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BIDS

Bodies for Sale: Assessing the Features & Maintenance of Illicit Organ Markets

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A Case Study of Kidney Trade in Cairo, Egypt

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Abstract

Illicit organ markets have grown with medical advancements and greater global interconnectedness. Many organ vendors come from poor socioeconomic backgrounds and are coerced into the sale which lacks the altruistic notion often associated with transplantation. This is a case study based on a literature review with a focus on Sudanese migrants in Cairo, Egypt. The purpose of this study is to investigate illicit organ trade by examining how structural features drive kidney markets. Short-term impacts on vendors are the second object of inquiry. This thesis focuses specifically on kidney trade due to high demand for kidneys worldwide. Body commodification theory and labor commodification theory provide the framework for analysis. There are two key findings in this study. First, it was found that organ trade is facilitated by ineffective UNHCR policies, a lack of cohesion within the medical community, and economic exclusion which leads to kidney sale. Second, short-term outcomes for vendors included fatigue, inability to work, depression, social stigma, and reduced income. The study concludes that the intentional neglect of the Egyptian state of migrants heightens their vulnerability which creates an underclass of kidney vendors.

Keywords: organ markets, Egypt, kidney trade, commodification, transplantation

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List of Abbreviations

CLD(s)	Commercial Living Donor
EMS	Egyptian Medical Syndicate
FFA	Four Freedoms Agreement
LE	Egyptian Pound
MOU	Memorandum of Understanding
RSD	Refugee Status Determination Interview
THOTA	Transplantation of Human Organs and Tissues Act
UNHCR	United Nations Refugee Agency
WHO	World Health Organization

1. Introduction

Advancements in transplantation medicine have facilitated the emergence of a global market for organs and a continuous increase in organ transplantation. It is estimated that illicit organ trade[1] generates profits of $600 million to $1.2 billion per year worldwide (Piotrowicz et al., 2017). An estimated 5-10% of organ transplants worldwide are conducted illegally each year, with kidneys constituting a large portion of that percentage (Shimazono, 2007: 959). Kidney transplants provide the only durable solution for those on long organ waiting lists wanting to escape arduous dialysis (Hamdy, 2012). Often, the desperation of these patients is enough to overlook the purchase of a kidney from impoverished or trafficked organ vendors, in turn sustaining illicit organ trade networks.

Further, the growth of organ markets can be attributed to the growth of decentralized healthcare and the emergence of medical ambiguities which transcend moral and political boundaries. This has led to new bioethical dilemmas that have amplified disparities between the Global North and the Global South. Organ trade has rapidly expanded to international contexts involving buyers[2], sellers[3], brokers[4], bureaucrats, and medical staff from multiple countries. This makes tracing organ trafficking difficult, especially when organs are purchased in illicit markets that are unregulated. Organ trafficking has been studied in India, Pakistan, and China, but less studied organ hubs, such as Egypt, necessitate equal inquiry.

Since transplantation first began in Egypt in the 1970s, organ trade has grown significantly. The situation is markedly more complex due to Egypt's position as a major transit and destination country for migrants, particularly from neighboring Sudan (Grabska, 2005). Cairo is considered one of the world's largest organ bazaars (Columb, 2017a), a reputation created largely because of

[1] Illicit organ trade is "The illegal sale and purchase of human organs for transplantation" (Cerón et al., 2017: 6)
[2] The term 'buyer' is used to refer to the kidney recipient in order to represent the commerciality of kidney transplants in this context
[3] The term 'seller' and 'vendor' is used interchangeably throughout the thesis. Both refer to commercial living donors. The term 'donor' is avoided since altruistic motivations are absent from commercial kidney transplants.
[4] There is no agreed definition of what a broker, which exemplifies the ways in which ambiguity is navigated. Yea (2010: 372) defines brokers as "An intermediary between a kidney buyer and a seller who connects the two using his/her knowledge of medical personnel and facilities that engage in illegal kidney transplantations". Doctors and analytic labs also function as brokers in some cases (Hamdy, 2012). Therefore, this definition is not restricted to individual actors but can apply to coordinated, multitier recruitment activity involving individuals, medical organizations, and other affiliated facilities.

the large number of Sudanese migrants[5] in Cairo who often fall victim to kidney trafficking. Migrants who have been rejected for refugee status often remain in Egypt illegally, depending on limited, informal labor[6] and support from other migrants (Jacobsen et al., 2014).

Though Sudanese migrants are a historically established group in Cairo, they continue to face a great deal of harassment from the local community and law enforcement which induces segmentation and marginality[7] (Grabska, 2005). Thus, as migrants remain on the fringes of society, without protection and stable employment, they often seek alternative sources of income – a circumstance organ brokers fully exploit.

2. Disposition

This thesis will begin with the aims of the study and research questions. A methodology section detailing the elected research design for this study follows. Background and contextual information are then provided to clarify the circumstances of Sudanese migrants within Egypt. The background portion of this thesis is two-tiered. The first part is a brief overview while the second part provides additional information that is seminal to this study and the interpretations later drawn in the analytical portion. Previous research follows the background section. The most recent and relevant studies on kidney trade and Sudanese migrants in Egypt are highlighted with a focus on four main studies. The use of two commodification theories, body commodification and labor commodification, provide the theoretical foundation for this study. These theories are then employed in the analysis portion. Finally, a concluding discussion summarizing the main findings ends the thesis.

[5] The terms 'migrant' and 'refugee' are used throughout the thesis to refer to Sudanese individuals present in Egypt despite the fact that their core definitions differ. Many Sudanese do not identify exclusively as one or the other (Grabska, 2005: 16), therefore interchangeability is suitable.

[6] Heterogenous economic activities occurring outside of state-regulated boundaries. The informal economy is contingent on the trends and circumstances of the formal economy (Desai & Potter, 2014: 200)

[7] "Marginality refers to economic, cultural, legal, political, and social inequality and exclusion, a state of 'being underprivileged and excluded' in terms of access to physical security, social, economic, and legal needs…" (Grabska, 2005: 10)

3. Aim & Research Questions

While the majority of commercial living donors (CLDs) in Egypt are Egyptians (Budiani-Saberi & Mostafa, 2010), the focus of this study is Sudanese migrants because they remain on the fringes of society hence reaffirming their aggravated vulnerability. This study aims to explore the ways in which the Egyptian state and society implicitly enable illicit kidney markets to thrive. This is done by examining the existing literature and research conducted on this group. Kidneys were chosen as the object of this study since they are the most commonly traded organ worldwide (Shimazono, 2007). Further, this thesis is androcentric because males are exposed to significant labor insecurity and lower wages which increases the likelihood that kidney sale is elected as a method of income generation. Compared to female migrants from Sudan, males are more disadvantaged in finding labor (Grabska, 2005) because employers prefer hiring females for domestic work and this type of work tends to generate greater income (Budiani-Saberi & Mostafa, 2010; Budiani-Saberi & Karim, 2009; Columb, 2017a; Petrini, 2014; Grabska, 2005; Yea, 2010). Thus, this study aims to assess the heightened vulnerability of male migrants in this context. On a broader level, the ways in which networks operate will be explored to show the intricacies of power hierarchies and relations between sellers and brokers, which are connected to structural aspects[8]. The impact of illicit kidney trade on sellers is also a major part of understanding the processes and consequences of illegal organ trade. Therefore, the research questions for this study are as follows:

1.a. How can structural features drive illicit kidney trade of male Sudanese migrants in Cairo, Egypt?

1.b. How can the linkages between structural features and illicit kidney trade be interpreted theoretically?

