable. They believe that if something bad happens accidentally during the operation, Allah will forgive them and send them to heaven for their sacrifice. They keep their trust in Allah, as he is the supreme authority. Some sellers do a nofol roza, special fasting from dawn to dusk, for Allah’s blessing. Recipients’ families also pray to Allah and recite the Koran; even Batpar promises to fast on the day of the operation. Sellers are glad they will be free of such a stressful situation once the operation is over.
Nonetheless, sellers are miserable inside; they are terrified knowing that their operation will be performed in a matter of hours. Many of them do not feel like eating, so their recipients invite them to a nice restaurant, and try to please them by buying them food and providing goodies. Sellers, meanwhile, are exhausted and frustrated thinking about why Allah made them poor and made them go through such a horrible experience. To help himself forget for a while, Mohabbat (27) boldly asked his recipient for 500 Rupees ($12); he used the money to buy a 500-ml bottle of whiskey. As he described:

I felt terrible on that day as I was selling my kidney. Many thoughts came to my mind. I did not want to talk with anybody; rather, I felt like leaving this place and forgetting everything. I bought a bottle of whiskey, finished it all at once, and slept alone. I did not disclose it to the recipient, but he probably noticed, as they were in the next room. His family asked me to have lunch but I could not get up. When I woke up, I rushed to the hospital.

Sellers are admitted to the hospital with a feeling of deep sorrow.

In the hospital, their illusions break down. Their bodies shake relentlessly and nothing can calm them, even though by now they are familiar with the hospital environment. They realize that they are taking the biggest risk of their lives. They understand that one of their body parts will be lost to them forever. Even though doctors and buyers tell them that there is no physical harm, sellers believe that their lives will be riskier with only one kidney. They dwell on the fact that they will not be able to live as they used to; they might not be able to play cricket or run or lift heavy loads. They become restless and upset, even when recipients repeatedly say that the sellers’ action is noble because it saves lives and helps others. As Mofiz (41) said, “I did not want to listen to the same record again and again.” Sellers realize that everything – including the operation, receiving payment, and post-operative health – is uncertain. Sellers think they are making the biggest mistake of their lives and that they will have to pay for it. They
ask themselves why they came here and why they are doing such a thing. Yet, they know they are trapped: they can neither back out of the deal by leaving the recipients behind, nor run away without their passport. At this point, their fears far exceed their hopes.

It is a heartbreaking story. While recipients are surrounded by their families, who traveled from Bangladesh for the operation, sellers cannot even phone their families because the buyers will not permit it. Sellers are alone. Even Batpar is often not there to keep them company, as he goes back and forth to Bangladesh on business. He at least calls them and assures them that everything is set for the operation. Many sellers ask him to come to their operation, as he had promised; he falsely states that they will see him when they first open their eyes in the Intensive Care Unit. Some other Bangladeshis, including sellers, donors, and recipients who are there for transplantation, come to visit sellers; they offer support and prayers as sellers ask them for *doa*, or blessing. Most of the sellers they came with have already left after their operations; the remaining ones are waiting hopelessly for their turn.

In the renal ward, sellers and recipients are admitted to the same room. Both are silent as they lie next to each other. Nurses make rounds every half hour. Both sellers and recipients take some light food for dinner, as they cannot eat any food afterwards in preparation for the surgery. Nurses then hook them up to saline drips. Sellers feel very irritated about everything: for example, Mofiz (41) kicked a nurse who poked him three times looking for a vein. Nurses pat and encourage them, saying how successful organ transplantation is in this hospital. In the late evening, a doctor visits them and tells sellers that the operation will be performed on the left side of their body. Sellers become so terrified that nothing calms them down.
When night arrives, “it is like hell.” Sellers are unable to close their eyes the entire night. They stare at the white wall in the renal ward. They feel nothing, see nothing, hear nothing. They wait anxiously during the last few hours before the operation. The time passes quickly, unlike their year-long wait for a matching tissue. Although it is a nightmare for sellers, it is a happy dream for recipients. When the night is over, sellers will be the saddest beings, but recipients the happiest people on the planet. As of the next day, sellers will be weaker, while recipients will be healthier.

Sellers and recipients support each other to get through the night. Both think constantly about what will happen in the operating room. When one is terrified, the other offers encouragement. Sellers tell recipients that they will return to Bangladesh together, emphasizing the hospital’s successful transplantation rate. They also say that if something goes wrong for themselves, their parents will be fine because they have more siblings. Likewise, recipients cite astakferullah, or mercy to Allah, and ask sellers for forgiveness if they did anything wrong. Many promise sellers that they will make the payment if the broker cheated them; sellers ask recipients to make the payment to their families if they die.67

Sellers think constantly about their families, who are far away and unaware of their actions. They feel guilty for not being able to follow their parents’ advice – that “people who pass schooling, one day they will ride the car.” The night before his surgery, Mofiz (41), whose sister died after finding out about his selling, thought about his sister. He saw her face in a flashback in a dream. Keramat (25), whose little brother asked for a toy when Keramat left Bangladesh, wondered whether he would be alive to give the child

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67 Some sellers worried that their families would reveal their action after receiving the payment, so refused this idea. They argued that their families should not use money earned by their death.
a toy. Sellers realize that if they die on the operating table, their children will be orphans, their wives will be widows, and their parents will lose a child.

Sellers believe that upon their deaths, brokers will not send their bodies to Bangladesh because of the expense, and their families could not bring them back because of the secrecy involved. Therefore, some sellers ask their recipient to send the body to their families without disclosing the kidney deal. Others ask recipients to bury them in an Indian graveyard, believing that otherwise their families would face trouble for the sellers’ disgraceful actions.

Sellers see God as the owner of their bodies. Nozrul (27) and Hiru (38), whose recipients belonged to a different religion, were especially worried about their actions. All sellers feel ashamed. They believe that God is watching them and they are selling his gifts in front of the giver. They are unable to answer many questions: Will Allah ever forgive them? How will they return his property? What will they say to him in the afterlife? Even though sellers are miserable that night in the hospital, they are still able to perform a special namaz, or prayer, as they are hooked up to a saline drip. They raise their hands to Allah and recite Islamic stanzas, hoping he will save them in the operating room.

The morning of the operation, sellers begin to cry. They predict that their tears will not stop until the day they die. As Dildar (32) described this moment, “When a fox catches a chicken, the little one cries. I was the chicken, and the buyer was the fox.” Like Dildar, most sellers wept while describing the operation to me, while some did not even have words to express their feelings.
Sellers have much to do to prepare for the operation on the day. The hospital boy shaves their bodies from chest to knee and washes their left side well; sellers then take a shower. Awwal (28) was so traumatized that he accidentally hit himself on some metal in the bathroom and needed a bandage to stop the bleeding. Sellers try to behave normally, but “it is hard, very hard.” Their heads spin. Sodrul (22) was terrified, believing that his recipient would die at any moment:

My recipient’s health deteriorated at four in the morning. He was vomiting and shouting. A nurse called the doctor, who prescribed some medication and told us not to worry. However, the recipient became nearly senseless after taking the pills. I thought it was game over. The doctor came at dawn and instructed the nurses to prepare everything for the operation.

Sellers are shocked to find out that they will be under the knife first, while the recipients who will get their kidney will have their operation later.

Zero hour arrives. Nurses put sellers on a stretcher, cover their hair with a cap, and tie them down with belts. Sellers feel like a kurbanir goru, a sacrificed cow purchased for slaughter on the day of Eid. The stretcher finally starts moving. Sellers pass room after room filled with equipment. The people they pass look anxious. Sellers are unable to ask the stretcher man where they are going. The man takes them to the elevator and the stretcher bangs the inside. Sellers float in the capsule. After they traverse a long corridor, the stretcher stops in front of a big door.

When the door opens, sellers are surprised to see bright lights and lots of equipment; the room is so bright, it is like daylight. Nice music plays. About 15 people are busily working there; none of them talk to each other. All of them are incognito in masks and aprons; sellers cannot identify any of them. A masked man welcomes sellers and verifies their name. The man takes their blood pressure, puts one hands on the
sellers’ forehead, and then leaves. In a few minutes, two other masked men push the stretcher again, place sellers in a bed, and cover them with a white sheet. Sellers see a bright light on their faces; their heart starts beating faster and they recite *kulhuallah sura*, a stanza from the Koran. One masked man asks sellers how they are feeling. Sellers say they are cold and ask for the air conditioning to be turned off; the masked man covers them with blankets and pushes a needle into them. Then around ten masked men line up by the bed. Although sellers cannot move, they try hard to open their eyes. Some masked men start talking. One touches the seller’s body to check the pulse; he asks for another injection. Sellers shiver from the cold feeling; it is almost as if they are in a refrigerator. In a few minutes, one masked man says that the dose of anesthesia is ineffective; he asks to raise the dose and another injection is given. All of the masked men crowd around and the sellers can no longer concentrate on them. The lights become blurred; the seller can no longer see or hear anything. They can only remember that one masked man put an oxygen mask on their face. Still, they cannot decide whether they lost consciousness because of their panic or because the masked men made them senseless.

At one point, sellers see a red room. They are waking up in the middle of the operation. Dildar (32) shared his experience:

I saw five to seven people sewing and stitching my body. Their hands were covered with blood. I felt scared but did not feel pain. What was happening? Somebody loudly stated something, like that I was returning to my senses. He gave me two injections at once. I closed my eyes and the operation was done.

Awwal (28) sensed his blood dripping from his body as somebody was taking out his kidney, but could not open his eyes. At this point, sellers still seem to see the operation as a bad dream.
A Rough Cut

Sellers wake up to an intolerable sharp pain; their body burns as if on fire. Their belly is heavier, as if someone put a big weight on their stomach. Although they are scared, they cannot make a sound; they can only hear that someone is coming towards them. A nurse gives them an injection and they go back to sleep. When they open their eyes again, the unbearable pain returns. They can neither move nor lie on their side; if they cough, they feel their bodies exploding into pieces. They see that their abdomen is covered in bandages; they place their hands on the bandages to ease the pain, but the nurse moves their hands off. They are so thirsty they could drink the entire ocean, but the nurse will not give them even a drop of water. If they had known they would suffer from such pain, they would never have given away their kidney even in exchange for lakhs, or millions, of Taka. Sellers feel that they should have died on the operating table; they start to weep. Now they would gladly have worked at the worst job in life instead of coming here; they decide to tell other prospective sellers about the pain. Their physical pain intensifies when added to their mental pain thinking about their families. A nurse gives them another injection; the pain is relieved, but only for a short time. Even now, all the sellers I interviewed vividly recall this severe pain. They remember staying in a soundless room with the television switched on but muted. They could not distinguish between day and night or even remember the date. They frequently ask nurses the time, but cannot comprehend how time almost stopped there.

The following morning, a doctor thoroughly checks the sellers’ health. He listens to their heart, checks their blood pressure, and asks a nurse to test their urine. The doctor is not keen on offering medication, even though the sellers are in terrible pain. He is
satisfied with their progress despite the fact that they can neither eat nor go to the toilet. Nonetheless, sellers are relieved to see their recipients lying next to them; the operations were successful and they are both reborn! They pray to Allah, who saved them from death’s door. They are content knowing that their kidney is keeping someone else’s body alive. They notice that they have strange similarities with their recipients now, as if they are real siblings. They ask recipients how they are feeling. Recipients gratefully say that they got a new life because of the sellers’ invaluable gift; they promise to keep the relationship for the rest of their lives. Visitors cannot enter the ICU unit, so the recipient’s family and other Bangladeshis wave to them from behind the glass.

The doctor asks the sellers to walk. They are scared at first, as their body is like a bow and they cannot straighten up. The doctor and nurses tell sellers how to stand up, but they still feel pain in their abdomen. Very slowly, they take one step, then rest, take another step, and finally walk. The doctor takes out the catheter so that sellers can pass urine normally. For the first few days, sellers can take only liquid nourishment, such as lantern soup, juice, milk, coffee, and tea. Ward boys sometimes wash the sellers’ entire body with a sponge. Nurses change the bedsheets regularly. Sellers are pleased to discover that the Indian hospital is very clean, unlike the Bangladeshi ones. After a few days of recovery, sellers are transferred from the ICU to the renal ward.

Usually on the third day, the doctor removes the bandages. Sellers are terrified; they do not wish to see their wound. Finally, they notice a rough cut of 18 to 20 inches, sweeping from their back to their belly; they scream in fear. They do not know that if the recipient or broker had paid only 8,000 Rupees ($200) more, the surgeon could have used laparoscopic surgery, which requires an incision as small as 4 inches. Even today, sellers
cannot comprehend why the recipient has a small scar in spite of having a more major operation. (Sellers think that the recipients’ operation is more complex because the doctor must remove both their kidneys, then replace them with the new one, whereas the sellers’ operation is simple because the doctor only removes a kidney). The scar becomes a symbol of the sellers’ pain; whenever they look at the scar and its surrounding stitches, they suffer. Sellers see the stitches as staples, 33 or more of them. They are afraid: how can they hide this rough cut from their families? They have neither the strength nor the words to answer their family if the scar is revealed.

Sellers slowly notice a difference after the operation. Recipients’ families take care of sellers for the first couple of days, but gradually become busy with their loved ones. Jobbar (28) shared his dissatisfaction:

I did not have an appetite and disliked the hospital food, but the recipient’s mom was not taking care of me at all. She was bringing milk or whatever she could every hour for her son. It was so apparent that we were brothers. One nurse even mentioned to her, “You have two sons but you always take care of your elder son; what about your younger one?” The recipient’s mom replied, “I do not know what to do. The older one is sicker than the younger one.” I then realized it was a bad decision to give my kidney to this family. It was not even a week and I was already getting this kind of return.

At this point, when they ask something of the recipients’ families, sellers are advised to talk with Batpar, who is usually in Bangladesh. Recipients think that since they already paid the broker, they are not responsible for looking after sellers. Meanwhile, brokers leave sellers at the buyers’ mercy to maximize profits. Thus, sellers are sandwiched between brokers and recipients: they must ask their recipient for support, but do not receive proper care from them.

Sellers complain to Batpar about recipients and their families when he calls. He advises sellers not to ask anything of them, but does not make any effort to help them,
either. He falsely promises to come to the hospital before the sellers’ departure but does not bother, especially since the deal is done. Many sellers mentioned that Batpar did not visit them in the hospital even though he was in India. When sellers call, he promises to bring milk and fruit but usually does not show up. After several reminders, Batpar gives a little money to his employee to take care of them. Sellers are helpless; they are pleased to receive care from the nurses. All sellers are surprised to see how Indian nurses are different, as Jobbar noted: “They are from a different religion, but they care for human beings.” Nurses are sellers’ only “family” there.

Buyers’ behavior continues to deteriorate after the operation. Some buyers transfer sellers to cheaper accommodations, having them released from the hospital earlier than they should be after having such a serious operation. As Jobbar (28) said, “The ICU charge was 1,650 Rupees ($40) per day, so the buyer immediately transferred me to a ward for 600 Rupees ($15), and managed to release me from the hospital in four days to minimize his cost.” Most sellers also claim that in order to save money, buyers do not provide enough medication. Jobbar also noted, “When I asked for medication from the doctor, he just said that walking is my only medication. When I asked him again, he prescribed some medicine to continue for a month, but the buyer bought my pills for only a week.” Some sellers believe that doctors do not prescribe them enough medication, or they prescribe cheaper pills to make buyers happy. As Jobbar added, “When sellers screamed for pain they received cheaper pills, but when recipients suffered they received an injection right away.” A few sellers receive certain pills just after the operation; none receive any type of medication after being discharged from the hospital.
Medical complications are also evident among some sellers, as Sodrul (22) experienced:

On the first day after my operation, I noticed that I was not peeing. As the nurse advised, I tried but it did not work. I felt so much pain in my belly that I screamed. The recipient’s husband and brother came to see me. They promised to discuss my problem immediately with the doctor. The doctor visited me the following morning and advised me to walk to pass the urine. I walked but the urine did not pass in a few hours. The nurse gave me hot water to drink, but it was ineffective; my stomach got very swollen. The nurse called the doctor again; he advised treating me with a hot pack. It also failed, so the doctor visited again in the later afternoon. I walked with him but my urine still did not pass. He advised pushing a pipe through my penis to solve the problem. I realized that it would be painful, so I disagreed. But the doctor insisted, saying he did not have any other alternative. Two nurses therefore brought all the medical equipment and held my hands tightly. The doctor pushed about 18 inches of a long pipe through my penis hole. I screamed so loudly from the pain that the hospital seemed as if it was shaking. When the entire pipe entered, I started peeing and filled a bag with 1.5 liters of urine. The doctor finally took out the pipe. From then on, the nurse took my urine report every hour. She helped me walk constantly. After a few hours, I went to the bathroom and peed without any pipe.

Monu (27) had pus in his bandage, so he had to stay longer in the hospital. Others had problems with digestion, and thus experienced gas. Some vomited right after the operation. At this stage, any health complications are extremely painful.

Sellers usually spend a day in the general ward before being released from the hospital. Even when the doctor states that they are fully recovered, sellers are worried about their post-operative health. The doctor advises them to walk at least two hours and drink four liters of water per day, and not to eat spicy food for at least a month. He also warns them not to lift more than two kilograms for at least three months. Finally, they must be careful at all times, even in the shower. The doctor tells them not to travel to Bangladesh for a few weeks, and asks them to visit him again so he can remove their stitches.
Sellers are generally pleased with the health care they receive in India, and believe that if their operations had been done in Bangladesh, they might not be alive now. At this point, they are thrilled to be seeing their family soon. Their release from the hospital is the happiest moment in their lives; for a while after the operation, they forget they have sold their kidney and pretend that they are cured from a disease.

After being released from the hospital, some walk to the apartment alone. Sellers return to Batpar’s unhygienic apartment or to their recipient’s shelter, but often are no longer made to feel welcome there. But because they have nowhere else to go, they must stay in the apartment until they are strong enough to travel. When sellers need something, buyers say they do not have cash or proper change to offer them. Some buyers do not concern themselves about the sellers’ daily needs; these sellers often prepare the food, even though they are in such an early post-operative recovery state. Sodrul (22) could not cook, so he had to buy roadside food, which is spicy and unhealthy, and often detrimental to recovery. Sellers cannot afford healthier food, such as fruit and milk, as they must depend on buyers for groceries. They do not have fresh clothing to wear, as they are too weak to wash clothes by hand and there are no washing machines. As there is no elevator in the apartment building, sellers must struggle by taking the stairs in order to visit the doctor. Many lose weight at this stage. The living conditions are so inconvenient, many sellers travel back to Bangladesh within a few days, despite the doctor’s recommendation to stay a few more weeks. Buyers arrange the sellers’ trip immediately to avoid having to spend more money on them.

In times of extreme desperation, people can rely only on themselves; sellers somehow take care of themselves because they are worried about their health. They walk
regularly, mostly in parks, both in the morning and in the afternoon. They take showers carefully and avoid lifting heavy containers of water. They also avoid spending time in the sun or in cold air. Sellers worry about any bodily function, however normal: for example, Nozrul (27) went to the doctor after a wet dream. Every day, sellers visit their recipient, who must stay longer in the hospital. They bring food, medication, and other necessary items, and clean the recipient’s hospital room. The value of their sacrifice is linked to the recipient’s survival. The sellers are terrified if their recipients experience any post-operative complications. They regularly pray to Allah for their recipient’s fast recovery and longer life.

They feel a “special connection” with the recipient, as if their blood and body parts are now connected. Some sellers envision the recipient’s face becoming similar to theirs after receiving the kidney. Sellers may walk with their recipients and discuss each other’s health and family. Likewise, some recipients feel a strong bond with the sellers, and take care of them. They advise sellers to get some rest, to eat healthily, not to carry heavy loads, and to quit smoking. They also promise to compensate the seller for the loss of a kidney. Most sellers feel ashamed of themselves for selling their kidney; when they meet an altruistic donor, they feel very small inside.

Sellers go to a doctor to have the stitches removed, usually two weeks after the surgery. When sellers seem worried about this procedure, the doctor tells them that he removes stitches almost every day and “it is so simple that even female donors do not complain about it.” Sellers do not feel any pain during the procedure, especially after two or three stitches are removed. That is usually the final visit sellers make to the doctor. Sodrul (22) is an exception. He went to a doctor for post-operative follow-up care before
his trip to Bangladesh, which cost him 290 Rupees ($7), even though the doctor gave him a 50% discount. Sodrul had no choice: his recipient refused to pay, arguing that he had already paid the broker. No other sellers received any post-operative check-up, since the buyers did not pay for it.

Some sellers want to return home with their recipients, but recipients would rather spend money on themselves, so they send the sellers back to Bangladesh as early as possible. Mofiz (41) noted:

The recipient’s husband told me that she had to stay three months in India under health care, so they discussed arranging my return trip. I did not want to return alone as I felt bad for leaving her earlier. The doctor even told me to stay two more weeks because he had traced blood in my urine. However, they were spending about 300 Rupees ($7) every day for my stay in an Indian hotel. Consequently, they arranged my trip on the second day after the stitches were removed.

The broker Batpar, on the other hand, often does not arrange the sellers’ immediate return since for him the deal is now over; recipients must pay the sellers’ return fares. Some of Batpar’s sellers therefore end up waiting as long as six months to go home. Three such sellers, Jobbar (28), Hena (28), and Nargis (23), had to borrow money from their recipients to return to Bangladesh. Jobbar (28) described their experience:

I was in Bangalore for six months waiting for Batpar to come. I did not have money to return to Bangladesh. I often called Batpar from a Bengali pharmacy on credit. Every time, his manager told me that he had already started arranging the trip. I called again in a few weeks. One day, Batpar picked up the phone, and immediately passed it on to his manager after identifying that it was I on the other end of the phone. I realized that he did not want to take care of me after the deal. I discussed this with two other sellers, who were having the same problem. We decided to ask our recipients for the money. Each of the other sellers received 5,000 Rupees ($125) but I got only 2,000 Rupees ($50). I bought a bag, put whatever I had into it, and we started our trip home together. On the road, I could not close my eyes because I was worrying about the payment from Batpar.
If Batpar is in India, he does arrange the sellers’ return trip; he arranges for their stitches to be removed sooner than usual and sends them home immediately to maximize his profits. Sellers return to Bangladesh much earlier than their recipients. Even the few sellers who do return with their recipients travel by ground while their recipients fly back.

Before the trip, sellers ask buyers about receiving payment for their kidney. Breaking their commitments once again, buyers decide to pay after returning to Bangladesh. They argue that sellers cannot carry this huge amount or cross the border with it; in any case, buyers do not have enough money with them in India. They therefore promise to pay the entire amount all at once just after returning to Bangladesh. Since sellers do not have any other options, they must trust the buyers once again. Some recipients who are not working through a broker tell sellers to collect a portion of the payment from the recipient’s family in Bangladesh; the rest will be paid upon their arrival. Sellers, who worry about not getting paid if the recipient dies, ask if they will receive their payment if something happens to the recipient. Recipients guarantee their payment under any conditions. Sellers, knowing that the recipient is alive because of their sacrifice, trust that they will not be deceived, but rather that the recipient will be grateful to them for the rest of their lives. Even in cases arranged through a broker, sellers try to comfort themselves that no human being would ever cheat on this payment that has saved a life.

After this challenging trip, sellers who wish to buy gifts for their families ask buyers for some money. (Some sellers buy nothing, fearing that their family will find out they have been in India.) Most sellers receive a couple of thousand Rupees ($50), but others are flatly refused. Those who have money go to a shopping mall and cheerfully
purchase gifts, such as bags, shirts, trousers, sarees, salwar kameez, shawls, atar (perfume), cosmetics, a pressure cooker, chocolate, toys, and prayer rugs. Abul (32) received a gold chain, a watch, and a flashlight from his wealthy recipient, who had the operation done in Singapore. Homecoming is an exciting moment for the sellers; they cannot wait to surprise their family with gifts from a foreign country.

Over the last few days in the city, sellers see the sights, eat out, and watch Indian movies. They treat their friends, who are also sellers waiting for their own operation to be done. They visit people they know and say goodbye. Some sellers, worried about their health, speak to the Bengali patient liaison officer, who is easily accessible. For example, Hiru (38) asked whether he could have sex with his wife after the operation. When the liaison officer replied that he could do so three months after the surgery, Hiru was relieved. Finally, sellers receive transportation costs from buyers, but are unable to afford first-class train tickets.

Sellers meet with their recipients for their final goodbyes. Both recipients and sellers are emotional as they feel they are now related through their body parts and the rough days they went through together. They hug and cry at the final separation. Jobbar (28) even touched the feet of the recipient and his mother, a practice of respecting elders in Bangladesh. Sellers are sad to leave recipients behind in India, and worry about their recipients’ survival. They are anxious about whether recipients will properly value the sellers’ sacrifice later. Recipients assure sellers that they will return to Bangladesh within a month and pay them right away. They also promise to provide sellers with lifelong post-operative health care and buy them cellphones after returning to Bangladesh. Recipients pledge to maintain a long-lasting kinship with sellers.
Most sellers arrive at the train station alone. They are anxious throughout their two-day train trip from South India to Calcutta. They regret disobeying the doctor’s advice to stay longer as the stitches had not yet healed, especially when they might not be able to afford health care if their health deteriorates back in Bangladesh. At the train station, sellers can neither lift their heavy bags nor afford a porter, so they push them with their legs. They cannot walk quickly, either. The trip is bumpy; many sellers experience intolerable pain or have high fevers on the journey. Some have some bleeding from their surgical wound. Malek (28) described what happened to him:

At dawn, I went to the toilet, then returned to my chair. Suddenly, I felt a burning pain in my wound. Within half an hour, I felt blood dripping out. I told the passenger next to me. He gave me his undershirt and I wrapped up the wound. The train was running and my incision was opening. At every breath, I felt my stitches breaking. In total, six stitches came out and opened up my incision. I was fortunate that this incident happened close to Calcutta. It was bleeding for 15 hours and the train compartment was full of blood. When I arrived in Calcutta, a passenger called a taxi and I went to the hospital alone. The doctor asked me about the incident. I had to tell him everything. He asked why I took such a risky step. He diagnosed me and advised me to be admitted to the hospital for a week. I did not have enough money, so I just paid 600 Rupees ($15) for his fee. I took some rest and had a 15-hour bus ride to Dhaka.

Sellers like Malek realize that it was a bad decision to travel just one or two weeks after the operation.

It is a three-day trip back to Bangladesh; sellers decide not to stop over or rest in Calcutta because they want to see their families as soon as possible. At the border, they put on a mask, describe their absence as a search for medical treatment, and bribe the immigration officer, as their visas have expired. After crossing, sellers are deeply relieved that their ordeal is over, but they re-enter their old lives with newly damaged bodies.
CHAPTER EIGHT

Blue: Suffering

We are living cadavers. By selling our kidneys, our bodies are lighter but our chests are heavier than ever. – Keramat, a 25-year-old kidney seller

This chapter outlines the post-operative experiences of the kidney sellers that I interviewed. It highlights their reintegration into society, financial dealings, health conditions, and the new kinship established with recipients. Sellers have sold their kidneys hoping for a better life, yet, in the end, they experience excruciating social, economic, medical, and moral suffering. Selling a kidney does not change their state of poverty; on the contrary, their living conditions deteriorate in the post-vending stage. In this “deal,” they are caught in a system of serious deception executed by buyers; this result is so devastating that sellers begin to feel blue.

