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Kidneys on Sale? An Ethnography of Policy, Exchange, and Uncertainty in Iran

DISSERTATION

submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in Anthropology

by

Elham Mireshghi

Dissertation Committee:
Associate Professor Michael J. Montoya
Professor Bill Maurer
Professor Susan Greenhalgh

2016

به نام خداوند جان و خرد

To

Maman, Baba, Alireza, Hassan, Ali Sina, and Zari

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CURRICULUM VITAE

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ABSTRACT OF THE DISSERTATION

Kidneys on Sale? An Ethnography of Policy, Exchange, and Uncertainty in Iran

By

Elham Mireshghi

Doctor of Philosophy in Anthropology

University of California, Irvine, 2016

Associate Professor Michael J. Montoya, Chair

Since 1997, Iran has implemented the world's only program for living paid kidney donation. The program has been developed and administered by a non-profit NGO – the Kidney Patient Foundation (KPF). Though sanctioned by Shi'a Muslim jurists and celebrated in the West as the "Iranian Model," the program has been rife with moral unease and uncertainty in Iran. While organ donation after death is valorized, undergoing transplantation for cash is stigmatized. Furthermore, there is little agreement among policy actors that facilitating paid organ giving is a good idea. In this dissertation, I examine kidney "selling" both at the level of the exchange – where I analyze the experiences of kidney givers and recipients – and at the level of institutional and bureaucratic process, legal and scientific reasoning, and practical and ethical negotiation, to explain how Iran came to uniquely sanction and bureaucratically routinize kidney selling. I disentangle the dense threads of moral reasoning and experience among a range of actors - from donors and recipients to doctors, policy activists, and Islamic jurists – that undergird the policy's development and implementation. I have conducted ethnographic field

research (2011-2013), including observation inside medical and Islamic institutions in Tehran and Qom, and indepth interviews of kidney givers and patients, KPF personnel, doctors and legal scholars and jurists. I have also analyzed Islamic legal texts, as well as visual and textual media.

My analysis brings together analytic approaches within the anthropology of public policy, medicine, morality, and exchange, while also contributing to a growing interest in Iranian Studies to venture beyond themes of repression and resistance. I consider Iran's living kidney giving program within the context of Iran's post-revolution medical modernization projects, its haphazard economic liberalization, and ongoing commitment to social welfare, alongside an examination of the role of Islamic jurists and other "experts" in policy making. I elucidate the socio-economic conditions and aspirations that motivate kidney givers, and the "medical imaginary" that facilitates their decision as well as the legal reasoning of jurists. Lastly, I offer an alternative to the "commodity paradigm" in examining exchanges involving money that can contribute to bioethical discussions of organ sales.

Chapter 1: Introduction

A Transplant

August 2013: Teaching hospital in Tehran. Inside the operating room.

7:45 am. The kidney donor lays awake on the operating bed, undressed and beneath a green sterile sheet. I intermittently record his rapidly changing pulse: 100, 105, 112. I stand in a corner of the room wearing green scrubs, white plastic slippers, a green *maghna'e* headscarf, and a surgical face mask. I scrupulously avoid brushing against any sterile equipment as I jot down notes in my journal. The room is abuzz with the surgical team chatting and stepping in and out of the room. A technician casually places a bag on the donor's chest. His pulse rises: 97, 108. A male resident surgeon examines x-ray images of the donor's kidneys. "We'll be removing the left kidney," he exclaims.

7:53 am. The team prepares the young man for sedation. The male anesthesiologist stands behind his head, asks if he knows of any drug allergies. "I had a surgery ten years ago" he mutters. His pulse rises: 126, 133, 135. "[Are you] a relative (*famil*) or a stranger (*ghareebe*)?" asks the resident surgeon. "Stranger," he whispers back. My heart races.

An anesthesia mask is placed over the donor's mouth and nose. "Breathe." His head shifts to the left, then to the right. His pulse is 117. He's unconscious.

7:59 am. The sheet is lifted from his lower body. He's already shaven from the abdomen to the knee. His groin is then covered with a folded sheet. His eyelids are taped down. Another sheet is placed vertically over the donor's chest so that his face is only visible to the anesthesiologist. A catheter is quickly inserted into his penis. There's profuse bleeding.

Three personnel reposition the donor and secure him onto the bed, exposing his left side and groin.

8:05 am. Two large projectors beam over his abdomen. I feel warm, especially as I breathe into a dampened mask. Medical students organize the equipment as a female nurse rubs dark yellow, and then red antiseptic fluids on his exposed skin. I stare at the dark mixture dripping down his abdomen. Someone in the room turns to me. “Don’t write something so they make fun of us. We work based on intention (*niyyat*),” he jokes. “When your intention is good, everything stays sterile!”

8:15 am. They poke and prod the operating site clearly demarcated with folded sheets. I hear a buzzing sound as the resident surgeon makes an incision with an electrical surgical knife. I can smell burnt skin. Someone mentions the donor is 22 years old. My heart races again.

I step closer to the bed. I see red and pink flesh and small pebbles of fat where the incision is made. “Don’t let go, see how I do it, alright?” instructs the resident. They use a steel retractor to hold back the skin and muscle. His pulse is 90. His unconscious body jerks.

8:20 am. One of the attending surgeons walks in. “Has the [piece of the] rib (*dande*) been removed?” he asks. “Not yet, professor.” I hear a buzzing sound and smell a familiar odor. It smells like a dental office when a tooth is shaved. The buzz grows louder and the smell more intense. The resident surgeon hooks his pointing finger beneath the rib as he continues cutting the bone. They press and pull and finally remove about three inches of the rib and place it in a stainless steel tub. “What should I do with this *doktor*?” asks a medical student. “If you’d like to make a stew with it, keep it,” jokes the resident surgeon

calmly. Someone facetiously mutters, "I think the patient is awake!" His pulse has risen to 107. The anesthesiologist injects an anesthetic. His pulse drops: 95, 92, 91, 87, 85, 82.