2. *What are the short-term impacts of kidney sale on vendors?*

For the purpose of this study, structural features are understood to be the lack of employment opportunity, lack of social provision, unclear UNHCR protocols, and rigid segmentation within Cairo. This interpretation is based on factors that have been identified as highly relevant to organ trade by several studies (Grabska, 2005; Petrini, 2014; Columb, 2017a;

[8] This interpretation was drawn based on the information found and presents just one way of interpreting illicit organ trade

Columb, 2017b; Jacobsen et al., 2014). In terms of the Egyptian State, the focus is mainly on the existing welfare scheme which excludes major portions of the Egyptian population and migrants. The short-term impacts of kidney sale are crucial to understanding the ramifications of illicit organ sale on vendors. Refugees in Cairo are highly mobile (Grabska, 2005: 55) and it is difficult to trace long-term outcomes, hence the focus is on short-term impacts. This remains a sub-question since the focus is analyzing how the conditions for illicit kidney markets were created to begin with.

In addition, there have been several studies conducted on the socioeconomic and health consequences of kidney trade on vendors in India, Pakistan, Bangladesh, and Colombia. Since this thesis aims to fill specific knowledge gaps relating to the mechanisms behind illicit kidney trade, question two is more complimentary than it is central to the thesis. Nevertheless, both questions aim to provide a more holistic understanding of large-scale kidney trade and the processes enforcing the practice.

3.1 Delimitations

Preexisting studies were used to gather the necessary data for this study. Literature review revealed significant information upon which this thesis is based. No studies older than 2005 were used to ensure that information was relevant. The scope of this thesis is confined to Cairo, Egypt though other organ source countries have been referenced as well to provide crucial information on the ways in which organ trade operates in similar contexts and to increase the reliability of the claims made in this thesis.

Despite significant political instability and economic turmoil caused by the Arab Spring, organ trade has remained a consistent feature of Cairo's urban landscape (Wilkens, 2018). The decreased economic opportunity and the increased price of subsidized staples have led both Egyptians and Sudanese alike into greater poverty heightening the likelihood of illicit market participation (ibid). For this reason, the impact of the Arab Spring on organ trade and Sudanese migrants is not the object of this study, but its importance in shaping the overall political and social climate in Egypt should not be disparaged.

For the purpose of this thesis, Sudanese migrants are understood to be individuals who migrated to Egypt, were either denied refugee status, were in the process of filing for refugee status, or were residing in Cairo illegally. Further, there is no universally accepted estimate on the number of Sudanese in Cairo, with estimates ranging from 50,000 to 4 million (Zohry, 2007: 47;

Grabska, 2005: 17). The discrepancy in estimates is an obstacle to the study in the sense that the studied sample size is not clearly defined.

Because this thesis explores a highly specific group and is confined to one city, its generalizability is not possible. However, the findings of this study should not be disregarded as they provide valuable insight into the Egyptian case, which has been left largely unstudied. Further, the furtive and dangerous nature of illicit organ trade has made it a difficult phenomenon to study, especially due to the limited data available (Columb, 2017a). Figures provided by the Egyptian government and medical bodies tend to underestimate the numbers of transplantations or provide only estimates which cannot be relied upon fully (Budiani, 2007). Therefore, this thesis carries some numerical ambiguities which are characteristic of studies on illicit activity and organ trade.

4. Methodology

A case study approach has been chosen for this thesis. "Case studies are a design of inquiry found in many fields, especially evaluation, in which the researcher develops an in-depth analysis of a case, often a program, events, activity, process, or one or more individuals." (Creswell & Creswell, 2018: 51). This is suitable because the focus is on a highly specific trade within Cairo that involves multiple actors and features. This necessitates close investigation of relevant factors. Though the generalizability of case studies remains one of the greatest limitations, case studies provide an important glimpse into the processes shaping specific development phenomena (Bryman, 2012). Research conducted in India, Pakistan, and the Philippines was also assessed to strengthen the arguments in this thesis. Though this thesis is not a comparative case study, it is critical to assess organ trade in other regions to draw parallels between the types of networks, broker-seller relationships, and the circumstances driving individuals to take part in the trade. The findings from studies conducted in other common origin countries were highly congruent with illicit kidney markets in Egypt.

A literature review was the main data collection technique. This was deemed the most appropriate as it provided a cohesive picture of organ trade during the established period of the study (2005—2018) instead of relying on data only collected during one point in time. "Moreover, this type of review allows the author not only to summarize the existing literature but also to synthesize it in a way that permits a new perspective." (Boote & Beile, 2005: 4) which is what this thesis aims to do. Recent research, as well as older studies, were referenced to ensure that organ

trade was assessed multidimensionally. Secondary sources were the main type of material accessed, however, these differed in nature. Ethnographic studies, as well as qualitative fieldwork and formal reports by NGOs, were accessed to obtain essential data on the nature of kidney trade. These sources reveal the motivations for kidney sale, general living conditions of the Sudanese, and postoperative outcomes for sellers.

Investigation was conducted by triangulating data from four significant studies conducted in Cairo. Triangulation relies on the convergence of several different sources of data which adds to the validity of the study (Creswell & Creswell, 2018: 274). Studies conducted by Jacobsen et al. (2014), Columb (2017b), Hamdy (2012), and Grabska (2005) all had compatible findings. These provided vital data as well as interview excerpts from key informants. Auxiliary information was provided by the remaining sources. Despite the lack of data on illicit organ trade in Egypt and the proclivity of the Egyptian Medical Syndicate (EMS) to underreport figures on transplantation, adequate review of these studies provided reasonable data for analysis.

5. Overview

Egypt is the largest human organ bazaar in the MENA region (Columb, 2017a) and has consistently maintained this reputation despite the introduction of both international and domestic legislation banning the practice of organ trafficking and non-related[9] organ transplants. Of the estimated 500-1000 transplants per year performed in Egypt, 80-90% of CLDs are unrelated to the recipient (Budiani-Saberi & Mostafa, 2010: 319). In addition to the absence of a cadaveric procurement program, there is no consensus on brain death within the medical community leading to a reliance on CLDs for organs. This leads to gross violations of the 2010 Transplantation of Human Organs and Tissues Act (THOTA) which was the first cohesive attempt to prohibit the sale or purchase of organs. However, the law has had little impact on organ trade within Egypt (Columb, 2017b).

The willingness of brokers to recruit, sellers to sell and doctors to transplant have not diminished since the passing of THOTA and kidney markets continue to persist (Columb, 2017b). The kidney trade occurs in Cairo, where Sudanese migrants are clustered and transplantation clinics easily accessible. Poverty remains the consistent driver of the buyer-seller nexus. Between

[9] 'Non-related' refers to the lack of blood relation between buyer and seller

2015 and 2018, the poverty rate in Egypt increased by 4.7% and now stands at 32.5% (The World Bank, 2020) indicating that a larger number of individuals are exposed to socioeconomic precarity. Further, informal employment constitutes 55% of total employment in Egypt (The World Bank, 2019) and 69% of Egypt's GDP (ILO, 2012 in Columb, 2017a: 292) indicating that it is a central feature of the economy and occupational climate. Informal labor is the only form of employment currently accessible to Sudanese migrants who remain in Egypt illegally or awaiting refugee status, for which the chances are slim. Approximately only 13,000 of all Sudanese in Egypt are recognized as refugees (Columb, 2017a: 292).

6. Background

This portion of the thesis will provide additional information about the context within which kidney trade in Egypt occurs. The first subsections are concerned with the UNHCR as well as migrant processing. Egyptian transplant medicine and the welfare system are discussed in the final part of this in-depth background section. As mentioned earlier, these are the identified structural features which are linked to illicit kidney trade in Cairo. Therefore, this expanded background section provides the foundation for later analysis while specifying the environment and obstacles Sudanese migrants encounter.

6.1 On the Margins: UNHCR & Migrant Status

Currently, Egypt lacks a domestic policy on refugees and leaves case processing and eligibility determination to the UNHCR in Cairo. The Egyptian government assigned the responsibility of refugee processing and resettlement to the UNHCR through the Memorandum of Understanding (MOU) in 1954. The eight operative articles of the MOU outline the responsibilities of the UNHCR which are mainly to facilitate voluntary repatriation and ensure cooperation with the government. However, "Local integration is not a recognized durable solution for refugees in Egypt" (Badawy, 2010: 7) meaning that aside from resettlement, migrants are provided with few integration opportunities.

