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“Living Cadavers” in Bangladesh:

Bioviolence in the Human Organ Bazaar

The technology-driven demand for the extraction of human organs—mainly kidneys, but also liver lobes and single corneas—has created an illegal market in body parts. Based on ethnographic fieldwork, in this article I examine the body bazaar in Bangladesh: in particular, the process of selling organs and the experiences of 33 kidney sellers who are victims of this trade. The sellers’ narratives reveal how wealthy buyers (both recipients and brokers) tricked Bangladeshi poor into selling their kidneys; in the end, these sellers were brutally deceived and their suffering was extreme. I therefore argue that the current practice of organ commodification is both exploitative and unethical, as organs are removed from the bodies of the poor by inflicting a novel form of bioviolence against them. This bioviolence is deliberately silenced by vested interest groups for their personal gain. [organ trade, kidney seller, bioviolence, suffering, social justice]

When a fox catches a chicken, the little one cries. I was the chicken, and the buyer was the fox. On the day of the operation, I felt like a *kurbanir goru*, a sacrificial cow purchased for slaughtering on the day of *Eid* [the biggest celebration in the Islamic world].

—Dildar, a 32-year-old Bangladeshi rickshaw puller who sold one of his kidneys

The “miracle” success of transplant technology, alongside the commercialization of health care and the increasing polarization between rich and poor, has created conditions for an illegal but thriving trade in human organs. In this article, I will examine the organ market of Bangladesh, through the ethnography of kidney sellers,¹ whose living bodies become sites of organ harvesting. My investigation will be driven by these timely questions: How are organs of the impoverished populations being commodified? What are the impacts of commodifying organs on their living body and embodied self? How is organ commodification linked to broader social structure and individual ethics? Universal human rights and social justice issues are also relevant here as modern medicine, such as organ transplantation, often justifies a system for prolonging the lives of the “haves” over the lives of the “have nots.”

MEDICAL ANTHROPOLOGY QUARTERLY, Vol. 26, Issue 1, pp. 69–91, ISSN 0745-5194, online ISSN 1548-1387. © 2012 by the American Anthropological Association. All rights reserved. DOI: 10.1111/j.1548-1387.2011.01197.x

I will argue that organ commodification is seriously exploitative and ethically reprehensible, as organs are extracted from the bodies of the poor by inflicting a novel form of bioviolence against them.

The People's Republic of Bangladesh is an emerging organ bazaar that has been in existence for more than a decade. It is tacitly endorsed by national media that openly publish newspaper classifieds seeking kidneys, livers, corneas, and any other transplantable part of the human body. Every day, organ classifieds reach millions of poor rickshaw pullers, day laborers, slum dwellers, and village farmers, some of whom eventually sell their body parts to try to get out of poverty. The recipients are either local or overseas residents (almost all of them are Bangladeshi-born foreign nationals) who purchase organs within Bangladesh and then obtain their transplant surgery mostly in India, as well as in Bangladesh, Thailand, and Singapore.² Amid this trading, a number of organ brokers have expanded their network and run the business for a hefty fee. Medical specialists also benefit from this illegal exchange. In 1999, the Bangladeshi Parliament passed the Organ Transplant Act, which imposes a ban on trading body parts and publishing any related classifieds. The Act explicitly states that anyone violating this law could be imprisoned for a minimum of three years to a maximum of seven years and penalized with a minimum fine of 300,000 Taka (\$4,300; see *Bangladesh Gazette* 1999:1819). Nonetheless, the organ trade is growing in Bangladesh, a country where 78 percent of its inhabitants live on less than \$2 a day, not to mention it virtually has no cadaveric organ donation program until today. The average quoted price of a Bangladeshi kidney is currently 100,000 Taka (\$1,400)—a figure that has gradually dropped because of the abundant supply of body parts from the poor majority.

The market of human organs is recurrently theorized as both a global-economic and a macro-ethical phenomenon, as it is embedded in a larger system of exchange and extraction across differences of wealth and encompasses the broad dynamics of both the developed and developing worlds. The historical relationship of conquest, colonization, and extraction has shaped the transformation of actual Third World bodies into raw materials in their own right. The outcome is a serious form of exploitation of the Third World, where impoverished populations become organ suppliers to prolong lives for the Western few. Predominantly, the global organ trafficking analyzed through the East–West dichotomy is the focus of our ongoing investigation. 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 (2000:193). Shimazono also identifies that the most common way to participate in organ trafficking is through “medical tourism,” in which potential recipients travel abroad to undergo organ transplant and buy organs from the host country (e.g., Japanese recipients receive transplants from Chinese prisoners in China). In addition, there are reported cases of living sellers of different nationalities being brought to recipients' countries for transplant surgery (e.g., a Moldavian seller to an American recipient or a Nepalese seller to an Indian recipient). In other cases, recipients and sellers from two different countries travel to a third country for transplant surgery (e.g., an Israeli recipient and an Eastern European seller travel to South Africa [Shimazono 2007:956–957]; see also Scheper-Hughes 2005:26).

In contrast, my research focuses on domestic organ trafficking that is operating at national, regional, and international levels. In Bangladesh, the common scenario of organ trafficking is that local recipients (almost all of whom are wealthy) 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; they receive organ transplants within Bangladesh (i.e., Bangladeshis sell to Bangladeshi recipients, and their transplants are performed in Bangladesh). In a very few cases, Bangladeshi recipients (wealthy people) travel abroad for organ transplant and buy organs from the host country (e.g., 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 (e.g., North American, European, or Middle Eastern recipients and Bangladeshi sellers travel abroad for transplantation). Domestic organ trade, which perhaps comprises the majority of organs being trafficked worldwide, also ought to be examined in depth, as opposed to global organ trafficking on a broader spectrum.

Organ trade also needs to be explored through the ethnography of kidney sellers, as they offer subaltern voices against the dominant discourse. However, only half a dozen succinct ethnographies and research reports on kidney sellers in particular have been published to date (Budiani-Saberi and Delmonico 2008; Goyal et al. 2002; Moazam et al. 2009; Naqvi et al. 2007, 2008; Scheper-Hughes 2003a; Zargooshi 2001a, 2001b); none of them reveals the detailed processes and experiences of selling organs, as well as the broader ramifications of this trade.

Further, no rigorous longitudinal study among kidney sellers exists to date. Even though a few long-term studies on living kidney donors have been published recently (El-Agroudy et al. 2007; Ibrahim et al. 2009), they focus mostly on the physical impacts of the procedure (Bruzzone and Berloco 2007:1785; Danovitch 2008:1361; Davis and Delmonico 2005:2103), and are based on data from kidney donors who are mainly from developed countries. In contrast, my ethnography demonstrates that selling kidneys causes serious physical, psychological, social, and economic harm to kidney sellers.