Homecoming

After a long and painful journey, sellers happily return to their homes. At the same time, they are immensely worried about important issues, such as facing their families, collecting and using the money they receive from the buyer, future consequences of the surgery on their health, and maintaining the relationship with their recipients. Still, they feel somehow relieved that they successfully “donated” a kidney and now have a chance for a brighter future.

After crossing the border back into Bangladesh, sellers first go to the broker’s office or the recipient’s house to collect their payment, even though they are exhausted from the three-day trip from South India. Brokers or the recipients’ families enquire
about the sellers’ health and treat them well. Instead of paying the full amount, however, they offer a few thousand Taka (about $50) and ask sellers to come back in a few weeks for their payment. Sellers begin to worry about whether they will ever get paid. Some decide to stay at the recipient’s house or broker’s hostel until they receive payment. Again, buyers (brokers or recipients’ families) pay these sellers only a small portion of the full amount, and tell them to visit in a few weeks for the rest. Sellers are forced to trust the buyers, and say they will come back according to the new timetable, even though this arrangement goes against their original agreement.

Sellers are eager and relieved to see their own families. As they stand in front of their houses under a blue sky, they realize that this homecoming is not what they expected. They feel anxious that their families might find out about the kidney selling. At their first encounter, families weep with joy; the children had already cried during their parent’s long absence. Families happily hug, but sellers find this contact painful as their incisions are not yet healed. Families then ask questions about the sellers’ absence and health, as many of them have lost weight and look paler since the operation. In reply, sellers lie and blame their work for the fact that they were not able to call their families during their hard times. Afterwards, they offer gifts and are pleased to see their children play happily with the toys they bought for them. In this memorable reunion, friends and neighbors visit, and sellers make phone calls to family members who live far away and are also concerned. Some sellers arrange a milad, or special prayer, where they invite a few dozen people and host them with sweets; sellers are grateful to God for keeping them out of danger and helping them to recover from their operation. Homecoming is a celebration of hope and joy for sellers.
For some, however, happiness fades when they hear bad news that happened in their absence. Awwal (28) was devastated when he found out that his mother passed away during his year-long stay in India. The recipient knew that Awwal’s mother had died, but did not tell him in case he would want to return to Bangladesh without giving away his kidney. As Awwal explained:

When I came back to Bangladesh, I stayed at the recipient’s house in Dhaka. A few days later, I visited my aunt, who behaved like a crazy person when she saw me. She hugged me and cried, asking me where I was when my mother passed away a few months ago. I did not believe this news but started crying out loud. I borrowed some money from her to visit my village. The recipient’s brother joined me as he saw my miserable state. When we came to my village, everyone told me about how this bad incident happened. I went to my mother’s grave and asked for her forgiveness for not being there for her and for selling my kidney. Everyone asked where I went for such a long time. I was silent and did not answer their question. My sister informed me that when our mother was dying, my brother-in-law came to Dhaka looking for me. He asked everyone, including the recipient’s brother [the recipient’s brother and the seller were friends], who said they did not know where I was. I realized that the recipient’s family knew my mother had died, but hid this devastating news from me. How could they? I came back to Dhaka but cried throughout the entire trip for my mother’s death as well as for my shameful act of selling my own kidney. Upon returning, I immediately packed my bags and left the recipient’s house.

Upon hearing such bad news, sellers feel even angrier with themselves for selling their kidney.

In general, sellers realize that their family experienced difficult times during their absence; many could not pay rent or buy food, since the seller is the only breadwinner. Sellers feel guilty for not being able to support their families during that time and are upset that their families have suffered because of their own actions. In two cases, moneylenders assaulted sellers’ families, who then left the city and sheltered in the villages. Moyna’s (43) wife, feeling anxious, went to the recipient’s family to ask for money; they refused and misbehaved with her. Sellers also find out that their families did
not receive any money from the broker, who had promised to pay them in return for having the seller stay longer in India.

After the homecoming, sellers rest, walk with care, and avoid any long journeys, as they are constantly concerned about their health and safety. Some are so cautious that they avoid taking rickshaw rides because of the bumpy roads and big potholes. Many become prone to other health problems in this early phase of recovery, such as high fever, pain, low appetite, weight loss, typhoid, or diarrhea. A number of sellers anxiously visit doctors and take medication regularly, but continue to lie to their families to conceal the fact that they sold their kidney. Mohabbat (27) described how he left his home for a number of days, worried that his family would find out what he had done:

Just after I came back to Bangladesh, my body temperature rose to 105° Celsius. I went to a doctor and had to disclose that I had sold my kidney. He dejectedly stated that I had destroyed half of my life. He also said that money comes and goes – why did I do such a big thing for a small sum? He concluded that it was a wrong decision and prescribed some antibiotics and painkillers. I felt so bad that I went to a hotel located in my local town and stayed five days there. As many people know me in my town, I could not go out. In the hotel room, I was alone watching television all the time. The hotel boy bought food and took care of me. After four days, when my fever dropped, I came back home and told my family that I went to Dhaka for a job. I talked as little as possible about my strange absence.

Evidently, sellers are under constant psychological pressure to explain their long absence and hide their actions. They believe that kidney selling is the most humiliating thing a person can do. This view is related to their individual dignity, social status, and moral position. They realize that their families care for them and would never force them to sell body parts. If they ask themselves why they took such a risky step without their family’s consent, they are at a loss for words. They believe that selling body parts is so undignified that their families could never accept their action. Their families would
disown them, which they could never afford, especially in their current state of pain. Also, sellers worry that if their families knew what they had done, they might die of shock or cry for the rest of their lives, worrying about the sellers’ health. Tofail (27) outlined his reason for hiding his action:

If my family knew, they would not have given me consent to sell my kidney. No parent wants to see their children selling their body parts. No wife would accept her husband bringing food with this money. A wife can live with her husband even under a tree and can sell their home if their debt is increasing. However, they would not live with a bodiless husband. If my wife finds out about it, she would be senseless. If my family finds out about my action, they would have never touched the gifts I brought them. I will never disclose it, ever.

Sellers do not want to bring further suffering to their families, so they avoid discussing their absence.

Sellers also fear social stigma and public embarrassment from disclosing their action to society. They fear that society would mock them and their social status would be drastically devalued to the lowest level if their actions were revealed. They also believe that villagers would disgrace them by calling them sala, or wife’s brother, a derogatory phrase in Bangladesh, and pointing at them to identify them as kidney sellers. Also, they think villagers would spread the news immediately from villages to districts to regions, and society would hurl bad comments, laugh, disrespect, and even curse sellers for doing such a shameful thing. Sellers realize that society would neither help financially nor give them back their kidney, but rather would focus on the disgraceful aspect of kidney selling. Sellers further consider that their families would face severe criticism, which can lead to major marital problems, especially for sellers’ sisters.

Moreover, sellers are ashamed about doing such an immoral thing. They feel guilty for selling Allah’s gift, an action considered to be haram, or unacceptable. Many
sellers regularly pray to Allah, hoping he will forgive them for selling his gifts in order to save a life. Sellers reflect on their moral agony in various ways. For example, as Motlab (27) mentioned:

We live in a society, but I have a black hole inside. I failed to keep my body intact, so I feel embarrassed and disgusted at my actions. I always feel very small inside. How could you tell someone about this disgusting action? I would rather die with this secret.

Motlab sincerely believed that his scar would dissolve one day and he would be able to live a normal life, as time heals all wounds. Most sellers, however, know that their actions can never be expunged, so they decide not to disclose what they have done. A few sellers choose to reveal it right before they die, fearing that their families will be shocked to see the big scar on their corpse.

All sellers suffer by carrying the scar and keeping their sadness inside. Hiding such a long scar is very difficult, but sellers attempt it in various ways. They wear undershirts to cover their torsos, even on uncomfortable summer days when the temperature is 45° Celsius. They avoid lifting up their arms in public. In the shower (in a tube-well in an open space, a common practice in rural Bangladesh), they pull their lungi or a skirt like traditional Bengali trousers up to their chests. Abdul (30) got fake documents from a medical doctor (who purchased Abdul’s kidney for his own brother-in-law) saying that Abdul had been in an accident.

But not all families accept sellers’ long absence without question. In such cases, sellers lift up their undershirts from the uncut side to confirm that their bodies are healthy. They are so worried about hiding their scars that Nozrul (27) spent only one day with his family after coming home, then went to live with his recipient’s family for a month to give the incision time to heal.
Inevitably, however, sellers’ families discover the scar within a few months. Some sellers make up a story of some unfortunate accident they had during their job in a distant city. Some say they were cut by broken glass during a terrible road accident and needed stitches. Joidal (37) tore off his T-shirt and told his family that he had had a fight with the workers, which left the scar on his body. Some family members are suspicious of the sellers’ sadness and notice their mood changes; sellers threaten to leave if they continue to be questioned over such things.

Yet, some sellers are not able to hide their scars, especially from their wives. When the scar is revealed, sellers disclose their acts in order to relieve themselves of the heavy burden of concealment. When their wives scream upon seeing such a long scar, sellers try to convince them that they did not sell their kidney, they “donated” it. As Manik (32) said to his wife, “I donated one of my kidneys to save a life, and in return, I will receive gifts. Only bad people might say that I sold a body part, but the intellectual would remark on my noble act.” Some sellers draw upon unfortunate circumstances to rationalize their actions to their families. Mofiz (41) described the argument he had with his wife when he tried to explain his actions:

It was terrible when I told my wife that I had sold one of my kidneys. I do not know how the words came out of my mouth. I had to disclose it because she saw the scar. She started behaving like a crazy person; she repeatedly asked me why I did it. I told her that I donated my kidney to save a living person. My wife did not buy my argument and asserted that she would not eat in this home and would leave immediately. I tried to convince her, stating that many people die from train accidents, but I am alive. I just donated the kidney for the better future of our two children. She asked me why I did not inform her before making such a life-threatening decision. I asked for her forgiveness and disclosed everything that happened to me. Then I gave her 20,000 Taka, the first payment I received from the recipient’s family. She did not touch the money and told me to leave our home. She threatened that she would file a case against the recipient and me. I left and did not go back home for 15 days. I was angry at the entire situation and slept in my tea stall. I asked my wife not to tell anyone what I had done; otherwise,
people would start speaking ill of me. She, however, disclosed it to our two children. The elder daughter did not take the news well. She asked me why I sold the kidney without discussing it with the family. I could not answer her question; what could I possibly say? My family blamed me, saying I could not do anything in life, not even hold onto my body parts. I often ask them to disregard what happened in the past, but can we really forget our past? Everyone in my family suffered from my reckless action.

Sokhina (37) had a fight with her mother after disclosing the selling. They stopped seeing each other as a result of their argument. Rahmat (28) had to reveal his action to his mother when she was arranging his marriage seven months after his homecoming. However, he hid the selling from his new wife, as he outlined:

My *ma* always told me to marry someone, but I was not interested after selling my kidney. I believed that I would have health problems in the future, thus I did not have the right to marry someone who might face my premature death. But my *ma* arranged my wedding, so I had to tell her everything. My *ma* is a simple village woman who could not understand the consequences of my selling, but she cried a lot as I had lost one of my body parts. Then I mentioned to my cousin that I had a kidney problem, and asked him to tell the prospective bride to cancel the wedding. She replied that she would marry me anyway, even if I died the day after the wedding. Since our wedding, she just knows that I had an accident while working in a distant city. I thought I should get to know her better first and then reveal my action, but now I feel like I should not tell her because I do not want to make her sad. Now she is pregnant and I do not want to create problems in our happy life.

Three other sellers likewise revealed their actions, but only to friends, not to family. Forid (28) had to disclose it to his roommate, who noticed blood when Forid returned from the operation at BIRDEM in Dhaka. Forid’s friend slapped him, saying that a person should beg before selling a body part; this friend left Forid after knowing the story. Clearly, selling body parts is treated as a highly stigmatized act in Bangladesh, which stops most sellers from being open about their actions and related feelings.

Hiding the fact of selling a kidney leads sellers to live in social isolation. Sellers avoid talking with families, friends, and neighbors for fear that their actions will be
revealed. They worry constantly about how they will deal with the situation if someone finds out. When people discuss and debate kidney selling, sellers fear that they have been found out. Sellers typically become depressed about hiding their biggest regret in life. Their homecoming is not as pleasant as they had imagined. It is a constant battle of fear, anxiety, and uncertainty about receiving payment, managing their health, and staying alive.

*The Futo Paisa*

As mentioned earlier, most sellers do not receive the full payment they had been promised. After returning home, they receive a small sum from the buyers. From then on, they constantly call buyers, even going to their houses and offices and staying a few days to receive the total payment. Buyers, however, offer them as little as possible and deduct numerous hidden expenses from the principal amount, ultimately paying much less than they had promised. Sellers are unable to improve their financial conditions with this *futo paisa*.

They are spitefully deceived, not only by brokers, but also by recipients. Surprisingly, some recipients betray sellers more than brokers do. Monu (22), a college student who sold his kidney, received less than a third of the promised payment from his recipient. He cried relentlessly as he described how his recipient tricked him:

Before the operation, I asked my recipient and her husband to deposit the money in my bank account in Bangladesh, as they had promised. However, her husband (the proxy) argued that he did not have money in India, so he wanted to pay me in cash just after crossing the border. When we returned to Bangladesh, I stayed for

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68 *Futo paisa* (literally, an empty coin) refers to an amount of money that is almost worthless. Just after independence, the 2 Paisa coin was introduced in Bangladesh (100 Paisa equals 1 Taka). This coin is a circle with a hole in the middle. Hence, Bangladeshis commonly call it *futo paisa*. Its worth was so low, people could barely buy anything with it.
a week in their house but he did not arrange for the money. I left their place and called him two weeks later, as he had requested. Yet, when I came to his place, I received only 30,000 Taka ($430). He scheduled another date to pay the rest of it. When I called, he asked for another month to arrange the money. I called after a month, but he asked for two more months. He thus stalled for a few months and finally declared that he did not have any money to pay me. I was shocked but did not know what to do. I asked him to discuss it with me, but he refused to meet. So, I went to the broker Dalal (who introduced me to the recipient), informed him of the situation, and said that if he could collect the money, I would pay him 10,000 Taka ($145). Dalal called the proxy (recipient’s husband) and said that he was coming to talk about my payment. However, the proxy replied that he was out of his village and would pay me soon. I started calling him frequently, but he repeatedly said he was not able to collect the money. I finally threatened him, saying that I would report him to the police, as he was not paying after I took such a lifelong risk. The proxy said he would pay me soon after collecting the money. The moneylender was hassling me, so I regularly called both proxy and Dalal, but could no longer afford to pay the telephone bills. Dalal finally warned and pressured the proxy, coming to Dhaka to resolve it. Fortunately, the proxy and his two bodyguards came to Dhaka and Dalal and I met with them in front of the BIRDEM Hospital. We had lunch together, but he did not give me a quarter and again promised to pay me in a month. I warned him that I would take legal action otherwise. After a month, I did not phone him but went to his house directly, but he sang the same song again. I negotiated, telling him that if he paid me only 20,000 Taka ($300) more, the deal would be settled. The proxy asked for another month. This time he kindly gave me 500 Taka ($7) for returning home, but said it would be deducted from the principal amount. When I called him after a month, this bastard told me that he could not arrange the money. I was feeling vulnerable and miserable, and especially worrying about the moneylender. I called Dalal to save me and demanded that if the proxy did not have the money, he should give his motorbike to my moneylender so I could get out of debt. Ah well, it did not happen. I met with a lawyer (whom I met in Chennai, as he went for kidney transplantation there), who advised me either to take legal action or compromise with the recipient. I wanted to take legal steps but Dalal opposed it and said I could be in big trouble if I followed this route. Together we notified the proxy about the lawyer and gave him the final warning. Extraordinarily, he paid me 10,000 Taka ($145) in two days. That was the final payment I ever received from him. The moneylender asked me to pay my debt, but when I called the proxy, he hung up on me. Once I went to his home; their maid opened the door but did not let me in; she told me nobody was home. In sum, I received 40,000 Taka ($575), plus 15,000 Taka ($200) that I spent in Chennai for sightseeing and buying gifts, but originally I was promised 130,000 Taka ($1,850).
After listening to Monu, I could not resist phoning this proxy myself. He refused to speak with me, saying that he did not know anyone named Monu. Later, I found out through Dalal that this proxy was an elected politician, well connected with local police and *mastans*, or thugs, so nobody could take action against him. A few other interviewed sellers also heard about this case and were upset about not being able to stand up against this influential racketeer.

Another seller, Awwal (28), was in a far worse situation then Monu. He had stayed more than a year with the recipient in India, but received only 12,000 Taka ($175) in seven years. He gave the kidney to his friend’s sister, believing that the rich family would support him in creating a better life for himself, but was gravely deceived in the end. As we saw in chapter 6, Awwal fell in love with the recipient, but later was humiliated, as he described:

I only received 9,000 Taka ($130) from the recipient after coming back from India. In the first three months, I got a job in their garment business, typically called a buying house, but I did not get any salary as the business went bankrupt. The recipient’s brother promised to give me a store in the local market, but it did not become a reality. In India, the recipient wanted to be with me for the rest of her life, but she later married a different person after returning home. At one point, her brother came to know about our relationship; he became angry at me. He called me *haramjada* and a *bodhmayesh* [Bengali slang for a bad person], and warned the recipient not to talk to me. I told them that I stayed more than a year with the recipient during her troubles, and now he was repaying me the favor with such disrespect. I demanded my payment. Alas, the recipient argued that her family had already paid me through my lodging and trip to India. I immediately left their place swearing. After the fight, I did not receive any payment from the recipient, except once only 3,000 Taka ($40) when I was almost dying. However, this was only because my friends went to the recipient’s house and asked for help as I had saved her life and now it was her family’s turn to save mine. Almost seven years passed and many things happened, including the death of my recipient and my own marriage, but nothing changed about getting my payment. Recently, I asked the recipient’s brother for 100,000 Taka ($1,450) as a loan. I hope that they will pay me at least when I am in my grave.

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As a researcher, I should not have called the recipient, but my humanity forced me to bypass the research ethics here. I am not convinced that my actions were wrong in this context.
Awwal still hopes for support from his recipient’s family, even though it is evident that he is utterly deceived, as if he is chasing a golden deer.

Many sellers receive less than half the promised payment from their recipient. Sellers are fooled when recipients deduct a significant amount of money for various hidden costs. Mofiz was angry to receive so little, but could not fight back. He was abused, tortured, threatened, and forced to falsely sign the contract. His wife was severely beaten up as well. Mofiz told of his recipient’s dealings with him:

After crossing the border, I came directly to my recipient’s house in Dhaka. The recipient’s brother-in-law, an army officer, gave me 20,000 Taka ($300) and told me to sign a paper. I am illiterate so I signed it without understanding the agreement. A few days later, my wife learned about the selling and became worried about the payment. She pressured me to bring either the entire amount of money or the entire body. My wife and I, therefore, went to the recipient’s house, but we received only 10,000 Taka ($145). The proxy promised to pay the rest after the recipient’s arrival, which took almost two months. Upon her return, the recipient’s husband told me he could not pay me until the next month. It was not right, but I did not argue with him. I came back again on the first day of the promised month. The recipient’s family did not treat me well, did not even bother to offer me tea or biscuit [a common Bengali way of treating guests]. Her husband gave me only 5,000 Taka ($70) and said he would pay more after getting his monthly salary in a few days. My wife argued with me, saying they would never pay me. I came back to Dhaka once again, according to the schedule. This time he gave me 15,000 Taka ($215) and said he was in a financial crisis but promised to pay the rest of it in a few weeks. When I came back, he argued that he had already paid me in total 50,000 Taka ($700), plus he would deduct 35,000 Taka ($500) for additional costs (such as 15,000 Taka for traveling to India, 10,000 for my daily allowance in India, 5,000 for buying gifts, and 5,000 for supporting his family during his absence for the operation). When he summed up, my head was spinning. I told him that this is not right, as he was supposed to pay my transportation cost, and never mentioned the deduction of the additional costs. He rejected my claim and offered me a final 10,000 Taka ($145). So far, I had received 60,000 Taka ($855), even though he had promised to pay me 200,000 Taka ($3,000). I thought he was joking. He warned me not to come to their house in hopes of receiving more, and that if I ever did ask for more, he would call the police. I could not comprehend why he was creating problems with a poor fellow; I told him to pay me the entire amount. He called his relatives, including the army officer. The husband said that I sold the kidney so he had been sympathetic towards me on humanitarian grounds, but now he would be cruel and throw me in
jail if I demanded more money. I am not a thief or burglar, so I replied that his behavior was absolutely ridiculous. He warned me to remember what he had just said. So I asked him to call the police to get justice. He asked me to get out of their place immediately. I came back home and told everything to my wife. We decided to go back together to Dhaka in two weeks, as I feared they might kill me if I came alone. The recipient and her husband refused to pay me anything more. My wife said she would not leave the place without getting the money. The recipient held my wife’s neck and pushed her towards the wall. My wife’s forehead was cut and blood started dripping from it. I caught her and placed her in a chair. The recipient’s elder son closed the door and locked it. He brought a long stick and started beating me up. He threatened me that if I ever came to their place again, he would kill me. I feared for my life. He then threw 2,000 Taka ($30) at us. I did not take it at first, but he forced me to do so. They told us to leave, and slammed and locked the door in our faces. We went to the train station and cursed them over the phone, saying that everything would be destroyed for them. The bastards even got my signature and made false papers so they could show everyone that the deal was over.

Mofiz’s case shows how recipients deceive sellers in a brutal way. Mofiz completed the HLA test and all other medical examinations, but in the end the recipient and her husband took another seller to India for the operation. Yet, they kept Mofiz on standby in Bangladesh, and when the Indian doctor rejected the first seller, they begged Mofiz for his kidney then spitefully tricked him.

The above-mentioned three cases (Monu, Awwal, and Mofiz) are not isolated ones: they reveal many general threats in the sellers’ dealings with recipients. Typically, recipients pay much less than they had promised, deduct hidden costs, delay payment many times, and give false commitments to sellers. Although most sellers fix the price ahead of time, recipients refuse to pay in full. Sellers who do not settle on an amount, hoping they will get a better rate than the market price, end up receiving much less than they expected. Recipients usually deduct many invisible costs, such as the sellers’ transportation, accommodation, food, daily allowance, supplementary medical expenses (e.g., kidney stone removal), gift buying, and advance family payments, none of which
are discussed in detail and are mostly not mentioned during negotiations. Furthermore, recipients often promise to pay sellers’ costs for accommodation, transportation, and preparing documents, then renege, deducting some of these expenses. Brokers deduct a commission as well, although this fee is never spoken of when the deal is made. Moreover, many sellers often do not receive the final payment, which is about 10,000 Taka ($145), as recipients ask for a discount. After all they have gone through, some sellers receive only 40,000 Taka ($600), or even less.

Almost every seller receives payment late and in small fragments. Sellers come to Dhaka as many as 50 times to collect their money. Moyna (43) noted that he spent more than 10,000 Taka ($145) on transportation and telephone bills, and still failed to receive full payment after two years. So, too, Mohabbat (27) got typhoid and diarrhea from traveling 10 hours one way by road to collect the money, and thus ended up spending about 12,000 Taka ($200) on health care; his recipient promised to pay before going on the Hajj (pilgrimage to Mecca), but did not keep his word. Similarly, Motlob (27) went to his recipient and found out that the entire family had left the rented house without paying or informing him. He was fortunate to find them through one of their family members whom he met during medical testing. Motlob visited his recipient more than 25 times, but received only 65,000 Taka ($930) of the 120,000 Taka ($1500) they had agreed on. In an interview, Motlob expressed his grief to me:

I went to my recipient’s house many times and waited for my money. They offered me payments ranging from 15,000 Taka ($215) to 200 Taka ($3). I could not pressure them, as they claimed they did not have money. But they should not have deceived me of the payment for my kidney.
In the end, many sellers give up trying to collect the remaining amount owed to them, since it is inconvenient to travel and dealing with buyers is next to impossible. Clearly, sellers are brutally exploited in this trade.

Notably, only six sellers out of the 33 I interviewed got the full payment from their recipients. Rahmat (28) received the entire payment even though his recipient died immediately after the transplantation. Anu (31) obtained the correct payment, as well as a 50,000 Taka ($700) loan from his recipient, of which he has already returned 35,000 Taka ($500). Manik (32) got all the money plus a job, as his recipient had sincerely promised him beforehand. Abul (32) received a slightly higher amount without any deductions, plus valuable gifts from his wealthy recipient. Sokhina (37) also received the entire payment from her recipient, who lived in the same city. Salam (32), too, obtained the entire amount, perhaps because of his brother Shamsu (30), who worked as broker Dalal’s assistant and mediated the selling. Because they received the promised amount right away, these sellers view their recipients as honest people. Yet these are exceptional cases, barely constituting one fifth of the population of sellers in this study.

Sellers are spitefully deceived by the broker, the major swindler. Based on the previously mentioned deceitful transactions made by recipients, it is simple to imagine how brokers deal with sellers. None of the sellers who dealt with Batpar received the entire amount; he treated them all harshly. Like recipients, he pays much less than was promised, and sellers must make countless trips to collect their payment. He also deducts hidden costs, and adds the cost of bribes to Indian doctors and preparation of false documents. What is more, he sometimes issues bad cheques. Keramat (25), a seller who dealt with this broker, described his fraudulent dealings:
When I came back from India, Batpar told me he did not have money but promised to pay me in a few days. I called him based on his schedule, but he told me to call him in one week. I called again, but was told to call back in two weeks. I wanted to go to his office, but he told me that there was no profit in coming. I kept calling, even twice a day. His weeks finally turned to days, as he started telling me to come in a few days. One day I did not call him but went directly to his office. He gave me only 15,000 Taka ($215) and promised to arrange the rest of the payment in two days. I started calling him again. After a few weeks, I told him again that I was coming. He replied that he could not pay me that day and promised in the name of Allah to pay exactly two days before *Eid*. I called then and told him that I was taking a bus to come to Dhaka. He said he had already left Dhaka and gone to his village for *Eid*. I wanted to celebrate *Eid* but did not have any money, so I came to Dhaka. Surprisingly, I saw him sitting in his office. He told me that he came back from the village because of me! I had not told him that I was coming, so I asked how he had known about my trip. He replied that I am like his brother, so he had some telepathy with me! He then gave me 5,000 Taka ($70) and told me to come after *Eid*. I was angry and asked him what I was supposed to do with this small sum; he promised in the name of Allah that he did not have any more money. I called him the next week, called him almost every day about a thousand times, but he claimed that the recipient had not paid him yet. I came to Dhaka several times, but he said he had no money left. Finally, I asked for a post-dated bank cheque. He calculated that he had already given me 50,000 Taka (15,000 as a first payment, 5,000 for the second payment, 4,000 that I received before going to India, 15,000 for transportation, 6,000 for accommodation, and 5,000 for meals), equivalent to $700, and had decided to pay me only 17,000 ($250) more. I told him that I was a kidney seller who had almost given his life. If he posted a newspaper ad, I did not have any other body parts to sell; everything was finished. So I bent my head, closed my hand, and begged for 5,000 Taka ($70) more. He, however, wrote me a cheque for 20,000 Taka ($300), which could be cashed in one month. What fate I have! When I came to cash the cheque, I found out there was no money in his account. I called him. His manager told me that he had gone to India with new clients and would return in a month. One day he picked up the phone. I asked him how he could give me a false cheque. He told me to come to Dhaka the following week. This time I did not call him and went to his office. Again, he said he did not have any money. I told him I would not go until I got the money, so I stayed in a hostel. I got 20,000 Taka within two days and gave his cheque back. I received only one third what I was promised. That’s all. I do not want to see his face again, ever. All sellers curse him so much that he will die soon.