Since the mid-1990s UNHCR has run one of the largest resettlement programs in the world (Petrini, 2014) which has attracted large numbers of refugees. Despite the historically central role of the UNHCR in refugee case processing and resettlement, the capacity of the UNHCR to cope

with cases remains unstable. Since 1997, funding for UNHCR assistance has fallen by 37.5% while the number of asylum and refugee applications has risen by 725% (UNHCR, 2006 in Rowe, 2009: 11). The lack of capacity to process applications along with dwindling funds has been ineffective in coping with migration leaving many in a legal limbo (Jacobsen et al., 2014: 148).

The Wadi El Nil Treaty (1976) enabled Sudanese migrants to enter Egypt without needing a residence visa and granted access to education, property ownership, and employment. This solidified the historically significant relationship between Egypt and Sudan while providing migrants with viable integration via quasi-citizen status**.** However, the 1995 revocation of the Wadi El Nil Treaty did little to disincentivize migration from Sudan which was the result of famine, conflict, and political instability. The introduction of the Four Freedoms Agreement (FFA) in 2004 was an attempt to return to the openness granted by the Wadi El Nil Treaty allowing Sudanese to obtain residency permits upon arrival as well as the possibility to apply for work permits. However, migrants must find a sponsor who is willing to pay the $40 USD fee and must prove that they are uniquely qualified to perform the work (Jacobsen et al., 2014; Columb, 2017a). Many migrants engage in low-skilled work, therefore the conditions of the FFA do not provide a realistic path towards secure employment. Citizenship in Egypt is granted *jus sanguinis*, therefore refugees are not able to obtain Egyptian nationality (Jacobsen et al., 2014). Further, the registration process at the UNHCR is ambiguous leaving migrants to their defenses while awaiting a decision. Refugees also remain subject to the UNHCR meaning that they lack the privileges extended to Sudanese nationals who are considered *legal* migrants. Thus, refugees and asylum seekers experience heightened vulnerability compared to those who have been formally granted refugee status (Grabska, 2005) while the likelihood of being granted status has decreased immensely.

6.2 Registration Procedures

To register with the UNHCR, migrants are expected to provide a passport, driver's licenses, civil documentation, marriage or divorce certificates, birth certificates, family booklets, high school diplomas, university diplomas, proof of any prior registration with UNHCR in other countries as well as two passport photos of each family member (UNHCR, 2019). It is clear that these procedures are already a major obstacle for migrants who can provide limited or no documentation. Migrants are first granted a white card which serves as proof of a pending asylum

application (UNHCR, 2019). Once valid documentation is presented and an official application for refugee status is made, a yellow card is granted which permits refugees to remain in Egypt for 18 months until a Refugee Status Determination Interview (RSD) can be conducted. This often takes months during which migrants must depend on their own resources to survive. If an RSD is granted and migrants are given a blue card, their status as a refugee is considered recognized. They are granted legal residence in Egypt for three years (UNHCR, 2019). "The main difference between a recognized refugee and an asylum seeker is that recognized refugees are eligible for UNHCR's 'durable solutions': local integration, voluntary repatriation, or resettlement" (Jacobsen et al., 2014 in Columb, 2017a: 289). In 60-70% of cases, legal status is rejected (Sperl, 2001: 26). Many of the 'closed files' remain in Cairo in a legal limbo and rely on informal labor and other subsistence activities to survive (Jacobsen et al., 2014: 146).

> "I have a closed file, but look at me, I am not dead. I am still alive, my family is alive, we need to eat, pay rent, and my children need to go to school. I am still a human being"
>
> - Closed file, Cairo (Grabska, 2005: 33)

This sentiment is reflective of the inadequacies within the migrant processing procedures of the UNHCR that leave migrants without security. The connection between illegality and increased precarity is clear, especially regarding daily survival and employment prospects. At the core of the issue, migrants, legally present or not, must provide for both themselves and dependents despite the narrow opportunities they have access to.

6.3 "mafish nizam fi Masr"[10] : Transplantation Discourse in Egypt

Opinions on body ownership, organ transplantation, and what is acceptable or not remain largely divided among Egyptians and within the medical community. Islam has played an influential role in determining which transplantation practices are *haram*[11] and which are *halal*[12]. It serves as the foundation for the judgment of morality and extends far into the realm of medical practice (Hamdy, 2012). The first religious order regarding organ transplantation was issued in

[10] "There is not a system in Egypt"
[11] That which is considered sinful in Islam; forbidden
[12] What is considered permissible in Islam; not sinful; has a positive connotation

1979 establishing that the use of living donors in the case of kidneys was, in fact, ethical. However, the public remains opposed to the practice and relegated transplantation is a medical 'gray' area.

The use of CLDs is viewed as unfavorable in society causing in the tabooization of organ transplantation. Despite widespread disapproval, CLDs provide 90% of transplanted organs in Egypt (Hamdy, 2012). Purchasing a commercial kidney from a CLD is seen as the last resort, the final option for a patient with no other alternative and facing imminent death. Egypt has no national cadaveric organ procurement system (Ambagstsheer, 2017) and organ transplantation is monitored by the EMS. The EMS is responsible for licensing doctors and for granting formal approval for transplants through standardized bureaucratic processes. It has "…adopted an absolutist stance against organ commercialization, echoing the official policy of developed Euro-American nations" (Hamdy, 2012: 234). However, the role of the EMS in preventing transgressions has been marginal due to the flexibility of the approval process and the use of *wasta*[13] in Egypt.

Despite contemporary trends in transplant tourism, foreigners are not the only buyers of commercial kidneys. Egyptians constitute a large portion of kidney buyers as well since obtaining organs from relatives is often cumbersome and deemed inappropriate (Hamdy, 2012: 224). The use of CLDs is not permitted by the EMS, therefore during the meeting between the Syndicate, seller, and recipient, blood relation must be demonstrated. Paperwork is signed to confirm that the transplant is not commercial (ibid). However, this official procedure is easily circumvented by the ambiguities of the system which leaves room for the approval of commercial transplants as well. Private clinic medical activity and transplants are even further removed from the restrictions imposed by EMS which leads to a large market for organs sourced from CLDs.

For Egyptians, there is a prevalent interpretation of the body as sacred and a belief that the parts of the body should never be separated as this could impede the afterlife. In other words, the body belongs to God and should not be tampered with (Hamdy, 2012). It is seen as dishonorable and *haram* to sell one's body and organs (ibid). However, there are mixed views on whether it is also *haram* to purchase an organ. Because social suffering is seen as an inevitable feature of society, the use of a socioeconomically disadvantaged seller is not necessarily viewed as wrong. Consequently, the blame is put on the seller who is willing to sell an organ instead of the buyer

[13] Defined as "the intervention of a patron in favor of a client in an attempt to obtain sources or privileges from a third party" (Mohamed & Mohamad, 2011 in Mohamed, 2018). The role and use of these informal social networks is highly significant in Egypt. *Wasta* is viewed as a positive thing especially among those in lower socioeconomic strata.

who is demanding one. Poverty is viewed as shameful, a result of negligence and a lack of dignity (ibid). Thus, doctors often align their sympathies with recipients rather than sellers and this reflects in major differences in post-operative care for both.

Major schisms exist within the medical community and Egyptian society about the acceptability of organ transplantation due to the ambiguity surrounding the definition of legal drain death[14]. While some believe that brain death is acceptable enough for organ removal, others see cardiopulmonary death as the only *halal* means of organ procurement. The lack of legal recognition of brain death combined with the highly commercialized, unregulated nature of organ transplantation in Egypt has led to medical malpractice and the expansion of illicit organ markets. Where governmental oversight sees the formulation of comprehensive national policies on medical interventions, the likelihood that transplantations are commercial decreases while protection for both vendor and recipient increases.