Medical anthropologists have contributed centrally to the scholarly discussion on organ trafficking. They strongly oppose commodifying body parts, arguing that this practice purportedly capitalizes on the distress of those in need, particularly because, as the poor can participate in such a system only as organ sellers, it is an exploitative practice. As Scheper-Hughes concludes, the grotesque niche market for organs has created 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 propositions” (2003b:1648). Similarly, Lawrence Cohen argues, in the ethical realm of organ transplant, advancement of expensive biotechnology and commercialization of health care becomes increasingly synonymous, while options for life-saving treatment for the poor are unimaginable (Cohen 1999:149; see also Sanal 2004). Anthropologists also argue that certain living things should not be alienable for commercialization, as such a practice is carried out against culture and humanism in general (see also Fox and Swazey 1992; Joralemon 2001; Sharp 2000; Tober 2007).

Although organ trafficking is critically analyzed by medical anthropologists, the violence—what I prefer to term *bioviolence*—for procuring “fresh” organs from a subset of the population has yet to be examined. I consider bioviolence a blend of physical, structural, and symbolic violence, all of which are carried out to extract organs from the oppressed bodies of the poor. Margaret Lock (2000) addresses the symbolic violence, particularly in cadaveric organ procurement, elaborating how the transplant industry creates an insatiable demand for organs, which will, as she argues, always remain greater than the supply because the medical eligibility to receive an organ grows even more acute (see also Illich 1976; Koch 2002; Scheper-Hughes 2003a; Sharp 2006). At the same time, the industry studiously ignores the source of harvested organs almost all the time. Lock therefore underscores that this artificially created organ scarcity and the procuring of organs from every source generate unavoidable violence, which flourishes in every aspect of the transplant enterprise, but has been largely masked by powerful rhetoric associated with “the gift of life.” According to Lock, this constitutes symbolic violence, as it folds seamlessly into the institutional setting, appears as a natural phenomenon for daily life, and becomes normalized through the rhetoric of scientific progress (Lock 2000:291). In this article, I examine the bioviolence against the living poor, whose kidneys are being extracted in the underground organ bazaar of Bangladesh.

What is Bioviolence?

Bioviolence is an instrument to transform human bodies, either living or dead, either whole or in parts, as sites of diverse exploitation viable through new medical technologies. In essence, bioviolence is an act of inflicting harm and intentional manipulation to exploit certain bodies as a means to an end. This term not only refers to the act itself (i.e., extracting organs from the physical body) but also to the processes involved (i.e., deception and manipulation for organ procurement) in the exploitation of bodies, mostly of impoverished populations. Bioviolence is the byproduct of technological experimentation and a vehicle for structural exploitation to fulfill the medical need and desire of the affluent few, but at the cost of bodily harm to the deprived majority. For example, the recent advancement of biotechnology has fragmented the human body into 150 reusable parts, such as organs, tissues, sperm, and blood (Hedges and Gaines 2000) to alter, increase performance of, and prolong the bodies of the privileged minority. However, these “spare parts” are removed almost exclusively from the poor by inflicting bioviolence against them. Similarly, assisted reproductive technology (i.e., *in vitro* fertilization) has produced another form of bioviolence, whereby a poor woman reluctantly carries and delivers a child for a wealthy infertile couple, but at the expenses of her own physical health. Here the body of the surrogate mother is intact, as opposed to the organ trade, where the body of the kidney seller is fragmented. In a similar way, biopiracy refers to another form of bioviolence, through which the dominant class or developed countries are patenting biological resources, such as genetic cell lines or plant substances of the marginalized populations or developing nations without fair compensation or agreement. For instance, the immortal HeLa cell was taken from Henrietta Lacks’s body without her consent and has been commercially used in numerous scientific research studies, such as for cancer, polio, AIDS, and gene mapping, for more than

half a century (Skloot 2010). While in clinical drug trails, the bodies, again mostly bodies of the poor, are subject to medical experimentation, often through improper consent and deceptive promises. At the end, they are deliberately left untreated; this entire process and dynamic constitutes another form of bioviolence. Bioviolence is an important analytical tool to examine the exploitation of the poor, elapsing on the margin of “other cultures,” but at the target of emerging medical technologies.

To examine bioviolence, particularly in the organ bazaar of Bangladesh, it is essential to synthesize the structural processes and individual agency, as opposed to focusing on one aspect to the exclusion of the other. I will therefore explore how bioviolence is carried out to extract organs from the living poor. How is it rationalized but kept silent in a particular setting? Does it contradict the principles of social justice and human rights? In addition, I will elaborate on what are the medical, social, and economic ramifications of bioviolence. To what extent can bioviolence be determined through victim’s suffering? And does bioviolence destroy their homeostatic balance of body and self? These questions will allow me to explain bioviolence in the context of the Bangladeshi state, national media, health specialists, and organ buyers (both recipients and brokers), as well as complicate this account with the agency of kidney sellers, all of whom sustain this trade.

To analyze the bioviolence, my ethnography documents through the lens of the victims how the poor typically sell their kidneys to wealthy recipients. What are the lived realities that these sellers experience after selling their body parts? And, do they support or resist organ trading in the postvending period?

Exploring the processes and magnitudes of bioviolence, in this article I will elaborate how transplant recipients prolong lives, organ brokers flourish, and medical specialists profit at the crossroads of the neoliberal state, the commercialization of healthcare, and grinding poverty that intersect with the violation of justice to impoverished populations, turning them into “living cadavers.” I will argue that a gross bioviolence is routinely carried out to extract organs from their bodies; however, it is deliberately concealed to protect personal interests and is justified by individual ethics.

Fieldwork in a Black Market

Conducting fieldwork in the illegal market of human organs is often demanding, both ethically and methodologically. Scheper-Hughes addresses how she investigated organ trafficking by conducting “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 (2004:32). Scheper-Hughes’s ethnographic method was “to follow the bodies”—what George Marcus formerly describes as “follow the things” (1995:107). However, one of the critiques of this approach is that following things leads followers away from the unique perspectives of the locals who experience things removed from them (Walsh 2004:226). The question is, then, how can we deeply delve into the local details by offering fleeting glimpses of ethnographic data from a vast number of research settings? Accordingly, I did not follow the methods of a large-scale, multisited ethnography but chose to explore a localized ethnography on the organ trade.