Keramat was fortunate to receive cash in place of Batpar’s cheque. Other sellers told me that Batpar often gives cheques that bounce. After numerous calls and false promises, sellers eventually give up.
Brokers deceive sellers in every possible way. Not only do they fail to provide funds for sellers to return to Bangladesh from India, forcing sellers to borrow money from their recipients, brokers also do not make the full payment. Jobbar (28) described what happened to him:

I had to wait six months in India for the return trip to Bangladesh. Whenever I called, Batpar promised to arrange my trip, but it did not happen. I therefore borrowed money from the recipient and returned to Dhaka. Upon arrival, I called Batpar’s office; his manager lied to me, saying that the boss was about to go to India to arrange my return trip. I went to the office and asked Batpar why he was lying. He made up a list of his problems! I told him how much I suffered by staying so long in India. But he argued that he did not have money to visit India and was facing financial hardship. Therefore, he asked me to come back later for my payment. I told him that I would not go back home without the payment. Batpar told me to stay in a hostel for two days. I stayed and phoned him according to the schedule. His manager told me that Batpar was sick and unable to come to the office that day. On the third day, Batpar did not come to the office again. On the fourth day, he picked up the phone, so I asked him why he did not pay me. He made excuses about his apparent sickness, so I said I could have come to him or he could have sent his manager to meet with me with the payment. He promised to pay me the next day. I called him three times the following day, and finally received only 20,000 Taka ($300). He promised to pay the rest in a week. From then on, I came to his office almost a hundred times in seven months; my shoe soles were worn out. In the end, I received only half of my payment (50,000 Taka, equivalent to $700) in seven months – that’s it, even though the deal was fixed at 100,000 Taka ($1,450). After the first payment, the highest amount he gave me was 10,000 Taka ($145), but my friend had to come with me and threaten him. Otherwise, he paid me 5,000 Taka ($70), 2,000 Taka ($30), even 100 Taka ($1.50) each time I requested. He deducted many hidden costs, even lying that he had paid a bribe of 10,000 Taka ($145) to the Indian doctor. I knew from the recipient that Batpar received 400,000 Taka ($5,700), and only spent a maximum of 25,000 Taka ($350) on me for transportation, accommodation, food, passport, and other documents. After finding out that he was making a profit of about 375,000 Taka ($5,350), I asked how he could do this nasty business, especially when he had been a seller himself. In response, he gave me 10,000 Taka ($145) more. The last time, I warned him that if he did not pay me, I would report him to the police. He threatened me, saying that my parents would receive my dead body for doing this. I am scared to report him to the police; rather, I still call him sometimes hoping that he will pay, but each time he hangs up on me.

As we have seen, buyers (both recipients and broker) repeatedly try to dodge paying the sellers in various ways. They do not pay in full, deduct many hidden expenses,
and disburse small amounts. The recipients’ major trick is to convince sellers that they do not have the money, especially after this costly transplantation. Brokers, meanwhile, say that because recipients did not pay them, the sellers’ payment is delayed. Because none of the sellers receive payment beforehand, buyers can deceive them after the operation. Sellers trust the buyers, believing that no human being could ever betray someone who has given a body part that saves another person’s life. Yet, in reality, most sellers do not receive the entire payment; their hopes and dreams turn into nightmares.

Many sellers are also promised that their buyers will pay them in the transition period between recovery and finding a job. However, only two sellers received a monthly stipend of 5,000 Taka ($70) three times from their recipients. The others were denied. Buyers also promise to offer jobs to sellers who lose theirs because of the sporadic scheduling of medical tests in Bangladesh and their long stay in India for the operation; this is an empty promise. Mokhles (41) cannot comprehend why his recipient, who owned a big garment factory operated by a hundred employees, did not offer him a job there.

Yet, because they do not have the financial ability to fight the case, sellers cannot take legal action against buyers. Sellers know that it takes almost a decade to resolve a dispute in the Bangladeshi courts. Moreover, sellers are not sure whether trading body parts is legal in their country. To make matters worse, they fear for their lives, especially when dealing with a dishonest broker. In any case, they cannot fight the injustice publicly for fear that their actions will be revealed and they will be permanently stigmatized. The poor have no legal recourse in this situation.
Whatever money sellers do receive they cannot use productively, as buyers offer tiny amounts each time. With payment, sellers mostly pay off their debts, support their families, and purchase material things. When they receive the first payment, they hope to pay off their debts and change their fate, but in the end what they receive is insufficient: a 
*futo paisa*, an empty coin. On the flipside of this *paisa*, sellers see the moneylender’s face; they pay him right away. But because they do not receive full payment from the buyers, many sellers cannot pay off their entire loans. They beg the moneylenders to show them mercy, but the interest on their debt increases until it is even higher than the principal loan. Sellers are often harassed by the moneylenders and are charged interest as high as 5,000 Taka ($70) for months when buyers take longer to pay. Some sellers must first pay back the extra loans they accumulated for traveling frequently to Dhaka for tissue matching and payment collection. Sellers must also pay back the loans that their families took out in order to survive during the sellers’ absence at the time of the operation.

Sellers must spend some of their earnings supporting their family, including arranging dowries, paying for health care, and settling disputes. At least three sellers managed to arrange dowries for their sisters and daughters. Two sellers bought health care for their families. Ironically, Montu (38) could not save his mother from kidney failure, “a cruel karma of fate,” as he put it. Two sellers settled disputes with their income, such as paying their wife for a divorce or offering bribes so a falsely imprisoned father could get out of jail. One seller renovated his house, which had been damaged by a cyclone. They often feel morally obligated to support their family, especially as they have hidden the act of selling their kidney from them.
Besides these essential expenditures, sellers also purchase material things, such as televisions, cellphones, gold chains, furniture, clothing, and expensive meals. Moyna (43) described how he spent his income:

The recipient gave me 30,000 Taka ($430) in the first installment. I paid off the debt of 20,000 Taka ($285), and kept 10,000 ($145) Taka for household expenses. As the recipient could not pay me for three months, I used up the money. Then the recipient gave me 15,000 Taka ($213). I could not decide what to do with this small amount. My children had to go to the neighbor’s house to watch television, so I bought a TV. Then I received 25,000 Taka ($355) a few months later. I bought a gold chain for 8,000 Taka ($103), a dressing table for 3,000 Taka ($43) for my wife, and a cellphone for 3,000 Taka ($43) for myself. When I received the last payment of 10,000 Taka ($145), I fixed a bribe to get a job, but later found out it was only for short contract work.

Spending money on material things indicates that sellers cannot use the money productively, as they receive it in such tiny portions. Also, many sellers do not know how to use the money effectively. As Sodrul (22) said, “My body burns if I misuse one Taka from the kidney payment, but I do not know how to start a business with this small amount.” But getting a lump sum does not ensure that it is used properly, either, especially for the poor, who often do not have previous experience in handling capital productively. Thus, a few sellers, including Sodrul, who could have saved a few thousand Taka, realized that their savings would not last long and they would be back to their original financial state, but now without a kidney.

On the other hand, a few sellers managed to start a business (such as storing potatoes and rice at harvest and selling them when they became harder to get, and contracting renovation and construction), hoping they could live without engaging in jobs that required physical labor. Unfortunately, they failed in their new businesses, because they did not have previous experience or large amounts of capital. Some sellers attempt to go abroad, but are unable to follow through the whole process. Hasmat (32), for
example, found a factory job in the Middle East, but could not afford to pay the commission to the manpower office and buy the ticket to get there. He spent money on driving lessons and a license because his recipient promised to hire him as a driver, but then withdrew the offer after the operation. Jional (37) wanted to buy a taxi with a down payment, but could not find a guarantor, so he spent all of the money within a year. The two female sellers, Hena (28) and Nargis (23), reported that their husbands took the entire amount, started small businesses, and bought cellphones.

In the end, a large majority of sellers did not benefit economically from the process, although a few fortunate ones started businesses or arranged jobs. Only two sellers profited through selling: Rahmat (28) bought land because he was too emotional to spend the money on other things, including his wedding, especially since he received the payment when his recipient died. Abul (32) bought a hundred chickens, ten cows, and a farm with the payment. But in almost all cases, the economic gain of kidney selling is very insignificant. Many sellers therefore believe that God has purposely slowed down their income because they sold his gifts. Overall, sellers are unable to change their economic conditions afterwards.

The negative consequences of selling are profound. Now that sellers are back from India, it can take three years or more to find a job, due to high unemployment rates, which means a significant decline in post-vending income. They cannot return to physically demanding jobs, such as rickshaw pulling, cultivating land, or heavy industrial lifting, because their bodies are no longer strong enough. As Abdul (30) said, “I lost my kidney as well as my job. Now I cannot engage in heavy lifting or work longer; what kind
of life is this? If I had strength in my body, I could work at anything and could easily earn that little sum I received for selling.”

There are other consequences from selling as well. Due to their economic instability, some sellers must relocate from the city to the village, calling themselves “defeated soldiers.” Two sellers reported that friends borrowed 10,000 Taka ($145) after discovering that the two had sold a kidney; although the friends did not pay back the loan, the sellers could not pressure them for fear that their actions would be revealed and their social dignity and honor destroyed.

In this economic spectrum, sellers make minimal gains from selling, are often deceived, and cannot improve their lives. They end up spending all of their payment, their options for jobs are limited, and they worry constantly about their health. Sellers belatedly realize that money is not the most important thing in life; rather, their health forms the most important part of their happiness.

Health Suffering

After the surgery, sellers end up living under much poorer and riskier health conditions, both physical and psychological, than before. They cannot afford post-operative checkups, have poor hygiene, work in dire conditions, and take fake prescribed medications that have severe detrimental effects on health, especially for someone living with only one kidney.

Nephrologists advise sellers to visit them every three months after the operation, and to have checkups at least twice a year, but sellers do not follow up on these instructions because of the commercialization of health care. In Bangladesh, a post-
operative checkup for a kidney seller usually costs about 2,000 Taka ($30), which includes the specialist fee of about 400 Taka ($6) and the medical test of about 1,600 Taka ($24); most sellers cannot afford this amount. Although buyers promise to bring sellers back to India for the first checkup, and to buy lifelong post-operative care, the promise never becomes a reality. Three sellers of the 33 I interviewed had a post-operative checkup, but only once: Sodrul (22) paid for it out of his own pocket; Salam (32) received free tests and medication in a public hospital, arranged by his recipient, who was a doctor; Awwal (28) faced severe health problems, so his friends pressured the recipient and received 1,500 Taka ($21) for the checkup. Every seller wants to have regular checkups, but most cannot afford it; some avoid the checkups to avoid disclosing their shameful actions to doctors. Sellers believe they are alive without any health-care support only through the mercy of God.

All 33 sellers reported that they did not receive medication from their recipients after the operation. Motlob (27) was an exception: he received multivitamins from his recipient, as the doctor prescribed just after removing Motlob’s stitches, but had to buy them for himself after one month. Many sellers were still experiencing pain in the lower abdomen, and had fought typhoid, diarrhea, and jaundice. Because they cannot afford a visit to a doctor, they typically end up taking *lal bori*, red pills from village pharmacist. Taking medication from the village pharmacist, who often selects pills without any education, can be highly detrimental, especially for sellers with only one kidney who are living in slums with dire pollution and poor hygiene. Some sellers recall taking Aeristobit B, Civit, Napa, Doxicap, Dyzine, and Proxivon, which are painkillers, vitamins, and antibiotics, some of which might be unnecessary and even harmful.
Sellers suffer from physical pain even years after the operation. As Keramat (25) said, “The Indian doctor advised me to avoid heavy lifting only for three months. But I usually do not lift heavy loads, and if I do I feel so much pain that my kidneyless side could be broken in pieces. I often fail to bend my body.” Likewise, many sellers feel pain in their scars when they work, walk, stand, climb stairs, or travel. Many cannot sleep on the injured side for months. If they lean on that side for longer periods while sitting or sleeping, it is painful; some sleep with side pillows. They also have pain in the back, joints, and spinal cord. Some sellers have stomach pain near their belly button. After playing volleyball, Jobbar (28) experienced sudden pain, so he had to take antibiotics and stop playing any type of sport. What is more, many sellers feel burning pain while passing urine, so they usually drink a lot of water in order to reduce the discomfort. Many cannot sneeze or scream, as the resulting sudden pain often lasts for hours. Some pains are acute, like those they experienced right after the operation, while others are minor. Experiencing sudden but endurable physical pain especially in the lower abdomen is also very common.

They become weaker as their bodies become more and more fragile by the day. As Mohabbat (27) described:

I was much healthier when I worked days and nights and lifted 60 kilograms of weight on my head, but now I cannot even carry 10 kilos. I become tired more quickly and always get scared if I need to carry weight. My body was like a strong tree trunk, but now it is like an old banana tree that anyone can stab with a finger.

Many are so weak that their hands and legs begin to shake; they frequently feel their head spinning. Mokhles (41) stopped taking the bus because he could not push to secure a spot during rush hour. He argued, “The seller cannot be healthy because the scar is too long.
They lose their strength because they only depend on one kidney instead of two.” In addition, most sellers lose a significant amount of weight. Further, their bodies become unpredictable; many experience frequent illnesses, such as fevers, coughs, tonsillitis, and ulcers. Some also experience blackouts, shortness of breath, and excessive sweating. Many feel itchiness along the scar and live with constant headaches. Some notice water retention in their bodies. Mofiz (41) lost the sight in one eye; he believed it was related to losing the kidney, because the blind eye was on the damaged side of his body. As a result of these health problems, many sellers lose the desire to work; others must reduce their hours and change from hard-working occupations to “sedentary, sitting-type jobs,” as they phrased it.

Sellers also experience loss of energy and other limitations. Tofail (27) said that his energy and spirit levels dropped from five to one. It is common for sellers to do everything more slowly; even a small amount of work requires all their energy. They also lose their appetite and tend to vomit after eating large portions of food. In addition, they live with having a different body structure than before; if they travel frequently, they encounter a rising body temperature. They are unable to run, walk, jump, play, or do exercises as before. Their bodies become limited, as Shofi (25) experienced:

Now I cannot pump tube-well for my daily shower or wash my clothes by hand. I always need to ask someone to help me. So, I take someone else with me if I plan to go somewhere. I do not even drink water from someone’s glass, fearing that I might get sick.

Sellers are extra vigilant in doing anything, including eating, drinking, biking, and taking rickshaw rides. Due to poor hygiene in Bangladesh, it is very difficult for them to follow the doctor’s advice, so they often end up eating bananas for lunch rather than the oily
food from the market if they are away from home. It is an endless agony to live in such restricted conditions.

Above all, sellers encounter severe psychological problems, such as anxiety, distress, depression, and trauma. Every year when the anniversary of the operation day arrives, they remember every moment of their ordeal. They feel empty and do not want to live. Mofiz (41) thought about committing suicide, as he outlined:

Every day and every night, when I think about it I become agitated. I can neither talk with anyone nor eat meals. I tell my wife not to come or call me in this kind of time. I just lie down and think. My body sweats, and the tears drop from my eyes. I stay in one place, speechless and sitting in the dark alone. But I cannot commit suicide because of my children. Who would take care of them in my absence? So, I try to rationalize that I am a victim of an accident. When I am surrounded by people, I do not think about it. But when I am alone in my bed at night, my brain runs fast and constantly pushes thoughts in my head; I feel like dying.

Like Mofiz, many sellers are living in deep sadness. They feel much older than before; their hair starts to turn white. They are psychologically much weaker than before; they refer to themselves as “sick” for not having a kidney.

Losing and then living without a kidney is traumatic. While sellers are overall fairly peaceful before the operation, they experience endless agony afterwards. All 33 sellers I interviewed believe that they will die much earlier than if they had two kidneys: they argue that one kidney is taking the load of two, and thus the body is becoming damaged faster. As Moyna (43) outlined, “The body is like a machine; when a part is missing, the machine can run but you have to push for it.” Sellers therefore predict that they will experience many diseases in the future, as their bodies have now become weaker. As Tofail (27) said, “The worm can get into a softer place easily, but cannot enter the harder surface. My body cannot avert the worm’s attacks.” Moreover, sellers
argue that the body without a second kidney means destruction of the homeostatic balance. Therefore, even a minor illness will lead to a major problem. If they encounter lesser health problems, such as high temperature, headaches, or changing urine color, they worry. Many sellers therefore go to palm readers to check their lifespan. As Mohabbat (27) said, “The village doctor confirmed that I would survive five or six years at the most, as my body is half and I am already half dead.” This seller was so anxious that he deposited the entire kidney payment in the bank and signed an affidavit for his daughter, believing that he could die soon and nobody would help his family. Sellers are severely distressed because they cannot afford health care but believe they will face a drastic decline in their health soon.

The scar is a reminder of their ordeal: whenever they see it, they remember their kidney being taken from this side. Putting their hand on the scar, they are momentarily transported back to the operation. Although the scar heals, their nightmares do not. Sellers are deprived of many things by having this huge mark on their body. As Jobbar (28) mentioned, “I can never walk or stand under the sky with my uncovered body.” A few of them who had just had the operation were unable pray namaz, because it stretched their scar. Sellers are constant struggling to hide the scar, causing deep psychological suffering from living with a shameful mark. They live like prisoners, socially isolated. Villagers often ask to see the scar, which heightens the sense of isolation and being different. Sellers detest the scar; many asked me how to get rid of this painful spot on their bodies.

Some sellers decide not to get married to avoid disclosing their shameful actions. Awwal (28) and Rahmat (28) married without telling their wives about the surgery. They
did not want to risk being rejected. Instead, they made up a story about an accident to convince their wives that they were entirely healthy, without any physical or mental problems. Awwal’s wife blamed her parents for arranging the marriage without knowing the groom. Some sellers do not get married because they believe they will die soon, and consider it unrighteous to turn their future wives into widows so early. Other sellers worry about their inability to have children. Nergis (23) was told by a village pharmacist that she might never have a baby. Hena (28) was five months pregnant during our interview, but worried about the birth. As she said:

I was feeling constant pain in my tummy, so I went to the village doctor and told him everything. The doctor did not offer any medications. I am tense all the time. I am scared about whether the baby will be alive. I think it is common among kidney sellers not to have a baby. I might have a risky delivery, however I do not know whether there is a solution for it. I am coping with it only because I am a mentally strong person.

Living under such traumatic and distressful conditions is psychologically troubling.

Selling a part of one’s body is also morally challenging. Many questions arise to sellers, including the following: Why did they have to sell their kidneys? How could they make such a brainless decision? What kinds of sins did they commit to deserve this? How will they depend on just one kidney? Sellers battle with these moral and mundane questions over and over again.

To sum up, kidney sellers’ health profoundly deteriorates in the post-vending stage. Sellers experience serious physical problems and immense psychological suffering, but lack the means to follow up with post-operative medical care and proper medication. A longitudinal medical study on kidney sellers is essential to examine the in-depth health outcomes of selling a kidney (Schepet-Hughes 2007; Cohen 2002). It is apparent to me that sellers are unhealthy, often malnourished and skinny, as well as traumatized and
depressed. These conditions were reflected through their constant crying, sad faces, and poignant narratives during the interviews.

*The “Commodified Kinship”*\(^70\)

Sellers feel a deep bond with their recipients, considering them as special close kin; they hope to continue this lifelong relationship with their recipient. If their recipient dies, sellers are devastated; for them, selling a kidney is not only the cause of social, economic, and medical suffering, but can result in a personal loss as well. In contrast, recipients establish a commodified kinship, and do not maintain it for fear that sellers might ask for money, jobs, or extra compensation, or create legal problems after the deal is over.

Sellers consider that by sharing their blood and kidney, sellers and recipients become one body, one person, one being. As sellers commonly thought, because they give blood to their recipients, they become blood relatives; because they also give body parts, they become body mates. Since the seller’s kidney is filtering blood in the recipient’s body, their kinship with recipients is stronger than ordinary blood ties. Sokhina (37) mentioned, “I felt bonded with the recipient more than my children, wife, and parents. She is the closest person in my life. I felt as if we had known each other for a long time.” Consequently, many sellers see their recipients as jomoj bhai/bone, or twin siblings—separated but somehow tied together. Even though sellers’ two kidneys are in two bodies, they somehow feel as if they are in one body. When their recipients become sick, sellers feel a mental disruption. As a result, they literally call their recipients bhai or

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\(^70\) Here I adopted the phrase “commodified kin” from Lesley Sharp (2000).
bone (brother or sister), and identify recipients’ families by similar Bengali kinship terminology.

Sellers said that they do not forget about their recipients, even for a day. Initially, they did not realize that their feelings would be so strong, as recipients usually live far away. But each day sellers think about how their kidney is working in the recipient’s body; it means a lot to them. When they meet with their recipients, they feel great satisfaction. As Anu (31) stated, “When my recipient looked at me, I felt fulfilled and realized that he tried to say something; we shared our happiness without exchanging words.” Sellers are sympathetic towards recipients, since they can somehow survive with a transplanted kidney but are always fighting against death. Sellers treat their recipients as if they are brothers-in-arms, both trying their best to stay alive.

Sellers’ sacrifice, satisfaction, and success are invested in the recipients’ survival. In the sellers’ perception, in this entire world, the recipient is the only living being who holds the sellers’ body part and keeps it alive; the death of a recipient signifies the end of a seller’s body part. No seller, therefore, desires to see the death of his body part before he himself dies. When recipients are sick after the operation, sellers regularly pray to Allah, even fasting every week so recipients will recover. Jobbar (28) even donated his blood to save the recipient’s life, as he described:

My recipient was sick after the operation. His family whispered that he became sick after taking my damaged kidney, which was affected by kidney stones. However, I do not agree with them, as the doctor examined and accepted my kidney before transplantation; the only problem I could see was that my kidney might be working slowly in his body due to kidney stones. The recipient asked for my blood, believing that my kidney would set in his body properly. He mentioned that after receiving my blood, his blood would regenerate, his veins would become bigger, and the kidney would function properly. So, I gave him blood four times in the last five months for his survival. I do not want to hear that the recipient died because of receiving my kidney. Yet, he did not care for me, did
he? If he did, he could have prevented me from frequent blood donation in the uncertain conditions after the operation. Instead, he just bought mango juice for me each time after I gave blood; that’s it.

Nevertheless, each seller worries for their recipient’s health; they cry when they hear that their recipients are sick.

Regrettably, four sellers learned of their recipients’ deaths. The first recipient died just two weeks after transplantation, as her seller, Rahmat (28), described:

Only a day after the operation, my recipient’s belly swelled. A few of her stitches broke; blood was coming out from there. I thought my kidney did not set in her body properly, and I was worried for her life. She became emotional and wanted to see me. Her body became weaker the next day. The doctor carefully sewed her open stitches. However, her tummy swelled even more in the following days. The doctor had to operate a third time. The recipient’s family and I purchased blood from outside. Everybody was tense; we could not eat or sleep. We came here for better health for her, so why was this happening? I asked the doctor if she would be okay. He replied that they were trying their best: if Allah kept her alive, she would survive, so he told me to pray to Allah for her life. A couple of days passed, but my recipient’s health deteriorated. She could not speak and was on oxygen. Early one morning, around 1:30, she died. The phone rang; her husband woke me up with the news. He hugged me and with a strong face like stone told me that the reason we came here was not fulfilled. He then started crying like a crazy person and spoke without making any sense. I felt senseless, too, and did not know what to do. We went to the hospital right away. I saw my recipient’s body covered with a white sheet. I cried and cried, realizing that I came to save her but failed to do so. The doctor kept the body in a morgue. My recipient’s family arranged the police certificate, hospital permission, and plane ticket for the return. On the third day, they took a plane. They gave me some money, telling me to return by train and join them in Dhaka. I felt bad for leaving Bangalore; I came here to save my recipient but she returned to Bangladesh as a corpse in a box. Before leaving, the doctor said that my kidney did not set in her body. On the road home, I constantly thought, why did Allah do this? Was it my fault? I went directly to her family’s house in Dhaka two days later. The family had yet to bury my recipient. We all went to her village, located in the town of Chandpur, three hours from Dhaka, with the dead body. She was buried there in peace. On the fourth day, we had a milad, a special prayer ceremony. I met all of her family. They were sad and told me Allah did not fulfill my dream, but whatever he did there was a reason behind it. Before leaving, I went to the graveyard and prayed to Allah to forgive my recipient’s sins and send her to heaven. Her husband told me not to take things personally, as what happened was beyond our control. He advised me to eat well, not lift heavy loads, and keep in touch by phone. He gave me 4,000 Taka ($57) to get home. He phoned me two weeks later and asked me to
come to his home. He gave me 4,000 Taka ($57) again. He told me to come on the *kulhkani*, a special celebration on the 40th day after her death. On that day, he offered me a cheque for 140,000 Taka ($2,000). I told him that I had given my kidney to someone who had already left this world; how could I take this money? He said that I had no other option. I asked him what I would do with this money. He said, whatever I wanted to. I felt very bad taking this money. I could not save my sister (as they always called my recipient in front of me), but took money at the cost of her death.

Not every seller receives payment upon the death of the recipient. Awwal (28) has yet to receive payment four years later: even thought he is dissatisfied that he has not received the money, he is devastated that his recipient died. Awwal depicted his experience in this way:

One day my recipient’s family called and told me that my sister’s (as they always called her) situation was serious. She was lying senseless in the hospital but saying my name and wanted to see me. I visited her right away. She slowly opened her eyes and held my hand. She then repeatedly asked, “Would you please forgive me for whatever wrongs I did to you?” “Yes, yes, yes,” I told her. Her eyes became wet. After half an hour she suddenly became completely calm and then died. I could not stand being there. My body became softer and weaker; I fainted. I was treated by a doctor. I saw my own body part die in front of my eyes. From then on, I was waiting for my turn.

These sellers often feel guilty, believing that their recipient died because the seller’s kidney was weak and thus failed to be accepted by the recipient’s body. Sellers consider the recipient’s death and in turn their kidney’s death a total waste, as no one can use it now.

For some sellers, the death of their recipient is more painful than the death of a family member. They cannot comprehend how someone could leave this world with the seller’s kidney. It is a strange experience, as one part of their body is dead while the other part is alive. Sellers also question what their kidneys will do in the afterlife. Recipients permanently take the seller’s kidney to a totally different world, one that sellers had no awareness of. They want to know whether their kidneys are in heaven or hell. Two sellers
sometimes go to their recipients’ gravesites and feel some deep connection between the two worlds. When they pray in front of the tombs, they feel as if their kidneys are right in front of them, but somehow far away. They pray for a good afterlife for their kidneys. Sellers further ask: How would Allah judge and punish them for selling his gifts? They worry because now they are not able to return their entire body to Allah and will never know how Allah will treat the recipients, who went to the afterlife with different parts. Thus, it is a complex religious puzzle to sellers.