6.4 Welfare & Social Protection in Egypt

Social protection[15] in Egypt remains largely fragmented. Formal employment serves as the linkage between the individual and social protection meaning that roughly half of Egyptians are excluded due to their participation in informal labor. Equality levels in Egypt have greater variability than those of similar states in the region, namely Tunisia. Particularly large disparities exist between rural and urban areas. Cairo has the highest GNI in Egypt at 0.35, while GNI in rural areas is 0.23 (Abid et al., 2016). Evidently, asymmetries in urban areas are more pronounced leading to unequal access to opportunities, gaps in earnings, and high levels of informalization (ibid). Youth unemployment has been a characteristic feature of the Egyptian labor market, thus individuals in their most productive years are not able to utilize their full labor potential nor are they able to maximize their earnings. Wood & Gough (2006) would classify this type of regime[16] as an insecurity regime. In this type of welfare regime, individuals rely on community and familial relationships to meet security needs which leads to the development of asymmetries. The weak

[14] Brain death is interpreted as the irreversible loss of all function in the brain (Hamdy, 2012: 71)

[15] "Social protection is concerned with preventing, managing and overcoming situations that adversely affect people's well-being...[and] aims to assist individuals and households in maintain basic consumption and living standards when confronted by contingencies such as unemployment, illness, maternity, disability or old age, as well as economic crisis or natural disaster." (Desai & Potter, 2014: 470)

[16] A regime is defined as a "…set of rules, institutions, and structured interest that constrain individuals through compliance procedures." (Krasner, 1983 in Wood & Gough, 2006: 1698)

role of the Egyptian state in regulating the labor market reinforces informalization and generates the instability needed to deprioritize the extension of social protection to the greater part of the population.

Egypt could also be classified as a conservative statist welfare regime based on prevalent clientelism, informality, and the exclusion of social benefits from large segments of the population (Mohamed, 2018). This typology is complimentary to Wood & Gough's classification of insecurity regimes. Mohamed (2018) identities two major features of the conservative statist regime. First, the large informal sector is excluded for benefits and job security. Second, formal employment is the gateway to social benefits meaning that those in the informal sector cannot depend on formal welfare programs and protection schemes. Around 50% of Egypt's employment is informal (Mohamed, 2018: 74) meaning that not only Sudanese migrants but most Egyptians are left without benefits. This system generates a tremendous amount of insecurity among the population and increases the need for individual to commodify their organs given that dependency on the market is high.

The growing privatization of the public sector coincides with the influence of globalization on the Egyptian state and economy. As distribution becomes more unequal and welfare programs become increasingly more targeted rather than universal, social stratification[17] is reinforced. Welfare programs in Egypt have largely preserved social stratification via uneven distribution. Programs have been found to favor the richest quintile which receives 28% of welfare and subsidy resources (Mohamed, 2018: 73). Therefore, the poorest groups must rely on *wasta* or extended family networks to obtain irregular social services. This type of 'backyard social protection'[18] results in the development of relational hierarchies among the population while reducing the accountability of the Egyptian state to provide legitimate social protection simultaneously equalizing welfare distribution.

Further, eligibility is contingent upon citizenship, which as we have seen in the previous section, is not a possibility for Sudanese migrants. Therefore, welfare within the Egyptian context functions as 'trickle-down' institution with the least services and protections reaching the lowest social strata among which the Sudanese rank last. From both a legal and social standpoint, they are the lowest in the hierarchy of welfare beneficiaries. Therefore, the extension of social

[17] Refers to the creation of strata by the welfare state which then orders social relations (Esping-Andersen, 1990)
[18] 'Backyard' is used in this context to denote informality

protection to Sudanese is improbable since the Egyptian welfare system is exclusionary rather than inclusionary.

7. Previous Research

Preexisting research on kidney trade is limited due to the inconspicuous nature of kidney trade and the difficulty of identifying sellers for research. Though research exists on more well-known organ hubs, such as India, there is a gap in research concerning the Egyptian case. Data were collected from four main sources which were all based on studies conducted in Egypt specifically. Compounded, these illustrate the realities experienced by the Sudanese as well as the features of kidney trade. Jacobsen et al. (2014) focus on the livelihood strategies of the Sudanese by investigating the economic activity of migrants and chief coping strategies of migrants. The findings show that while 89% of Sudanese were economically active, income was not enough to cover basic expenses (Jacobsen et al., 2014). Research conducted by Grabska (2005) focuses specifically on Sudanese with 'closed files' in Cairo and how they navigate social and economic exclusion. This study indicates that marginality is largely the result of UNHCR policies and harassment from Egyptians which both create tremendous obstacles for migrants (ibid). In addition to harassment, the greatest difficulty faced by the Sudanese was found to be the inability to pay rent (Jacobsen et al., 2014; Grabska, 2005), which points to long-term insecurity and compromised income generation capacity.

This finding is supported by Columb (2017a) who found that the majority of individuals have little choice but to sell an organ due to their poor socioeconomic status (Columb, 2017b: 1301). The study is centered around the ways in which organ networks recruit sellers who are made readily available through weak UNHCR protocols and anti-trafficking laws, specifically the THOTA (2010), which enhances the illegality of organ trade as opposed to reducing it (ibid). Exclusion from formal labor is identified as a major source of insecurity leading to the acceptance of precarious labor conditions and low wages (ibid). Moreover, informal street markets were found to be centers of economic activity and broker recruitment (Columb, 2017b: 1307). Most kidney sellers are first approached by brokers who are familiar with their situation while informal settings provide brokers with easy access to potential vendors. They are then promised large sums of money or a night with a sex worker (Columb, 2017b: 1311) – both inducements to sell.

There is a significant difference in what sellers receive for a kidney, but in most cases the differential between the amount given and the amount promised is high, further illustrating the unethical aspect of the trade. The average offered to sellers in Cairo is $1908 USD (Columb, 2017b: 1310). However, a large number of sellers reported receiving less than the promised amount. This is due to deductions for what brokers claim to be 'medical and clinic fees' as well as broker commission. Instead of competing among each other, brokers cooperate to ensure that the market price for a kidney is standard (Columb, 2017b). They also inform one another on recruitment strategies, share profits from successful operations, and disperse contact information for medical staff in cooperating clinics (ibid).

Brokers employ various deceptive strategies for persuasion. Sellers are told myths about the "sleeping kidney," which purports that though a healthy person has two kidneys, one is functioning while the other 'sleeps' until 'woken' by surgery (Moniruzzaman, 2012). Others are not informed of the health consequences of living with only one kidney and potential ailments that can develop as a result. In some cases, sellers are not even aware of the kidney's functions and told that the operation removes the 'smaller' of the two kidneys, which are believed to be different in size (United Nations Office on Drugs and Crime, 2015). Post-operative care was not offered to kidney vendors in any donor country studied, which further compromised both sellers' short- and long-term post-operative health (Budiani-Saberi & Mostafa, 2010; Columb, 2017a; Moniruzzaman, 2012; United Nations Office on Drugs and Crime, 2015; Cohen, 2013).

In terms of socioeconomic and health outcomes post-transplant, vendors have consistently shown notable deterioration. First, there is a great stigma surrounding kidney sale, therefore leading individuals to keep the sale secret from spouses, family members, and their larger community. Studies have found that this stigma leads to ostracism and lower employability as well as emotional and physical distress for the seller (Budiani-Saberi & Mostafa, 2010; Petrini, 2014; Moniruzaman, 2012; Budiani-Saberi & Delmonico, 2008). Furthermore, Moniruzzaman (2012) found that economic distress following the sale affected 81% of sellers in Egypt, who used the money within five months of the operation suggesting that sustained economic improvement is not a reality for most sellers. Overall, outcomes were negative because of the increased fatigue, weakness, depression and inability to resume work after kidney sale (Columb, 2017b; Budiani, 2007; Karim & Budiani-Saberi, 2009). Since reliance on informal labor is high and strenuous work is common in this sector (Columb, 2017a), vendors are at further risk of debt and unemployment.