I faced difficulties, particularly in gaining access to kidney sellers, as they are involved secretly in the underground organ bazaar of Bangladesh. Most sellers do not disclose their actions to anyone—not even to spouses or siblings—as the organ trade is outlawed and is considered a disgraceful and humiliating act there. Yet, I successfully interviewed 33 kidney sellers (30 male and three female), but only after gaining the trust of Dalal, an organ broker who became my key informant and intermediary of this research. To locate kidney sellers after all of my initial attempts (i.e., contacting doctors, recipients, and journalists) failed, I had no alternative but to contact an organ broker, who is connected to them like a spiderweb.³ I introduced myself to Dalal, stating that I was neither an undercover police officer nor a journalist, but a “harmless” researcher. My local family background, university teaching in Bangladesh, institutional affiliation abroad, and my partner’s identity as *bedeshi* (foreigner) played an essential role in gaining Dalal’s trust, while my familiarity with the Bengali language aided me in sharing my thoughts and determining my initial approach to Dalal without any confusion.

My rapport with Dalal raises an ethical challenge: how researchers gain access to “hidden populations,” especially when the key informant is engaged in criminal activities and is exploiting research subjects. As my research would have not been possible without the support of Dalal, I consider that a key informant technique is effective in gaining access to “hidden populations” (see Bourgois 2003; Whyte 1981). The question, however, is how a researcher can negotiate with such key informant. I maintain a methodologically effective approach without impeding ethical integrity. For example, while Dalal assumed that he would receive lofty monetary benefits, I reimbursed him only for his transportation and communications costs (on average, 500 Taka, equivalent to \$7) for each seller. Or, when Dalal demanded that I include his photos and contact address in my “English publication,” assuming that this would disseminate his business abroad, I refused his plea, arguing that having his identity revealed could bring him serious troubles. My point here is that the researcher needs to persuade the key informant persistently, unhurriedly, and ethically to gain access to invisible populations (as opposed to large-scale, multisited ethnography, in which the researcher may approach hastily or conceal his or her personal identity to obtain data quickly).

My fieldwork was carried out in Dhaka, the capital of Bangladesh, and was conducted mainly in 2005. While “hanging out” in the field, I introduced myself as former professor in a Bangladeshi university and doctoral candidate in a Canadian university to gain access to various groups, that is, nephrologists, urologists, and postgraduate trainees, as well as recipients, their families, and their organization, Bangladesh Kidney Patients’ Welfare Association, along with brokers, lawyers, journalists, and members of a private body donation group. To conduct research at Bangabandhu Sheikh Mujib Medical University Hospital, the major center for organ transplants in that country, I attained permission from the head of the Department of Nephrology after submitting my written application. I also obtained approval from the Ethics Review Board at the University of Toronto to conduct this research. Predominantly, I used in-depth interviews with kidney sellers, as well as informal discussions with other groups, to collect my data. I also employed participant-observation, focus group discussion, and case study method. I spent an average of ten hours with each kidney seller. All interviews were unstructured and narrative based.

The Labyrinth of Bioviolence

Thirty-three Bangladeshi kidney sellers—all of whom are poor—document the bioviolence inflicted on them to procure organs from their bodies. Through this “processual ethnography,” they outline the processes and experiences of commodifying kidneys, and from which they suffer severely afterward. In this section, I reveal the various stages of kidney selling, describing how sellers are entrapped, meet with a broker, obtain fake passports, travel abroad for the surgery, and return to Bangladesh with a permanent scar and extreme suffering. This ethnographic account addresses how the bioviolence against kidney sellers is being individualized and contextualized. Their odyssey for selling their kidneys is characterized into three sections: hope—the preoperative, sacrifice—the operative, and suffering—the postoperative.

Hope for a Better Life: The Preoperative Period

Poverty forced my research participants to sell one of their body parts. When these impoverished populations come across newspaper advertisements seeking a kidney donor, they are tempted to “donate” because of the lucrative offers (i.e., monetary reward, job offer, or overseas visa) made in return for their kidney. Of the 1,288 organ classifieds I collected, Figure 1 provides an example of an advertisement posted by a potential recipient.⁴

In this advertisement, the recipient is very likely making false promises, as she cannot guarantee the seller’s visa abroad.

The interviewed sellers have very limited knowledge about organs in the human body. As Mofiz, a 43-year-old tea stall owner and kidney seller, mentioned: “I saw an ad looking for the 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.” All sellers hope that by selling their kidneys, the wheel of their fate will turn in their favor, but they also fear the life-threatening consequences of the surgery. The sellers eventually start gambling between hope and fear.

Curious about the newspaper classifieds, sellers contact the potential buyers, who are either recipients or brokers.⁵ The interviewed sellers reported to me that the recipients attempt to convince them by portraying “kidney donation” as a “noble act” that saves lives and does not harm the donor. The recipients promise to bear all the expenses and compensate the “donors” well. Most sellers also revealed that brokers encourage them to participate in the trade by repeatedly telling a story about *the sleeping kidney*.⁶ The story goes like this: A person has two kidneys: one works and the other one sleeps. If one kidney is infected, the other kidney automatically starts working. But if one kidney is damaged, the other one will be damaged, too, because of the polluted blood. Therefore, everyone can be healthy with only one kidney. During the operation, the doctor first starts a donor’s sleeping kidney with medicine. The “newly awakened” kidney stays in the donor’s body and the “old” kidney is removed and given to the transplant recipient. In this manner, selling a kidney is presented as a win-win situation. The sleeping kidney story is



Figure 1. The Daily Ittefaq, 4 January 2000.

Translation:

Request for Kidney Donation

Both kidneys of a USA resident, Kulsum Begum, are damaged. Kidney specialists advise her to transplant a kidney immediately. A heartfelt request is made 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) must travel to the donation. The transplant will be performed at [a U.S. university] medical center.
 3. The donor must be in good health and between 19 and 40 years of age.
- All the relevant expenses will be covered by Kulsum Begum. To discuss details, contact urgently the following address.

Md Iman Ali, House B-12/7, Agargoan Taltala Government Quarter
Sher-E-Bangla Nagar, Dhaka – 1207, Telephone: 8125959.

widely circulated in Bangladesh, which reflects how poor citizens are deceptively manipulated, a common thread of the bioviolence carried out for the purpose of organ extraction from their bodies.

Once persuaded, the buyers match blood groups and arrange tissue typing for the sellers. Matching tissue is very difficult, which partly explains the role of a broker. When the broker successfully matches tissues, and the sellers are medically fit, the buyers bargain over the payment. They initially offer the sellers only 80,000 Taka (\$1,150) for a kidney, arguing that the market value of their organs is low because their blood types are in ready supply. After further negotiations, the buyers finally agree to pay 100,000 Taka (\$1,400). However, they warn that the entire amount will be given to the seller just before they enter the operating room, as the sellers might run away with the money without relinquishing their kidneys.