Although sellers and recipients feel a deep connection with each other, their kinship does not last long. Most recipients treat this relationship as commodified kinship built from a business deal and executed through broken promises and distrust. Sellers, meanwhile, maintain a stable relationship from the beginning and persist in keeping contact and respecting their recipients. However, they discontinue this kinship when recipients deceive them. They had believed that they donated their kidneys to their real brothers, who would never betray them about their payment, but their hopes are dashed. As Motlob (27) noted in anger:

My recipient is not a human being. He did not have any humanity. I never ever thought that he could cheat me, especially when I saved his life. He paid me less and in such a way that I could not use the money. I should have taken my payment beforehand. If I forced him to pay me before the operation, they would not have another option, especially after spending 30,000 Taka ($430) on my medical tests. I gave him all the benefit, but he deceived me in return. I will never see him and his family again. I did not call them for the last two years. I thought people would help each other; even if a vulnerable one falls in the drain, the others pull him out. However, instead of supporting me, they deceived me brutally. In addition, my kidney is gone and I will never get it back.

Similarly, Mokhles (41) was so enraged at his recipient that whenever someone asked about the scar he replied that a street dog bit him. (Having a dog as a pet is unacceptable in Islam and is considered profane and dirty as this practice is associated with street
dogs.) Sellers consider recipients as enemies due to their severe deception, which is the major cause of their broken kinship.

Their kinship is mostly discontinued because of recipients’ broken promises about such things as job opportunities, post-operative care, visas, and citizenship abroad (even though sellers are mostly ineligible for the latter two). After the deal is done, many recipients walk away, saying that they are sick and thus unable to offer support. Some recipients, especially those living abroad, promise to buy sellers a cellphone to keep in touch, but it never happens. As Salam (32) noted:

My recipient told me that he was economically disadvantaged after not working for a while. He told me that he would be better off after returning to Canada. He promised me that then he would provide supports, such as buying a cellphone for me in few months. He also agreed to call and write letters regularly. He left for Canada for six months but has not contacted me yet.

It should be noted that only three sellers received jobs from their recipients; these jobs turned out to be temporary or involved heavy labor, so the sellers lost them in the end.

Nozrul (27) told me:

One month after the recipient’s return, I asked for a job he had promised. Every time I reminded him, he stated that I need patience to get a job. After three months, he told me to drop off my resumé at an office. Surprisingly, I went for the interview, but could not get the job. Two months later, his brother-in-law told me to apply for another job. This time, I was offered a job as a quality control officer for a sweater factory in Dhaka. My salary was 2,700 Taka ($40) a month, and I had to work a 12-hour shift six days a week. It was not the job they promised me, but I accepted it anyway. I was happy on the first day of my training. I was a trainee, so I performed better to have a permanent position. I worked there for almost 14 months. However, I had to quit because I was asked to do night shifts and overtime. The recipient did not help me anymore, but rather blamed me for quitting this job.

No sellers were fortunate enough to receive a second job after quitting their first jobs. They feel betrayed by these recipients who do not fulfill their promises. Sellers are so
upset that they refused to talk with the recipients, even though I offered free calls from my phone.

The commodified kinship also did not last because recipients predominantly mistrust sellers. In contrast, sellers were forced to trust that recipients would pay them after the operation. Some sellers had to sign written agreements to receive their money. For example, Mofiz (41) had to sign the following agreements (Figure 8.1) to sell his kidney and receive the payment, even though he was illiterate.

![Figure 8.1](image)

**Figure 8.1** Contract between a recipient and a seller. The left document is an agreement that indicates Mofiz (the sellers), who knows Jamuna (the recipient) in person, willingly donating one of his kidneys to save her life. It also points out that if any accident or damage due to kidney transplant occurs, Mofiz will be solely responsible for this. The right document is a proof of payment that indicates that Mofiz altruistically donated a kidney to save Jamuna’s life. In return, Jamuna’s family members were kind enough to give Mofiz various gifts, such as clothing, shoes, suitcase, as well as valuable things, such as Seiko 5 watch and 3 bands radio plus cassette player. Besides, Jamuna’s children gave Mofiz 1,16,530 Taka ($1,660) in various days that are specified in the following.
Mofiz had to sign on both documents indicate that the above-mentioned information is correct, as well as Mofiz family member would not be able to demand anything from Jamuna in the future, and if anyone demands something, it will be void.

Hasmat (32) had similar experience, as he expressed:

I had to sign a legal paper printed with a government stamp that indicates: I donated one of my kidneys on humanitarian grounds. For the donation, I received a gift of 60,000 Taka ($850) out of 120,000 Taka ($1,700) in exchange for my kidney. My family would not oppose my action and I would not take any legal action. I had to sign the document to receive the payment. When they asked me to sign it I was shocked; I trusted them so much, but they deceived me in return. When I was signing on the stamp, I should have had a written document from them stating when they would give me the other half of the payment.

Moreover, recipients ultimately consider sellers greedy because they are selling kidneys for money. This view is reflected in many sellers’ narratives. As Tofail (27) mentioned:

When my recipient came back from India, I immediately visited her house. But she was not happy to see me, as she thought I came to her house for the payment. She asked how could I visit them knowing that they had come back only yesterday. I replied by calling her sister, saying that I did not come for the money, rather I came to see her and know about her health. My recipient became silent, but I was not sure if she believed me.

Furthermore, some recipients refused to take phone calls from sellers who were in dire need and wished to ask for a small loan that they would repay after the harvest. Two sellers who had arranged jobs in the Middle East could not make the trip as their recipients denied them a loan. It is evident that recipients immensely mistrust sellers; a few recipients even move to new places to avoid them, as Malek (28) outlined:

Before the operation, my recipient always told me to stay at his place whenever I came to the city. I always thought that I had a relative in Dhaka. But one day post-operation when I came to the recipient’s house, I found out that the whole family had moved out. They did not even bother to inform me. I looked for their new address, but the current tenant did not give it to me; I felt very sad. I always wished the recipient well, but he did not keep his word. I want to know about his health, so I always pray to Allah. A few months ago, I called my recipient’s brother-in-law, but he lied that he did not know the address. From then on, whenever I want to know about the recipient’s health, I call his brother-in-law.
Sellers do not maintain the kinship, especially when their recipients openly distrust them in such manner.

Some sellers are also angry because recipients misbehave toward them in various ways, such as beating, assaulting, and threatening, especially when dealing with the payment. When the game is over, recipients and their families often do not behave well when sellers ask for their due. Many recipients do not even bother to contact the sellers after returning from India; sellers then feel hurt because they hear their arrival news from the broker. Sellers become outsiders, and are even considered as outcasts. Some sellers mention that they wrote letters to their recipients, but only one received a reply. Sellers are disturbed by this coldness, as Sodrul (22) indicated:

The recipient and her family mistreated me, so much that even a dog would not want to keep in touch with them. They did not treat me as a human being, so why should I treat them in such a way? They did not even let their maid talk with me. From their point of view, I was a bad person who does not have any dignity as I sold my kidney for money. Thus, poor sellers cannot be welcomed by the rich recipients; they can never stand in the same row as the rich do.

Such behaviors are unacceptable, so sellers discontinue the commodified kinship with recipients.

A few sellers also choose not to continue this kinship because recipients clearly avoid them. Mojnu (35) feared that if he called, his recipient might think he was calling out of need:

I did not talk with my recipient after coming back from India. She asked me to pray, but never invited me to her home. She did not ask for my home address when I left India. I have her phone number but do not know where she lives. Before the operation, the recipient told me that Allah sent her to this world for getting help from me. Her family always told her not to misbehave with me, as I am selling my kidney in the early stage of my life. At that time they were worried that my kidney would not set up in her body if I did not give it willingly, or my curse would hurt her strongly. But in reality, the rich recipient forgot my donation after taking the kidney. So, I do not call her anymore. If I call, she might not ask
me to visit and feel that I am calling because of my need. I do not want to risk getting hurt and feeling bad.

Other sellers do not go to the recipients’ homes because they feel their presence would remind the recipient of the operation and make their pain worse. Also, some do not want to see the recipients because they are ashamed of their unethical deal. Overall, the commodified kinship does not continue due to the recipients’ deceptions, broken promises, mistrust, and misconduct.

However, an obvious question arises: why do recipients not maintain the kinship? Recipients consider kidneys as commodities, and their exchange as a business deal; they establish a commodified kinship just to execute this deal. Thus, when the deal is done, the relationship is over. Mokhles (41) outlined how his recipient maintained this business relationship when they bumped into each other at a restaurant:

I was having breakfast and saw my recipient enter the restaurant where I was eating. I exchanged salam and asked about his health. He just responded “fine.” He sat down at another table, finished the food, paid the bill, and left the place. After coming back from India, this was my first and last meeting with the recipient. My kidney is in his body, but he did not want to talk with me. He neither asked about my health condition, nor offered a cup of tea. I always think about it. He did not treat me like a family member, as he did before. However, I did not see my fault in this. Perhaps my recipient thought that he already paid for something he bought, so why would he need to bother keeping a relationship with me?

Before the operation, all recipients take extra care of their sellers, but after the operation, most of them treat their sellers as passive agents. Keramat (25) added, “The work is over and the need is fulfilled. Before taking our kidney, they loved us as much as they hate us now.” Nevertheless, only a very few sellers think that recipients avoid them out of guilt after purchasing their kidney and then disrespecting the sellers’ sacrifice. The commercial
aspect of organ commodification is a barrier to continue the kinship between recipients and sellers.

Sellers are astounded at their recipients’ behavior, as they had hoped for a lifelong caring relationship. It was never the recipient’s family members who came forward to donate, but rather an unknown seller who saved the person’s life. Sellers, therefore, assumed that they had special rights over their recipients, who could fight with their own families but not with sellers. Yet in reality, none of the recipients ever visited the sellers’ homes. Nozrul (27) was outraged because his recipient did not take the time to visit him when he was in hospital a few months after the kidney operation:

I had an anal fistula, so I had to be admitted to the hospital for the operation. As I could not disclose this operation to my family, I called my recipient, but nobody even bothered to visit me – I was left alone. The recipient and his family were so busy with their work that they did not even send food or medication for me. What kind of person would do such a thing? Life is so unfair, isn’t it? After the operation, I had to quit my job to take care of myself.

Sellers have many expectations; they are devastated when recipients do not fulfill their obligations.

Sellers are extremely frustrated by this situation, as Motlob (27) pointed out: “I saved my recipient with my soul, otherwise his flesh and bones would have been destroyed by mud now. I gambled with my life, but we have not been in touch for three years now.” Most sellers told me that if they were able to talk with their recipients, at least they would feel at peace and their sadness would be relieved. Yet, many sellers cannot express their dissatisfaction to recipients. As Nergis (23) noted, “If I go to his house, the family would not open their front door.” A few sellers do convey their frustration when visiting their recipients. Hasmat (32) expressed his grief:
I just came to see my recipient because she was very sick and her family asked me to come. My recipient asked me how I was doing. I did not answer her question at first; she was sad. But when I remembered that she got a signature from me for giving me my payment, I could not forgive her. So I told her, whatever I am doing should not be your concern. I told her that our relationship was over. She cried and asked why I was behaving like this. I told her that she pushed me that way. She asked my forgiveness but only when she was sick. Oh well, I forgive her as my kidney is in her body. But I realize that a recipient should never distrust a seller in such a manner.

Since most sellers are not able to continue kinship with their recipients, but still worry about the person, they often try to find out about the recipients’ health in various ways. Some sellers call the broker and are relieved to hear that their recipient is in good health. Mofiz (41) was so inquisitive, he even came to Dhaka and stopped by the recipient’s home in the evening so he could hide; he asked the neighbors about the recipient’s health. Sellers feel that it would have been better to donate their kidney to someone who would remember them and be grateful to them for the rest of their lives.

The kinship between sellers and recipients does continue in some cases. Two sellers, Sokhina (37) and Forid (28), were satisfied because their recipients treated them well. Sokhina described their bonded kinship:

I have a good relationship with my recipient and her family. She treats me like her sister. They live close to my house. Her families visit me almost every other week; I feel good seeing them. They ask about my health and I inquire about her health. She sends fruit, food, and clothes for me. If I need some money, they give me 200, 400, or 500 Taka ($3 to $7). The recipient’s husband treats me like his sister and her mother behaves as if I am her daughter. They always ask me to stay a few days with them when I visit. My recipient was in the hospital for four months; I visited her every week, as we feel for each other. They are good people, but they are poor. They borrowed money and sold land to arrange the cost of transplantation and my payment. When they paid me (100,000 Taka, equivalent to $1,450), they said it was their gift. We maintained the relationship perhaps because both of us are poor. If my recipient were rich, she might think that I am keeping the relationship for some advantage.
In both Sokhina’s and Forid’s cases, sellers and recipients have regional affiliation and lower economic conditions that might contribute to their maintaining the kinship.

Another two sellers, Manik (32) and Montu (38), also continued the ties with their recipients, both of them were living abroad. As Manik described:

I think he is my elder brother. When my recipient is by my side, I feel brave and courageous. I feel like he is my man. I look at him with surprise. He is alive with my insides. I feel for him more than my siblings. I often call his home and ask about his health. If I can use the Internet, I keep in touch every week. When I talk with him over the phone, I feel good. He advises me to take care of myself. He tells me to inform him if I have problems. He loves me as he does his brother. He gave me a job, and when it was terminated he gave me 15,000 Taka ($215) to set up a phone fax store. He always brings gifts when he visits the country.

Likewise, Montu always receives gifts, such as soap, shampoo, and skin cream, when his recipient visits Bangladesh. Manik’s and Montu’s relationships continued because the recipients’ families cooperated with the sellers in the recipients’ absence. These sellers believe that if their recipients were not so far away, they would have an even stronger kinship.

Two sellers, Dildar (32) and Anu (31), were also encouraged by their recipients to maintain the relationship. Dildar said:

My recipient is a very good man. We often call and write letters to each other. We discuss our health, job, and life. Although he purchased my kidney, he has good morals; he is honest and kind and paid me on time. If I do not call my recipient, he becomes restless. He often calls me and asks me to visit him in Dhaka. If I cannot come, he starts crying. When I go to see him, I bring fresh fish and organic rice from my village. We always eat together at one table.

Here I asked Dildar what his recipient usually does during the visit. Dildar jokingly replied:

What else can he do? He will not dance with me. I am poor and cannot afford their sophisticated food at home, so I stay a few days with him. However, I do not like visiting his house because his younger son looks at me differently. One day he told me that he did not like talking with me because I was a kidney seller. He
also warned me to keep my distance from them. I cannot mention this to my recipient, who would be very hurt. My recipient cares for me so much, he did not even allow me to donate blood for my mother’s operation.

These recipients maintain kinship as they feel a deep connection with their sellers.

During the end of my fieldwork, two sellers, Tofail (27) and Salam (32), had just returned to Bangladesh after their operations; they dreamed of a lifelong relationship with their recipients. Tofail had yet to receive his payment, so he worried that his ties with his recipient might be destroyed if the recipient did not pay. Both sellers mentioned that the kinship depends on two parties, not solely on the seller. When they asked me about the general trend of kinship between sellers and recipients, I changed the subject.

Shattered Dreams

Among the 33 kidney sellers I interviewed, virtually every seller’s hopes and dreams had been broken into tiny pieces due to extreme and widespread deception. In addition, their social, economic, and health conditions had significantly deteriorated. Further, the vast majority found it impossible to continue their kinship with their recipients. Ultimately, all sellers, even those who received full payment and have ongoing kinship with their recipients, regret selling their kidney.

As we have seen, sellers sell their kidney hoping that their economic situation will improve, but are maliciously deceived. The majority does not receive the full payment, but rather obtain a portion of their due in small fragments in an untimely manner. With the futo paisa, the empty coin, that they receive, they cannot pay off their loans entirely or use the money productively, and so their financial problems – which motivated them to sell their kidney in the first place – remain unresolved. Above all, trading a kidney
leaves sellers disadvantaged in other ways. In the post-vending stage, many sellers become jobless and unable to engage in work that requires heavy lifting; their income declines significantly. As Gofur (41) noted, “Before [the surgery] I left home in the early morning and came back in the late evening, and thus I was able to earn about 6,000 Taka ($86) a month, but now I can earn only about 4,000 Taka ($57) monthly.” Likewise, Mofiz (41) told me, “Before, I sold meat in the market for seven days, but now I can only go there for two days. I cannot work hard and I feel weak chopping the meat into pieces, so I hired an employee and I just weigh the meat and collect the money.” All sellers feel that if they had all of their body parts, they might be able to fight against their economic hardship, but now they are completely defeated. Selling a kidney is an irrevocable loss for them.

All of the interviewed sellers were unaware of the detrimental health consequences of selling a kidney, and thus could not make an informed decision when they engaged in this trade. Currently, every seller suffers from serious deterioration of their health. All experience not only physical problems, such as pain, weakness, and low energy, but also psychological agony, including anxiety, depression, and trauma. Living in poverty in everyday life is difficult, but the deep psychological suffering of the loss of a vital organ is unbearable. The loss of a kidney jeopardizes sellers’ mind-body relationship; they are living with a damaged self. Yet, very few of them receive a single medical follow-up during post-transplantation, and indeed are forced to live with poor hygiene, which is extremely detrimental to their health.

Sellers all hope for lifelong kinship with their recipients, but these relationships rarely continue, as recipients deceive and mistrust sellers and treat them as commodified
The relationship recipients create is a fraudulent kinship in which sellers are entrapped by being convinced to “donate” a kidney and receive gifts in return. Sellers are then manipulated and misinformed in light of the noble act of saving a life. In the end, they realize that recipients’ “sweet words” make sellers kidneyless. They find satisfaction in their recipients’ survival, but if their recipients die, sadness at selling surpasses their happiness at giving.

Many sellers conveyed to me that they felt that they had lost dignity from selling a kidney. Many were so ashamed of their actions that the majority hid the operation from their families. As a consequence, sellers became socially isolated, afraid that if their actions were revealed, their social position would be lowered. Some sellers who could not hide their scars were socially humiliated. As Awwal (28) said, “Wherever I go, the villagers call me a kidney man. I do not know how much longer I can carry this shameful burden.” In addition, sellers encountered moral sufferings. As Sodrul (22) noted, “I always think I am a bad person in society. How could I come to this wrong path and do such a nasty thing?” The long scar thus is a symbol of deep sufferings.

In conclusion, the return for selling is significantly less than expected, while the suffering is enormous. Thus, almost every seller sees kidney selling as an uneven trade. Keramat (25) echoed other sellers when he said, “We wasted our lives by selling our kidneys.” Many feel that they ran after an illusion and engaged in risky business, but still could not fulfill their dreams. Whatever money sellers received, they could not escape poverty. As Rahmat (28) said, “Where I was before, I am still there, sitting and eating
with my parents but hiding my kidneyless body.” Kidney selling thus dismantles sellers’ dreams and disorders their lives. Above all, as the stories indicate, selling a kidney increases the vulnerability of the poorest citizens. Almost all sellers are disadvantaged as a result of selling their kidney; they are living in worse conditions than ever before.

All the sellers I interviewed were convinced that they had shortened their lifespan through the surgery. They also predicted that they would experience many other financial problems in the near future, but did not have other organs to sell. Many worry that this deal might turn them from being poor to being beggars. My study population therefore concluded that living in poverty is a better option than living without a kidney. They proclaimed kidney selling to be the biggest loss of their lives; if they had a second chance in life, they would not sell their kidney. As Keramat (25) said while weeping uncontrollably, “We are living cadavers. By selling our kidneys, our bodies are lighter but our chests are heavier than ever.”
CHAPTER NINE

Fair Trade Kidneys?

Reason has always existed, but not always in a reasonable form.
– Karl Marx, Letter from the Deutsch-Französische Jahrbücher to Ruge, 1843

In 1987, Dr. C. T. Patel, a well-known Indian nephrologist, argued in a daring presentation in Pittsburgh, “Kidney donation is a good act: It is the gift of life. The financial incentives to promote such an act are moral and justified” (Patel 1988: 1098 as quoted in Daar 1992a: 2088). Patel defended the payment for living, unrelated kidney donors, calling it “gifting with reward.” Thus, the term “rewarded gifting” has been entered into the professional debate. Dr. Reddy, who has done more than 2,000 renal transplants in India, took another step to defend the paid-donor program. In 1993, he coined the phrase “To buy or let die,” and considers that “Banning the [trade] option in order to remove the immoral elements is like throwing the baby out with the bathwater.” He adds that to dismiss the possibility of paid donors because of the ethics of expediency is to deny patients the right to live (Reddy et al. 1990: 910–911).

Similarly, Abdallah Daar, one of the pioneers of the paid donors program proposition, argues in favor of legalizing the organ trade. Daar considers it to be almost impossible to stop the corruption against organ donors due to limited infrastructure in most Third World countries, especially in situations where brokers, not donors, are the primary financial beneficiaries of this exchange. Thus, he argues that rewarded gifting should be acceptable for certain parts of the world, such as India, for the benefit of both recipients and donors (personal interviews with Daar;71 see also Daar 1989, 1992a,)

71 I spoke with Dr. Abdallah Daar at the Centre for Bioethics, University of Toronto, in February 2004.
Based on similar justifications, some other transplant surgeons argue that rewarded gifting is a part of life: “People give large donations to the Cancer society – they want to cure cancer – but they also get a gift back in the form of tax deduction” (Monaco in 1990: 897). Bernard Dickens, a lawyer at the University of Toronto, in response to such reasoning, also notes,

> It may be incongruous and hypocritical that, when hospitals make volumes of money from transplantation, physicians and associated health professionals advance careers and incomes, drug companies profit, and the medical industrial complex is enriched, the original donor of tissues is supposed to be altruistic. (Dickens 1990: 905)

Clearly, some medical and other professionals, including the Nobel laureate economist Gary Becker, argue in favor of rewarded gifting (Becker and Elias 2007).

The most common argument against rewarded gifting is that it purportedly capitalizes on the distress of those in need, particularly because, as the poor can participate in rewarded gifting only as sellers, it is an exploitative practice. Those who can afford a transplant can exploit the poverty of organ sellers, who would not have sold their body parts given better circumstances in life (Abouna et al. 1990: 919). For some, the exploitation of organ sellers veers close to human slavery (Berlinguer and Garrafa 1996 in Delmonico and Scheprer-Hughes 2003: 387; see also Somerville 2008: 1-2). George Annas therefore argues, “An exchange of human organs places a very high value on individual rights and a very low value on equality and fairness” (Annas 1987: 332). Dr. J. V. Thachil, a Canada-trained urologist who, with his team, has done hundreds of kidney transplants in Chennai, India, concludes, “It is criminal to exploit the poor in order to keep less than one per cent of the population alive” (Frontline 1997: 8).
In addition, rewarded gifting raises issues concerning commodification of the body that “injure human beings by treating them as things, as less than human, as objects for use” (Nuffield Council on Bioethics 1995: 40). In such commodification, “mutual respect for all persons will also be slowly eroded” (Dossetor and Manickavel 1992: 66). M. K. Mani, an Indian nephrologist and one of the leading opponents of the paid donor program, therefore argues that the idea of paid donor transplants dehumanizes the donor, and turns him or her into a biological machine (Frontline 1997: 12).

Further, rewarded gifting promotes special health-care costs involved in the organ trade: for example, it might reduce the quality of health care and lead to poorer-quality organs (Jonsen 1997; Fried and Mavrodes 1980; Kennedy 1979); the donor might experience surgical harm and even death, since organs are being procured in unrecognized medical clinics (Transplantation Society 1986); and the procedure could lead to lower life expectancies for patients (Daar et al. 1990; Abouna et al. 1990; Salahudeen et al. 1990). In addition, rewarded gifting “invites social and economic corruption … and even criminal dealings in the acquisition of organs for profit” (Abouna et al. 1990: 920).

What is more, rewarded gifting does not satisfy recipients emotionally. In a study by Abouna and others of 49 Kuwaiti renal patients, one recipient said, “I felt so worried about taking a kidney from a skinny Indian donor that I first put him in a hotel for a month at my expense to nourish him before taking his kidney!” (Abouna et al. 919). This position clearly argues that the practice of “rewarded gifting” is ethically and pragmatically unacceptable. Until today, the dominant paradigm has been an explicit and unequivocal stand against any form of payment, trade, or commerce in organ exchange.
In this chapter, I argue against rewarded gifting or any form of commerce or market of human organs. While the above-presented standpoints in favor of or against rewarded gifting are mainly based on opinions, I have ethnographic data to support my claims. Reviewing the existing literatures on this debate and citing the narratives of my interviewed kidney sellers, I explore why such a trade is unethical.

Before delving into this discussion, it is important to note that the current conditions of organ exchange are complex. There are seven major types of organ exchange:

(i) Cadaveric donation (with prior informed consent, organs are removed from deceased donors);

(ii) Living-related donation (unpaid donation from parents, brothers, sisters, or children);

(iii) Living, emotionally related donation (unpaid donation from a spouse or close friend);

(iv) Living altruistic donation (donor does not necessarily know recipient; the donation is a pure act of altruism, with no expectation of a material reward of any sort);

(v) Rewarded gifting (an exchange of an organ in which the donor alone is “rewarded” or compensated for inconvenience, hospitalization, loss of income, and any other payment associated with the act of donation);

(vi) Rampant commercialization (payment is given not only to the donor but to a middleman and brokers; the ultimate goal is a market-based program of commercialization); and

All major health and humanitarian organizations accept the first four kinds of organ exchange and condemn the last three. However, the issue of rewarded gifting evokes divided opinions and complexities, which are frequently discussed in popular media and academic journals – for example, as in the featured issue of the British Medical Journal in June 2008 and the Journal of Medicine and Philosophy in October 2009.

Notably, the terminology of “rewarded gifting” is highly controversial; it promotes the concept that organs are not bought; rather, donors receive a “reward” for their gifted organs. As Lesley Sharp notes, “rewarded gifting is an oxymoronic euphemism that downplays the contradictions inherent in attempts to blend altruistic and market principles; rewarded gifting and direct payment occupy different points on the same continuum” (Sharp 2008: 4). Similarly, Robert Veatch argues, “rewarded gifting is a blatant corruption of the language as it signifies that the transfer of money is not a ‘reward,’ but a payment.” He sees rewarded gifting as more justified if and only if a non-monetary reward, such as “a few bonus points,” are provided for an organ (Veatch 2000: 158–159; Bagheri 2006: 272–273). Further, rewarded gifting cannot always be separated from commodity commercialization, since vested interest groups, such as brokers, agencies, and government officials, are involved in this commerce. Therefore, the Nuffield Council on Bioethics considers that “rewarded gifting arrangements should be viewed as commercial transactions in that they offer inducements for permitting removal of human organs” (Nuffield Council on Bioethics 1995: 52). For the last two decades, the
impulse of rewarded gifting is carried out through other parallel concepts, such as donor compensation, paid donor program, or the most popular: the organ market.

Arguments for the organ market are nested in three broad categories of market ideology: free market, regulated market, and anti-market. The free market is based purely on the notion of supply and demand, cost and benefit, and individual rights and liberties. The proponents of the free market focus mainly on utilitarian grounds by increasing the supply of organs for saving lives, and thus rationalize legalizing this trade (see Friedlaender 2002; Barnett et al. 2001; Malek 2001). The regulated market is built on the idea of efficient outcome and equitable distribution by either the state or the charitable organization. The promoters of the regulated market highlight that such a system could save the lives of dying patients and argue that in this system, the sellers’ exploitation is minimal but unavoidable for greater benefit, and regulation would lessen this exploitation (see Hippen 2009, 2008, 2006 & 2005; Hippen et al. 2009; Friedman and Friedman 2006; Bakdash 2006; Larijani et al. 2004; Erin and Harris 2003; Marino et al. 2002; Mahoney 2000; Levine 2000; Adams et al. 1999). The anti-market standpoint, on the other hand, is based on the idea that organ trading is unjust and inhumane, and concludes that certain things should not be alienable (see Scheper-Hughes 2008, 2006e, & 2003b; Danovitch 2008 & 2007; Danovitch and Delmonico 2008; Jha and Chugh 2006; Jha 2004; Rothman 2002; Rothman and Rothman 2003).