Ethnographic research conducted by Hamdy (2012) revealed the societal implications of organ trade as well as the norms governing transplantation. Though the center of her research is not on illicit organ trade, her exploration of the broader context and medical field in Egypt is linked to commercial organ sale. Her research showed that the purchase of a kidney is deemed unfavorable by Egyptian society as it is enormously risky. The moral underpinnings of this condemnation stem from Islam, which regards the body as sacred. Hamdy's research is centered on the discord existing between medicine and society which results in the growth of shadow kidney markets. Further, her investigation of the ambiguities of Egyptian bureaucracy, especially within the EMS, emphasizes the inadequacies of the system in ensuring that transplants are non-commercial. The lack of accountability on the part of the medical professionals was found to be present in both private transplant clinics and public hospitals (ibid) emphasizing the blurred lines between legal and illegal transplantation.

7.1 Constructing a Seller Profile

In all studied origin countries, kidney sellers tended to be from the most marginalized socioeconomic strata suffering from debt and instability. Several trends were found among sellers in India, Pakistan, the Philippines, and Bangladesh. First, across all studies of kidney vendors, vendors were paid less than the agreed amount and were recruited for the sale meaning that voluntary participation was absent from the transaction (Budiani-Saberi & Mostafa, 2010; Moniruzzaman, 2012; Budiani-Saberi & Delmonico, 2008; Hamdy, 2012). The typical seller profile indicated that a seller is on average between 20 and 40 years of age (Piotrowicz et al., 2017: 124) which indicates that younger sellers not only carry large personal debt but also provide for dependents. The number of dependents was found to be between 4-7 per vendor (Naqvi et al., 2007). Socioeconomic outcomes were especially poor with the percentage of sellers below the poverty line increasing by 17% after surgery (Cohen, 2013: 272). Across several studies, the percentage of vendors reporting a decline in overall health after the operation was found to be 78% (Hamdy, 2012: 219; Budiani-Saberi & Karim, 2009: 49; Budiani-Saberi & Delmonico, 2008: 927; Budiani-Saberi & Mostafa, 2010: 320). This strongly correlates to Cohen's study, which found that sellers' annual household income decreased by $200 after the operation (Cohen, 2013: 271). It is clear that the impact of a kidney sale has life-altering consequences on vendors often resulting in deeper poverty than experienced prior to the kidney sale.

A notable finding in Cairo was that sellers are young, urban men. Younger sellers are preferred for medical reasons and sought after by buyers who want to be sure that the purchased kidney is from a healthy, young seller[19]. Budiani-Saberi & Karim (2009: 49) & Shimazono (2007: 960) found that 95% of sellers are male indicating marginal female participation in the kidney trade. Findings on gender wage variability provide a plausible explanation for the overwhelming number of male CLDs. Female migrants have greater employment chances and higher wages due to their involvement in care and domestic work. Male Sudanese migrants are paid between 250-350 LE ($40-$55)[20] per month while women receive an average of 400-600 LE ($64-$100) (Grabska, 2005: 61). In addition, the informal employment accessible to men involves hard labor, such as construction, which is valued less than domestic work. These gender disparities push male migrants even further into social marginalization while increasing the chance of debt, insecure employment, and eventual organ sale as a last resort.

Their illegal status makes exploitation easy and migrants have little bargaining power resulting in lower wages than those earned by Egyptian counterparts for the same work. Migrants are also more exposed to insecurity as well as being underpaid (Jacobsen et al., 2014: 154). Without legal status and valid documentation, Sudanese migrants are reluctant to report abuses for fear of prosecution accepting precarious working conditions and derisory salaries.

The average monthly salary for migrants was not enough to cover even basic expenses (Jacobsen et al., 2014; Columb, 2017b). Instead, migrants rely on remittances from family members or borrow money from other Sudanese migrants if deficits occur (Jacobsen et al., 2014). Food scarcity and squalid housing were common obstacles for migrants (Petrini, 2014). Grabska (2005: 55) found that over 60% of the monthly budget for a Sudanese migrant was spent on living expenses which leaves little to no surplus when all other expenses are factored in. This largely fuels debt, which was reported as the main reason for kidney sale across all studies in donor countries reviewed for this thesis[21]

According to Grabska (2005: 32), 63% of Sudanese men were economically active *prior* to migrating to Egypt. However, upon arrival in Egypt, 68% of Sudanese men were unemployed (Budiani-Saberi & Mostafa, 2010: 320) further illustrating severe labor insecurity which fuels

[19] The average age for a seller in Cairo is 33 years (Piotrowizc et al., 2017)
[20] This conversion was calculated using an exchange rate of LE 6.16 to 1 USD (Grabska, 2005) despite the fact that this rate has fluctuated since
[21] See references list

debt. Sudanese men work as street vendors, selling perfumes, construction workers, cleaners, and repairmen earning between LE8- 12 ($1.2-2 USD)[22] per day (Grabska, 2005: 66). Despite moderate education and literacy levels among migrants (ibid), informal labor is the only accessible form of income generation for migrants. These forms of employment do not generate consistent income as they occur on a temporary basis in informal settings. These informal settings are also where tacit broker-migrant interactions occur leading to recruitment.

7.2 Recruitment Strategies & Networks

Recruitment is a small yet critical part of the commercial transplantation transaction. In Cairo, recruitment occurs exclusively through vis-à-vis interactions. It should be emphasized that in the absence of broker solicitation, kidney sale is not considered a viable solution. More importantly, brokers are often Sudanese or connected to the community in a way that elicits trust among potential vendors. Recruitment involves a two-stage process in which the first step is persuasion of the potential seller. This is done usually by presenting the kidney sale as a lucrative source of income while being aware of the seller's economic precarity and background (Piotrowicz et al., 2017). In the second stage of the process, the price for the kidney is briefly negotiated and, often, the amount received for a kidney is directly related to the length of time a migrant has resided in Cairo i.e. migrants who have been in Cairo longer can expect to receive higher compensation for a kidney sale than those who are newly arrived (Beckert & Dewey, 2017: 62; Columb, 2017b: 1310)

Peonage is also known to begin upon the initial arrival of migrants. A hotspot for this practice is the Ataba hotel where recruitment often begins. The vulnerability of the newly arrived is fully exploited and their lack of familiarity with Egypt as well as constrained financial situation often makes persuasion easier for brokers. Migrants are told that they are in debt for their stay at the hotel and the only way to repay the bill is to sell a kidney (Columb, 2017a). This is referred to as a *capture process* (Beckert & Dewey, 2017) by which the broker facilitates seller dependency by asking to be compensated for 'help'. After persuasion, diagnostic testing and tissue typing is done even before a prospective recipient is found. This is significant because it shows that the recruitment process itself is unethical and fraudulent. The costs of these tests immediately become

[22] This conversion was calculated also using an exchange rate of LE 6.16 to 1 USD (See footnote 20)

a form of medical debt peonage for the seller who is expected to personally cover all costs. Therefore, resignation from the transaction is not a viable option for sellers who must proceed with the operation regardless of their willingness to do so. In cases of outright withdrawal, coercion, harassment, and threat are typical strategies used to intimidate the seller and enforce the onus of selling the kidney.

> "They [the brokers] told me that they would never let me change my mind. They said, if you change your mind you will pay for all the health checks, and we will never leave you alone. We will take your money and your passport. We will never let you go. Every day they paid me 50 or 150 LE. They told me that I owe them now. I couldn't pay them back so I had no choice but to continue."
>
> - Patrick, kidney seller in Cairo (Columb, 2017b: 1313)

This is the most common avenue of recruitment found in previous studies conducted on organ trade in Cairo, however medical staff at both public and private clinics may take on a broker role as well. The removal of a kidney during an unrelated medical intervention is also an avenue for kidney acquisition. By convincing patients of false anatomy and promoting organ 'donation', doctors act as brokers (Scheper-Hughes, 2002; Wilkens, 2018). This bio-theft is not revealed to the patient after the operation, and in this case, the removal of the organ does not result in any reimbursement for the victim. In these cases, the physicians act as brokers without explicit recruitment. However, the secrecy surrounding the intention of the operation and the complete disregard for obtaining consent from the patient form the foundation of this alternate 'recruitment' strategy.

