Masculine Bodies in the Biocapitalist Era: Compromising Human Rights of Commercial Kidney Donors in the Philippines

Gina Rocafort Gatarin

Abstract
Commodification of kidneys has become a new locus for co-optation of the human body, bioethics, and legal standards on organ donation and transplantation in the biocapitalist era. Neoliberal policies operate through a new constitutionalism, which opens the healthcare system of developing countries like the Philippines to transplant tourism’s promises of huge economic gains. This article explores how the human rights of most male providers from poor communities who sell their kidneys are seriously compromised by the inconsistent and inadequate rules governing organ donation, transplantation and bioethics. I have employed textual analysis of the existing Philippine laws on organ donation and transplantation; biographical narrations of kidney sellers from Baseco, Manila; and key-informant interviews with organizations opposing organ commodification in this area to explore how the bodies of the poor are treated as “organ banks for the better off” in an era when biotechnology promises longer lives to those who can pay. As a way forward, I suggest that the actors involved in the organ donation and transplantation process should share the responsibility to address the social injustices associated with it.

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Baseco, bioethics, biocapitalism, human rights, kidney selling, masculinity, organ trafficking, the Philippines

Introduction

Advances in kidney transplantation in the biocapitalist era promise longer, quality lives for people suffering from kidney diseases through technologies of donation and transplantation. However, the World Health Organization (WHO) reported that 10 percent of the 63,000 kidney transplantations done annually around the world involve payment of non-related donors of different nationalities (Garwood, 2007, p. 5). The Philippines—alongside Pakistan, India, and China—has been one of the top organ-exporting countries (Shimazono, 2007, p. 957). The island of Baseco in the capital, Manila, for instance, is widely known as “one kidney island” (Debbyshire, 2007). It is estimated that around 3,000 of its 100,000 residents have sold a kidney, and that most of these donors are men (Yea, 2010, p. 362).

Despite the WHO ban on organ sale, it continues to thrive, since governments, such as the Philippines, still have no clear and consistent policy on donations by living, non-related donors. According to Asia Against Child Trafficking (Asia ACTS), a regional NGO, Filipino kidneys are the cheapest in the organ black market, costing only USD 1,500, which is 20 times cheaper than the United States (Uy, 2008). A typical Filipino who sells a kidney is male, with an annual estimated income of USD 480 and an average of seven years of education (Scheper-Hughes, 2005, p. 27).

The reason why men from these poor areas sell their kidneys has not been thoroughly explored, except in some media reports (Mendoza, 2010a, p. 257). This study aims to bridge this gap by situating masculinity in the commodification of human kidneys as is the case in the Philippines. Collier observed that while men are essentialized as “unemotional, independent, non-nurturing, aggressive and dispassionate,” they are also described in terms of non-dominant positive actions such as “bringing home a wage, sustaining a sexual relationship, and being a father” (as cited in Connell & Messerschmidt, 2005, p. 840). This
article contends that men’s role as providers coupled with the belief that they are more capable of enduring the risks of kidney removal is proving to be a double-edged sword since it is for the very same reasons that they are targeted for their organs. The representation of strength through financial and physical power is often employed to persuade poor breadwinners to sell off their kidneys in exchange for instant cash. It must also be noted that even women providers get duped in such a dangerous trade.

To illustrate these complex issues, I explored conceptual, empirical and normative considerations to question the biocapitalist ideology of individual autonomy within this dangerous trade involving mostly male commercial donors from poor communities, and show how medical ethics and the laws on organ transplant in the Philippines fail to guarantee the well-being of this vulnerable group.

Case studies of three kidney sellers from Baseco, all breadwinners in their families, were undertaken to illustrate the multiple ways in which agency is twisted under biocapitalist rules. While not representative of the great number of people from poor communities who sold their kidneys, these three cases could sensitize us to the ways in which the masculine social role of being a provider serves as a means for thanatopolitics (politics of death) to render these people’s bodies as nothing but a repository of easily accessible organs for those who can pay.

This article also demonstrates how ethics in kidney donation are caught within the debates of the legalization of an “organs market.” These debates run along a vast spectrum from universal commodification to absolute non-commodification. The liberal view espouses what Radin (1996) calls universal commodification, which argues that everything has a price. It asserts that with legalization and regulation come better social welfare policies for both donors and patients (Becker & Elías, 2007). Radin, herself a liberal, does not agree with this extreme position of putting kidney selling into the hands of the free market, since it overlooks structural factors such as unequal wealth distribution. However, neither does she support a total ban, since such prohibition of “desperate exchanges” will not render justice to poor people needing money to survive (Radin, 1996, p. 125). Radin argues for an incomplete commodification, which she describes as “an expression of a nonmarket order coexistent with a market order,” making it possible to preserve the ideals of personhood and community (Radin, 1996, p. 113).
On the other hand, Marxists argue that organ selling is exploitative to its core, and hence never morally justifiable. They contend that organ sale reinforces the structural inequality embedded in capitalism, and the donor-patient relationship is an extension of class oppositions between those who have the capital to pay and those whose bodies have been transformed by poverty to become commodities for the former to purchase. The poor are treated as a mere “organs’ bank for the better off” (Cohen, 2001, p. 25), or what Scheper-Hughes (2001a, p. 4) describes as an “invisible and discredited collection of anonymous suppliers of spare parts” while patients are portrayed as “moral subjects and suffering individuals.”