At present, Iran is the only country in the world with a regulated market of kidneys, which has operated since 1997, but there is a regulation of the allocation of organs to non-local citizens, thereby restricting the international organ trade (Ghods and Nasrollahzadeh 2005: 351). The Charity Association for the Support of Kidney Patients
(CASKP) and the Charity Foundation for Special Diseases (CFSD), two non-governmental organizations, control the regulated market of organs with the support of the Iranian government (Bagheri 2006: 271). These organizations match donors to recipients, set up tests to ensure compatibility, and arrange transplantation. After the procurement, CFSD pays the donor a fixed amount of 10 million Rials ($1,090) as a social gift (Barheri 271). Although this regulated market has eliminated both the waiting list for kidneys in Iran and organ traffickers from other countries, the number of living unrelated donors is rapidly increasing in this country due to poverty and unemployment. By the year 2000, 76% of total donations were from living unrelated donors (Ghods 2002: 223). Also, additional and unregulated payments by recipients have become the norm, dictated by brokers (Harmon and Delmonico 2006: 1146). It is reported that paid donors are often recruited from the slums by wealthy kidney activists and are paid “a pittance for their body parts” (Scheper-Hughes 2003b: 1646). Moreover, donors receive no follow-up care afterwards, and some who have subsequent medical problems are turned away (Scheper-Hughes 2003a: 220). Further, the regulated market has been aggressively promoting living commercial donation over cadaveric gift giving; in fact, it is the greatest obstacle to establishing a cadaveric transplant program there (Zargooshi 2001a: 387; Tober 2007: 159). Still, a very few countries, such as Saudi Arabia, Kuwait, and Israel, are currently considering establishing a regulated market to resolve their organ shortage. Meanwhile, the organ trade is outlawed in every other country in the world. In the following pages, I review the current debates on the organ market and then argue that such a market is ethically reprehensible.
In Situ: Organ Market

The debate on the organ market is currently being carried out by a number of medical doctors, social scientists, bioethicists, and philosophers. Concentrating on the fact that many potential recipients are dying due to a shortage of organs, advocates of such a market urge that it saves lives. Efficiency and individual autonomy are their focus of analysis. In contrast, arguments made by opponents of the organ market are rooted in the principles of equity and social justice. These arguments emphasize the accompanying risks, harm, and exploitation of the poor sellers involved in this trade, and discuss cultural issues pertaining to organ commodification.

Proponents of an Organ Market


The discussion against organ sales is derived not from the principles and arguments, but rather from strong feelings of repugnance, which exert an invisible but powerful influence on the debate, distorting the arguments [and working] to the detriments of the [very] people most in need of protection. (Radcliffe-Richards 1996: 375)

Based on the principle of autonomy and consent, but outweighing harm and exploitation of the donor, Radcliffe-Richards defends her arguments in favor of a regulated organ market and proposes direct payment to a vendor as a remedy for resolving his or her poverty. She notes that the poor have the right to sell their body parts because doing so could be the only or the best option they have (Radcliffe-Richards 391). Therefore, she argues that the ban on organ trade takes away their autonomous rights and leaves them in a situation that they think is even worse than the loss of a kidney (Radcliffe-Richards 377). She also raises questions such as this: “Why should vendors be made to prove
altruistic intentions, rather than be allowed to judge their own best interests?” (Radcliffe-Richards 408). She continues, “If a living donor can do without an organ, why shouldn’t the donor profit and medical science benefit?” (Radcliffe-Richards et al. 1998: 1951).

In turn, philosopher Mark Cherry (2009, 2005, & 2000) argues that a market is a humane, efficient, and effective way to procure and distribute human organs (Cherry 2005: 12). Cherry focuses on saving lives, rather than on “purported human exploitation” and “irrational moral repugnance” of selling organs. He argues that a regulated market, rather than being “a misguided prohibition,” would likely be more successful “in preventing exploitation, preserving human dignity, and reducing needless human sufferings than current governmental bureaucratic procedures for procuring and allocating organs for transplantation” (Cherry 14). In his view, the market is the most efficient means for distributing resources. He asks, “Since most Americans accept this system, why should body parts be excluded?” (Cherry 76). He concludes that the prohibition of organ sales very likely causes more harm than benefits (Cherry 147).

Philosopher James Stacey Taylor (2009, 2005, & 2002) also argues that the market of human body parts is morally imperative, since it is a viable and ethical solution to resolving the organ shortage. Based on the idea of individual autonomy, he argues that

Respect for autonomy would require that a current market in human kidneys be regulated, by, for example, requiring that the vendors give their informed consent to the sale of their organs, requiring that they receive adequate post-operative care, and requiring that they receive a certain minimum payment for their organs. (Taylor 2005: 3–4)

He also specifies that an international market should be used to distribute kidneys procured through market means (Taylor 3).
Meanwhile, medical surgeon Arthur Matas (2008 & 2004; Matas and Ibrahim 2007; and Matas and Schnitzler 2004) similarly supports a regulated system of living kidney sales, indicating that potential transplant candidates are dying on the waiting lists. He emphasizes that even if all potential deceased donors became actual donors, there would still be a substantial shortage of organs (Matas 2008: 1342). He therefore advises promoting living as well as cadaveric donation, increasing the number of transplantations, and, thus, decreasing death rates and suffering of patients living on dialysis (Matas 2008 & 2004). He argues that a regulated system would provide strict control, limit harm, and ensure that “every candidate has an opportunity for a transplant; full donor evaluation; informed consent; oversight; long term follow-up; treatment of the donor with dignity and appreciation for providing a lifesaving gift; and illegality of any other commercialization” (Matas 2004: 2011). He further points out that a regulated market would protect both recipients and living sellers and would respect the autonomy of potential sellers; compensation would increase donations (Matas 2008: 1342).

Detractors to an Organ Market

Physician Francis Delmonico (2009, 2008, 2007, 2006, 2005a-b; Delmonico et al. 2002) rejects the proposition of organ commercialization. He argues that assigning monetary value to the human body or its parts, even in the hope of increasing organ supply, diminishes dignity and devalues human life (Delmonico 2005a: 639). He adds that “an attempted scientific justification of medical benefit or economic analysis concluding that organ sales save money does not overcome the ethical objections to selling kidneys from human vendors” (Delmonico 2008: 97). He claims that an organ
market may force the physician to make decisions about transplantation based on the terms of the market principle, rather than on what is best medically for both donor and recipient. Delmonico elaborates on this viewpoint by showing how “transplants are becoming a booming industry for making profits,” but generating exploitation of the poor (Delmonico 2007: 924). He continues, “the payment for organs does not ensure justice, especially when it comes to protecting the poor from harm,” and concludes that a paid donor program is an unethical approach that “shifts the tragedy from those waiting for organs to those exploited into selling them” (Delmonico 2008: 98).

Bioethicist Jeffrey Kahn (2008, 2003, 2002, & 1999; Kahn and Delmonico 2004) notes that the price of an organ market in social and ethical terms is too high, ranging from exploitation of desperate donors to undermining of the fundamental ethics of organ donation. He argues that “a regulated market of organs would give rich people the chance to get available organs, and would exploit people who need money and would not donate except for payment” (Kahn 1999: 1). He adds that in such a system, “few would choose to sell organs if they had any other options, leaving the desperately poor with few prospects other than the sale of their body parts” (Kahn 2008: 99). This proposition would therefore accept a policy environment that “would make exploitation the rule rather than the exception” (Kahn 98). Kahn additionally argues that an endorsement of organ sales would represent an undermining of the moral foundations of our present organ donation policies and practices. It would also represent a failure of government itself, and would undermine the moral foundations of our society. He concludes that the proposals to encourage organ trade are unlikely to be effective.
Similarly, physician Luc Noel (2009; 2007; Noel and Martin 2009) states that the “organ trade is exploitative since the rich have no reason to sell their kidneys; the commercial exploitation of organs denies equitable access” (Noel quoted in Ritter 2008: 2). Noel notes that on the Internet, there are literally hundreds of desperate, poor, and vulnerable people who are offering to sell a kidney; he urges everyone, especially health-care professionals, to protect these people (Noel 2007: 905). He considers that “transplant tourism is far from being finished, but that there is now a realization that it is harmful to both living donors and recipients” (Noel 905). As he states, “The profit motive predominates in this trade, more than the interest of the patients, and care for the live organ donor is secondary or non-existent” (Noel 905).

Meanwhile, physician Jeremy Chapman (2008) argues that selling organs does not help people lift themselves up from destitution. The only people who clearly benefit are the intermediaries, who take money as the kidney transits from the vendor to the recipient: organ brokers, transplant surgeons, hospitals, government officials, and the wealthy health insurance companies of the West and the Middle East (Chapman 2008: 1343). He notes that “the wealthy advocate the sale of organs as a fundamental human freedom, but this right is exclusively exercised by the poor” (Chapman 1343). He argues that “solving poverty is unachievable, but if there were no poor people in the Philippines or indentured workers in Pakistan, sales of their organs would be unlikely to continue” (Chapman 1343). He asks, “Which family member will donate if the government will pay someone else?” (Chapman 1343).

All of the above-mentioned studies offer invaluable insights on the free market, regulated market, and anti-market propositions of organ commercialization. However,
they are not based on empirical research, and do not include the detailed contexts and consequences of selling kidneys, mostly because only half a dozen research studies on kidney sellers have been published to date (Zargooshi 2001b; Goyal et al. 2002; Schepers-Hughes 2003a; Budiani-Saberi and Delmonico 2008; Naqvi et al. 2007 & 2008; Moazam et al. 2009), and most of them are based on rapid survey data and were conducted primarily in those settings where the organ trade was not yet outlawed. In addition, sellers were often invisible, or under-represented, particularly in the pro-market writings; in fact, sellers are formally recognized only in recent resolutions carried out by the Amsterdam Forum and the Vancouver Forum (Delmonico and Council of the Transplantation Society 2005; Barr et al. 2006; World Health Organization 2004a; The Declaration of Istanbul 2008). Further, these studies broadly focus on the global context of organ trafficking, rather than the local realities of organ commodification.

In anthropology and beyond, Nancy Schepers-Hughes (2008, 2007, 2006a-e, 2005, 2004a-b, 2003a-c, 2002a-c, 2001a-c, 2000, 1998a-b, & 1996) is the most outspoken researcher and activist speaking against the organ market. Schepers-Hughes strongly opposes “putting a market price on body parts,” since “it exploits the desperation of the poor” (Bakdash and Schepers-Hughes 2006: 1700). Based on ethnographic realities, she argues, most kidney sellers are extremely poor. Because their health may already be compromised due to their poor living conditions, the usual risks of donating a kidney are multiplied. She further adds that kidney sellers face everyday suffering, such as exposure to urban violence, transportation and work-related accidents, and infectious diseases, all of which can compromise their remaining kidney. “If and when that spare part fails,” she says, “they would have no access to dialysis let alone to transplantation” (Schepers-
Hughes 2003b: 1646); such “violence associated with kidney selling gives reason to pause” (Bakdash and Scheper-Hughes 2006: 1701). Additionally, Scheper-Hughes notes, transplantation and other modern technologies violate “longstanding modernist and humanist conceptions of bodily holism, integrity, and human dignity,” as well as “cultural and religious beliefs in sacredness of the body” (Scheper-Hughes 2003a: 204). She concludes that “the arguments for ‘regulation’ as opposed to prohibition have some merit, but are out of touch with the social and medical realities in many developing countries” (Scheper-Hughes 2003b: 1646).

Anthropologist Lawrence Cohen (2002 & 1999) likewise warns that the contemporary debate on the ethics of the sale of organs removed from the bodies of the poor is shifting. Increasingly, philosophers, physicians, and social scientists are considering allowing the market of human organs, even though there is no data available on the long-term effects of nephrectomy to sellers or their families (Cohen 1999: 149). Yet, in reality, sellers decide to sell their kidneys not to raise cash for a future goal, but rather to pay off a high-interest debt to local moneylenders, and are frequently back in debt within several years. As Cohen says, “even though one has only one kidney to give, at some point, the money runs out and one needs credit again, and then the scar covers over the wound not of a gift but of a debt” (Cohen 141). Cohen argues that “the suppression of viable donors, not recognition, turned transplantation into a major industry” (Cohen 2002: 11). He concludes that the ethics of a regulated market for organs is concerned with the small minority of citizens who can afford the cost of dialysis or transplantation (Cohen 1999: 146).
Meanwhile, Donald Joralemon (2001; 1995; Joralemon and Cox 2003) argues that commodifying human body parts is terribly wrong; he argues for keeping the cash out of transplantation. Rather than locating precisely where the wrong lies, Joralemon starts from the premise that there is an “intuitively unambiguous connection we feel to our bodies” and that “traditional assumptions of self-body integrity” exist. These assumptions, in his representation, are “static” and “universal” (Joralemon 1995: 347). By focusing on the evaluation of attitudes towards compensation plans from the early 1980s to the present, he notes that “once the professional norm has slowly begun to be replaced by an open debate of plans that offer financial rewards to persons willing to have their organs removed, the profession will suffer a serious setback” (Joralemon 2001: 34). Since the American Medical Association proposed compensating families for cadaveric donation, Joralemon has warned that this proposal assumed that the body is dissociable from the self and the body is treated as property; such a view, he said, is “out of step with the rest of the culture” (Joralemon and Cox 2003: 27).

Lesley Sharp (2008, 2006a, & 2000) also considers that body parts are not alienable forms of property but, rather, belong in relation to self and personhood. She argues that economic rewards “deny the sanctity of the human body” and “debase us as human beings” (Sharp 2008: 2). She concludes that “incentives have a collective effect, in that they erode away at the fabric of civil society, favoring the needs of one group over another; such practices are therefore inescapably exploitative” (Sharp 2). Yet, in medical discourse, as Sharp points out, “the clinicians assume that kidneys are anatomically redundant and thus do no harm to donors in removing one of two healthy kidneys through safe medical practice for the pronounced medical needs” (Sharp 10-12). Sharp explains
that although organ donation is frequently described as “gifts of life,” “the rhetoric of gift
exchange disguises the origins of commercialized body parts, silencing in turn any
discussion of the commodification process” (Sharp 2000: 303–04; see also 1994). Sharp
concludes that the proponents of the organ market consider that “the market is the great
equalizer because payments, rewards, reimbursements ultimately appeal to everyone, and
treat equally, but in fact, it defined an imagined and untested future market set within a
highly specialized and rarified medical realm” (Sharp 2008: 7-9).

In general, anthropologists strongly oppose the market of human organs by
critically examining the global context of organ trafficking, the expansion of transplant
technology in neo-liberal capitalism, and the ethical, cultural, and political realities of
commodifying organs in various settings. However, an in-depth ethnography on the
kidney sellers, which is almost entirely absent in anthropological and other scholarly
disciplines presented earlier, is essential to examine the underground organ market, the
debate on the regulated organ market, and relevant medical, social, and cultural issues
pertaining to the organ trade. Based on the narratives of my interviewed kidney sellers
and their detailed experiences of selling their kidneys, in the following section I argue
against the organ trade for these reasons:

1) It constitutes structural violence against the poor;
2) It is seriously harmful to sellers;
3) Sellers’ subjective suffering is far from over afterwards;
4) Deception is widespread in the organ trade;
5) Sellers are manipulated into selling their kidneys;
6) This trade is executed through misinformed consent; and
7) It has various negative outcomes.

Bangladeshi kidney sellers’ opposition to the organ market is outlined afterward.

**Structural Violence Against the Poor**

In 2006, Umma Habiba Dipon, a 27-year-old middle-class Bengali fashion designer, arranged a charitable art exhibition and a musical concert in Dhaka. Many Bangladeshi celebrities donated artworks and performed during this event. With the funds she raised, Dipon went to Pakistan and purchased a kidney from a poor villager. At least a dozen Bangladeshi newspapers covered Dipon’s story in support of arranging her transplantation. One of the national dailies published the following piece:

**Asking for Help for Health Care**

Dipon is lying on a hospital bed in between life and death after losing both her kidneys. Currently, she is under the health care of Dr. Krishna Mohan Sau at Apollo hospital in Dhaka. Health specialists avow that she will leave us too soon without an urgent kidney transplant. As Dipon cries out: “I want to live with my family under the light and air of this beautiful world through the revolution of medical science in the 21st century.” Alas, Dipon’s husband, a young artist working at Bangladesh Children Academy, is unable to bear the high cost of transplantation. If all of us can donate a small amount of money, we can snatch Dipon from the cold grip of her death. (*The Daily Khabarpatra*, 9 August 2005)

Dipon’s husband also widely circulated a leaflet in Dhaka. On the leaflet, which featured Dipon’s photograph, he wrote:

**Can We Light up Dipon’s Flame of Life? Step Forward to Save Dipon**

Soyad is the name of an 8-month-old boy. His mother, Dipon, lost both of her kidneys when she gave birth to him. Now Dipon is getting closer to death as she cannot afford the monthly expenses of 50,000 Taka [$700] for dialysis. Doctors advised Dipon to have an urgent kidney transplant, which costs about 1,500,000 Taka [$21,500]. Dipon’s family is unable to arrange this huge amount of money. Shouldn’t good-hearted persons of our society do something? They generously helped in the past; Let’s offer our hearts to an artist family.
The media coverage highlighted Dipon’s vulnerability, plea for survival, and inability to afford health care – common themes of local Bangladeshi newspapers introducing a transplant recipient.

What is immoral in Dipon’s case is that she spent the charity money on the outlawed practice of buying a kidney, instead of looking for a donation from a family member. I revealed this dealing when Dipon’s husband once visited me in Dhaka in 2005.72 When I advised him to donate one of his own kidneys to save his wife, he refused my proposition, stating that he would not gamble with his life, especially as he was the only breadwinner in the family. He also admitted that he did not ask other family members to donate because transplantation is a potentially life-threatening operation that can have post-transplant health complications; he considered that it was his “social obligation” not to endanger the lives of his family members. Like Dipon, most other rich and middle-class Bangladeshi recipients, who can afford to do so, typically purchase organs from the market, as my fieldwork reveals.73 However, these recipients either conceal or misleadingly represent their kidney shopping to their peers, who are artists and journalists, saying publicly that they need to find an unrelated “donor” because they are unable to match tissues with family members, or their family members were unwilling to donate. Thus, Bangladeshi recipients justify their kidney purchase by saying that kidneys are not available from their own families, but are abundant among the poor.74

72 After learning that I was conducting research on the illegal organ market, Dipon’s husband visited me to find out more about this trade. In our meeting, he asked me for the contact numbers of kidney brokers in Bangladesh. I refused his request and advised him to donate one of his own kidneys to his wife.
73 Most of my interviewed kidney sellers told me that their recipients did not ask family members to donate; rather, recipients bought the kidney from the market.
74 The scarcity of organs in the medical discourse is also a “social invention” (see Lock 2002a; Koch 2002; Scheper-Hughes 2003a; Sharp 2006a).
What is highly problematic here is these recipients’ corrupt ethics, extracting “fresh” kidneys from the bodies of the poor instead of obtaining kidneys from family members. If they do not want their own families to undergo this surgery because it is risky and harmful, why do they act as if it is not so risky and harmful for the poor, who are already living without the basic necessities of life? Why do recipients never receive punishment for their unethical dealings of purchasing a kidney, but instead have their actions patronized through charitable donations, newspaper advertisements, and vested interest groups? How can recipients execute such a harmful, deceptive, and oppressed trade, even though it is outlawed by the state? These are stark examples of “structural violence” that perpetuates commodifying kidneys from the poor.

“Structural violence” is a term that was first used in 1970s by liberation theologian Johan Galtung. Galtung (1969) notes that this form of violence is silently built into social structures and social institutions that systematically prevent individuals from achieving their full potential (Galtung 1969: 168; see also discussion on constraining the “capabilities of each person” by Sen 1998: 2; and how it constricts the agency of its victims by Farmer 2004: 315). Structural violence is also defined as physical and psychological harm that results from exploitative and unjust social, political, and economic systems (Mukherjee 2007: 116). So, how does structural violence come to “harvest its victims”? (Farmer 2004: 315). Galtung answers:

The structure deprives them of chances to organize and bring their power to bear against the topdogs, as voting power, bargaining power, striking power, violent power – partly because they are atomized and disintegrated, partly because they are overawed by all the authority and topdogs present. (Galtung 1969: 177)

Galtung refers to the condition of structural violence in relation to social injustice (Galtung 171). Similarly, liberation theologians consider that structural violence is
“generated and fostered by two factors: 1) the institutionalized injustice in various social, political, and economic systems; and 2) the ideologies that use violence as means to win power” (Eagleson and Scharper 1978: 194). Paul Farmer closely links structural violence to “social injustice” and “social machinery of oppression” that are embedded in a “larger matrix of culture, history, political economy” that fosters human rights abuses and extreme sufferings (Farmer 2004: 307 & 2005: 29–50; Farmer et al. 2006: 1686).

So, who are the victims of structural violence? As Farmer answers, “today, the world’s poor are the chief victims of structural violence” (Farmer 2005: 50). This is the case simply because the effects of structural violence disproportionately impact the poor. As liberation theologian Leonardo Boff observes, structural violence “creates a situation where the rich get richer at the expense of the poor, who get even poorer” (Boff 1989 quoted in Farmer 2005: 41). Farmer’s work eloquently shows us how structural violence contributes to the plagues of tuberculosis and HIV/AIDS among the global poor, but lessens both their access and adherence to effective therapy (Farmer 2005, 2004, & 1999).

My ethnography reveals the severe extent to which poor Bangladeshi kidney sellers are victims of structural violence. As chapter three outlines, the deeply rooted structural violence derived from colonial exploitation, neo-liberal readjustments, and severe corruption have led to immense economic inequality that has resulted in 35 million Bangladeshis (nearly one quarter of the population) living in hunger. Yet, transplantation – a highly expensive medical technology – is booming in this country, to fulfill the needs of less than 1% of the population – wealthy (and some middle class) citizens. The majority – the poor – are at the utmost risk of organ failure, but usually die
without receiving a transplant, let alone dialysis. Transplantation is not just a new technology, it is a life-saving procedure; therefore, these ethical questions arise: New technology for whom? Who suffers from organ maladies, but who receives the care? Should not the poor have an equal right to save their life through this miracle technology?

Yet, at present, Bangladeshi poor are literally begging for money in local newspapers in order to afford the cost of transplantation. Regrettably, many of these poor end up selling their land and jewelry and borrowing money to arrange the operation. As a result, they experience serious negative consequences. As one respondent, the brother of a kidney transplant recipient who died from organ rejection just one month after the operation, stated, “All of our family members tried our level best to save my brother’s life. But we could not save my brother and we are still paying off the debt” (Moniruzzaman 2003: 86). Similarly, many poor recipients I interviewed could not afford post-operative medication and were literally counting the days until they would die. One of them was living in the corridor of Bangabandhu Sheikh Mujib Medical University Hospital (BSMMUH), the major kidney transplant center in Bangladesh, for about two years to arrange the cost of post-operative medications. His profession became helping kidney specialists and wealthy recipients visiting this hospital in exchange for cyclosporines and cell-cepts. For the few “fortunate” poor, then, the question becomes this: Organ transplant, but at what price? Evidently, transplantation offers hope only to the rich, while it creates immense burdens for the poor. It does not proceed according to the principle of equity.

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75 This is so common in Bangladesh that a few such newspaper articles appear every day; Bangladeshis no longer pay attention to them.
Not only are the poor deprived and made to suffer as a result of transplantation, at the same time, their body parts are deliberately being extracted to prolong the lives of the affluent few. As my ethnography reveals, most wealthy and some middle class Bangladeshis unethically harvest organs from the poor, severely exploiting them in exchange. Due to uneven power disparities, these buyers (both recipients and brokers) deliberately lure poor sellers, and then oppress and deceive them when the “deal” is over. Due to widespread economic inequality, buyers create an exploitative trade in which the poor are selling body parts, but at a high medical, economic, and social cost. Organ commodification is a gruesome exploitation of the poor; the rich are beneficiaries, while the poor are mere suppliers of their own body parts.76 These grim realities beg fundamental questions: Why exploit the poor for the benefit of a few wealthy people? Should not the poor have an equal right to keep their organs intact inside their bodies?

Organ commodification is a form of structural violence, as well as physical violence that directly impairs the poor kidney seller’s bodily and psychological integrity (see the discussions on harm in the next two sections). Some may argue that the organ trade does not involve physical violence, as buyers (both recipients and brokers) do not use direct physical force, such as hitting, slapping, or kicking. Rather, some may say, sellers voluntarily sell their kidneys in exchange for money. In contrast, my ethnography reveals that some buyers do use coercion to extract kidneys from poor sellers (see the upcoming discussion on manipulation). But, predominantly, buyers use structural violence that perpetuates physical violence, causing harm by extracting organs from the bodies of the poor.

76 See various discussions on exploitation, generally explained as an unjust gain through harm (Munzer 1990: 171), or deception (Feinberg 1988: 176-79), or coercion (Moore 1973: 53).
Due to structural violence, Bangladeshi buyers, like Dipon, take various unscrupulous steps to harvest organs from the poor. My fieldwork reveals that most buyers prefer “fresh” organs from younger bodies. Even a 72-year-old Bangladeshi (a member of the Islamic fundamentalist party, which forbids the sale of organs) purchased a kidney from a 22-year-old slum dweller; however, this would-be recipient died just before the operation. Some other wealthy recipients purchased a second kidney after the first one failed. As long as recipients have money, organ brokers solicit poor sellers and health-care personnel overlook the source of the kidney. Meanwhile, private entrepreneurs expand this outlawed market. These vested groups thus deliberately execute physical violence, which is carried out through exploitation, dehumanization, and suffering. The poor, who are already victims of structural violence, are now also subject to physical violence – a serious violation of justice.

Yet, ironically, violence against kidney sellers is rarely seen as one of the “social ills”, and an emerging voice, particularly from the liberal thinkers, argue for starting an organ market. Liberals not only support the practice of organ commodification, but also propose a “fair trade” of kidneys from the bodies of the poor. These liberal thinkers do not consider that the poor are subject to long-standing deprivation, oppression, and exploitation; rather, liberals believe that the need to sell organs is the fault of the poor. These thinkers are not concerned that it is our responsibility to provide proper transplant care to the poor, rather than harvesting organs from their bodies.

Allow me to outline how an organ market would treat the poor.

The organ market would unjustly but seriously discriminate against the kidney sellers, almost all of whom are poor. As my ethnography shows, Bangladeshi recipients
employ all viable means to carry out physical violence against the poor, despite the fact that the Organ Transplant Act, which states that trading kidneys is “strictly illegal” and not performed in Bangladesh, is in effect there. The poor not only lose their kidneys, they are also severely deceived and harmed, which makes them more vulnerable. The proposed organ market cannot eliminate the enduring structural violence that the poor experience in their everyday lives. Rather, it would generate a disproportionately exploitative system in which violence against the poor is rationalized, legalized, and widely practiced. An organ market would multiply physical violence and promote structural violence against the poor.