Many sellers are not pleased; the buyers promise to offer them a job, arrange a visa and citizenship they will need for going abroad, or allocate land. All sellers are fearful; the buyers guarantee that the operation is 100 percent safe, saying that the sellers will be in the hands of world-renowned specialists. The buyers also mention that going aboard (particularly to India, where most of the transplantations for Bangladeshi sellers were performed) will be fun, as the sellers can visit new places, eat out, shop, and watch Indian movies. Thus, buyers lure potential sellers through trickery, lying, and false promises, other widespread elements of bioviolence in the organ bazaar of Bangladesh and beyond.

The broker arranges sellers' fake passports and forged legal documents that indicate that the person is donating a kidney to his or her kin and advises the seller not to disclose his or her true identity lest the Indian healthcare personnel reject the case.⁷ To establish this newly commodified kin relationship, Hiru, a 38-year-old Hindu seller, underwent circumcision because his recipient was Muslim. When the recipient asked Hiru to get circumcised, Hiru agreed to do so, hoping that selling a kidney would change his social standing:

When we are finalizing the trip to India, the recipients told me that we are going to India as “brothers.” He continued, “But brother, you are Hindu, and I am Muslim. We would not be able to complete the deal as Indian doctors could reveal our fake identities, especially during the operation while we would be lying naked. The doctors would find out that I am circumcised but you are not.” He therefore proposed to cut off the foreskin from my *sonar matha* (the head of the penis), his only solution to resolve this problem. What an unbelievable crisis I faced! I could not step back from the deal, but needed to circumcise against my religious decree. Regretfully, I asked the recipients to arrange the circumcision at Dhaka, but he told me to handle it in my village. The next morning, I went to a doctor, but due to the high cost involved I ended up at a *hazam*, a local practitioner of my village. The *hazam* told me that circumcision is an easy matter. He injected a medicine [local anaesthesia] in the skin of my *sonar matha*. He rubbed the surrounding skin and asked whether I was feeling any pain. He told me to look up at the roof and it was quickly done. I did not feel any pain, so I went to the market and called the recipient; he was relieved. When I was coming back home, the anaesthesia stopped working, and I felt like it was a nightmare.

In the post-transplant phase, Hiru was deeply worried, believing that God would not forgive him for his reckless action, as well as for not returning his body intact. Hiru's case documents how organ buyers materialize bioviolence at any cost, even violating kidney sellers' religious faith.

Separation, Sacrifice, and the Rough Cut: The Operative Stage

After crossing the Indian border, buyers seize the sellers' passports, ensuring that the sellers cannot return to Bangladesh until their kidneys are removed. Following the buyers' instruction, the sellers stay in terrible accommodations, rooming with

as many as 10 other sellers in a tiny bachelor apartment permanently rented by a broker. All the medical tests need to be redone, as the Indian doctors do not accept the Bangladeshi results. The sellers begin to feel isolated, as they are not allowed frequent trips outside. In this bioviolence, the buyers gradually establish their authority, while the sellers turn into their passive agents abroad.

If some sellers confront the buyers' bioviolence, they also face threats and warning about dismissal from this trade. However, some sellers demand an increase in their share after discovering that the broker is making a high profit of about 400,000 Taka (\$5,500). The broker tries to explain the huge expenses and high risks involved in this murky business. Sodrul, a 22-year-old college student, decided not to "donate" his kidney and asked the broker for his passport so he could return to Bangladesh. The broker and two hired local *mustans* (thugs) beat up Sodrul, assaulted him, and threatened him into the operation. Here we witness the use of coercion, another evidence of bioviolence dispensed to abuse kidney sellers viscerally.

The day before the operation, sellers ask for their payment, as has been promised. The buyers break the commitment again and decide not to pay the sellers until they return to Bangladesh. The sellers think constantly: What is going to happen next? What happens if I die in the operating room? The sellers realize that the buyer would not send their dead bodies to Bangladesh because of the expense, and their family members cannot bring them back because of the secrecy involved. Sellers enter the operating room feeling like they are prisoners in the buyers' hands.

After the surgery, the first thing the sellers notice is the rough cut about 20 inches long on their bodies. The sellers are unaware that if the buyers had paid only \$200 more, the surgeons could have used laparoscopic surgery, which requires an incision as small as four inches. To minimize the cost, the sellers are also released from the hospital within five days after having this highly sophisticated operation. Sellers return to the broker's unhygienic apartment with a permanent scar of this bioviolence.

Staying in India, especially after the operation, is so inconvenient that almost every seller travels back to Bangladesh within a few days, despite the doctor's recommendation to stay a few weeks longer. While travelling by train in such early stages of recovery, some sellers experience bleeding from their wound. Malek, a 28-year-old seller, visited doctors in Calcutta for the bleeding but could not afford to stay for his treatment. When the sellers cross the border into Bangladesh, they reenter their old life with a new, damaged body, the end product of the bioviolence.

Shattered Dreams and Suffering: The Postoperative Phase

After returning home, sellers are under constant psychological pressure to explain their absence and to hide their scars.⁸ If the scars are revealed, the sellers make up a story of an unfortunate accident that happened during their job in a distant city. However, some sellers are unable to hide their actions; they are stigmatized and are called "the kidney man." A few sellers also decide not to get married, ever.

Above all, the sellers' health profoundly deteriorate in the postvending phase. They experience numerous physical problems and went through severe psychological suffering. The sellers refer to themselves as "handicapped." Yet, none of the

sellers could afford the biannual postoperative health checkup, which costs only 1,500 Taka (\$22). The outcomes of this bioviolence are severe.

In addition, most sellers (27 out of 33 sellers) do not receive the full amount of money they had been promised. Once the sellers have gone home, they constantly call the buyers to receive their full payment. The buyers offer them a little sum of money each time and deduct numerous hidden expenses. Whatever money the sellers receive, they cannot use it productively. They use it mostly to pay off debts, start a business, pay bribes to get a job, or arrange a dowry. Some sellers spend the money on material goods, such as televisions, cell phones, and gold chains. Only two sellers, Abul (32) and Rahmat (28), benefited economically, opening a livestock farm and buying land with the payment. The others have not escaped poverty and are actually living in worse conditions than they were before their operations. As Abdul, a 30-year-old seller, said, "I lost my kidney as well as my job. Now I cannot engage in heavy lifting jobs such as rickshaw pulling, cultivating land, or heavy industrial lifting; what kind of life is this? If I had the strength in my body, I could work anything and could easily earn that little sum I received from selling." At the end, sellers realize that they are running after a *sonar borin*, a golden deer that is just an illusion.