However, the extreme views posited by both liberals and Marxists miss the profound cultural transformations embedded in biocapitalism that facilitate the acceptance of commercial donations, and which only tend to be trapped in a blame logic. This article then asserts the necessity of reconceptualizing our notion of responsibility of the actors involved in the organ donation and transplantation process as a way of protecting and upholding the human rights of the donors. This is because the tensions between individual autonomy and structural inequality become exacerbated under biocapitalist rules, as poor people’s bodies turn into repositories of vital organs for this “market,” with the rationale that they help in saving lives. In such reconceptualization of responsibility, the network of actors involved and their concerns and roles have to be carefully considered to avoid the reductionist tendencies of the extremes posed by the liberal and the Marxist perspectives. For example, the presence of brokers linking the medical institutions and the kidney providers illustrate the complex web of ties and motives that trigger such transactions. This can be attributed to the rise of a new constitutionalism, which elicits such flexibility in bioethics, and reinforces the ideology of individual autonomy over one’s body and welfare by adjusting rules and regulations governing kidney donation and transplantation. I review these regulations in the next section alongside advocacy groups strongly opposing kidney selling, such as the Philippine Society of Nephrology (PSN) and Asia ACTS. The neoliberal reforms in the health sector, which open up markets for selling body parts and celebrate individual control over one’s own body, are encouraging poor providers to risk their lives by selling their kidneys, thus becoming the modern variant of what Agamben (1998) calls bare lives—people living outside the law and at the mercy of society whose body parts can be readily used for patients.
portrayed as suffering *qualified lives* to be saved by the modern technologies of transplantation. Through these currents of co-optation of modern technology and bioethics, I suggest a way forward, which would entail a systematic transformation of biocapitalism through a plurality of rules to anticipate and prevent such exploitation masquerading as gratuity toward the donors. As Young (2006) argues, ending such social injustices requires an account of how structural processes permit such wrongs, even allowing repetitions on a wide scale.

**Political Economy of Kidney Selling in the Philippines**

Kidney diseases are consistently one of the top ten leading causes of death among Filipinos, and were ranked ninth in 2009 (DOH, 2011). To facilitate cadaveric organ donations, the Philippines enacted Republic Act (RA) No. 7170 or the Organ Donation Act of 1991. The Act has provisions for organ donation through the issuance of a legacy of a person, or the permission for donation of the deceased donor’s family in the absence of a will.

However, despite the presence of this law and the Philippine Organ Donation Program (PODP), which establishes policies on organ donation and transplantation based on (1) benevolence; (2) non-maleficence; (3) altruism; and (4) volunteerism (DOH, 2003, p. 3), cadaveric organ donation has never really taken off. In 2007, for example, Padilla (2009, p. 120) noted that only 29 kidney transplants using cadaveric organ donation were recorded, equivalent to only 0.34 persons per million population a year.

With an increasing number of patients needing kidneys for transplantation, commodified donations has become an “inevitable activity … masked by the rhetoric of ‘saving lives’” (Moniruzzaman, 2012, p. 84). It was a while before the rampant sale of organs in the Philippines attracted the government attention. According to Dr. Alberto Chua (personal communication, July 13, 2012), a nephrologist and advocacy officer of the Philippine Society of Nephrology (PSN), commercial donations peaked in the year 2007, coinciding with the collapse of the country’s economy due to the Asian financial crisis as shown in Table 1.
There were many reports at that time, of people being trafficked for the “removal or sale of organs,” which led to organ trafficking being considered a crime under RA No. 9208 or the Anti-Trafficking in Persons Act of 2003. But organ trafficking was only tangentially included in that law, since it was primarily focused on women and children trafficked for sexual work and labor. It was only in 2009 that Implementing Rules and Regulations (IRR) were finally approved in the Congress, strictly prohibiting the buying and selling of human organs. The IRR states in Article 1, Section 2, that its objective is to fully protect the “poor and the most vulnerable sector of our society from the growing commercial traffic in human organs, eliminate traffic in human organs and establish institutional mechanism for the support and protection of trafficked persons” (Republic of the Philippines, 2010).