Certainly, an organ market is not the answer; it disproportionately strikes and exploits the poor. Proponents of the organ trade intuitively promote the market as a great equalizer, but disregard the fact that their proposed market operates within the global capitalist system, in which the exploitation of the poor is the primary focus. In such a market, the poor cannot control the means of production; therefore, the ruling class would unfairly exploit the poor by extracting the surplus value of both kidney and labor. Proponents of the organ market avoid answering this question: Who would come forward to protect the poor and ensure justice and equity in transplantation?

An organ market does not ensure social justice for the poor. If we believe that \textit{health is a human right}, a principle adopted by the Universal Declaration of Human Rights, organ commodification should be denounced (United Nations 1948). Accordingly, harvesting organs from the poor is a human rights abuse, since it promotes physical violence against the poor, whose bodily integrity is violated in this trade. In addition, the deprivation, oppression, and exploitation resulting from this trade cause
enormous suffering among the poor. This is a severe injustice to the poor, who are exploited not through their wages or gender, but rather for their healthy body parts. Hence, human body parts cannot be commodities, remaining available only to those who can afford them and extracted from those who are already living in poverty, violence, and injustice.

Rightly, liberation theology argues for a “preferential option for the poor,” by reason of their poverty (Farmer 2005: 139), as well as for ensuring justice and equity for them. If we apply this option to transplant medicine, it rules out extracting organs from the poor, and instead provides them with proper care if their organ fails. A “preferential option for the poor” is to establish an equitable transplant system that remains available to those who need it the most. It ensures that saving life through transplant is a right, while keeping organs within a healthy, living body is a necessity. Yet, there is almost no initiative to lessen the transplant inequalities or bring justice to poor organ sellers; in Bangladesh, very few non-governmental organizations are currently working to create awareness about the outcomes of transplantation, but not promoting justice and equity for poor sellers. The destiny of the poor in the 21st century should not be losing their body parts; they deserve justice.

Yet, pro-market viewpoints on the organ trade disregard the injustice to sellers, arguing that because both buyers and sellers benefit from the process, it should not be treated as an exploitative trade (Radcliffe-Richards 1996 & 2003; Wilkinson 2003; Cherry 2005; Taylor 2005; Matas 2004). In contrast, my ethnography shows through case studies how organ buyers are exploiting the poor in seriously unjust and unethical ways, to the severe detriment of sellers. Power inequalities not only allow the harvesting of
organs, but also promote arguments for legalizing the organ trade from the bodies of the poor. Due to structural violence, organ commodification is executed through widespread deception, manipulation, and misinformed consent – all of which are common elements in the organ trade and are indicative of the highly exploitative nature of the dynamics at work here.

**Harm to Sellers**

Proponents of the organ market (entirely armchair researchers) argue that kidney sellers face little physical harm for commodifying their organs. Following the basic bioethics principle that weighs the benefit over the burden, they conclude that the kidney trade offers “non-fatal harms” to sellers; therefore, it should be permissible, especially for saving lives of the recipients (Cherry 2005; Taylor 2005; Matas 2004). Surprisingly, these claims are based on anecdotal evidence; there are no rigorous longitudinal studies on kidney sellers to date (Cohen 2002; Scheper-Hughes 2003a). Although a few long-term studies on living kidney donors do exist (Ibrahim et al. 2009; El-Agroudy et al. 2007; Fehrman-Ekholm et al. 2006; Rizvi et al. 2005), these studies are predominantly ill informed, limited, and biased, as well as are mostly based on data from organ donors living in developed countries. Also, notably, these studies do not distinguish the lived realities of procuring organs from donors versus sellers.

In contrast, a handful of ethnographic studies have studied kidney sellers. These studies demonstrate that selling kidneys causes serious harm to sellers; it is even considered “a serious medical, social, economic, and moral pathology” (Scheper-Hughes 2003a: 220). After reviewing the existing ethnographic studies, I contend that the trade of
human organs is ethically reprehensible, since it consists of physical and structural violence that causes severe health, economic, and social harms to poor kidney sellers.

*Health Impacts*

My ethnographic data reveal that 33 Bangladeshi sellers typically experience health problems, such as pain, weakness, weight loss, and frequent illness, and suffer from serious psychological agony due to anxiety, distress, depression, and trauma after selling their kidneys. Yet, all sellers are deprived of post-operative health checkups (see chapter eight).

Other studies on kidney sellers sketch a similar scenario. In the regulated market of Iran, medical doctor Zargooshi (2001) reveals that among 300 kidney vendors, selling has profound negative health impacts, particularly on vendors’ physical abilities and stamina. Seventy-one percent of vendors had severe post-operative depression, and 60% had anxiety. Additionally, 62% of Iranian vendors reported negative effects on their sense of being useful due to kidney loss. As a result, the effects on general health of these sellers declined between 22% and 58%. However, poverty prevented 79% of vendors from attending follow-up doctor visits (Zargooshi 2001b: 1790).

In the illegal organ market of India, medical doctor Goyal and others (2002) surveyed the health consequences of 305 kidney sellers. Eighty-six percent of these sellers reported deterioration in their health after nephrectomy. Of that group, 50% complained of persistent pain at the nephrectomy site and 33% complained of long-term back pain (Goyal et al. 2002: 1589-91).
In the open bazaar in Pakistan, medical doctor Moazam and others’ (2009) recent study on 32 kidney sellers found that many continued to experience physical pain, weakness, tiredness, dizziness, and shortness of breath, while three had elevated blood pressure readings or had blood or protein in their urine as a result of having one kidney. Sellers commonly experience psychological suffering, such as emptiness, fear, hopelessness, and regret (Moazam et al. 2009: 33-34). Medical doctors Naqvi and others (2007 & 2008) reported similar scenarios on the health conditions of 239 Pakistani kidney vendors. According to their surveys, 98% of vendors reported deterioration in their general health status (Naqvi et al. 2007: 934). Fatigue, fever, pain, urinary tract symptoms, dyspepsia, loss of appetite, and depression were prevalent among vendors (Naqvi et al. 2008: 1446). The alarming finding of the research was that vendors had a high risk of developing renal impairment and failure in the long term (Naqvi et al. 2008: 1448-49). However, consistently, vendors have no access to health-care facilities or to follow-up care (Naqvi et al. 2007: 935; 2008: 1449).

In Moldova and the Philippines, anthropologist Nancy Scheper-Hughes (2003) found dozens of kidney sellers who were in poor health, suffering from such medical conditions as hypertension and kidney insufficiency, without access to adequate medical care or medication. Many sellers did not want to see a doctor, as they were ashamed to appear in a public clinic with their scars (Scheper-Hughes 2003a: 220).

In Egypt, ethnographer Budiani-Saberi (2008) reported on the health, economic, and social conditions of 50 vendors. Of this group, 78% reported deterioration in their health conditions. She noted that this situation is likely a result of factors such as
insufficient medical screening, pre-existing health conditions, and the vendors’ labor-intensive jobs (Budiani-Saberi and Delmonico 2008: 927-28).

Similar to these ethnographic studies, medical literature also supports this claim about kidney donors’ physical health. There are reported cases where kidney donors die (as do recipients) after donation; the risk that the donor could die due to surgery has been put at one in 3,000 (Bruzzone and Berloco 2007: 1785; Garwood 2007: 5). One analysis found that 0.04% of kidney donors since the inception of the United Network for Organ Sharing/Organ Procurement and Transplantation Network (UNOS/OPTN) database have become transplant candidates themselves, some within four years of donation (Davis and Delmonico 2005: 2103).

The medical community further claims that donors have a higher risk of developing chronic kidney disease in the long term (Naqvi et al. 2008: 1444). It is also evident that donors commonly experience an alarming incidence of hepatitis, a disturbingly high incidence of hypertension, presence of noticeable hemorrhage, and evidence of impaired kidney function, compared to the controls (Danovitch 2008: 1361). The donors’ deaths as a result of HIV/AIDS, Hepatitis B & C, infection, and other diseases are noticeable, particularly in the developing world (Naqvi et al. 2008: 1448-49). Importantly, the risk of death and suffering as a result of having only one kidney could be much higher among sellers compared to donors, since sellers’ health is compromised due to living in dire conditions without post-operative care and without family or social support.
All of these studies consistently demonstrate that the health impacts for selling kidneys are alarming, as sellers are without access to post-operative care, which is a visible outcome of structural violence against the poor.

**Economic Consequences**

In addition, selling a kidney has a devastating economic impact on sellers. In Bangladesh, 94% of sellers could not improve their economic condition by selling a kidney. In fact, the interviewed sellers reported that their economic condition deteriorated in most cases (78%); many (48%) lost their jobs and were still unemployed, while others (30%) worked fewer hours in different jobs, as they could not engage in hard work and long hours after the surgery. In addition, most of these sellers (81%) did not receive the promised amount for their kidney; the payment they did receive had already been spent on paying part of their debts, supporting their family, and buying material goods. Still, most of them (72%) were carrying on their debt burdens. As a result, some sellers (15%) became engaged in organ brokering.

Similarly, the study among Iranian sellers reveals that vending caused serious negative effects on employment for 65% of the studied vendors; their income declined by 20% to 66% (Zargooshi 2001b: 1790).

Indian sellers, as Goyal et al. (2002) note, were promised payment averaging $1,410, but the amount they received on average was $1,070. Whatever money these sellers received, they used it to pay debts and to buy food and clothing. Although 96% of studied sellers sold their kidneys to pay off debts, three quarters of them were still in debt at the time of the survey. Sellers’ average family income declined by one third, and the
number of them living below the poverty line increased after trading. As a result, 79% of sellers would not recommend to others that they sell their kidneys (Goyal et al. 2002: 1589-91). In another study, conducted among 30 kidney sellers in Chennai, India, anthropologist Lawrence Cohen also revealed that all sellers sold their kidneys to pay off debts, but were back in debt again. Selling kidneys did not change the sellers’ economic and social condition, as Cohen concludes (Cohen 1999: 152).

In Pakistan, Moazam and others (2009) found that none of the studied sellers reported receiving the total amount they had been promised, and almost all had to pay Rs. 10,000 ($200) to Rs. 20,000 ($400) to the middleman. These researchers also note that more than half of these sellers could not manage to pay off their debts (Moazam et al. 2009: 33). Similarly, in another study, Naqvi et al. (2007) note that none of the vendors received the promised amount of money; they had agreed to the mean sale price of $1,737, but received $1,377 after deductions for hospital and travel expenses (Naqvi et al. 2007: 936). Although 93% of these vendors said they sold their kidneys to repay debts and free themselves from bondage (an example of modern-day slavery, as the authors called it), their priorities changed on receipt of payment (Naqvi et al. 937). This study also notes that the majority of vendors felt that nephrectomy had compromised their economic condition, as 62% of them said they felt physically weaker and were unable to work long hours, as they had done before nephrectomy (Naqvi et al. 936). According to Naqvi and others, 88% of vendors reported that they had no economic improvement in their lives after the operation (Naqvi et al. 934).

When Moldavian and Filipino sellers returned to their villages or slums after selling their kidney they faced unemployment, as they were unable to engage in heavy
agricultural or construction work, the only labor available to them (Scheper-Hughes 2003a: 220).

In Egypt, a kidney sale does not solve the vendor’s economic problems. Eighty-one percent of vendors spent the payment within five months of the nephrectomy, mostly to pay off financial debts, rather than investing it in quality-of-life enhancements (Budiani-Saberi and Delmonico 2008: 927).

All of these studies reveal the stark realities of structural violence. Most sellers did not receive the promised payment of the kidney. Regrettably, their economic condition worsened or unchanged due to selling their organs.

**Social Effects**

Sellers also experience serious social suffering for selling their body parts. In Bangladesh, all of the sellers I interviewed were ashamed of their “disgraceful” act, and thus most of them (79%) become socially isolated due to the high stigma placed on selling organs. They are afraid people will ask questions about their actions or see their scar. Sellers whose actions were revealed reported that they had lost their social status, human dignity, and even ties with their families. Because of these wide-ranging effects of the sale, some sellers (12%) have already become addicted to drugs as a way of trying to escape from the psychological pain of their actions.

Similarly, according to the study conducted by Zargooshi (2001) vending interfered negatively with Iranian vendors’ lives. The majority (70%) of vendors were socially isolated. In total, 37% of vendors concealed the truth of their kidney sale from everyone, 14% disclosed it only to their spouse, and 43% to first-generation relatives;
94% were unwilling to be known as a vendor. Vending increased marital conflict in 73% of sellers, of whom 21% divorced following the surgery. Sixty-eight percent of vendors’ families strongly disagreed with the selling; as a result, 43% of vendors were rejected by their families. On the whole, the quality of life among Iranian kidney vendors significantly declined (Zargooshi 2001b: 1790).

The social impacts on Pakistani vendors are alarming but consistent with previous studies. Moazam et al. (2009) reveal that almost all of the interviewed sellers regretted selling their kidneys. Some of them expressed feelings of profound shame at having sold a kidney and thus concealed their act from family members. Those who could not hide the selling noted that their act had resulted in shame for the entire family, and added that people in the community made fun of them (Moazam et al. 2009: 35). All sellers said that they would not recommend that anyone sell a kidney. In addition, some sellers had a sense of being victimized and deceived by the medical profession. As one female vendor said, “They [the health personnel] sucked out all my blood; they send us home after turning us into corpses” (Moazam et al. 35). The authors conclude that the negative ramifications of selling a kidney affect not only the vendors themselves, but also their families, communities, and even the country as a whole (Moazam et al. 29).

In Scheper-Hughes’s study (2003), Moldavian and Filipino sellers also documented social disability. They feared being labeled as “weak” and “disabled” by their employers and co-workers, as well as by girlfriends or wives. If they were single, they were already stigmatized, as nobody would agree to marry them, since people generally believe that someone who has only one kidney would not be able to support a family (Scheper-Hughes 2003a: 220).
Likewise, Egyptian vendors were not eager to reveal their identities: 91% expressed social isolation and 85% were unwilling to be known publicly as an organ vendor. Overall, 94% of vendors regretted selling (Budiani-Saberi and Delmonico 2008: 928).

Evidently, sellers became socially isolated, were stigmatized, and experienced marital conflict due to selling their kidneys. Thus, most of them not only regret their action, but also have decided not to recommend that anyone sell a kidney.

In sum, all of these studies reveal that sellers’ health deteriorated, economic conditions worsened, and social sufferings were enhanced in a serious manner after they sold their kidney. The harm and risks associated with selling a kidney are deeply disturbing, which gives hefty reasons to rebut this trade (see also Delmonico 2008; Danovitch 2008; Zutlevics 2001). The psychological harm to sellers, outlined in the following section, offers vital grounds to oppose the practice.

**Sellers’ Subjective Suffering**

Proponents of the organ market generally overlook the long-term subjective experiences of kidney sellers for commodifying their body parts. Rather, they often consider their opponents’ discussions on these issues as being emotionally charged, minimally explained, and lacking proper evidence (Taylor 2005; Matas 2004; Radcliffe-Richards 1998). As Mark Cherry argues, it is claimed that organ procurement incentives lead to the commodification of the body, the demeaning of human dignity, and a disregard for the respect of the person and the sacredness of life; however, it is implausible to view organ sales as significantly harmful for vendors (Cherry 2005: 90).
Gill and Sade similarly point out that selling kidneys does not violate human dignity: “My kidney is not my humanity; humanity – what gives us dignity and intrinsic value – is our ability to make rational decisions, and a person can continue to make rational decisions with only one kidney” (Gill and Sade 2002: 26). Some proponents of the organ market further argue that sellers’ self-respect is meaningfully enhanced by selling their kidney. For example, Dr. Reddy goes so far as to claim that for many Indian vendors, a positive motive is given by the duties of Hindu ethics, and that respect and self-respect increase because of a duty done (Reddy 1991 in Radcliffe-Richards 1996: 389). Radcliffe-Richards also extends Reddy’s viewpoint to Western cultures, saying, “If some of the unemployed could get a large sum of money and start again, supporting their families instead of living on the dole, would there be anything but a huge increase in their self-respect, and the respect of others?” (Radcliffe-Richards 1996: 389). Thus, proponents of the organ market disregard or diminish the subjective experiences of kidney sellers.

In contrast, opponents of the organ market argue that the organ trade is inherently wrong, as it violates bodily holism and integrity, as well as human dignity. These cultural practices, they argue, are not solely the legacy of Western Enlightenment (Scheper-Hughes 2003b: 1648). As Papagaroufali argues, many societies share an “imagined” sense of “original wholeness … as unique to humans” (Papagaroufali 1996: 241). Opponents thus argue that the organ trade is impermissible because it violates bodily holism and self-body integrity, which are embodied cultural practices. Through the humanistic lens, they consequently argue, certain living things should not be commodities that are alienable for commercialization (Scheper-Hughes 2006e; Sharp
2000). As Fox and Swazey note, the market approach entails that “increasingly, organs are being thought of as ‘just an organ,’ rather than as living parts of a person – this biological reductionism has insidious implications for construction of self, definition of what it means to be human, and more generally of life as it should be lived” (Fox and Swazey 1992: 207). Sharp, in turn, scorns the commodification of body parts, since it has become a highly lucrative industry – an outcome of high-end millennial medical practice – that “quickly erodes already shaky public investment in medical trust” and “readily threatens the integrity of species, of humanity itself, and of individual bodies too” (Sharp 2006a: 11–12 & 222). Eloquently, Delmonico and Scheper-Hughes also note that “our society still subscribes to a fundamental principle that all humans are created equal, and that each individual life has intrinsic value, so that the person cannot be sold or physically dismantled or bartered away” (Delmonico and Scheper-Hughes 2002: 387). Lock therefore criticizes the proponents of the organ market as “studiously avoiding any discussions of inequalities, dissent, and above all, the lived experience of those at center stage” (Lock 1995: 392). Thus, opponents of the organ market argue that the commodification of body parts operates against selfhood, cultural practices, and humanism in general.

To date, there is a dearth of research that examines the subjective experiences that kidney sellers endure as a result of commodifying their body parts. So far, I have come across only one recent study that focuses on the psychosocial impacts of selling a kidney on 32 Pakistani sellers and their families (Moazam et al. 2009). Based on ethnographic interviews as well as a self-reporting questionnaire developed by the World Health Organization and administered by a psychologist to screen for psychiatric problems,
Moazam et al. (2009) note that these sellers commonly experienced psychological suffering, reporting on the sense of pain, numbness, burning sensation, and emptiness for selling their kidneys. After selling kidneys, they typically expressed that they have transformed into an incomplete person; one of them called himself “a half man” (Moazam et al. 2009: 34). Some sellers also believed that selling a kidney lessens a man’s sexual power and reduces a woman’s childbearing capacity (Moazam 2006: 166-67). The authors also note that most sellers were persistently concerned about being left with one kidney; they reported signs of anxiety, including the fear that their remaining kidney would stop functioning. As one seller stated, “Before I was like a lion, now I am like a she-goat” (Moazam et al. 2009: 33). Further, these sellers reported crying spells, loss of appetite, and lack of peace in life after selling their kidneys. Sellers’ families also noticed their loved ones’ change in behavior, since some sellers were in pain, could not sleep, and often walked around during the night (Moazam et al. 34). Furthermore, sellers commonly experienced regret, sadness, and remorse for selling their kidneys, since they could not still pay off their debt, or believed that selling a kidney is intrinsically wrong (based on religious perceptions). Regrettably, two sellers were considered possible suicidal risks; one reported already attempting suicide (Moazam et al. 34-35). The authors’ ethnographic “thick description” of kidney sellers is deeply disturbing.

My ethnographic narratives reveal the profound psychological and psychosocial suffering of kidney sellers, in particular to their selfhood. As I will show, living without a kidney is not just a bodily alteration, but a disembodiment and ontological impairment of being in the world. Bangladeshi kidney sellers feel disembodied, and feel that their self
has severely suffered from the consequences of selling their body part – what Robert Murphy called “the damaged self” (Murphy 1987: 85).

The Damaged Self

After he was paralyzed by a benign spinal tumor that progressed to quadriplegia, anthropologist Robert Murphy wrote a book titled The Body Silent about disabled bodies:

Not only are the bodies altered, but also their ways of thinking about themselves and about the person and objects of the external world have become profoundly transformed. They have experienced a revolution of consciousness. They have undergone a metamorphosis. (Murphy 1987: 87)

Murphy considers that the body is not just a mere object; rather, it is a mediator between self and being in the world (Murphy 1987: 90; see also Merleau-Ponty 1962). Therefore, as Murphy experienced, bodily dysfunction creates fracture between his self and body. Similarly, for most of my interviewed kidney sellers, their self suffered deeply after they lost this body part.

Almost all of the Bangladeshi sellers I met consider that kidney commodification jeopardizes the homeostatic balance of their body and self. Living without a kidney, they sense that their new body exists in a binary opposition to the old body:

<table>
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<tr>
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<td>Damaged</td>
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<td>Complete</td>
<td>Incomplete</td>
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<tr>
<td>Whole</td>
<td>Partial</td>
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<td>Filled/Solid</td>
<td>Empty/Hollow/Vacuum</td>
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<td>Stronger/Hard</td>
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<td>Intact</td>
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Post-transplant, these sellers are living in an incomplete, damaged, and weaker body. They feel as if lacking a part ultimately splits their entire body, as Jobbar notes:

My body is cut in half; now I am living only on one side. Before the operation my body was intact and whole, but now the loss of a kidney makes the body fragmented and partial. One side has less strength than the other. The right side is filled but the left side is empty. When I stand up, one side is beautiful but the other side is marked with an ugly scar.

Many sellers therefore said that they turned into a “half human” (see also Moazam et al. 2009: 34; Moazam 2006: 164) and, by extension, their self had become disordered.

Some sellers also mentioned that they became “other human” after selling. As Sodrul (22) said while pointing at me, “We are the same but different in some way.” What he meant is that he and I are both human beings, but he has only one kidney while I have two; what is normal for a human being is different for a kidney seller. Sellers’ narratives reflect that their altered body and self are both somatically and metaphorically constructed. As seller Anu expressed, “Nobody can see any problem in my body, but it is like a train line – it looks straight at the front but is crooked farther down.” These new meanings lead to sellers’ subjective suffering.

By losing a body part, sellers’ ontological experience is often disconnected from reality. For example, Jobbar said, “When I sleep on the left, I cannot feel my kidney on my right and vice versa. I could feel a kidney in here and it is not in there. I sensed its existence and non-existence.” These sellers are like amputees who have the illusion that they still possess a missing arm or leg, as Merleau-Ponty illustrated in reference to the “phantom limb” (Merleau-Ponty 1962: 81). According to Merleau-Ponty, the amputee is
missing more than a limb; he is also missing one of his conceptual links to the world, an anchor of his very existence (Murphy 1987: 99). Many sellers often feel that they have an entire body, but when they see the scar they touch and tap on it, and realize something is missing under their belly; they are momentarily back in the operation and sense that they are living in *shunno* or vacuum bodies. They feel as if they are living in nothingness.

Most sellers live with an impaired psyche after commodifying their kidney. Every year, they vividly remember their operation day – “the death day,” as one of them called it. All sellers believe that they will die much earlier as they turn into “living cadavers.” They argue that their recipient could not survive with two kidneys, so how could they themselves live longer with only one? Living with a fear of dying is traumatic; many sellers experienced burning pain in the chest, which felt the same as when they woke up after the operation. Every day, Mofiz (41) recites a verse from the Koran – *Inna lillahi wa inna ilayhi raji’oon* (to God we belong and to him we will return) – a verse Muslims recite when they hear any news of death or see a dead body passing by.

All sellers imagine a deep connection with their recipients, who nevertheless remain strangers to them. Some sellers note that recipients are the closest persons in their lives, even closer than their spouse, children, and parents. By sharing flesh and blood, seller and recipient become one body, one person, one being. Whenever Manik met with his recipient post-transplant, he felt “oneness” with him: “I felt as if my body is in his body. The [ontological] questions often come to my mind: Is it he or I? He is I.” Manik (32) also sensed that one of his kidneys was with him, while the other one was traveling to London, where his recipient lived; nonetheless, he felt as if he were physically in London. Here Manik considered that he had an integrated selfhood with the recipient. No
wonder sellers feel strange when their recipient dies. Sellers whose recipients died cannot comprehend how one of their body parts can have died when they themselves are still alive. How can they be in existential life once their kidney goes to the afterlife? They feel as if they are here but their body parts are there, akin to “bodiless living” – the mind is here, but not the body. The sellers asked me this question: Is it the death of their kidney or themselves? When they bury their recipient, they feel as though one of their sides is covered in mud. These ontological puzzles cultivate a distressed self.

Some sellers are also worried about the consequences of losing a kidney. They asked me whether they would face any sexual difficulties in the future as a result of the surgery. They believe that all of the organs are harmonically tied up together, so the loss of a kidney might affect their sexual potency, making them impotent. Many sellers thus became careful when having sex, believing that it could hurt their body as well as their partner’s body. Nergis (23) believed that she might not be able to get pregnant, and if she was fortunate enough to conceive, the baby might die due to a riskier delivery. Similarly, Pakistani sellers reported that losing a kidney somehow makes a person incomplete, lessens a man’s sexual power, and reduces a woman’s childbearing capacity (Moazam 2006: 166-67). Living in such states of discontent increases the heavy burden that the sellers’ self carries as a result of selling a kidney.

Almost all sellers experience a deep sense of unfulfilled loss that is reflected through their narratives, thoughts, and writings, or even imprinted on their faces. When I read Monju’s (37) diary, which he wrote during his journey of selling his kidney, I realized the severity of his impaired self. Monju started his diary by asking why God was not taking him away from the earth so he could save his two kidneys. Monju questioned
God: Why was he the most unfortunate man in the world? Monju concluded his writing by suggesting that God not direct a human being to follow in his footsteps. Later, Monju wrote a poem in his letter to me:

How unfortunate am I!
Oh, brother Moniruzzaman,
Should you know?
My life does not die,
My days do not go by.
While I count my ill fate,
Teardrops are my only friends.
Parents left me long before,
Nobody shares my sorrows,
All and sundry hate me.
Who else can offer love?
Being in a mammoth wave,
A mountain of sadness is mine.
Sitting in a full moon,
My tears flood the pond.
While floating with the wave,
My life only passes, adding more teardrops.
Days do not go by,
Years do not pass by,
Teardrops are my only friends.77

Monju’s self is acutely damaged as a result of his decision to sell part of himself. Yet, most sellers could not share their sorrows with anyone close to them, due to the high social stigma around commodifying body parts. Consequently, a few sellers wrote letters to me, while Nozrul at times called me, even in the middle of the night when he had insomnia. In these ways, some sellers attempt to make their self lighter. Yet, disembodiment intensifies the impairment of the sellers’ self.

77 My translation.
Disembodiment

Embodiment theories can prove helpful to understanding how organ commodification creates a crisis in the existential ground of body, self, and culture. Embodiment theories emerge from the work of Merleau-Ponty, who eloquently examines “the bodily aspects of human subjectivity” (Merleau-Ponty 1962). According to his understanding, “disembodiment entails not so much a change in body image, but a distinct physical distancing from one’s own body” (Morse 1998: 668). Robert Murphy considers disembodiment to happen when “the body becomes other to the self,” not only “through an experiential rending of the unity of body and self,” but also “through belief systems that devalue it or cultural practices that discipline it” (Murphy 1987 in Lindgren 2004: 150). Thus, Murphy emphasizes the vital role that culture plays in shaping human subjectivity. Following this, as he considers, the disabled bodies (people who are not born with this condition, i.e. paraplegia or quadriplegia) need to become re-embodied; in grave conditions, they may even become disembodied (Murphy 1987: 100; see also Lindgren 2004: 150). Bangladeshi kidney sellers’ narratives reveal that most of them feel disembodied due to selling their body parts.