My ethnography reveals the maze of the bioviolence inflicted on kidney sellers. The short-term financial gain verses the long-term medical, social, and economic harms to kidney sellers reveal that bioviolence is seriously detrimental to them. As Keramat, a 25-year-old seller, said while weeping uncontrollably, "We are living cadavers. By selling our kidneys, our bodies are lighter but our chests are heavier than ever."

The Untold Story: Biosocial Impacts of the Bioviolence

The bioviolence that was deliberately carried out against the kidney sellers is devastating and invasive. Although medical studies have claimed that the donors' death risk owing to surgery to be at one in 3,000 (Bruzzone and Berloco 2007), and that donors have a higher risk of developing chronic diseases (i.e., hepatitis, hemorrhage, and hypertension) and viral diseases (i.e., HIV/AIDS, malignancy, and infection) in the long term (Chapman 2008:1343; Danovitch 2008:1361; Naqvi et al. 2008:1444), my ethnographic account and other existing studies document that kidney sellers' health deteriorated, their economic conditions worsened, and their social standing declined in a serious manner after they sold their kidneys. Moreover, Bangladeshi kidney sellers reveal that selling a kidney has profound psychological and psychosocial impacts on them, especially in relation to their selfhood.

The Damaged Self: Disembodiment and Ontological Suffering

The narratives of Bangladeshi sellers reveal that living without a kidney is not just a physical alteration, but a disembodiment and ontological impairment of being in the world. Many of the sellers I interviewed considered that kidney commodification jeopardizes the homeostatic balance of their body and self. Postvening, they sensed that their new body existed in a binary opposition to their old body. They felt as if lacking a part of their body split their entire body. As a result, some of these sellers

said they turned into a “half human” (see also Moazam et al. 2009:34), and, by extension, their self had become disordered.

Bangladeshi sellers feel as if they are living in nothingness. Whenever they see the scar, they are momentarily back in the operation. Every year, most sellers vividly remember their operation day—“the death day,” as one of them called it. Every day, all sellers live with the fear of dying sooner because they have only one kidney; seller Mofiz often recites a verse from the Koran—“Inna lillahi was 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 felt that they had an integrated selfhood with their recipients. By sharing flesh and blood, seller and recipient become one body, one person, one being. Some sellers therefore felt strange when their recipient died. Those sellers could not comprehend how one of their body parts could have died when they themselves were still alive. These ontological puzzles cultivate a distressed self.

In addition, most Bangladeshi sellers felt disembodied because of selling their body parts. This action violates long-standing cultural and religious practices, such as body ownership, bodily integrity, and human dignity. For example, many of my interviewed sellers expressed fear and emptiness at not being able to return their whole body to God in the afterlife. These sellers believe that God is the owner of their body; they regret selling God’s gift. Further, many sellers mentioned that organ commodification is one of the most disgraceful acts a human can commit; they lost their self-respect, intrinsic worthiness, and moral judgment after selling their kidneys, and they considered themselves “subhuman.”

Because of such disembodiment and ontological suffering, the self of many Bangladeshi sellers is severely damaged. The sellers I interviewed tended to withdraw from their family, friends, and society. They suffered from grave sadness, distress, hopelessness, and crying spells. In their frustration, some sellers therefore became addicted to drugs. Seller Mofiz told me that he often sat down, speechless, in a dark place, and thought about committing suicide (see also Moazam et al. 2009:33; Zargooshi 2001a:1796).

The Long-Term Consequences of Selling Kidney: Social and Physical Dimensions

Bangladeshi kidney sellers also experience severe social suffering for selling their body parts. These sellers revealed that they usually do not disclose their actions because of the high social stigma placed on selling body parts; as a result, 79 percent of them become socially isolated. Similarly, Pakistani sellers expressed feelings of profound shame at having sold a kidney and added that people in the community made fun of them (Moazam et al. 2009:35). Moldavian and Filipino sellers were also being labeled as “weak” and “disabled” by their employers and girlfriends; if they were single, nobody would agree to marry them, because people generally believe that someone who has only one kidney would not be able to support a family (Scheper-Hughes 2003:220). Iranian sellers also reported that vending increased marital conflict in 73 percent of sellers, of whom 21 percent divorced following the surgery (Zargooshi 2001a:1790).

In addition, selling a kidney has harsh economic impact on kidney sellers. Of Bangladeshi sellers, 78 percent reported that their economic condition deteriorated

in most cases after the surgery; many sellers lost their jobs and were still unemployed, while others were able to work fewer hours because they had only one kidney. As a result, some of Bangladeshi sellers (15 percent) have already engaged in organ brokering. Similarly, Indian sellers also reported that their average family income declined by one third, and the number of them living below the poverty line increased after trading (Goyal et al. 2002:1589–1591). Another study reported that most Indian sellers sold their kidney to pay off their debt, but they are back in debt again after the operation (Cohen 1999:152). In Pakistan, 88 percent of vendors reported that they had no economic improvement after the operation (Naqvi et al. 2007:934; see also Moazam et al. 2009:33). Moldavian and Filipino sellers also faced unemployment after they returned to their villages (Scheper-Hughes 2003a:220). Again, in Egypt, 81 percent of vendors spent the payment within five months of nephrectomy, mostly to pay off financial debts, rather than investing it in quality-of-life enhancements (Budiani-Saberi and Delmonico 2008:927). Iranian sellers likewise reported that vending caused serious negative effects on employment for 65 percent of the studied vendors; their income declined by 20 percent to 66 percent (Zargooshi 2001a:1790).

Furthermore, selling a kidney has numerous negative impacts on health, including on sellers' physical abilities. Thirty-three Bangladeshi sellers typically experience pain, weakness, weight loss, and frequent illness after selling their kidneys. Similarly, in India, 50 percent of the 305 sellers reported persistent pain at the nephrectomy site, and 33 percent of them complained of long-term back pain (Goyal et al. 2002:1589–1591). In Pakistan, 32 studied kidney sellers also experienced tiredness, dizziness, and shortness of breath, while three of them had elevated blood pressure readings or had blood or protein in their urine as a result of having one kidney (Moazam et al. 2009:33–34). In another study there, 239 sellers further reported fatigue, fever, urinary tract symptoms, dyspepsia, and loss of appetite (Naqvi et al. 2008:1446). In Iran, 300 sellers reported deterioration between 22 percent and 58 percent in their general health status after nephrectomy (Zargooshi 2001a:1790). Consistently, published studies demonstrate that the health impacts that result from selling a kidney are alarming, yet almost none of these sellers received the promised postoperative care—not even one appointment. In sum, the above-discussed bodily impairment and social suffering associated with kidney selling reflect that this bioviolence is deeply disturbing and highly unethical.