However, the IRR is not clear about people who provide their consent for the removal and sale of their organs, since it presupposes the presence of coercion. It also failed to make the government take steps to

Table 1. Philippine Transplant Registry Data, Number of Recipients and Ethnicity, 2006–2009

<table>
<thead>
<tr>
<th></th>
<th>2006 (N = 690)</th>
<th>2007 (N = 1046)</th>
<th>2008 (N = 679)</th>
<th>2009 (N = 511)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreigner</td>
<td>282</td>
<td>536</td>
<td>178</td>
<td>34</td>
</tr>
<tr>
<td>LRD*</td>
<td>30</td>
<td>3</td>
<td>9</td>
<td>28</td>
</tr>
<tr>
<td>LNIRD**</td>
<td>249</td>
<td>531</td>
<td>168</td>
<td>3</td>
</tr>
<tr>
<td>Deceased</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Filipino</td>
<td>408</td>
<td>510</td>
<td>501</td>
<td>477</td>
</tr>
<tr>
<td>LRD*</td>
<td>151</td>
<td>170</td>
<td>183</td>
<td>223</td>
</tr>
<tr>
<td>LNIRD**</td>
<td>224</td>
<td>313</td>
<td>286</td>
<td>192</td>
</tr>
<tr>
<td>Deceased</td>
<td>33</td>
<td>27</td>
<td>32</td>
<td>62</td>
</tr>
<tr>
<td>Prevalence</td>
<td>6997</td>
<td>7472</td>
<td>10052</td>
<td>11172</td>
</tr>
<tr>
<td>Dialysis Patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Filipino</td>
<td>5.83%</td>
<td>6.82%</td>
<td>4.98%</td>
<td>4.27%</td>
</tr>
</tbody>
</table>

Notes: *Living, Related Donor, **Living Non-Related Donor.
prevent the increasing commercial donations in the country as is evident from the absence of any convictions for organ trafficking (A. Chua, personal communication, July 13, 2012). Regulations have been highly inconsistent right from the promulgation of the 1991 Organ Donation Act to the 2009 IRR. During this period, there were instances when even the Philippine Health Department became open to the idea of gratuity packages (usually cash given by the family of the patient to the kidney donor) and regulation of transplantation to foreigners. But anticipating the 2008 Istanbul Declaration on Organ Trafficking and Transplant Tourism, the Philippine government declared a total ban on transplantation to foreigners when the country was branded by the WHO as one of the top five hotspots for organ trafficking in 2008.

The inconsistency in regulations can be attributed to a number of reasons, according to my interviews with Chua (July 13, 2012) and Abueva (July 30, 2012). First, the Anti-Trafficking Law 2003 is vague about the evidence required as the basis for a charge of trafficking in organs. Second, it is difficult to file cases, as many documented victims cannot remember the transplant surgeons and the laboratories involved. Third, the Philippine National Bureau of Investigation (NBI) is not familiar with the law, and often registers these cases as those of swindling rather than trafficking. Fourth, investigations into such cases entail looking into hospital records, which could be a violation of the right to privacy of patients and medical institutions. Lastly, the execution of the law is not receiving sufficient support from the Health Department, since authorities in this ministry are coterminous with the country’s President, which make the rules and regulations subject to the discretion of the incumbent of this office.

Anticipating the Istanbul Declaration, the Philippine Government issued Administrative Order (AO) 2008–0004, which prohibited medical tourism for the purposes of kidney transplantation in the country (DOH, 2008, p. 4). This order received a hostile reception from certain medical professionals and government institutions since organ transplantation has been a promising feature of the medical tourism industry, which attracts both foreigners and Overseas Filipino Workers (OFWs). The potentially USD 60 billion global business with an average annual growth rate of 20 percent (MacReady, 2007 and “Medical Tourism, Asia’s Growth Industry,” 2006 cited in Heung, Kucukustaa, & Song,
2010, p. 236), was threatened since the country’s Department of Tourism (DOT) was then already working closely with the Health Department alongside six public and private medical service providers to discuss the medical tourism cluster (Porter, De Vera, Huang, Khan, Qin, & Tan, 2008) and promote the Philippines as a destination for cheaper healthcare as compared to the US, Japan and Europe. As shown in Table 1, there was an increasing trend of living, non-related donations to foreigners from 2006 to 2007 before it was brought to a stop by the DOHAO 2008–0004, which anticipated the Istanbul Declaration. It is noteworthy that the issuance of the AO was followed by a steep reduction in living, non-related donations to foreigners from 168 in 2008 to three in 2009.

**Baseco as “One Kidney Island”**

People from poor communities, both in urban and rural areas of the Philippines are commonly targeted by organ brokers (Turner, 2009, p. 192). A survey by Mendoza (2010b) in two of the largest kidney-supplying regions shows that almost all (98.4 percent) kidney sellers in the country were men, and that the presence of dependents, regardless of marital status, significantly increased the propensity to sell a kidney. This masculine dimension of kidney selling could be attributed to the social and economic role of men as providers in the household, which was corroborated by this study. Their role and responsibilities as breadwinners outweighs the fear and risks associated with illegal kidney selling.