However, migrants are predominantly targeted by brokers in informal settings such as markets or cafes and do not come into contact with involved medical personnel until the transplantation process begins. The recruitment strategies used by brokers revolve around deceptive practices, including the creation of debt peonage. With little external support or chance of consistent income, migrants subsist in a precarious environment in which the pressures of financial insecurity, illegality, and segmentation lead to a marginal existence (Grabska, 2005).

7.3 Segmentation within Cairo

Cairo hosts one of the largest urban refugee populations with an estimated 8 million slum dwellers (Petrini, 2014: 51). While the exact number of Sudanese is contested, they constitute the largest refugee group in Cairo (Jacobsen et al., 2014: 146). Sudanese often live in clustered neighborhoods throughout Cairo due to the increased likelihood 'blending in'. This is a coping mechanism for migrants wishing to remain undetected by law enforcement as well as having access to social support networks that are largely present among Sudanese. Migrants often share accommodation to cut costs and rarely share housing with Egyptians (Grabska, 2005) which further deepens segmentation. Harassment and mistreatment are daily realities for Sudanese in Cairo which are a product of tense relations between Sudanese and Egyptians (Jacobsen et al., 2014: 156). Ideas of racial and social inferiority demote the Sudanese to the lowest social standing in Egypt making integration impossible.

> "Animals like donkeys, dogs and horses can move in the streets freely
> and no single Egyptian would bother them or throw stones at them.
> Why do they do it to me? Is it because they respect the animals more
> than me? I am afraid and it disturbs me"
>
> - Sudanese migrant (Grabska, 2005: 73)

The Sudanese remain dependent on their defenses since law enforcement not only ignores reports of abuse and maltreatment but is often the perpetrator. It is not uncommon for police to extort money from Sudanese whose refusal would result in beatings or arrest (Grabska, 2005: 72). The severity of threat from Egyptians leads to the concentration of Sudanese and increases migrants' reliance on informal community networks. Organizations such as CARE Egypt, Médecins Sans Frontières, Save the Children, and Caritas Egypt are located in areas of Cairo that are predominantly Sudanese and provide irregular aid to the neediest. Their role is to offset the fact that Egypt provides no assistance to refugees and asylum seekers (Rowe, 2009). The neighborhoods in which Sudanese are most concentrated are Maadi, Downtown Cairo, Dokki, Nasr City, Heliopolis, Dir al Malak, Ain Shams, and Arba wa Nus (Jacobsen et al., 2014).

Figure 1. Map of Sudanese neighborhoods (Source: Author)

Unlike the conventional image of illicit activity as something occurring on the margins of society and the outskirts of the city, commercial organ trade is embedded in the heart of Cairo and thrives in the absence of regulation and enforcement (Columb, 2017a). The openness with which recruitment and transactions are conducted illustrates the embeddedness of organ commercialization in Cairo.

8. Theoretical Framework

The theoretical framework for this thesis is based on two major theories. Body commodification theory (Scheper-Hughes, 2001) is the first theory presented. It is then linked to Esping-Andersen's labor commodification theory (1990). Both theories investigate the commodification of the individual within global markets and show how features of the Egyptian system may force individuals to commodify themselves for survival.

8.1 The Body as a Commodity

Body commodification[23] is at the fundamental core of organ trade where the sacrosanctity of human tissue is abased by bio-avarice. The commercialization of organs and human tissue aligns with the theory of body commodification (Scheper-Hughes, 2000) which will be employed at the first theoretical concept. This theory argues that global capitalism has turned everything, including human bodies, into commodities, and, as a result, widened the gaps between those 'supplying' and those 'buying' organs. Body Commodification theory highlights the asymmetries intensified by illicit organ trade in the sense that organs tend to flow from poor to rich, from young to old, from Global South to Global North, and from black or brown to white (Scheper-Hughes, 2000). The attachment of monetary value to human tissue and organs serves the center of the theory and emphasizes the blurred line between what is medically possible and what is morally acceptable. "Social justice hardly figures into these discussions because bioethical standards have been finely calibrated to mesh with the needs and desires of consumer-oriented globalization." (Scheper-Hughes, 2002: 62).

Further, the element of desperation on both sides of the transaction atomizes both the buyer and the seller. While the recipient is in a position of power, he/she is also reliant on the organ for survival. The seller, on the other hand, is motivated by the payment received from the sale for survival. In a basic sense, the transaction is based on survival – biological and financial. Thus, the bodies of the poor become 'spare parts' for those who are 'socially advantaged' (Scheper-Hughes, 2002). Scheper-Hughes emphasizes the specific targeting of marginalized groups such as refugees, guest workers, and displaced populations, for organ procurement, which is mirrored in the dynamics of organ trade in Egypt. The 'low' value of these individuals augments the perception of them as an abundant, dispensable source of organs. The biological and social distance between the buyer and seller emphasizes the commercial nature of transplantation. While sympathies often lie with recipients due to their chronic suffering and critical condition, rarely is the condition of the seller mentioned (ibid). The low value attached to the seller in both the medical and the social interpretation of transplantation underscores the inequity of commercial organ purchase. Not only is the seller objectified and extorted for valuable parts, but the seller is devalued in the hierarchy of doctors, brokers, bureaucrats, agencies, labs, and government entities. The differentials in the

[23] The sale and purchase of tissue or organs for material gain (Cohen, 2013)

payment received by the seller and the cost of the transplantation for the recipient indicate these skewed values. Sellers receive between $1,000-$2,000 USD while recipients pay between $40,000-$100,000 (Columb, 2017b: 1312). Thus, the lower intrinsic value of the seller is solidified by the financial realities of the transaction.

The maintenance of organ trade networks can be attributed to wealth inequality, which plays a significant role in the creation of underclasses that provide organs. Where financial instability is a reality, the payment given to the seller by the recipient may seem like an altruistic act in a sense, a form of "help" for the needy. While this type of illusory justification may alleviate guilt on the part of the buyer, the reality is that the detrimental repercussions of organ sale far outweigh the minimal financial boost attained by the seller.

8.2 Labor Commodification

Esping-Andersen's labor commodification theory (1990) allowed for new interpretations of state structure and individuals as active components of labor markets. Labor commodification relates to the structural characteristics of the state and welfare, both of which affect the socioeconomic variability among populations through the distribution of benefits and protection. Esping-Andersen's theory suggests that the welfare state is an active force in ordering social relations (Esping-Andersen, 1990: 23) through the creation of social stratification. In the context of this thesis, this relates to the creation and isolation of the underclass for both informal labor and organ procurement in the absence of a national cadaveric organ program. Labor commodification provides a useful analytical avenue for understanding the creation of welfare systems. Though Esping-Andersen's welfare state typology focuses on developed nations, it has a malleable application to developing contexts as well. The theory asserts that as competition between commodities increases, prices decrease. Therefore, in a system where organs are commodities, their widespread availability drives down the costs, and, consequently, the value of the commodity itself. As commodities, individuals are more prone to financial risk that is associated with what Esping-Andersen refers to as *macro-events*, such as illness. Because humans are commodified by markets in both a corporal and economic way, the connection between the labor and body commodification theories becomes clear.

This leads to Esping-Andersen's theory of de-commodification which refers to the extent to which an individual can survive independently of market participation (Esping-Andersen,

1990). When the market is informal and unstable, the individual has little choice but to commercialize whatever sellable goods he/she possesses, even if that means an organ (Rothman et al., 1997). The volatile relationship between the informal market and the need for Sudanese migrants to integrate themselves into the economy becomes apparent. Ironically, as individuals commodify their bodies and partake in organ sale, de-commodification decreases because kidney sellers are often left fatigued, ill, or unable to work altogether after the removal of a kidney (Budiani-Saberi & Delmonico, 2008; Hamdy, 2012; Shimazono, 2007). Their capacity to work in the informal sector, which requires heavy physical work, is subsequently reduced driving them further into debt and financial dependencies within their community.