The Dissection of Bioviolence: Physical, Structural, and Symbolic Violence for Organ Procurement within Bangladesh

The bioviolence, particularly for the extraction of organs, stems from the growth of the transplant industry and is closely linked to the suppression of the poor. It is not only widespread in the current practice of organ commodification but also in every aspect of transplant technology. I will argue that the bioviolence is seriously exploitative and highly unethical; however, it is deliberately concealed for personal gains of vested interest groups. So far I have documented how poor Bangladeshis are victims of bioviolence that turns them into kidney sellers and causes extreme suffering. In the remainder of the article, I will discuss the varieties of bioviolence,

including physical, structural, and symbolic violence that dominate the lives of kidney sellers.

In Bangladesh, about 35 million of its inhabitants (nearly one-quarter of the population) face the violence of needless hunger—what Amartya Sen calls a human-made disaster (Hartman and Boyce 1998; Sen 1982). Inevitably, 77 percent of poor Bangladeshis lack the minimal requirements for a healthy human existence; about 50 percent of women have anemia, and two million children are suffering from acute malnutrition (United Nations 2009). To make matters worse, socioenvironmental factors, such as arsenic poisoning, air pollution, pesticide use, and smoking tobacco contribute to a high number of organ maladies. Although the majority—the economic underclass—is at the greatest risk of organ failure because of high exposure to these factors, they die prematurely without receiving a transplant, let alone dialysis.

Kidney transplant is one of the most expensive medical procedures, starting at about 225,000 Taka (\$3,200) for the surgery and two weeks of postoperative care in a public hospital in Bangladesh. It is virtually impossible for most of the poor, as well as many middle-class Bangladeshis, to save this amount of money in their lifetime. Nevertheless, many of them strive for an organ transplant by literally begging for money in local newspapers, but in the end, they experience serious drawbacks.⁹ For example, a brother of a recipient who died from kidney rejection just one month after the transplantation told me, “All of our family members tried our best to save my brother’s life. We sold our land and jewelry, and borrowed money from the bank to arrange the transplant. But we could not save my brother and we are still paying off our debt.” Moreover, the health care for organs in Bangladesh is concentrated in two major cities; most poor people do not have access to organ care at all. Evidently, transplantation does not proceed according to the principle of equity: The poor suffer from organ maladies, but the wealthy receive care. The service of transplantation fulfills the needs of fewer than 1 percent of the population—the wealthy minority, while the majority of Bangladeshis die in silence, knowing they could have saved their lives through this modern technology. Consequently, the current practice of organ transplant constitutes a form of “structural violence” against the poor (see the detailed discussion on “structural violence” in Galtung 1969; Farmer 2005), which is palpable in every aspect of the transplant industry.

Not only are the poor deprived but also they are subject to physical violence as their vital organs are viciously removed from their living bodies. As my ethnography explores, the wealthy buyers (both recipients and brokers) create a desire for the poor sellers, most of whom do not understand the function of the kidney, but are tempted to “donate” because of the buyers’ fraudulent claim that kidney “donation” is a safe, lucrative, and noble act. Once the sellers are induced, buyers extract their organs through deception, manipulation, and without consent, and then deprive them once the scar is permanent. The deception is so extensive here that not only brokers but also most recipients do not pay the total amount they had promised to the sellers. For example, seller Monu received from his recipient as little as 40,000 Taka (\$600)—one-third of the promised amount. Some buyers even use coercive force to extract organs from the sellers. For example, seller Mofiz was unable to attend the funeral of his sister, who died of a heart attack after learning that her brother had left home to sell his kidney to arrange her dowry. Mofiz was then held

captive by three bodyguards at his recipient's house and was tricked into traveling to India a few days later. In the post-transplant period, both Mofiz and his wife were physically abused and threatened with jail while he disputed the payment with his recipient (see also the above-mentioned case of seller Sodrul). Furthermore, informed consent was completely flawed here, as buyers intentionally provide misleading and inadequate information (e.g., the story of the "sleeping kidney"); because kidney sellers cannot act competently and voluntarily (because of extensive manipulation, not to mention the coercion of poverty); and because sellers gave misinformed consent. These are means of the physical violence organ buyers use to exploit their counterparts.

The bioviolence is both exploitative and unethical, as organs are deliberately removed from the economic underclass to prolong the lives of the affluent few. In this visceral violence, the wealthy recipients are beneficiaries, while the poor sellers are mere suppliers of body parts, but at the severe cost of their suffering. This bioviolence constitutes an abuse of human rights (the 1948 Universal Declaration of Human Rights adopted that *health is a human right*), as the poor deserve proper transplant care, rather than losing organs from their underfed bodies. This bioviolence also violates the principle of social justice, as the poor have an equal right to keep their organs inside their bodies. They need their organs for their physical survival; the bioviolence against them is a serious crime.

Even though bioviolence in the organ bazaar of Bangladesh is all encompassing, it is deliberately disguised by vested interest groups, such as transplant recipients, organ brokers, medical specialists, and private entrepreneurs. These dominant groups initiate the acts of bioviolence for their own personal gain, but they conceal their actions through a "symbolic violence" that represents organ commodification as an indispensable act for "saving lives" of the dying patients (see the detailed discussion on "symbolic violence" by Bourdieu 1990; Lock 2000). This type of symbolic violence rationalizes an outlawed practice of organ commodification, not to mention buries the bioviolence against the poor.

Many interviewed Bangladeshi wealthy and middle-class transplant recipients who purchased kidneys from the marketplace dismissed symbolic violence, claiming typically that they had no other choice but to buy a kidney, either because (1) they were unable to match tissues with their own family members, or (2) their families were unwilling to donate their body parts. Medical and bioethics literature on global organ trafficking often generalizes and rationalizes such claims, implying that most transplant recipients, unable to secure a donated organ, desperately purchase a kidney to save their life. In contrast, my ethnography on the domestic organ trade reveals that many Bangladeshi recipients who can afford to do so purchase organs from the poor, rather than seeking organ donation from their family members.

For example, Umma Habiba Dipon, a 27-year-old middle-class Bengali fashion designer, arranged a charitable art exhibition and a musical concert in Dhaka in 2006. With the charity fund, she purchased a kidney from a poor villager and covered her organ transplant expenses. What is unethical in Dipon's case is that she not only spent charity money in an outlawed trade but also publicly concealed and misrepresented her kidney shopping. After discovering this (from one of her friends), I repeatedly asked Dipon's husband why he did not donate one of his kidneys to his wife. He eventually admitted that he was the only breadwinner in the family, so

he decided not to give away his kidney and gamble with his life. He also told me that he felt a “family obligation” not to put any of his relatives at risk, as organ donation can cause life-threatening health complications. The man concluded that he was desperate to save his wife’s life, so he purchased the kidney from a needy, young, and healthy seller.