Kidney trafficking continues unabated due to a combination of factors, including the poor implementation of policies banning organ commercialization and the failure of public awareness campaigns promoting organ donation. One of the communities notorious for selling kidneys is Baseco, short for Bataan Shipyard and Engineering Company. Located in Barangay 649 in the Tondo district of Manila, it consists of a 52-hectare engineer’s island and two stone breakwaters extending toward the Manila Bay, which was identified by Asian Development Bank (ADB) and the Pasig River Rehabilitation Commission (PRRC) “as a high priority area for urban renewal” (UNESCAP, 2004).
Baseco became known as “one kidney island” (Debbyshire, 2007) following the media attention it received when the documentary *Kidneys for Sale* was filmed there in 1999 by the TV network GMA. Threats of eviction, vulnerability to flooding, land reclamation and hunger are constant sources of anxiety for its residents. Although the Philippine government provides subsidies to poor families through its conditional cash transfer program, NGOs in Baseco criticize its targeting procedure as inefficient and not directed at those in need. Baseco residents use the acronym ALTANGHAP, shorthand for the three meals in Filipino—ALmusal (breakfast), TANGhalian (lunch) and HAPunan (dinner)—to describe their experience of destitution since they often eat just once a day. NGO representatives said people who sell their kidneys are often those who become frustrated with the problems of daily subsistence, although there are also anecdotes about men who have sold their kidney so that they could use the money for vices like alcohol and drugs. But as Yea’s study (2010) shows, almost all those who sold their kidneys from the area were men earning very low wages from multiple jobs. Scheper-Hughes (2000) observed that they engaged in this “sacrificial economy” so that they could provide for their families (cited in Yea, 2010, p. 363).

**Institutional Linkages in Commodifying Kidneys from Masculine Bodies**

The stories of the three kidney sellers I interviewed speak of lives entrenched in poverty, care, risk-taking and sacrifice. I was able to meet these respondents through Baseco’s Barangay Councilor for health, women and family, who advised me to give them groceries after my interviews, a practice perpetuated by media persons and researchers. The Barangay Councilor said earlier it was commonplace for outsiders to ask her whether she knew someone who could sell a kidney, indicating how this illegal trade used to be an ordinary activity in this area before it was banned.

Through the interviews, I explored how the “expectations and thwarted life plans” (Fischer & Goblirsch, 2006, p. 30) of the kidney-sellers had contributed to their decision to sell their kidneys. For purposes of anonymity, I have used pseudonyms to refer to these kidney
sellers and other actors they mentioned during our conversations. I also translated these interviews from Filipino to English. Table 2 summarizes the demographic profile of the three participants.

All of them had received only elementary education. Except for Amy, described by the Barangay Councilor as a “tomboy” who was single, the other two participants were married men I have named Jess and Neil. During the interview, Amy proudly claimed to be the only woman in Baseco to sell a kidney. While Amy is supporting an adopted daughter, Jess has 16 children and Neil seven. The two men also have to fend for their grandchildren. All of them migrated to Baseco for want of economic opportunities in the provinces, which resonates with the research findings of Asia ACTS in Camarines Norte and Davao City. There, the victims had stated that money was their motivation for selling their kidneys. They hoped to improve their situation by starting their own business, by building or rebuilding their houses, by supporting the education of their children, and by helping their families (parents, spouses) buy a parcel of land and pay off their debts (Asia ACTS, 2012, p. 3).

Interviews with Baseco NGOs and local officials revealed that the island is regularly frequented by brokers. Their involvement is an

<table>
<thead>
<tr>
<th>Name</th>
<th>Age in July 2012</th>
<th>Year Started Living in Baseco</th>
<th>Civil Status</th>
<th>Educational Attainment</th>
<th>Religion</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amy</td>
<td>42</td>
<td>2000</td>
<td>Single</td>
<td>Elementary graduate (Grade 6)</td>
<td>Roman Catholic</td>
<td>Vendor of nuts and food; caretaker of the village plant nursery</td>
</tr>
<tr>
<td>Jess</td>
<td>45</td>
<td>1991</td>
<td>Married</td>
<td>Elementary undergraduate (Grade 3)</td>
<td>Roman Catholic</td>
<td>Porter, boatman/fisherman</td>
</tr>
<tr>
<td>Neil</td>
<td>40</td>
<td>1985</td>
<td>Married</td>
<td>Elementary undergraduate (Grade 4)</td>
<td>Roman Catholic</td>
<td>Tricycle driver (vehicle not owned)</td>
</tr>
</tbody>
</table>

important prerequisite for a successful transaction as they often serve as “domestic servant of a vascular surgeon involved in renal transplantation” as Cohen (2001, p. 13) observed in Chennai, India. Interestingly, Scheper-Hughes (2001b) documented that often brokers consider themselves not as “outlaws” but as matchmakers helping the sick and needy.

This was substantiated by my interviews though the kidney sellers emphasized that it was not an easy decision to donate an organ. As shown in Table 3, lack of decent houses resistant to the frequent fires and the long process of land award keep their life uncertain, making them an easy prey for brokers promising instant cash. The three respondents said at times brokers also ask them to recruit other men to sell their kidneys.