Despite their exclusion from formal work and the rapid onset of poverty upon arrival in Cairo, migrants still constitute a group of consumers. *"*By paying high rents and being consumers on the Egyptian market, even the most marginalized refugees infuse substantial amounts of money into the Egyptian economy" (Grabska, 2005: 80). Therefore, the informal welfare regime present in Egypt enables the collection of revenue without the provision of benefits and services that reduce commodification. Further, the lack of protection experienced by workers in market-based societies results in a lack of collective action (Esping-Andersen, 1990) which allows for malpractice to occur without punitive consequences. The denial of rights, welfare entitlements, and disengagement of the state to mitigate migrant vulnerability results in a greater dependency on the market. Therefore, the features of the Egyptian system are likely to promote reliance on the market in a way that induces informality, precarity, and potential involvement in illicit activities.

9. Analysis

Four major analytical portions create the analysis. First, it is argued that body commodification has a purpose within the Egyptian context and does not occur spontaneously. The analysis continues with a section on the emergence of illicit markets in Egypt's underdeveloped context. The short-term impact of kidney trade on vendors is also investigated.

Because vendors hold no legal status, they are viewed as an import, a separate entity that is outside of the realm of Egyptian mortality and rules. The harassment endured by the Sudanese is based largely on Egyptian ideas of racial and cultural inferiority (Grabska, 2005) which justify the disposability of migrants for both medical and labor exploitation. By attaching the idea of inferiority to the Sudanese they become separate from Egyptian society, the 'other'. Since the

Sudanese are seen as inferior, replaceable, and 'low-value'(ibid), they are in a sense collectively commodified as a convenient bio-reservoir for Egyptians and foreigners alike. While the essence of Scheper-Hughes' (2002) body commodification theory focuses on the individual, collective body commodification can also occur in a case where the vendors targeted are not only poor but from a specific ethnic, racial or religious group. This suggests that the forces of social exclusion and racial segmentation play a significant role in generating the type of insecurity needed to create an underclass of desperate organ vendors. As it will become clear in the next section, body commodification and organ markets appear to be closely intertwined, and commodification has an important function within this nexus.

9.1 Theoretical Interpretation: Commodification with a Purpose

Humans have been commodified since the establishment of societies, most notably through the institutions of slavery and prostitution (Davidson, 2014). Therefore, commodification is not a new phenomenon, but in the case of kidney trade, it serves a different function. The following portion of the analysis establishes the three possible functions of organ trade. These functions are identified as *redistributive*, *regulatory*, and *economic*.

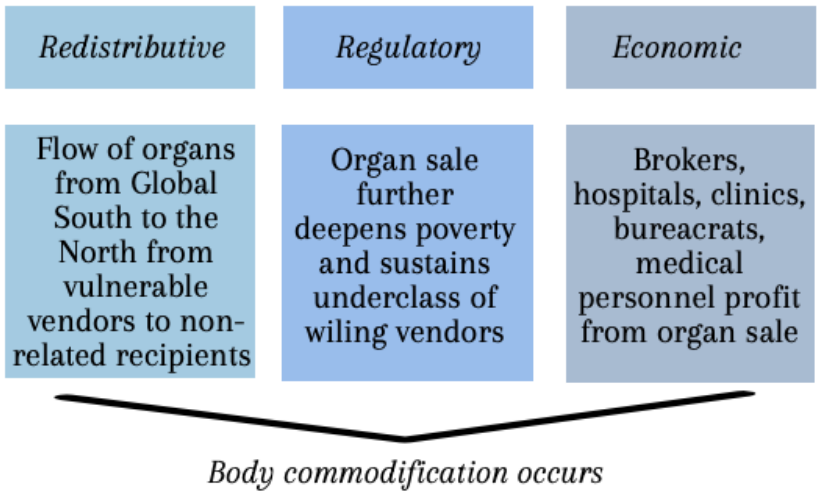

Figure 2. The three functions of commodification in the Egyptian relating to body commodification

The *redistributive* purpose of commodifying human beings is related to the flow of goods. Goods for which there is high demand and high scarcity in the Global North tend to come from the Global South. Organs are no different. Where waiting lists are long, chances of transplantation low, and dialysis hopeless, the inclination is to find external sources of organs. Therefore, 'low-value' places where a large underclass exists become the source of organs for 'high-value' places where the urgency to prolong a life outweighs the ethical considerations of purchasing organs from a marginalized seller. In this sense, organs are 'redistributed' from the Global South to the Global North (Scheper-Hughes, 2001). However, it should be noted that in the case of organs, the idea of the recipient as a citizen of the Global North is largely illusory since many recipients are from Egypt, China, the Gulf States, and Israel. However, the transfer of organs from marginalized individuals to desperate buyers not only confirms the redistributive function of body commodification but strengthens Scheper-Hughes' (2002) claims that, "In general, the flow of organs follows the modern routes of capital: from South to North, from Third to First World, from poor to rich…" (Scheper-Hughes, 2002: 193). This value differential exists not only between regions but between individuals as well. While both the buyer and the seller are equally desperate, more intrinsic value is placed on the buyer because it is assumed the buyer cannot survive with only one kidney while the seller can.

For organ markets to exist in the first place, there must be a group of individuals who are driven to participate in the sale due to chronic destitution. The underclass is an easy source of organs which reinforces the poverty needed to drive individuals into organ sale in the first place. Therefore, the second purpose of commodification emerges. The *regulatory* function of commodification reinforces the poverty that drives individuals to become organ sellers in the first place. Succinctly put, it keeps 'sellers' as 'sellers'. The fewer sellers can provide for themselves and their dependents, the greater the risk of poverty, ultimately forcing their children, spouses, relatives and other community members to also sell an organ.

The sale of an organ inherently carries the attachment of monetary value to live tissue. Therefore, the third function of body commodification is *economic*. While the profits of the seller from the operation are marginal, those involved in the sale generate considerable fiscal gains by participating. This includes brokers, medical staff, bureaucrats, clinics as well as the tourism industry for buyers coming from abroad. The cost of post-operative care for recipients constitutes yet another lucrative aspect of kidney sale. Hierarchical structures emerge whereby a 'trickle-

down" effect occurs. Recipients pay the largest amount and this sum is then dispersed via clinics, medical staff, and brokers with the seller receiving the smallest portion of the amount. Thus, the structure of the organ trade is an inverted triangle that stratifies profits based on the involvement and position of the actor within the economic hierarchy of the organ sale. Therefore, the sale of a kidney serves a multifaceted economic function that blurs the lines between legal and illegal markets.

9.2 Shadow Markets: A Condition or a Consequence?

Underdevelopment and informality are symbiotic features of systems based on instability, much like that of Egypt. Dewey & Beckert (2017) state that illegality is a part of capitalism since illegal markets are driven by demand for goods that would otherwise be inaccessible or heavily regulated in formal markets. Therefore, this begs the question of whether illicit kidney trade is a condition or a consequence of the Egyptian state. Returning to the Mohamed (2018) typology of Egypt as a conservative statist welfare regime, the exclusionary nature of the welfare regime in Egypt could be linked to illicit organ markets. Where the state fails to fill gaps and provide durable safety nets for the most vulnerable groups, illicit activity develops more readily since regulation is minimal and poverty is high.

The development of illicit organ markets is directly linked to globalization which has not only expanded illicit markets but has intensified the global competition for goods. The lack of transparency characteristic of black markets results in greater risk which actors cope with by amplifying coercive and violent measures. Therefore, the higher the demand for an illegal good and the greater the difficulty in attaining it, the more drastic the measures taken by actors to reduce risk. In the case of kidney trade, this is done via selective cooperation among brokers in addition to the use of threat or debt peonage to enforce the sale. Further, without an overview of market supply, vendors remain misinformed about the cost of a kidney which keeps the market prices low and gives brokers more leverage in negotiation.