I also documented that a 72-year-old wealthy Bangladeshi recipient (a member of the Islamic fundamentalist party, which forbids the sale of organs) deliberately bought a “younger kidney” from a 22-year-old slum dweller; however, this would-be recipient died just before the operation. Some other affluent recipients also purchased kidneys twice, after their first transplant failed. I discovered (from my interviewed sellers who sold their kidneys to the above-mentioned recipients) that none of these recipients sought organs from their own family members, as it is easy and cheap to buy kidneys from the poor. I could not say how many recipients hold such corrupt ethics, but many of them justified their act of buying organs through a symbolic violence that is shown as an inevitable activity and is masked by the rhetoric of “saving lives.”¹⁰

Prominent Bangladeshi transplant specialists whom I interviewed also impose the act of symbolic violence: they publicly state that “saving lives” is their duty, but in their professional ethos, organ commodification is condoned. Each year on World Kidney Day, these nephrologists and urologists remind us that about 40,000 Bangladeshis die every year, or five die every hour, from kidney failure (Hasib 2011:1); with the support of organ transplant many of them could return to normal life. Widely citing their success rate (their patients’ graft survival is 90 percent and 80 percent at one and five years, respectively, they claim, which is comparable to the world standard; see Rashid 2004:187), these transplant experts conclude that it is the scarcity of donors, along with inadequate organ health infrastructure, that impedes the growth of the transplant industry in their homeland. These specialists therefore encourage all citizens to consider “the gift of life,” portraying organ donation as a simple life-saving act. Others, particularly those affiliated with the National Institute of Kidney Diseases and Urology of Bangladesh, have already proposed to change the existing Organ Transplant Act, expanding the living donation pool by including donors beyond blood relatives (*New Nation* 2008:2). These executives also underscore that better allocation of government funding, introduction of medical insurance, and charity of NGOs are imperative to save lives of dying patients. Thus, on the one hand, these leading specialists insist on the act of “saving lives” and the expansion of organ transplants by all means, while, on the other hand, they deliberately conceal organ commodification from public view.

In this symbolic violence, what surprises me most is these eminent specialists’ utter discretion about the organ trade. To this day, they deny the existence of illegal organ transplant in Bangladesh, claiming that the Transplant Act is “strictly maintained” in their motherland.¹¹ During my fieldwork, when I challenged one of the notable nephrologists, pointing out a kidney seller’s advertisement that was posted on the door of the doctors’ reading room in his hospital, the nephrologist claimed that organ classifieds are published in Bangladesh, but that all transplant of Bangladeshis who are not related to each other (i.e., illegal transplants) are performed outside this country. I also found that local transplant specialists did not publish a single article on this topic; *The Renal Journal of Bangladesh* does not

even acknowledge this trade at all. Nevertheless, after collecting evidence from my interviewed kidney sellers (some of their transplants were performed by Bangladeshi nephrologists), I confronted one of the renowned nephrologists who initially claimed to me that they do not perform illegal kidney transplants in Bangladesh. When I told the nephrologist that I had evidence against his statement, he quietly replied, “We always maintain ethical protocol, but sometimes there might be very few cases that we are unaware of.” When I challenged him again, he concluded that nephrologists are not the police and their role does not constitute spying on recipients. Nephrologists’ roles are indeed limited, but perhaps I should have asked why they turn a blind eye to this outlawed trade.

Here is a speculative answer to my own question. The neoliberal market economy turns many Bangladeshi medical specialists to a “three-in-one man” (a businessman, politician, and doctor, as one of the interviewed recipients said), who “turn their backs” on the kidney trade, transplantation proceeds apace, and they accumulate huge profits. Because these specialists directly benefit from the expansion of organ transplants, they follow the general rule: more transplants mean more profits. Therefore, they conceal the kidney trade, invest heavily in private entrepreneurs, and even collaborate quite closely with organ brokers. My key informant, Dalal, claimed that over the years he has brought quite a few kidney sellers at a time to certain nephrologists, who overlook the entire situation on receiving visiting fees. Even though these specialists are affiliated with major public hospitals, they do not provide proper care until the patients visit their private chambers and pay high visiting fees, and the specialists receive large commissions from diagnostic tests. These specialists fight over clients so blatantly that a member of the Kidney Patient Welfare Association of Bangladesh told me that this association was disdained by prominent nephrologists, who lose business as the association invites an Indian nephrologist each year for the postoperative checkups of its members. On this economic chase, the major pharmaceutical companies (such as Novartis and Roche, the manufacturers of Cyclosporine and Cellcept, the key transplant medicine) sponsor senior Bangladeshi transplant specialists to attend conferences abroad, and in return these specialists prescribe only these companies’ medication to their patients, as one nephrologist unexpectedly mentioned to me. “Big Pharma” also regularly publishes advertisements in the *Renal Journal of Bangladesh*, the major chronicle of this field there.

Of note, Bangladeshi specialists do not participate directly in the illegal organ bazaar, but many of them diligently conceal the organ trade, as their personal interests often trump their professional ethics. During the fieldwork, one of the leading Bangladeshi nephrologists claimed to me that the organ trade cannot take place in his hospital, as various professional groups, such as nephrologists, urologists, psychologists, and social workers must screen the relationship between a recipient and his donor before approving an organ transplant. On the contrary, I found that the Transplantation Act is not even circulated among some of these professional groups. For example, a social work officer, who must consent to organ transplant, was not aware that a Transplant Act exists in Bangladesh; this officer asked me for a copy of this act, saying that she just followed doctors’ orders to sign off on the paper. This double-dealing standpoint of these transplant intermediaries is captured in a local proverb: “upore fitfat kintu bhitore shodorghat” [everything is lawfully

arranged on the surface, but muddled inside]. Thus, major Bangladeshi organ specialists conceal the kidney trade for their own personal interests, shifting the focus to saving lives and transplant success, which represent symbolic violence flourishing as the transplant industry thrives.

Organ brokers similarly enforce symbolic violence through the win-win rhetoric. As they commonly claimed, the organ trade is a noble act that saves the lives of dying recipients, while improving the lives of the poor. As Dalal, my key informant and an organ broker, said to me, “What is more important between life and money? For the wealthy it is life, but for the poor it is cash. So, why not help each other out?” However, brokers did not disclose to me how they unethically extract organs by any means to accumulate huge profit. I learned from the interviewed kidney sellers that a number of organ brokers and their agents openly compete over clients in major transplant centers in Bangladesh, because they are well protected by the dominant class;¹² these brokers have already established a wide network, from local to regional to national to international levels. The brokers typically approach the poor citizens, saying that kidney donation is a simple procedure (i.e., “the sleeping kidney” story) and is extremely profitable; brokers thus lure the poor with false hopes and at the end deprive them severely.