Selling organs is considered a highly undignified, humiliating, and stigmatized act in many societies (Schepner-Hughes 2003a; Moazam et al. 2009; Cohen 1999; Chengappa 1990). For example, in Bangladesh, Mofiz’s sister died of a heart attack after finding out about his kidney selling, which is seen as a disgusting act there. Likewise, Moldavian villagers will not marry kidney sellers, who are regarded as a new category of prostitute, unable to support their family (Schepner-Hughes 2003a: 220). Similarly, an Iranian kidney seller stated, “People see me as a cripple and treat me as if I have leprosy; when I had a
clash with one of my neighbors she shouted: If you touch me, I do what I can to you” (Zargooshi 2001b: 1792). Due to such high social stigma, most of my interviewed sellers hide the fact that they had this surgery and now live in social isolation after commodifying their body parts. Those whose actions have already been revealed are living in shame, regret, and agony. Consequently, most sellers felt disembodied due to high social stigma and subjective suffering for selling their body parts. In general, they possess a disembodied self due to the violation of long-standing cultural practices, such as bodily integrity, body ownership, and human dignity – three troublesome themes in organ commodification.

Selling organs is reprehensible because it permanently and deliberately alters bodily integrity. Toombs argues that “embodiment grounds duties to promote one’s bodily integrity” (Toombs 1999: 84). In turn, “to be healthy psychologically, an individual needs to experience self-agency (the ability to control what is done to one’s body) and self-coherence (the ability to maintain the body as a non-fragmented, integrated whole)” (Andrews and Nelkin 1998: 53). Organ commodification infringes on this sense of agency and coherence, since sellers are not able to preserve the wholeness of their body. On these grounds, the Bellagio Task Force Report on Organ Transplant declares that organ commodification undermines the bodily integrity of socially disadvantaged members of society (Rothman et al. 1997: 41).

Among Bangladeshi Muslims and Hindus, bodily integrity and bodily holism are existentially grounded as religious and cultural practices.\(^7\) Almost all of my interviewed

\(^7\) Notably, all major religions, including Islam, Hinduism, Judaism, Christianity, and Buddhism, accept organ donation as a noble act, but reject organ selling. As the Muslim scholars noted, it is prohibited to receive a price for an organ under any circumstances, because this is an insult to humanity and dignity, and is a violation of the sacred body (Sachedina 2009 & 1988; Quadri 2004; Adam and Iftaa 1996). So too, for
sellers considered that their bodily integrity and holism have been violated by kidney selling. As a consequence, they experience disembodiment and subjective suffering. For example, many sellers expressed fear, emptiness, and regret at not being able to return their whole body to God in the afterlife. Seller Mofiz was so concerned about this issue that he asked the local Mawlana, or Islamic scholars, whether Allah would accept the dead body of a kidney seller in the afterlife. The Mawlana discussed the question in the mosque and gave a fatwa, or resolution, that Allah would not accept the body that is deficient due to haram, or the impermissible act of selling organs. Rather, the ferestas, or angels, would come to the seller’s graveyard, count the body parts, and then ask: We gave you two kidneys, one liver, two eyes, and 207 bones, but why do you have only one kidney? Where is the missing one? Mofiz does not know how he would answer the ferestas’ questions, but he knows that the ferestas would severely punish him for selling it. From then on, Mofiz became afraid, believing that the ferestas would continuously ask him about the missing kidney and he would not be able to give them a satisfactory answer. For this reason, he asked his family to bury him close to a railway line. While the trains pass by, the land will shake, and ferestas will be frightened into leaving, as he envisioned. Mofiz’s self is so severely impaired that he often disintegrated himself from

Hindus, “the body is your vessel, your vehicle, to a higher realization,” therefore it has to be maintained in a healthy state; selling organs does not promote the dharma, the righteous living, according to Dhand (Scharper 2008). Similarly, in an address to the Transplant Society, Pope John Paul II states, “any procedure, which tends to commercialize human organs or considers them as items of exchange or trade must be considered morally unacceptable” (Pope 2001). Owing to the tradition of “filial piety,” Confucianism likewise requires that everyone take care of his or her own body intact and unblemished; this is why tattooing is traditionally not acceptable to Confucians, as Victor Hori observes (Scharper 2008). Therefore, organ commodification is reprehensible, as it violates bodily integrity and holism. See also the practice of bodily integrity in other cultural contexts (Lock 1995 & 2002a; Ohnuki-Tierney 1994; Sharp 2000; Namihira 1990; Ikels 1997; Tober 2007; and Aquinas 1947).

79 Here one may raise the question of bodily integrity and organ donation. If bodily integrity is violated by the surgical removal of a kidney, this presumably explains the unwillingness of most Bangladeshis to donate. Thus, kinship must come from those who are in such dire straits that they are willing to sacrifice bodily integrity in the hopes of alleviating other forms of suffering.
family and society; he sat down speechless in a dark place, and thought about committing suicide (see also Zargooshi 2001b: 1796; Moazam et al. 2009: 33).  

In addition, organ commodification raises culturally varied issues concerning the body and property rights. As Kass asked, “What kind of property is my body? Is it mine or is it me? Can it be alienated, like my other property, like my car or even my dog? What basis do I claim property right in my body?” (Kass 1985: 23; see also Kant 1931: 165; Locke 1988: 287–288; Chadwick 1989: 132). While the debate on whether one can consider one’s body as property has yet to be resolved, major legal discourses, such as the Roman, US, British, and French laws, ensure no property rights over bodies, both cadaver and living (George 2001: 16; Gracia 1998: 69; Fagot-Largeault 1998: 137). In the recent advancement of genetic research, the human body is also considered as “property of humankind” – “the common heritage of humanity” (UNESCO 1995: 97; Have 1998: 2). Organ commodification is therefore highly troublesome, as a living body is not just a personal property, an object of disposal.

In contrast to the Western discourse on individual property rights over the body, Bangladeshi kidney sellers commonly considered God to be the owner of their body, and their body parts his gifts. They believe that they only have stewardship of “God’s gifts” and do not have authority to treat body parts as personal possessions. Notably, a few sellers said that their parents are also the owners of their bodies. Rather than believing in the individual ownership of the body, God is the owner, a view that is mostly prevalent in

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80 Zargooshi noted that his interviewed 307 Iranian vendors reported on “suicide completion by at least 5 vendors, including 3 who set themselves on fires after becoming severely depressed because of their unchanged miserable living conditions and inability to provide the most basic necessities of life for their families despite losing 1 kidney. Many of the present vendors were suicidal” (Zargooshi 2001b: 1796). While, Moazam and others noted that, of 32 Pakistani vendors they interviewed, 1 reported attempting suicide with sleeping pills obtained from a local doctor and 2 were considered to be possible suicidal risks (Moazam et al. 2009: 33).
Bangladesh and elsewhere (see Garcia 1998: 76; Tober and Budiani-Saberi 2007: 6; Moazam 2006: 6). In light of this belief, almost all of the Bangladeshi sellers I interviewed noted that selling God’s gifts is *haram*, or prohibited, by their religion; they regretted commodifying their body parts for greed and money. Consequently, many sellers feel disembodied due to selling God’s property.

Further, organ commodification is highly problematic because it violates human dignity. Human dignity is considered a key human right adopted by various declarations throughout the 20th century, such as the Universal Declaration of Human Rights (1948), the American Convention of Human Rights (1969), and the African Charter on Human and Peoples’ Rights (1981). These declarations commonly state that all human beings should have the right to respect and inherent dignity. As the United Nations’ Declaration of Human Rights notes, “all human beings are born free and equal in dignity and rights” (UN Charter 1948, article 1). On these grounds, body parts cannot be up for sale, because this practice violates human dignity as well as respect for personhood (Awaya 2005: 69; Stempsey 2000: 195). The World Health Organization, in its guiding principle on transplantation, therefore outlaws organ commercialization, saying that “it is a violation of human rights and human dignity” (WHO 1991: 1; see also The Declaration of Istanbul 2008: 3).

Yet, some proponents of the organ market argue that there is no necessary connection between the commodification of bodies and the commodification of personhood (Wilkinson 2000: 196, & 2003: 54; Matas 2004: 2011). In contrast, I exemplify how organ commodification disembodies and damages the sellers’ self. Edward Keyserlingk similarly notes:
Human organs have a special status due to their intimate relation with persons. Furthermore, in life the body as an organic whole is a good, since it is the center and means of awareness and vehicle of communication. It is this link between self and body that grounds bodily inviolability. These characteristics make the body and its parts properly the subject of altruism and gift giving rather than commercial sale. To respect these characteristics of persons is to respect human dignity. Organ sales, in contrast, treat the body as a collection of spare parts, independent of the body’s intimate relationship to the life of a person. Organ sales thereby violate human dignity. (Keyserlingk 1990: 1005; see also Sutton 2002: 114)

Ethicist Margaret Somerville also argues,

Respect for fundamental human dignity and the special respect owed to the human body require we preclude its sale. To do otherwise is to implement a 21st century version of slavery where, instead of selling the whole person, we sell their body parts. It is difficult to decide which is more reprehensible. (Somerville 2008: 1)

Almost all the Bangladeshi kidney sellers I interviewed reflected that selling a body part signifies a self without dignity. They argue that organ commodification is the most disgraceful act a human can commit – a completely inhumane and immoral act – except for murder or suicide. After selling their kidneys, they lost their self-respect, intrinsic worthiness, and moral judgment; as Sodrul stated, “I always feel very small inside, as if I am living like an insect in a dark drain, as well as refrain from looking directly into people’s eye and my head is always down.” Furthermore, sellers’ self-esteem is also impaired. As Forid said, “I feel like a ‘defeated soldier’; every day passed by with fear of death, but without any hope.” Above all, some sellers expressed that they lost their human identity after selling their kidney; they described themselves as “worse than animals” or “sub-humans.”

In sum, organ commodification is deeply troublesome, as it proceeds against religious and cultural meanings of bodily integrity, body ownership, and human dignity that are embodied in many societies. Most sellers feel disembodied since they have
violated these cultural, existential, and historical practices. Consequently, their self is severely damaged due to disembodiment and ontological sufferings for selling their body parts.

Taken together, the above-mentioned two sections demonstrate that organ commodification causes devastating harm (physical, psychological, economic, and social) to sellers. Therefore, if we uphold the classic medical principle that is part of the Hippocratic oath of medical professionals – “above all, do no harm” – we cannot accept an organ market. Also, as John Stuart Mill once stated, “the only purpose for which power can rightfully be exercised over any member of a civilized community, against his will, is to prevent harm [either physical or moral compulsion] to others” (Mill 1913: 6; see also Beauchamp and Childress 1994). On these basic ethical premises, organ commodification should be condemned, since it is a form of physical and psychological violence that is being carried out at a severe cost to sellers.

Deception in the Organ Trade

Deception is rampant in the current practice of organ commodification. Existing ethnographic studies, published articles, and newspaper reports have revealed similar pictures in various countries, commonly indicating buyers’ deception towards kidney sellers regarding payment and post-operative health checkups (Goyal et al. 2002: 1591; Naqvi et al. 2007: 936; Moazam et al. 2009: 33; Zargooshi 2001b: 388; Scheper-Hughes 2003a; 220). My ethnography offers an excruciating account of the deceptions experienced by kidney sellers, which are widespread due to structural violence against the poor.
Bangladeshi sellers reveal how organ buyers (all brokers and most of the recipients) skillfully entrap them through lying, trickery, and forgery, and at the end intentionally deceive them. The deception is so omnipresent that buyers frequently offer false rewards in organ classifieds, which are published regularly in Bangladeshi newspapers (see chapter four).

After the surgery, sellers discover a rough cut of 15 to 20 inches on their bodies, unaware that if the buyer had paid $200 more, the surgeon could have used laparoscopic surgery, which requires an incision as small as four inches. The following photographs, placed in juxtaposition, reflect how sellers are harshly deceived about the surgery:

![The Rough Cut](image1.png)

![The Laparoscopic Cut](image2.png)

*Figure 9.1  The Cost of $200. Photo on the left by Md Moniruzzaman 2005; photo on the right by Lucon et al. 2007: 368.*

Upon the sellers’ return to Bangladesh, buyers’ deceptions amplify alarmingly. Most buyers spuriously deducted enormous amounts of unstated and hidden costs, thus depriving sellers of the full payment for the kidney. Also, buyers did not offer the jobs, business, visa, or citizenship that they had promised to sellers. Furthermore, recipients tactfully established “commodified kinship,” but most of them did not continue it after the “game” was over.
Due to such widespread deceptions, the pro-market researchers propose to establish an organ market, arguing that it would protect sellers from corruption, limit harm, and offer long-term follow-up care (Matas 2008: 1342; Cherry 2005: 96; Radcliffe-Richards 1996: 391). Their viewpoint implies that deception in the organ trade occurs because sellers participate in the black market and deal with brokers; if sellers exchanged their kidneys in a legal market and made direct arrangements with regulatory authorities, the deception would fade away. My ethnography, however, demonstrates that it is not only the brokers, but also most recipients as well as some doctors, who deceived the sellers. So, the question arises, how can a regulated organ market drastically eliminate such rampant deceptions?

Surely, an organ market (either regulated or free) will be ineffective in South Asia and many other countries in the world due to deeply rooted structural violence, as well as enduring corruption and deception that are commonly being carried out against kidney sellers. As Jha and Chugh note, “It is hard to imagine that in societies where there is a combination of desperate individuals, greedy and unscrupulous facilitators, and poorly developed justice systems, transplantation would remain untouched by all-pervasive corruption” (Jha and Chugh 2006: 467). A regulated organ market cannot eliminate widespread deception in such a system where vested interest groups, including the regulatory authorities, are involved in this trade (see also Muraleedharan et al. 2006: 51). The only regulated organ market in Iran offers, as Zargooshi documents, widespread practice of extralegal financial transactions, coercion, and blackmail between the Iranian sellers and recipients (Zargooshi 2001b: 389; see also Scheper-Hughes 2003b: 1646 &
On a practical note, a regulated market itself cannot prevent harm to sellers, or ensure their post-operative care. Some proponents therefore have argued for initiating a regulated organ market only in developed countries (Hippen and Matas 2009: 5). After examining social and psychological realities of kidney sellers, Moazam et al., however, keenly point out,

The vendor we studied may be specific to Pakistan, but their lives, and the circumstances in which they live them, reflect variations of economic disparities and social inequalities that are universal realities from which no country can be considered entirely exempt. (Moazam et al. 2009: 41)

In fact, a regulated market would not change the existing economic disparities and social inequalities that facilitate the exploitation of the poor in both worlds. Clearly, a regulated organ market cannot ensure justice; rather, it creates an unfair system where poor people are the donors, but rich people are the recipients. For the sake of argument, even if a very few regulated markets (operating mainly in the developed world) lessen sellers’ deception to some extent, such a deceptive trade multiplies in every corner of the world. Therefore, regulation is not the solution to eliminate deception, corruption, exploitation, and violence that kidney sellers commonly experience in this trade.

81 Proponents of an organ market consider sellers’ harm only in the medical sense. They believe that in the black market organ exchange, surgeries are typically performed in underground settings or unknown clinics. In contrast, my ethnography reveals that sellers generally obtain safe operations and standard care, since their surgeries are performed in renowned hospitals in India, Thailand, and Singapore. A regulated organ market would not be able to prevent surgical harm to sellers, let alone the other types of harm (i.e. physical, psychological, economic, and social). The regulated, paid system did not protect the Iranian kidney sellers who are experiencing profound harm (Zargooshi 2001a & 2001b).

82 Proponents of the organ trade argue that legalizing would offer post-operative care for the sellers. I, however, wonder how the governments of Third World countries would ensure better post-operative organ care when they cannot even offer primary health care to citizens. Currently, in Bangladesh, the sellers must travel to one of a very few urban centers to obtain post-operative organ care. The government might ensure better-equipped regional organ care centers, perhaps in the next few decades, but these would have to be amply funded. And, even though the fortunate sellers would travel to regional centers, many of them might refuse the care to hide their actions, due to the high social stigma on selling body parts.
Manipulation

In the debate on the organ trade, the pro-market arguments focus mainly on coercion rather than manipulation. Drawn from the classical writings of Aquinas, Hobbes, and Locke, as well as from Nozick’s contemporary account on coercion – the classical understanding of coercion is based on the direct use of force or violence as a form of coercion, while Nozick associates coercio

n with conditional threats or offers – pro-market arguments posit that coercion is absent in the existing organ trade and that sellers make an autonomous decision (Radcliffe-Richards 1996: 381-84; Cherry 2005: 92; Taylor 2005: 14). In contrast, many anti-market proponents suggest that organ commodification is a form of coercion against the poor. As Delmonico and Scherper-Hughes note,

Yes, even the poorest people of the world “make choices,” but they do not make these freely or under social and economic conditions of their own making. The pressures of organ brokers upon the poor make their decision to sell an organ anything but a free and autonomous choice. (Delmonico and Scherper-Hughes 2002: 387; see also Schep

er-Hughes 2006b: 1701)

However, this viewpoint is often challenged by pro-market advocates, who argue that poverty in itself cannot be coercive. As Wilkinson asked: Does this mean that poor people are forced by poverty into selling their organs? (Wilkinson 2003: 127). Poverty is not the physical actor; rather, due to structural violence and “pathologies of power,” wealthy buyers (both brokers and recipients) wrongfully manipulate, control, and even coerce poor sellers in this “deal.”

As my ethnography reveals, Bangladeshi buyers (both recipients and brokers, as well as recipients’ families and brokers’ employees) manipulate kidney sellers mostly through deception and control, as well as use coercion whenever necessary. I found a
number of examples of coercive behavior. The seller Sodrul was beaten up, assaulted, and forced by the broker Batpar to go to the operating room. Likewise, Mofiz, as well as his wife, were physically abused and threatened with jail by his recipient. Mofiz was also held captive by three bodyguards at his recipient’s house and was unable to attend his sister’s funeral before the trip to India. Jobbar’s life was threatened by Batpar when Jobbar tried to obtain full payment for his kidney. Two female sellers noted that their husbands pressured them to sell their kidneys and later took the money to open businesses and buy cellphones.

Buyers widely use deceptive manipulation to extract organs from the poor. In this “deal,” buyers create a desire for sellers, most of whom do not understand the function of the kidney but are tempted to “donate” because of the buyers’ fraudulent claim that selling is a safe and lucrative act. Buyers also emphasize moral grounds for saving a life (a noble act), offer false promises, and lure, trick, and mislead sellers. For example, seller Moyna noted that his boss, a high-ranking police officer, offered him a job promotion for donating a kidney to save the officer’s brother’s life. I witnessed an ex-member of the parliament of Bangladesh soliciting a kidney from poor villagers, slum dwellers, and neighbors, telling them how much of a janodoridi (human devotee) he was. Once sellers are entrapped, they become powerless agents, while buyers are entirely in control carrying out this trade.

Due to uneven power structures, wealthy buyers are at the top, while poor sellers are at the bottom; as a result, buyers, not sellers, have the authority to control this trade. As we have already seen, the poor sellers did not have any freedom of opinion all through this trade. Seller Hiru was circumcised against his religious beliefs, as his recipient
demanded. One proxy (recipient’s family member) gathered five potential sellers together and told them to write down how much money they were asking for their kidney; later, he read aloud to the group the name of the candidate who had been chosen – the one with the lowest price. Some sellers also had to work as a broker’s agent and recruit new clients while they were waiting for a matched recipient. Some buyers eliminate potential sellers based on their tooth color, assuming they are addicted to drugs if their teeth are discolored. All sellers must sign forged documents without comprehending the legal implications. Sellers felt powerless to confront the buyers’ manipulation; if they challenged the buyer, they faced coercion, threats, and warnings about dismissal from the deal.

Just after crossing the Indian border, the buyers’ manipulation increased; sellers became like prisoners in the buyers’ hands. All buyers seized the sellers’ passports, ensuring that sellers could not return to Bangladesh until their kidneys were removed. When a few sellers “disobeyed” the buyers’ rules, their buyers threatened them, even making phone calls to Bangladesh pretending to recruit new clients. Sellers had to serve buyers and fulfill their demands: Jobbar even had to give foot massages, and was being pressured to give his stone-free kidney to his recipient rather than having the stone in his other kidney crushed at the recipient’s expense.

Post-operation, sellers were also manipulated. Many sellers had to sign blank documents; in this way, buyers ensured that sellers would not be able to take legal action afterwards. After the operation, seller Jobbar donated blood to his recipient three times within four months, as his recipient exerted emotional pressure. In the end, most sellers
were brutally deceived; when they contested their treatment, buyers assaulted, forced, and threatened them in various ways.

In such widely uneven power disparities, how would a regulated organ market eliminate diverse manipulations and coercions to the poor sellers? Who would protect the poor from these manipulations and coercions? In fact, “the premise of a regulated market is based on the Western tenets – autonomy and choice – they do not correlate with the crude realities of poorer countries” (Moazam et al. 2009: 40). “The economic desperation for a poor [person] of selling his/her organ is not an autonomous choice” (Scheper-Hughes 2006b: 1701); rather, organ buyers entrap, manipulate, and coerce sellers due to their dire condition of poverty, which is a result of structural violence. When sellers are desperate and oppressed, what kind of autonomy or choice do they have? If sellers had a basic right to choose, none of them would sell their body parts.

*Misinformed Consent*

Informed consent is an agreement whereby a person competently gives an educated but voluntary consent based on satisfactory information on facts and implications of the action (Gillon 1986: 113; Faden and Beauchamp 1986: 14). Valid informed consent thus has three major elements: information, competence, and voluntariness (Wilkinson 2003: 76). The Transplant Society emphasizes securing the proper informed consent from kidney donors:

The person who gives consent to be a live organ donor should be competent, willing to donate, free of coercion, medically and psychosocially suitable, fully informed of the risks and benefits as a donor, and fully informed of risks, benefits, and alternative treatment available to the recipient. (Abecassis et al. 2000: 2919)
However, in Bangladesh, organ buyers intentionally provide misleading information; because kidney sellers cannot act voluntarily and competently, sellers’ true consent is impossible. I call this “misinformed consent.”

Sufficient and suitable information is the key for any valid consent. However, as we have seen, organ buyers induce Bangladeshi sellers through widespread misleading information, such as telling the story of the “sleeping kidney” or claiming that the operation is 100% safe when performed abroad. Buyers also provide minimal information in order to take advantage of sellers and ensure that they will not walk away from the deal. For example, buyers intentionally hide information about the basics of tissue matching, the numerous medical tests to be done in Bangladesh and redone abroad, and the details of operation procedures and post-operative complications. No sellers were informed about the option of having laparoscopic surgery; otherwise, they could have purchased this new technology, even deducting it from their payment, in order to have a much smaller scar. Post-operation, sellers experienced how buyers brutally deceived them, deducting many hidden costs without the sellers’ informed consent. Clearly, Bangladeshi sellers could not offer a valid informed consent.

Competence is another element of valid informed consent. Some may question whether there is such a thing as informed consent under such circumstances. Some may further argue that it could be virtually impossible to translate terms and procedures of a highly sophisticated medical world to the poor sellers. Or, even if the sellers were adequately informed, could they be competent enough to understand the consequences (see Wilkinson 2003: 77-78 & 125-26)? I noticed that buyers consistently misinformed and concealed information from sellers, who generally do not know about the function or
location of the kidney, not to mention the risks and complications involved in selling this organ, and thus are unable to give reasonable consent.

Voluntariness is the third facet of proper informed consent. The relevant question is whether kidney sellers make a voluntary decision to sell their organ. As I have revealed, sellers could not act freely due to buyers’ deception, manipulation, and coercion. Even if sellers were, let us say, “free” of manipulation (which is almost impossible, due to the uneven power structure and structural violence, even if the organ trade is legalized), one may further argue that sellers are under the dire condition of poverty and pressured by various forces, such as debt payment or dowry expenses, which undermine their voluntary consent.

Like buyers, health specialists (both Bangladeshi and Indian) did not provide adequate information to sellers, since the concept of informed consent in the health context of Bangladesh is almost entirely absent. From sellers I learned that doctors provided minimal information and often inserted their success rates for transplantation. This approach is effective, as it minimizes sellers’ fears about losing a kidney. Also, these doctors did not attempt to find out whether sellers were biological relatives of the recipients, as the law requires; rather, they concentrated on making profits. One may thus raise the question of whether it is possible to have fully informed consent in a profit-driven system. As we have already seen, recipients, brokers, and doctors extract organs in spite of sellers’ misinformed consent. Therefore, the question is how a regulated organ market can realistically uphold a proper informed consent, which is not even a reality in most health-care settings around the world. In sum, organ commodification is based on
deception, manipulation, and misinformed consent that cause serious harm, exploitation, injustice, and violence to the poor.

*Other Consequences*

A regulated organ market would have much wider negative impacts. It would likely destroy both cadaveric and living organ donation programs. In South Asia and many other countries in the world, the cadaveric donation is not successful and is ignored, since there is an alternative way of harvesting “fresh” organs from the poor. Similarly, in Iran, there is little or no cadaveric organ donation program, an outcome of the regulated organ market (Chapman 2008: 1343). Such a market would also hamper the living altruistic donation program. As I have seen, most wealthy Bangladeshi recipients do not ask their family members to donate; instead, they purchase a kidney from the market. Why would the wealthy donate if they can afford to purchase organs from poor villagers? Such a market would cause every patient to ask, “Should I wait for deceased organ donation, seek a family donor, or simply buy one?” (Chapman 1343). Moreover, many families would not donate, considering that their precious gift would not be properly evaluated if a market is out there. Shifting the value of an organ (from gift giving to market commodity) would be detrimental to establishing an altruistic donation program.

In addition, the regulated market would enhance rampant commercialization of organs, where demand and supply would be primary foci. In particular in the developing world, wealthy recipients would not obtain kidneys from their family, but rather would viciously entrap poor sellers with false promises. Many Bangladeshi poor would step
forward believing that selling a kidney is an easy way to make a quick profit; they would be exploited through the double brokerage (first by the broker’s agent and then by the broker, as we have already seen in Bangladesh). A great number of brokers and beneficiaries, who would even snatch organs through coercion and crime, would also be involved in this trade. The doctors would ensure profits rather than focusing on suitable tissue matching, safe surgery, and proper organ care, as well as ethical standards. A regulated organ market could not eliminate corruption, but rather would play an active role in rampantly exploiting the sellers. The moneylenders and Zaminders (landlords) would force the poor to pay off their debts through selling their kidneys. Due to the existing patriarchy, husbands would pressure their wives to resolve financial hardship. The price of a kidney would drastically decline; if it is set by the government, the vested interest groups would find ways to pay less and less to the poor sellers. Therefore, many proponents of a regulated organ market consider launching it only in the developed world (Hippen and Matas 2009: 5).