Although initially undecided, the love for family outweighed all the anxiety of these breadwinners. As Jess said with complete conviction: “I had my kidney removed… I could not have allowed my children to live on the sidewalks. It could not be. I had to build them a house.” Neil was also compelled by the same reason coupled with the need to help his

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Kidney Removal</th>
<th>Hospital</th>
<th>Amount Received for Kidney Selling</th>
<th>Reason for Kidney Selling</th>
<th>Knows the Identity of the Recipient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amy</td>
<td>March 18, 2005</td>
<td>NKTI (public)</td>
<td>USD 4,400</td>
<td>Build house</td>
<td>Yes</td>
</tr>
<tr>
<td>Jess</td>
<td>2002</td>
<td>St. Luke’s Medical Center (private)</td>
<td>USD 2,400</td>
<td>Build house</td>
<td>Only knows the name, the address and one sibling of the recipient of his kidney</td>
</tr>
<tr>
<td>Neil</td>
<td>2001</td>
<td>San Juan Medical Center (public)</td>
<td>USD 2,400</td>
<td>Build house, help sick father</td>
<td>Only identified the recipient of his kidney as an old foreigner (probably a Korean national)</td>
</tr>
</tbody>
</table>

Source: Interviews with Amy, Jess and Neil at Baseco, Manila in July 2012.
ailing father. All his seven children are still with him, with two in school and the eldest with a family of his own. Neil says “they have nowhere to go.” Though he was able to buy electric appliances and build a small store of canned goods, his quality of life didn’t witness significant improvement. This was true of Amy as well. As she put it: “I can’t say that my life has really improved since I am supporting somebody. The amount she [Mrs. X] gave me will never be sufficient for a lifetime of comfort. Of course, you have a mind, and you have to budget the sum yourself.”

People who sold their kidneys in exchange for instant cash are often called “one-day millionaires” by some members of the NGO Port Area of Baseco Neighborhood Associations League, Inc. (PABANAL), as they often spend their money buying electric appliances, entertaining friends, and giving loans to relatives. As a study by Asia ACTS (2012, p. 3) reported, there wasn’t any significant improvement in the living conditions of kidney sellers and the increase in their purchasing power was only temporary.

In the end, all they are left with is a scar and an abiding faith in God. The three respondents, who were Roman Catholics, cited their faith as an outstanding source of fortitude for them. Their accounts were frequently interspersed with the phrase “with God’s mercy” as they narrated the various ways in which they faced the everyday challenge of taking care of their families. Jess said he was deeply grateful to God when his wife bore him twins after the removal of his kidney. He already had 12 children prior to his kidney donation, and fathered four more children afterwards.

Meanwhile, Amy attributes to her faith the strength to donate as a way of caring for the needy patient, who she said had touched her heart. As she put it: “I have no money. I can live even if I don’t do this, but I always extend help to others out of my compassion for them.” She was in touch with the recipient of her kidney until the interview, unlike Jess and Neil, who were not aware of the identities of the recipients. This affirms the findings of the study by Mendoza (2010b) that point to massive violations of health policy that prohibits donations between unrelated individuals unless proven to have been done out of genuine altruism.

The accounts of the respondents showed how they were tricked by other actors involved in the transaction, including medical personnel. They were told by brokers and sometimes even the transplant surgeons that the removed kidney would “re-grow.” This myth of the “sleeping
kidney” was also documented by Moniruzzaman (2012, p. 75–76) in Bangladesh wherein poor, uneducated donors are duped by brokers and doctors who tell them that once a kidney is removed, another healthy one is re-awakened, making the donation appear to be a win-win situation. I was astounded when Jess, who was in an inebriated state during the interview, remarked that the doctor had told him that he could drink alcohol as long as it was hard liquor. He explained, “As time goes by, if you know how to take care of it, it is not allowed to produce bubbles…” I told him … ‘Doc, I am a drunkard.’ He said, ‘While you are drinking, the kidney, it will grow.’” In Neil’s case, the surgeon made it appear as a donation by telling him that he could come back for a check-up if ever he felt something amiss, and told him what to avoid, especially in diet. Although Neil thinks his health did not deteriorate as a consequence of the kidney removal, the scar occasionally hurts and becomes itchy especially when it gets cold. Despite occasionally falling sick (he was running temperature during our interview), he still has to work as a tricycle driver. His wife suffers from asthma, making him the sole breadwinner in their household. As the provider of the family, his responsibilities are enormous, but selling his kidney was a “sacrifice” he now regrets.

As kidneys are treated like any other commodity in the market, the question is how far these body parts are one’s individual property and a responsibility of the society. These bodies are what Moniruzzaman (2012) calls “living cadavers,” which become the loci for thanatopolitics (politics of death) just because they have to play the masculine role of providing for their families, a role reinforced by a system that pushes them to risk all that they have to fulfill their responsibilities out of limited life opportunities, and care for their loved ones.