The Bangladeshi media, which are mostly privatized, also enforce symbolic violence by shifting the discourse of organ trading to the act of “organ donation.” In the newspapers, classified ads from buyers (both recipients and brokers) appear as if buyers are seeking “organ donation,” which is represented as a “life-saving” or “gift-giving” act. Meanwhile, sellers’ advertisements are rendered as if they will resolve the hardships of the unfortunate poor, so their pleas are morally justified. By publishing these classifieds (making it appear as if recipients and sellers are participating in “organ donation”), as well as not reporting organ commodification, let alone the bioviolence associated with it, the Bengali media institutionalize organ trade, because the media provide the primary mode of circulation of information for the growing organ trade in this country.

Discussion and Conclusion

Although vested interest groups silence the organ trade, some liberal bioethicists have proposed that a regulated organ market would be an efficient way to save the lives of dying patients (Cherry 2005; Friedman and Friedman 2006; Hippen 2005; Matas 2008; Radcliffe-Richards 1996; Taylor 2005; Veatch 2000). In my opinion, these bioethicists generate a symbolic violence (if unconsciously) by emphasizing “saving lives” of the affluent few, while allowing bioviolence against impoverished kidney sellers. A regulated organ market is not an “Aladdin’s lamp” that by itself would eliminate widespread deception, manipulation, and misinformed consent, or ensure justice, equity, and rights to kidney sellers; rather, it would escalate the bioviolence for stripping organs from the poor majority at the high cost of their bodily and social suffering. It would rationalize, institutionalize, and normalize the bioviolence, which is extremely discriminatory against the economic underclass. Not surprisingly, 85 percent of the Bangladeshi kidney sellers I interviewed spoke against an organ market; many of them proclaimed that selling a kidney is an “irrevocable loss”; if they had a second chance in life, they would not sell their kidneys.

In summary, the bioviolence against kidney sellers is seriously problematic, even though organ transplant saves many lives. As the transplant industry flourishes, the structural violence against the poor becomes widely institutionalized. The physical violence for extracting organs from their bodies is increasingly routinized. However, it is justified by a symbolic violence that masks organ trade by the rhetoric of “saving lives.” Meanwhile, bioviolence against the poor remains concealed to promote the personal interests of vested beneficiaries. The bioviolence that is entrenched in the transplant enterprise, as well as other emerging biotechnologies, needs to be fully exposed to strike against the exploitation of the poor. This is the time to write a transplant manifesto that is grounded in social justice, and that promotes humanitarian ethics.

Notes

Acknowledgments. The research would not have been possible without the generous support of 33 Bangladeshi kidney sellers, who not only trusted me but also disclosed to me their hidden world. My thanks also go to transplant recipients, organ brokers, and medical specialists for their invaluable support. In North America, I am grateful to Hilary Cunningham, Lesley Sharp, Richard Lee, Michael Lambek, Krystyna Sieciechowicz, Linda Hunt, and Daniel Pacella for their critical attention on my research. Thanks also to MAQ editor Mark Luborsky and Andrea Sankar, as well as four anonymous reviewers, for their highly beneficial comments. The research was supported by Ontario Graduate Scholarship, Comparative Program on Health and Society Fellowship, Health Care Technology and Place Fellowship, Edward W. Nuffield Graduate Travel Grant, Lorna Marshall Doctoral Fellowship, and Dipty Chakravarty Bursary for studies related to Bengal and Bengali. Finally, I am indebted to Agnieszka, Tokai, and Raga for their ongoing encouragement.

1. I hermeneutically index the persons who sold their kidneys as *kidney sellers*, knowing that this term perpetuates the reductionism. Yet, I unfavorably use the term only to categorize these poor Bangladeshis who sold their kidneys in the marketplace. Throughout this article, *kidney sellers* refers to situated persons, rather than commodified constituents.

2. The recipients who purchase organs from the market are relatively wealthy. They usually travel abroad, mostly to India, for organ transplant because the health-care system in Bangladesh is in transition. Also the cost of transplant surgery there is comparable with that of India.

3. The snowball sampling method was not effective in this field situation, as my interviewed kidney sellers came from every part of Bangladesh and did not know one another. Rather they persistently concealed their identities from each other.

4. So far I have collected 1,139 advertisements from would-be recipients, compared to 149 advertisements from sellers published in five national major Bengali newspapers, namely the daily *Ittefaq*, *Jugantor*, *Prothom Alo*, *Janakantha*, and *Inqilab* between 2000 and 2008. Four anthropology students, Sudipta Chowdhury, Mohitush Sami, Abdullah Sumon, and Sania Tanzin helped me collect these organ classifieds, which took about six months of library research, mainly at the University of Dhaka.

5. Brokers usually publish their advertisements posing as potential recipients. However, their advertisements can be separated as they often seek donors of more than one blood type.

6. During my interview, most sellers mentioned that brokers repeatedly told them the story of the sleeping kidney that encouraged them to sell their kidneys. When I crosschecked this statement, organ brokers asserted that they believed in this scientific truth but could

not verify the source of it. Only broker Dalal mentioned that he heard this medical fact from some nephrologists and recipients.

7. I have collected some passports and legal documents, all of which show that sellers' names and addresses are entirely changed to fit with the recipients' identities; they become close "kin." Officially, the passports are issued by the Government of Bangladesh, and the legal documents are undersigned by authorized notary public.

8. To conceal their actions, the sellers initially inform their families that they are going to work in a distant city for the next few months.

9. Each day, Bangladeshi newspapers include a section where poor citizens beg for a charitable donation to resolve their life-threatening medical problems. These ads are published so frequently there that local Bangladeshis no longer pay any attention to them.

10. Of course, there are some other wealthy and middle-class Bangladeshi recipients who did not purchase kidneys because of both medical and ethical reasons. Some of them mentioned to me that they did not buy kidneys because the graft survival rate is better if the organ is transplanted from closely related kin. Some others stated that they did not purchase kidneys because organ trade is unethical and outlawed.

11. When the president of the Transplantation Society emailed an eminent Bangladeshi nephrologist asking about his statement on the organ trade in his country, including a synopsis of my research and the recent Declaration of Istanbul on Organ Trafficking, the nephrologist replied briefly that the Transplant Act is "strictly maintained" in Bangladesh.

12. I even witnessed one of my interviewed kidney sellers brokering in the dialysis unit at BIRDEM hospital in Dhaka.

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