Illicit markets could be the consequence of the Egyptian state for three main reasons. First, the lack of legislative and medical consensus on cadaveric organ transplantation promotes reliance on unrelated, desperate kidney vendors who are targeted due to their extreme poverty. The design of the welfare state is such that migrants remain excluded from any form of formal welfare or

social protection meaning that their reliance on informal markets increases as does the likelihood of illicit activity as an alternative source of income. Third, the UNHCR and other aid organizations implicitly exacerbate segmentation of the Sudanese by clustering them in specific zones of Cairo where they are not only more easily targeted, but more prone to dependency on other community members who experience equal precarity. The development of illicit markets in this context is not difficult to imagine given that the state takes a passive role in stabilizing markets, providing rights, and curbing informality.

9.3 Intentional Neglect

The interplay between the state, economy, welfare, and migration has been established and indicates that the Egyptian state has played a passive role in the regulation of migration, informality within the economy and medicine, and has done little to strengthen the social protection needed in the context of a developing. Oversight has been delegated to largely underfunded bodies that operate despite systemic issues with corruption, weak internal structure, and underfunding. The two main bodies relevant to this argument are the EMS and the UNHCR in Cairo. While seemingly unrelated, the disfunction of the EMS and UNHCR are critical to promoting illicit kidney trade in Cairo. The lack of cohesive migrant policy and ineffective case processing of the UNHCR leaves migrants at great risk for being recruited into kidney sale while the ease with which non-related transplants are approved by the EMS allows illicit kidney markets to flourish despite formal and cultural condemnations of commercial transplantation practice.

The lack of legislation since THOTA (2010) shows the low prioritization of organ transplantation in Egyptian society and politics. Despite the continuation of egregious recruitment strategies and deception, illicit organ trade has remained an embedded feature of the urban landscape which conveniently hosts large numbers of marginalized and poor individuals. The absence of a national cadaveric organ transplant program is largely due to the influence of Islam which has created notable discrepancies in both the medical community and the public attitude towards transplantation. The Sudanese are seemingly excluded from deliberations about Islam and ethical transplantation further emphasizing their status as a subordinate group in Egyptian society. However, the view of the Sudanese as an inferior group within Egyptian society and the belief that

poverty is a shameful result of one's negligence both serve to justify illicit markets for commercial kidneys.

Informal work results in low wages and precarious working conditions which drive poverty and deepen its impact. Deepened poverty is such that it affects not only the economic reality of the Sudanese, but results in negative outcomes in housing, health, and education. Segmentation processes, as discussed earlier, work to marginalize the Sudanese via geographical and cultural exclusion leading to greater reliance on individual survival strategies. These often involve borrowing money or depending on temporary informal loans from community members through which debt is accumulated. This coupled with the lack of social protection characteristic of Egypt's conservative statist regime increases vulnerability and dependency on informal networks (Jacobsen et al., 2014: 158). Thus, the structural mechanisms in Egypt create and sustain an underclass of individuals through socioeconomic marginalization and the denial of rights. They drive kidney sale via a systematic process of intentional neglect through which kidney sale becomes a last resort income supplementation measure. The structure of the Egyptian state, particularly welfare, medicine, and society, which remains heavily divided on transplantation, creates an environment of ambiguity in which the vulnerability of the Sudanese is easily exploitable.

9.4 The Cost of Selling: Impacts on Vendors

The impact of a kidney sale on sellers is significant both in the short-term and the long-run. Because the Sudanese are a highly mobile population and because studies on organ trade are fairly recent, there is a lack of studies on the long-term effects of kidney sale. However, several short-term impacts have been identified. Most notably, a deterioration in vendor health, both physical and mental, accompanies the operation (Hamdy, 2012; Budiani-Saberi & Karim, 2009; Budiani-Saberi & Mostafa, 2010). Depression, anxiety, feelings of diminished self-worth, and even suicidal tendencies among vendors have been common (Budiani-Saberi & Mostafa, 2010). There are accompanied by stigma from the local community and family often driving sellers to keep the sale a secret. The general negative view of selling one's body as *haram* creates a moral dilemma for the vendor, who is trapped between the limitations of religious orders and the realities of destitution. However, in most cases, the need for survival outweighs moral arguments against organ sale (Rothman et al.,1997).

As mentioned earlier, the money obtained from the sale is rapidly depleted since it is not invested but used for purchases or settling debts. Thus, there is very little improvement in sellers' economic situation. Instead, sellers are left weaker than before the operation and less likely to perform physically demanding labor leading to the accumulation of further debt (Cohen, 2013; Budiani-Saberi & Delmonico, 2008; Yea, 2010). The reduced capacity of sellers to work increases market dependency as well as dependency on informal relationships for support. Additionally, post-operative complications are the rule rather than the exception, especially in cases where post-operative care has been neglected. The short-term effects of kidney sale are far-reaching and drastically alter the quality of life for the vendor leading to poor socioeconomic outcomes.

10. Conclusion

This case study sought to analyze how structural mechanisms in Egypt drive kidney trade involving Sudanese migrants as well as the short-term impact that these commercial kidney sales have on the vendors. By assessing previous studies conducted on this group, it has become clear that the Sudanese in Cairo have reduced opportunity to find formal, secure employment and, as a result, often fall into debt. Males, in particular, have been the focus of this study and it has been shown that they are in fact more susceptible to recruitment for commercial kidney sale than female migrants. Further, illicit organ trade, particularly of kidneys, thrives within Egypt's climate of weak governance, fragmented medicine, and large socioeconomic inequity. The Sudanese are of particular risk due to their position on the fringes of both the economy and society. This supports previous studies that have found migrants, displaced persons, and guest workers are prime targets for recruitment (Scheper-Hughes, 2002). Recruitment strategies employed by brokers revolve around threat, deception, coercion, and even violence, emphasizing the lack of voluntariness surrounding a vendor's participation in a commercial kidney sale. Body commodification and labor commodification are complementary processes within kidney trade where humans become marketable for essential parts while reliance on the market increases. The market itself encourages such exploitation by attaching low value to sellers and, conversely, high value to buyers.

A deeper analysis of the Egyptian state reveals that there is a lack of interest and responsibility for migrant case processing. This task is given to the UNHCR which lacks the capacity to provide resettlement and support to the large influx of Sudanese claiming asylum. Therefore, many migrants remain in Cairo illegally relying on informal work and remittances to

survive. Moreover, the discrepancies between public and private clinics along with the lack of transparency characteristic of analytic labs have created the ideal environment for commercial kidney trade despite the state's legislative and moral proscription of the practice. Based on these findings, it can be concluded that kidney trade is an embedded feature of the Egyptian sociopolitical landscape. The intentional neglect of the state in regard to the Sudanese exposes the group to high risk for recruitment, yet, ironically, little is done to reduce this risk. Kidney trade is a lucrative business and the number of desperate sellers continues to rise as the pressures of globalization, rapid urbanization, and market dependency intensify.

The long-term impacts of kidney trade remain unclear and largely inferred. The difficulty of studying illicit trade, especially kidney trade, should not deter further inquiry. Growing global interconnectedness along with advancements in transplant medicine will only further stimulate the trade in human organs, for which there is burgeoning demand. This study has found that legislation has done little to prevent organ trade within Egypt, and other regions, indicating that alternative means of regulation are needed. Additionally, the lack of national organ procurement programs and cohesive discourse on transplantation within the national medical system point to pervasive disorganization.

Such conditions result in the recruitment of the most vulnerable segments of the population, especially those without legal status or entitlements. The short-term impacts of organ sale on vendors are increased fatigue, health complications, diminished ability to find or maintain work, and depression. Rapid depletion of money from the operation suggests that money is used for basic necessities and debt repayment rather than long-term investment. Thus, it can be concluded that the general short-term impact of kidney sale on vendors is a marked decrease in life quality. While the foundation of kidney trade appears to be benefit – financial gain for the seller and improved life quality for the buyer – its core is exploitative. Future research should continue to expand existing knowledge on illicit markets with the aim of understanding the mechanisms behind commercial organ sale as well as the broader ramifications of the practice.

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