**Elusiveness of Individual Autonomy in the Biocapitalist Era**

The ownership of one’s body has been a subject of intense ethical debates. The reasons given by the three kidney sellers for selling their kidneys reveal the elusiveness of consent and altruism in organ donation emanating from the neoliberal dogma of individual freedom. This is linked to developments in the field of biomedicine, which are cited to be
“overwhelmingly responsible for the growth in the commodification of body parts, by creating new technologies to fragment and isolate bodily components to serve a variety of purposes, and allowing these to be exchanged in commercial transactions” (Seale, Cavers, & Dixon-Woods, 2006, p. 25). While discussing immunopolitics, Cohen says through the complex nexus of the market mediating in meeting the global need for kidneys, suppression instead of recognition has “turned transplantation into a major industry” (2001, p. 11).

Scheper-Hughes (2001b, p. 34) laments that the invisibility and social exclusion of the organ suppliers have been ignored within the immanent goodness of transplant medicine. Kidney sellers are portrayed as nothing but “faceless individuals merely exercising their right to sell an organ” (Moazam, Zaman, & Jafarey, 2009, p. 30). The ethical debates on the legalization of organ sale, welfare of the poor and individual freedom continue to revolve around these issues. According to Rothman and Rothman (2006, p. 1524), ethics have become the battleground between those who emphasize autonomy as “the right of persons to sell their body parts, free of heavy-handed paternalism” and the proponents of fairness and justice who believe that organ sale could engender systematic exploitation. Barsoum (2008, p. 1928) also presents the divide along similar lines, between “community image and individual freedom” with those who believe in the values of human dignity, “completely condemning the core concept of donation for money” ranged against those “pragmatic defenders of ‘human rights’ of a sane adult to do whatever he/she wishes with his/her body, so long as no evil is done to the community, as well as his/her right to be compensated for this deed”.

But the powerful ideology of individual autonomy gained much momentum, especially with the support of well-known economists who are in favor of the legalization of paid organ donations. As poverty and economic marginalization induce such a “sacrifice,” particularly among desperate men who feel the pressure to provide for their families, kidney commercialization is justified as being mutually beneficial to both the donor and patient since they are both “in need to survive.” Cohen (2001, p. 20) characterized this mutual benefit as “horizontal” and “vertical” sacrifices. The former refers to the act of selling for the benefit of the seller’s family, and the latter describes the exchange of money and organ with the patient who needs renal transplantation. The Nobel laureate Gary Becker in his paper with Julio Jorge Elías (2007) even developed a
procedure for calculating the monetary compensation for the organ seller to eliminate the huge demand for organs. They argue that allowing compensation would spare the patients the long wait and wastage of their money in expensive treatments like dialysis. They argued that if women could get paid for surrogacy, selling organs should be made equally acceptable since it saved lives (Becker & Elías, 2007).

Such a discourse justifies the existence of a “legal organs market,” which is argued to be beneficial since those “unwilling to donate their kidneys would be willing to sell them” (Taylor, 2006, p. 167–168). It is also justified as a better way to regulate demand and supply. According to Yea (2010), this same argument is also used as a justification of those who want to legalize prostitution on the grounds that it could lessen the exploitation of sex workers (Yea, 2010). With these arguments, selling kidneys seems to appear as a lesser evil since it is not as bad as other forms of trafficking, especially as it saves lives. As my fieldwork in Baseco shows, the kidney sellers themselves justify the transaction, saying that they had sold their organ “out of free will.” Here, even bioethicists themselves are caught in a deadlock. In the US, for instance, Rothman and Rothman (2006) discussed how the neglect of the poor became the justification for bioethicist Robert Veatch to retract his opposition to paying donors. He argued that paying donors for organs could be a measure to assist them in their situation given the inadequacy of social welfare programs.

On the other hand, many medical professionals, anthropologists and social activists strongly oppose these schemes. Supporting Shimazono’s study (2007), medical practitioner Rashad Barsoum (2008, p. 1928) criticized commercial living, non-related donation as “pure business” since “motives of transplantation are clearly announced as such in different media, including the Internet, and the setup is geared as any other business.” Abueva (personal communication, July 30, 2012) also emphasized the negative outcomes of commercial transactions, since a large share of the profits go to mostly private transplant hospitals, while the long-term cost of healthcare for those who illegally sell their kidneys are shouldered by the government. Ethnographic studies in countries like Bangladesh and Pakistan, where a large proportion of the population lives on less than USD1 a day, also testify to such exploitation, targeting particularly poor fathers (Moniruzzaman, 2012; Moazam, Zaman, & Jafarey, 2009). Moazam, Zaman and Jafarey, (2009, p. 34) documented
how some men who sold kidneys in rural Pakistan suffer the stigma of “half man syndrome,” characterized by lower self-esteem and a feeling of being incomplete human beings that sometimes results in psychosomatic consequences such as decreased sexual power.