But the rampant commercialization of organs would also increase in the developed world. Due to global capitalism, commodities such as organs would easily move across transnational borders where the price is cheaper. Through the Internet, brokers could easily contact poor sellers and bring them to the First World to procure their organs in various ways, including in the name of medical adoption and altruistic

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83 My interviewed sellers considered that legalizing the organ trade would exploit vulnerable populations, especially women. As we have already seen, some of these sellers have already started selling their wives’ kidneys. In the illegal organ trade of Bangladesh, most of the sellers are male. Due to patriarchal values, Bangladeshi females usually cannot travel to India by themselves. Therefore, buyers are unlikely to bring female donors to India, due to the inconvenience and cost of bringing both a female donor as well as her husband to India for the operation. In the proposed regulated market in Bangladesh, women could be the majority of organ donors.
Therefore, the real concern is that the regulated system would either have to outlaw Internet shopping and set a controlled price, or would have to continuously modify the price to outbid Internet brokers and to keep up with emerging kidney markets elsewhere (Delmonico and Schepers-Hughes 2002: 388). Furthermore, a regional regulated market would not be realistic; a US congressional endorsement for payment would propel other countries to sanction unethical and unjust standards, as Dr. Francis Delmonico argues (Delmonico 2003: 2). Overall, the regulated market and rampant commercialization of organs turn out to be a profit-oriented industry that simply follows the survival of the fittest ethos – the powerful ones legally exploit the weaker ones. There would be an “organ war” where, ultimately, the north would harvest organs from the south through neo-colonialism (see this similar pattern on the commercialization of the Human Genome Project and the patenting of DNA of indigenous people, eloquently outlined by Cunningham 1998 and Cunningham and Scharper 2006). A regulated organ market not only challenges the morality of the trade, but also makes the market “obnoxious” (Kanbar 2004; Salz 2004).

Further, legalization of an organ market is a “slippery slope” proposition. The ultimate question is this: How far can we go with the new technology? Where is the boundary? Can we chop a leg and a hand from the poor, assuming that one of these body parts is enough for them? What we have already seen is that, not only human kidneys, but also fresh liver lobes as well as single corneas are increasingly put up for sale in Bangladesh. China has already defined a source of procured livers from executed prisoners; today the market has expanded to include living donors as well (Wingfield-

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84 For example, the illegal trafficking within America by overseas donors; such cases have been exposed recently (Interlandi 2009).
Hayes 2006: 1). The commodification of ‘fresh’ livers has also been noted for Southeast Asia (Scheper-Hughes 2003a: 198). Internet Websites, such as JoeNeedsaLiver.com and MatchingDonors.com, provide additional venues for liver ‘sales’ and advertising. However, the fact is, the survival rate of the liver recipient is still low, even though new immunosuppressive agents make a liver transplant feasible and the current advancement of “in situ” liver transplantation makes such an operation affordable. Also, the donor faces potentially life-threatening risks and could face long-term health effects that are not yet known (The Gift of Life 2005: 6). Despite these findings, some health professionals and bioethicists have already argued in favor of partial human liver commodification and extended their arguments to rewarded gifting (Daar 2004b: 370). Ongoing improvements of these technologies pose thorny ethical questions, such as these: Can we treat the human body as a machine? How much can we alter this machine with spare parts? How far can we enhance the body-machine? What are the consequences of ending the human body? What would be the premise of post-human ethics? These timely, relevant, and extremely important questions need to be critically examined before considering a “human body shop.”

Moreover, a regulated organ market might erode trust in the medical profession. Bangladeshi kidney sellers were generally angry at the health-care professionals involved in their transplant procedure, pointing out that health-care personnel knew about this “rotten trade,” but did not protect sellers, in order to gain profits for themselves. Pakistani kidney sellers had similar feelings; one of them bitterly described the hospital where his operation was performed as “it is all a business,” and health-care personnel there as

85 Proponents of the organ market often ask why the trade of human organs should be condemned while blood, sperm, and ova are already available in the marketplace. The simple answer is that the latter are regenerative fluids or cells, while organs are solid body parts.
“liars” and “butchers” (Moazam et al. 2009: 35). Thus, kidney sellers feel that they are being victimized and deceived by medical professionals involved in this trade. A regulated organ market would expand these negative feelings towards medical personnel, and in turn would disrupt the traditional doctor-patient relationship.

Furthermore, a regulated organ market could be litigious. At present, all major organizations, including the World Health Organization (2004), World Medical Association (2006), Transplant Society (2006), and Council of Europe (2003), as well as key summits, such as the Declaration of Istanbul (2008), Asian Task Force (2008), Bellagio Task Force (1997), and Nuffield Council of Bioethics (1995), hold in contempt any practice of organ commodification (see chapter one). All of these resolutions consider that organ commodification would bring many detrimental outcomes; they urge state officials and physicians to establish a legal framework to prevent such transactions. Legalization of an organ market would devalue these battles to combat organ trafficking that have gone on for over two decades. In addition, such a market could be legally burdensome; state officials, legislative authorities, and germane bodies could be reluctant to change the existing law.

Therefore, a regulated market for organs is not the solution. Rather, outlawing organ commodification is ethically and pragmatically essential. The recent ban on commodifying organs in China drastically reduces this trade there. It is reported that the number of execution and liver transplants fell from 3,500 in 2006 to around 2,000 in 2007 in that country (Chapman 2008: 1343). Yet, many proponents of a regulated organ market consistently argue that we should legalize organ commodification because a black market of organs is expanding anyway. If we strongly oppose the organ trade, we could
significantly reduce the black market, if not eliminate it entirely. In sum, the organ trade is harmful, flawed, exploitative, and burdensome; therefore, this trade is ethically objectionable.

Sellers’ Perspectives

Critical medical anthropology gives us essential tools to include the excluded. This section includes the “subaltern” voices of 33 Bangladeshi kidney sellers to understand the organ trade from the point of view of the victims.

Twenty-eight studied Bangladeshi sellers (85%) opposed the market of human organs. As chapter eight outlines, my interviewed sellers calculated their short-term financial gains versus long-term medical, social, and economic losses; they concluded that organ commodification is seriously harmful, risky, and life-threatening. Evidently, all sellers sold their kidneys hoping for a better life, but they are currently living in worse conditions than before. As seller Jobbar noted, “Before, I was making 6,000 Taka [$85], but now my income declined to 4,000 Taka [$55] per month.” Similarly, Mofiz mentioned, “Before I had 50% tension for paying off my debt, now I have 100% anxiety about my health.” Consequently, the majority of sellers did not support an organ market, arguing that it would be detrimental for them.

These sellers also pointed out that organ commodification is built upon deception, manipulation, and misinformed consent. They became angry as recipients tactfully treated them as commodified kin, and then mistrusted and mistreated them. For this reason also, they argued against the organ trade. As Mofiz noted,

It is better not to trade an organ. If recipients die for not having a kidney, let them die. There is no reason to feel bad for them who make us kidneyless and lifeless. I
am a “donor”. I sacrificed my kidney for a small sum, but the recipient did not pay me entirely. Each time he paid a small amount; I could not make any use of it. He did not behave well, rather he tricked me. This is a nasty crime, especially when I saved his life.

Seller Mofiz was so fumed that he indicated, “If the recipient’s husband (proxy) ever come to my city, I would not let him to run away. I would kill him. I am 100% sure. I would chop him in 100 small pieces. He destroyed my entire family.” These sellers rejected the idea of an organ market, considering the widespread corruption in Bangladesh. They said that if we legalize this trade, recipients, brokers, and doctors would ensure their own profits through corruption, but kidney sellers would be exploited just as before.

Many of these sellers also said that organ commodification has various negative outcomes for both sellers and recipients. As seller Rahmat notes, this trade results in two patients: with careful living, recipients (mostly older) somehow manage to live a few extra years, but sellers (mostly younger) struggle to survive for their entire life with a damaged body and endless suffering. He then asked, “Who gains what? What did I receive from selling?” Recipients are also living in agony for buying an organ. As one recipient (seller Dildar’s recipient) noted, “What a life I have, full of do-nots. I cannot go outside without a mask. Cannot eat spicy food. Cannot afford to miss a pill. Am constantly worried about how to afford medication and post-operative care; my entire family is paying for me.” Thus, although most sellers and recipients survive this trade, recipients are paying for prolonging their lives, while sellers are paying for losing a kidney.

Almost all sellers see the market for human organs as morally reprehensible. They emphasized that a kidney should not be valued in monetary terms, as it is not a thing.
They also argued that the payment of a kidney cannot replace their damaged and undignified self. Therefore, they concluded that selling organs is dehumanizing. As seller Hiru notes, “I do not accept selling any part, not even a hair of my body. It is entirely disgraceful; I cannot find anything good about it.” Many sellers still did not comprehend how they could have engaged in such a shameful act.

Many sellers were also concerned about the fact that the commercialization of various body parts is on the rise in Bangladesh. Sodrul, one of my interviewed kidney sellers, was surprised to meet with a potential liver seller, as he described:

I met Jahangir, who went to Chittagong to sell his liver. The buyer promised to offer a flat that costs 2,000,000 Taka [$35,000] in exchange for Jahangir’s liver. Initially, Jahangir thought that if he could live as a king for a month, that is a luxury. Jahangir came to Dhaka and asked a doctor about liver donation. Doctor told him that there is very little difference between death and donating a liver; it is almost a suicide. Doctor concluded that Jahangir can die, even in three months, as a lobe of his liver will be cut off and taken out from his body. Jahangir became scared and did not sell his liver.

Some sellers were shocked to come across the newspaper advertisement about selling a cornea. As Gofur expressed,

I felt awful after seeing the ad on selling an eye. How much grief it needs to make such a decision. It is not the same to see this world without an eye. Also, an eye is the symbol of beauty that would be totally damaged from selling one. Unlike kidney and liver that are inner organs, the eye is an outer organ, therefore how can an eye seller live when everyone looks at her in a nasty way?

Some of these sellers asked me, where are we going? As Salam (32) noted, “Tomorrow someone will sell skin, a toenail, or a hand; this is disgusting. We cannot live equally in society.” These sellers did not support selling body parts, let alone the organ market, arguing that it is morally repulsive.
All sellers did not foresee the negative consequences of commodifying organs at the beginning of this trade. Not surprisingly, the majority of them said that if they could turn back time, they would not sell their kidneys. As Hasmat (32) argued,

If someone donates a kidney, he can be satisfied mentally. But what did I get from selling? Neither do I have mental satisfaction, nor do I have economic benefit. Selling a kidney is a complete loss. Nobody could make a profit out of it; every seller’s face is sad. If I knew it before, I would have donated, rather than sold my kidney.

Seller Sanwar similarly outlined, “It would have been wiser if I had returned to my village and cultivated some land, rather than selling my kidney. Or, I could start a small variety store. Or, I could finish my BA and be a schoolteacher. Now, I have lost everything.”

Most sellers also did not support selling the kidneys of their families. They mentioned that if their families were to step forward to sell, they would prevent them, even by force. They would inform their family that the insignificant amount received in exchange for a kidney is nothing compared to the detrimental outcomes of this trade. As seller Sodrul said, “I would not let my family sell, never ever. What I thought did not happen. Rather, I am deceived, exploited, and carrying a disgraceful life.” Seller Joinal further argued, “In an unfair transaction, one party is hero, while the other is villain. Sellers were heroes, but became villains at the end of this trade.” These sellers believed that after knowing the details of this trade, their family would be concerned about the negative consequences of selling kidneys, rather than become greedy for the small sum offered. Some sellers even promised to help resolve their families’ extreme financial crisis.
Similarly, most sellers said that they would discourage other potential sellers from selling. As seller Mofiz noted, “I am dead, but I would not let other people die. I would rather tell them to fight as long as they can breathe without selling their kidney.” Most sellers believed that even if sellers were paid in full, they would not be able to change their social condition, since they have engaged in a reprehensible act. Consequently, some sellers have already discouraged other potential sellers (who came to them seeking advice and were in the process of selling) not to sell their organs. As Nergis argued, “If your mouth is burned by chun (a white creamy paste), you would be afraid to see yogurt.” Many sellers believed that if poor Bangladeshis were well informed about the consequences of selling kidneys, there would be a drastic shortage of donors.

Exceptionally, a few sellers (15%) were in favor of commodifying organs. The reason is mostly that: 1) they are working as brokers’ agents; 2) they could not repay their debts, therefore they are trying to resolve their remaining problems by selling their wives’ kidneys; and/or 3) they could not comprehend the widespread impacts of commodifying organs. When I challenged these sellers, they argued that organ commodification is detrimental, but it resolves the financial crisis of the desperate poor. I revealed that three of these sellers were in the process of selling their wives’ kidneys. As seller Abul told me,

One evening after the dinner, I discussed with my wife how much economic crisis we have. Then, I proposed to her that the only way we can resolve our problems is by selling one of her kidneys. My wife was scared and asked me what are the consequences of losing a kidney. I told her that selling a kidney is an easy task and there are no side effects of it. My wife did not say anything. So, the next day, I called Batpar and asked him to find a rich recipient for my wife. Afterwards, my wife and I went three times to Dhaka, but her tissues are yet to be matched. Of course, I am sad that my wife is sacrificing for our family. But I would not bring my daughters in this path. No parents can sell kidneys from their children.
Interestingly, no seller would agree to sell the kidneys of their own children.

Some of the sellers considered their action to be ethical, since they “donated” their kidneys in exchange for a gift. As Anu (31) mentioned, “I did not do anything wrong. I did not destroy the country, but rather I saved a life. When I was in trouble, the state did not help me out, so I simply donated my kidney.” Similarly, Shofi (25) said, “Organ donation is good in my eyes, as it saves life and resolves the economic problem of the poor. But selling is repulsive and immoral.” These sellers said that they would convince other potential sellers to donate rather than to sell, which would give them satisfaction to live with dignity.

Overall, most sellers stood up against a regulated organ market. Abdul was so angry about this trade that he even argued to ban transplantation entirely, so there would be no such trade. Even those sellers who received the entire payment did not support the regulated organ market. As Manik said,

I was fortunate that my recipient is a good person who paid me the full payment. But I do not support such a trade since my suffering from selling a kidney are enormous and devastating. If we introduce an organ market, the rich would not understand the poor people’s sorrow, but rather they would unfairly exploit the poor at any cost.

The overwhelming negative reaction of Bangladeshi kidney sellers offers convincing arguments for opposing the organ trade.

This chapter illustrates the perils of organ commercialization, which amplifies violence, harm, suffering, exploitation, and injustice to the poor, rendering the organ trade highly unethical. Looking through the eyes of kidney sellers, I strongly oppose the organ market, which generates many detrimental outcomes. In the next and final chapter, I point out that there are alternative ways to resolve organ shortages; for this reason, this
trade must cease. Proponents of the organ market are chasing a *sonar horin* or golden deer – an illusion.
CHAPTER TEN

Conclusion

What difference does it make to the dead, the orphans, and the homeless, whether the mad destruction is wrought under the name of totalitarianism or the holy name of liberty or democracy? – Mahatma Gandhi (1948)

In 2008, in a heated debate held at the University of Toronto, Robert Zurrer, a Canadian transplant recipient who purchased a kidney from a poor Pakistani, openly argued in favor of an organ market (MUNK Center 2008). The forum consisted of five speakers, including Mr. Zurrer, an anthropologist, an ethicist/religion scholar, a local nephrologist, and me. As the anthropologist argued against an organ market, Zurrer impatiently called her an “idiot.” The academic politely responded by showing her concern that Zurrer’s “individual desperation” is used to trump ethical treatment of other humans. For Zurrer (a libertarian), only a free organ market based on individual autonomy and freedom of choice matters; for the nephrologist (a liberal), a regulated organ market is cost effective, considering greater benefits to recipients and sellers; while for the others (communitarians), an organ market is unacceptable, since it exploits the poor. While these “highly polarized” and ethically contested discussions continue (see The Journal of Medicine and Philosophy, October 2009 issue on the symposium of

86 The Comparative Program on Health and Society organized and the Trillium Gift of Life sponsored an excellent symposium entitled Transplanted Bodies, Transformed Lives: The Commodification of Human Organs. The symposium was held at the Munk Centre for International Studies, University of Toronto, January 28, 2008. During the debate, transplant recipient Robert Zurrer openly discussed his experiences and provided arguments in favor of purchasing organs. The event is webcast at http://hosting.epresence.tv/MUNK/1/watch/43.aspx.

87 Liberal viewpoints consider that a regulated organ market saves recipients’ lives and ensures payment to sellers that can resolve their desperate financial situation, secures safety and reduces harm to sellers, and offers them post-operative care. According to this position, a regulated market is cost effective because it is either unexploitative or is insignificantly exploitative, and is necessary for greater benefits, such as saving lives and advancing medicine.

88 Labeling people based on their ideology is not straightforward; some might disagree with these classifications of libertarian, liberal, and communitarian.
the organ market), the preceding chapters illustrate that an organ bazaar is seriously unethical, since it results in violence and injustice to the poor at the high cost of their suffering.

Chapter One unfolded the broad spectrum of global organ trafficking and reviewed major resolutions against the organ trade in order to situate my research enquiries and theoretical lens, denoting that ethnography is essential to an examination of the current disputes around organ commodification. Chapter Two delineated how I gained access to kidney sellers and conducted my challenging but novel fieldwork in a “black” organ market operating in a domestic setting. In Chapter Three, I set the stage for this study, offering the historical and structural processes that generate widespread poverty in Bangladesh, and then exposing the plight of its poorer citizens who are selling their own body parts, while recipients, brokers, and health-care personnel profit. Chapter Four explored organ classifieds that are published regularly in Bengali newspapers, in order to illustrate how an outlawed organ trade is openly thriving in this country.

Chapter Five situated the deeply moving ethnography, describing how poverty, inequality, and corruption create conditions for extracting organs from the bodies of the impoverished kidney sellers with whom I conducted my fieldwork. Based on these sellers’ detailed narratives, Chapter Six discussed the pre-operative processes and experiences of commodifying kidneys, revealing how sellers are deliberately entrapped by false promises, are misinformed, and prepare to sell their kidneys. Chapter Seven outlined the sellers’ operative journey, which in most cases takes place abroad; this chapter exemplifies how sellers are oppressed, manipulated, and coerced in this trade.
Chapter Eight turned to depict the post-operative stage, exposing how sellers are brutally deceived, are deprived, and undergo great suffering in the post-vending period.

Chapter Nine examined the above-mentioned ethically contested platforms on the organ bazaar through the ethnography of Bangladeshi kidney sellers. I demonstrated that organ commodification is “structural violence” against the poor that is being executed through deception, manipulation, and misinformed consent at the high cost of the harm and suffering they experience. I strongly opposed the organ bazaar, as structural violence not only kills the poor, but also results in their fresh body parts being extracted when they are alive. The victims of structural violence also stood up against the organ trade, speaking out about their suffering, as well as various detrimental and unethical outcomes incurred from this trade. Chapter Ten therefore concludes that organ commodification causes serious violence and injustice to the poor. Offering alternative ways to resolve the organ shortage, this chapter aims to protect the poor and promote justice for all people.

For indeed there are alternative means to resolve the severe organ shortage without violating the principle of justice. For example, cadaveric organ donation, living related donation, biotechnological advances, and, in the case of kidneys, dialysis can significantly improve and perhaps resolve the organ shortage situation without exploiting the poor. Some may argue that cadaveric organ donation is not flourishing, even though it was implemented several decades ago. Evidently, a system of “presumed consent” – in which everyone is automatically a potential donor unless they opt out, which was first adopted in Spain in 1979, and then in Austria in 1982 and in Belgium in 1986 – significantly increases cadaveric organ donation in these countries (Gundle 2005: 113–115). To increase the donor pool, some countries, including Canada, have recently begun
accepting “non-heartbeating donors” (donors from cardiovascular death) in addition to brain death donors (Milne 2008: 37). Additionally, some scholars propose to re-examine the waiting list to “eliminate futile cases and establish age limits that would decrease the list by several thousands” (Schepers-Hughes 2007: 510); they claim that the scarcity of organs is socially invented (Koch 2002; Schepers-Hughes 2003a; Lock 2002a; Sharp 2006a). Israel is bringing out a new transplant law, in which people are encouraged to donate an organ by being promised priority when they need a transplant themselves (Milne 2008: 37). Meanwhile, in Bangladesh, about 12,000 people die each year from road accidents (Xinhua News 2005: 1), but their organs are being “wasted” as a successful cadaveric donation program does not exist there.

In addition, living related and non-related donations offer other viable solutions to resolving the organ shortage. Usually, family members step forward to save the lives of their loved ones. Also, some cases of non-related/non-directed altruistic donations do exist in India, Canada, and elsewhere (Truog 2005: 444). Recently, organ swapping – in which a living donor whose organ is not compatible with a loved one agrees to donate to a stranger, so that through a series of swaps their loved one does receive a compatible organ – is increasingly practiced due to the shortage of organ donors (CBC 2009: 1). Overall, living donors offer better and faster results than transplants from deceased donors, as medical personnel claim. Yet, living organ donation should be the last option, because of the potential harm, risk, and suffering involved in this exchange.

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89 Many countries, including Bangladesh, have a similar practice in the case of blood donation.
90 Based on the justification that living donors offer better results, proponents of the organ market often ask: Why is living donation acceptable, but not selling an organ (Matas 2004: 2009)? Wigmore et al. answered this question by arguing that organ selling violates body integrity [as well as body ownership and human dignity that provoke ontological and existential suffering] that is not well compensated for, other than by spiritual/philosophical [as well individual, familial, and communal] gains, such as acting in an altruistic fashion (Wigmore et al. 2002: 115).
Scheper-Hughes expresses concerns not with the medical risks but with the “less visible social and familial conundrums that living donation provokes” (Scheper-Hughes 2007: 510). Importantly, there are no rigorous longitudinal studies on medical, economic, and social impacts on living organ donors, as Chapter Nine outlined.

Further, the advancements of new biotechnology, such as stem cell research (genetic organs), bioengineering (mechanical organs), and xeno-transplantation (animal organs) are still “imagined as potentially viable solutions” to resolve the organ shortage (see discussions on such mechanical devices, xeno-transplantation, and genetic transfers by Sharp 2009, 2007, & 2006a; Harraway 1991; Hogle 1999 & 2002). Even though these “animal-human-machine hybrid bodies” are immensely challenging (Kass 2003; Fukumaya 2002; Annas 2003), some of these technologies offer promise for extending lives without exploiting the poor.

Furthermore, dialysis machines save lives without threatening ethical integrity. Even though dialysis is inconvenient, many desperate transplant patients choose to remain on dialysis rather than consider purchasing organs from the market. The choice between individual gains vs. the common good, or liberal vs. communitarian ethics, is clear to them.

Throughout this thesis, I consider that the current practice of organ transplantation should be grounded in social justice (see the discussions on justice by Farmer 1999 & 2005; Rawls 1971; Pogge 2008 & 2006; Sen 2009), rather than focusing mainly on autonomy and beneficence (for the wealthy), as liberals argue. I do so simply because an organ market does not speak to the lives of the economic underclass, but rather is seriously discriminatory against them. When the poor are already victims of widespread
poverty that is sustained by structural violence, we need to work to improve their lives, rather than harvesting organs from their skinny bodies. Proponents of the organ market are attempting, but naively, to legalize another form of structural violence that is increasingly being intensified to exploit the poor.

I argue that we must ensure that the poor have the basic minimum of life’s necessities. At the very least, they deserve to keep their body parts for their simple need of physical survival. When the poor are already dying from hunger in the streets of Bangladesh, legalizing an organ market would not ensure justice to them. Because structural violence exists in most Third World countries, an organ market would put the poor at graver risk. As the Bellagio Task Force has warned,

The physical well-being of disadvantaged populations, especially in developing countries, is already placed in jeopardy by a variety of causes, including the hazards of inadequate nutrition, substandard housing, unclean water, and parasitic infection. In these circumstances, adding organ sale to this roster would be to subject an already vulnerable group to yet another threat to physical health and bodily integrity. (Rothman et al. 1997: 2741)

Autonomy and choice – two tenets of Western liberalism – do not correlate with the crude realities of hunger and poverty in Third World countries (Moazam et al. 2009: 40). The violence and corruption in these impoverished countries are so extreme that the regulation of the organ market cannot prevent fundamental abuses to the poor, eliminate widespread deception, manipulation, and misinformed consent, and assure transparency, fairness, and a voluntary choice to sell, as my ethnography shows. It is certain that a regulated organ market is not an “Aladdin’s lamp” that would change all the existing economic inequality and political disparities; rather, a regulated market would enforce widespread physical and structural violence against the poor in order to prolong the lives of the affluent few.
I believe that poverty cannot be resolved and human rights cannot be achieved without the fair distribution of resources (fairness is a relative concept, but the distribution of wealth between the rich and the poor cannot remain the same as it is today). First, we must acknowledge this point, and then we need to decide how to act upon it. In contrast, the liberal standpoint tells us that hunger is there and cannot be resolved, so let us allow the poor to make the free choice to sell their organs. In such a viewpoint, we simply disregard that the rich deprive, oppress, and exploit not only the poor’s wages and gender, but also their healthy body parts. Liberals further argue that economically deprived persons accept risky jobs that others may refuse (such as working as fire fighters or at risky construction jobs), so why not permit the commodifying of organs (Radcliffe-Richards 1996: 385; Taylor 2005: 140)? Those with a liberal point of view do not explain why we should justify adding yet another danger to those that the poor already confront (Rothman et al. 1997: 2741). What is happening and what should be happening are two different things. If the poor have no choice but to sell their organs, at least they have the right to live with an intact body that does not compromise their lifespan and their ability to support themselves.

Reinforcing the ethics of justice, I underscore that the deprived deserve fair and equitable treatment. If we legalize the organ trade, the majority of the world’s population, the people who are at the greatest risk of organ failure, will die without receiving transplantation, while the affluent very few will benefit (Cohen 1999: 157). Therefore, I argue that life-saving technology should be distributed equally. As the World Health Organization notes, “transplantation should be made available to everyone on the basis of medical need and not on the basis of gender, ethnicity, religion, or social or financial
status” (The Declaration of Istanbul 2008: 3). Justice and equity should be ensured in providing access to transplantation and allocating organs.

Rather than debating this issue, we should immediately come to the consensus that organ commodification is a “criminal activity” that has not only adverse repercussions for the poor, but also social, economic, and political ramifications. The United Nations has already placed organ commodification on the same level as human trafficking (United Nations 2009: 1). The World Health Organization is also trying to adopt an international agreement to combat organ trafficking. In the meantime, the medical community should explicitly state its standpoint to those recipients who have been illegally purchasing organs: should health-care personnel offer these recipients transplant care, and if so, to what degree? The international community should also overtly express its stance on the Iranian regulated organ market, which has been operating for two decades. Ceasing the organ trade and offering strong opposition to the organ market may drive the enterprise further underground; a permanent monitoring body should counter the effects of such a change (Rothman et al. 1997: 2741).

In conclusion, I want to make it clear that I am not against organ transplantation, which saves human lives. Rather, I strongly oppose organ commodification, which facilitates violence and injustice to the poor. Even though the task of the ethnographer is to recognize and encompass opposing views rather than to resolve them, I cannot resist taking an activist standpoint. We cannot promote a system where the poor are subject to serious structural violence at the terrible cost of their own suffering. Where the violation of injustice is so grave that the vulnerable cannot keep their body parts, which are essential for their physical survival. Where the wealthy greedily eye the bodies of the
poor and execute gruesome exploitation to prolong their own lives. Where the bodies of the deprived are being chopped up bit by bit into raw materials and labeled with price tags. I argue that organ commodification should not be legalized when the solution lies in other viable ways. It is up to all of us to oppose the organ market proposition and emphasize the symbolic meaning of recycling body parts. This is the time to write a transplant manifesto that is grounded in social justice, promoting humanitarian ethics.
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