The systematic deprivation of the social, economic, and cultural right to decent living breeds rampant corruption of poor men’s bodies. The Philippine Government’s concern with mere impression management in the local media and among the international community is certainly not a solid ground for permanently bringing a halt to this inhuman trade since the market takes over the distribution mechanism when an entity to “govern allocation or standards for transplants” is absent (Budiani-Sabieri & Delmonico, 2008, p. 927).

Like racism, which according to Foucault (as cited in Rabinow & Rose, 2006, p. 201) “justifies the death-function in the economy of biopower by appealing to the principle that the death of others makes one biologically stronger insofar as one is a member of a race or a population,” poverty also becomes a rationale for the same logic under the regime of the new constitutionalism. Transforming kidney transplantation into a business creates a locus, which reinforces inequality in the right to life. As poor kidney donors are caught in circumstances of desperate need to provide housing and food to their families, their life of destitution reinforces this “death-function” since such a group is particularly vulnerable to exploitation. The ideology of individual freedom is waged on the plea that “it is their choice” to sell their organs and to find themselves stuck in poverty after kidney removal. But faced with a lack of sustainable source of income, who would not be forced to be involved in such trade? As Rothman and Rothman pointed out, many sellers could be attracted from the lower class and lower-middle class, since it is “doubtful that anyone with significant means would sell a kidney even for a substantial sum” (2006, p. 1526).

It is in the context of these circumstances that the poor have no choice but to bear hardships of poverty, the rules and regulations on organ donation and transplantation miss out the fundamental aspect of assessing the socioeconomic background of “willing” donors (A. Chua, personal communication, July 13, 2012). The absence of a well-explained procedure about the process and consequences of organ donation, which is the foundation of “informed consent,” amounts to denying people their right to information. Abueva (personal communication, July 30, 2012)
observed that kidney donors were not even asked for papers. Altruism and choice then operate as elusive discourses, which symbolically annihilate people’s subjectivities, especially since many bureaucrats and bioethicists have already succumbed to the viewpoint that the demand for kidneys will be met by market forces, even if at the expense of the poor.

**Human Rights as Shared Responsibility**

The existing norms of bioethics governing kidney donation in the Philippines do not provide a platform on which human rights are respected, protected, and fulfilled. Bioethics is co-opted by market regulations, which transform healthcare into a business through privatization and tourism. The neoliberal ideology of the rational individual, which worships individual freedom, that is, doing whatever one wants to one’s body, while disregarding the social and economic circumstances that affect the decision to donate, cannot be a ground for the realization of human rights. This celebration of the individual as the prime mover in the biocapitalist era by merely focusing on consent on paper as a requirement for kidney donation shows how individualist the framing of human rights is.

This is why governments have to formulate fresh measures, since the existing anti-trafficking framework, at least in the Philippines, does not offer social policies to protect the victims of organ trafficking (Yea, 2010). As long as the framing of human rights is limited to representing the human being as a legal entity, while our physical bodies and the environment in which we thrive are consigned to oblivion, corporeal integrity will continue to be compromised. Upholding the right to a decent standard of living, as enshrined in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, and the 1987 Philippine Constitution, require that bioethicists, health practitioners and government reframe the orientation on human rights toward improving the quality of life of poor people. The absence of a roof that can protect them from the harsh life in the city and the natural elements is denying them their humanity, and has been primarily the reason why most breadwinners in Baseco engage
in selling a kidney. Such a situation reproduces the vicious status of bare life (Agamben, 1998)—lives which can anytime be devoured, without pity and worse, without any possibilities for atonement. To render Kantian ethics here, human beings are never a means to do anything but are ends in themselves.

The stories of most male kidney sellers heading their households ground the human rights discourse in the human experience of having to give up a precious organ, which nature has given to human beings so that they can function well, and be a source of succor for others when used to extend somebody else’s life. Even the 2008 Istanbul Declaration is clear that transplant policies and programs have the primary objective of “optimal short- and long-term medical care to promote the health of both donors and recipients” (American Society of Nephrology, 2008, p. 1228).

Technological breakthroughs in medicine, which are supposed to help in saving the lives of patients with severe illnesses by connecting people’s existences, have ironically contributed to becoming a tool for waging thanatopolitics (politics of death) against this particular group of people. Foucault characterizes this age as the “right of death and power over life” wherein bodies are considered as machines whose capabilities can be optimized (1976, p. 139). As demonstrated by the social and economic circumstances that influence the decisions of kidney sellers who participated in this research, it is essential to ensure that a systemic analysis becomes a crucial element in guiding protocols on living, non-related donations. As Young (2006, p. 115) said, it is equally fitting to understand “how macro-social processes allow such exploitation in a variety of ways.” After all, as the rallying call of McGregor (2001, p. 88) goes, “[h]ealth care needs to be restored to a level that achieves social justice and protects and enhances human life and dignity.”

**Conclusion**

Kidney sellers from poor communities are equally qualified lives, whose human rights must also be reflected in bioethics. Through this article, I hope to contribute to combating thanatopolitics (politics of death) being waged against the vulnerable group of poor people by reconceptualizing
the shared responsibility of the range of actors involved in the organ donation and transplantation process. The complex networks of actors, institutions, and motives involved in such a dangerous trade targeting human bodies through a system, which elicits flexibility in bioethics, has to be accounted for. This must avoid the usual blame logic and the tendency to resort to absolute or non-absolute non-commodification of body parts as demonstrated by both liberal and Marxist perspectives, which miss out the importance of assessing the relationships of the spectrum of people and institutions involved in the kidney trade. Rethinking why such illegal activities endure by taking into account the diluted role of actors like brokers, who have the power to allure many male breadwinners to sell their kidneys, is an important aspect which came up in this study.

Bioethics must go beyond consent and altruism to analyze the role played by social and economic circumstances in making the mostly poor male providers agree to organ donation. The stories of kidney sellers from Baseco show how poverty could push people to enter into transactions commodifying body parts to fulfill their responsibility as providers for their families. This is akin to using masculinity to blackmail a human being. As declared in the 1948 Universal Declaration of Human Rights, “health is a human right” (Moniruzzaman, 2012, p. 83), and it is a gross social injustice that the people who are most at risk of getting sick, given their precarious jobs and poor quality of life in the slums, cannot afford medical treatment when they need it.

Several steps can be taken to combat this inhuman treatment of economically marginalized people. First, campaigns for cadaveric donations are crucial to address misconceptions and mistrust about kidney donations (American Society of Nephrology, 2008, p. 1227–1228; A. Chua, personal communication, July 13, 2012). Second, early screening for kidney disease must be encouraged as it is the best anticipatory mechanism to prevent kidney failure, and thereby the need for transplantation. This illegal trade can also be avoided by educating lay people and doctors about early treatment. Third, hospitals must play a key role together with transplant surgeons and ethical committees as kidney brokers are usually linked with them (A. Abueva, personal communication, July 30, 2012). It is easy to monitor kidney donations, since there are only few transplant hospitals and surgeons in the Philippines. Lastly, it is important to build partnerships for advocacy and research, which can be used to push firm
legislative measures to permanently ban the sale of organs. Findings from research in the Philippines, for example, were presented by Asia ACTS and PSN at international conferences. Later, the two organizations approached the Philippine Department of Justice (DOJ) for the implementation of the 2009 IRR of the 2003 Anti-Trafficking Law. This demonstrates that, in the biocapitalist era, no law will speak for itself unless we invoke it with horizons beyond the individualistic and market co-opted healthcare system.

Notes
1. “New constitutionalism” refers to a governance framework that gives power to the market in reshaping economic and social development in the world (Gill & Bakker, 2006).
2. PODP was established through the DOH Administrative Order 124 in 2002 under the Degenerative Disease Office of the National Center for Disease Prevention and Control.
3. The International Summit on Transplant Tourism and Organ Trafficking was a meeting convened by the Transplantation Society (TS) and the International Society of Nephrology (ISN) from April 30 to May 3, 2008, to engage government officials, doctors, NGOs, social scientists and ethicists on how to enforce the prohibition on organ trafficking and transplant tourism, since these are violations of the principles of equity, justice, and respect for human dignity (ASN, 2008) The Summit also called for a legal and professional framework and a transparent regulatory oversight system to avoid unethical practices (ASN, 2008). It produced the Istanbul Declaration on Organ Trafficking and Transplant Tourism, which sought the prohibition of organ trafficking and transplant tourism as they are violations of the principles of equity, justice and respect for human dignity.
4. This documentary won the Philippines’ first George Foster Peabody Award.
5. A people’s organization established by the Rogationists of the Heart of Jesus, an order of priests, under its Saint Hannibal Empowerment Center, Inc. (SHEC). SHEC aims to help in lifting poor urban people out of poverty in collaboration with local Churches on issues of housing, livelihood, education, health, environment and sanitation, justice and peace, youth formation and values formation (SHEC, n.d.).
6. Jess refers to the bubbles in the urine as caused by a possible fermentation of alcoholic drinks in his remaining kidney.
7. Cohen attributes the mobilization of large populations to search for tissue matches to the widespread availability of immunosuppressant drugs like cyclosporine, produced by Swiss pharmaceutical company Novartis AG. This
enables “a more pragmatic biopolitics of suppression, disabling the recognition apparatus so that operationability and not sameness/difference becomes the criterion of the match” (Cohen, 2001, p. 11). Scheper-Hughes (as cited in Yea, 2010, p. 362) also emphasized that without this drug, “there would be no story here at all,” which highlights its key role in the rise of transplant tourism.

References


http://shecrog.org/index.php?option=com_content&view=article&id=46&Itemid=56