8:35 am. The resident digs deeper in the abdominal cavity with his fingers. His gloves are covered with blood. He holds back muscle and skin with four fingers. He strains and breathes deeply. He inserts his entire hand inside. What was once a small incision is pulled open with a retractor into a wide cavity that could fit two fists. I catch a glimpse of the intestine. My upper back begins to ache from standing.

"Is he slender or fat" asks the attending surgeon from a corner of the room. "He's alright."

8:47 am. Another attending surgeon walks into the room. He washes and dries his hands. A medical student assists him with his gown and gloves. He offers me a closer look. I stand on a stool right above the donor's head. The left kidney is finally dislodged, but still connected by the ureter. The surgeon cradles the kidney in his hands. It pulsates as the resident begins to cut it loose. The renal artery, vein, and ureter are meticulously severed and then closed off with white staples. The organ is inert, without life.

8:58 am. "Is the ice ready?" asks the attending surgeon. He carefully lays the kidney in a tub full of ice. He fastidiously prepares the organ for transplantation. He injects the vessels and ureter with a syringe to flush out their vascular content and to lower the organ's temperature. The ice turns red.

The resident surgeon sutures the donor. His pulse is 94. The chief surgeon transports the tub containing the kidney next door where the recipient lays unconscious and ready for implantation. Minutes later I follow him.

9:15 am. The recipient, a frail young woman lays with a vertical opening on the right side of her abdomen. I notice a very thin layer of fat beneath her skin. Her fingers are long and pale. Her pulse is 79. The sound of a suction reverberates through the room. Blood flows into a cylindrical container hanging from a contraption with a dial. The resident surgeon is a woman wearing heeled slippers. She stands on a stool, her neck bent over the recipient. I'm tired and feel as though I'm melting into the noticeable calm in the room. Time passes by. The room is covered with green tiles. It is spotless.

9:51 am. The female surgeon pours a fluid in the abdominal cavity and then suctions it out. Several bloody gauze strips hang from a steel rod. I step closer to the recipient as the resident surgeon delicately sutures the donor's abdomen closed. I've lost track of the kidney being implanted... I admire the stitches extending down to the pubic area. They are beautiful--straight and evenly-spaced. They check the flow of urine in the catheter. Yellow fluid streams through. "*Alhmdullilah* (thank god)," reverberates through the room.

Someone covers the stitches with gauze. They remove the tape over her eyelids. They call her name three times. She tilts her head. "Open your eyes, your kidney is well."

Background: Regulating Kidney Sales

Kidneys are sold in Iran. In fact among all countries that have laws governing transplantation, Iran is the only country where it is legal to do so. Since 1997, the religiously sanctioned exchange of a kidney for cash has been regulated and bureaucratized. When the 22 year old donor above meekly whispered to the surgeon that

he was a “stranger” and not a relative, he was in fact declaring that he was a kidney seller. He would be one among over two thousand young men and women that year paid to undergo a nephrectomy at a public hospital. Though the financial component of the exchange does embarrass most, there would not be a legal need to conceal it from hospital staff. In fact the hospital would require an official letter from the organization administering the donor-recipient matching to declare the nature of the exchange and ensure compliance with official regulations. The letter would also allow the teaching hospital to perform the transplantation free of charge to both the recipient and donor.

Since 2011, I have been researching this phenomenon, both at the level of policy development and the level of experience and ethical deliberation. What follows is the culmination of my efforts to apply ethnographic research and anthropological analysis to understand how Iran came to uniquely sanction and bureaucratically routinize kidney selling. Moreover, I disentangle the dense threads of moral reasoning and experience among a range of actors - from donors and recipients to doctors, policy activists, and Islamic jurists – that undergird the policy’s development and implementation.

In 1987, Dr. Naser Simforoosh performed a kidney transplant between a husband and wife. It was the first time in Iran that a transplant took place between individuals unrelated through blood. Careful tissue-typing that reduces the incompatibility between donor and recipient, as well as the development of pharmacological immunosuppression that suppresses the body’s natural ability to attack and rapidly reject a foreign organ made it possible to transplant body parts from unrelated donors. Since then, and with the

regulation of living unrelated organ donation, over two thousand kidneys are transplanted every year.

Dr. Simforoosh, who has become a formidable figure and pioneer in urology, is a devout man, ideologically aligned with the Islamic Republic. He completed his residency in Chicago's Mt. Sinai Hospital and returned to Iran in 1981-- just at the onset of the Islamic Revolution and the Iraq-Iran war (1980-88). He soon founded both a urology (1981) and a kidney transplant ward (1982) at a university hospital in Tehran, and has since then become a full professor, authored a textbook on urology, made innovations in laparoscopic renal surgery, published over one hundred medical papers and won a national "Gold Medal of Knowledge" (2004), earning him the grand title of the "pole of urology" (*qotb-e oroloji*). He has also become a critical figure in shaping the direction of transplantation in Iran.

During the years of Simforoosh's tenure, advancements in kidney transplantation, and subsequently transplantation of other organs have become an important medical feat, alongside other invasive biotechnological procedures that have positioned Iran at the forefront of high-technology medical research and practice (Inhorn 2009; Saniei 2012; Tremayne 2015). It has occasioned an international presence for Iran as a model for high graft survival rates, and importantly, the regulation of donor-recipient matching between strangers. In this way it has also advanced the revolutionary republic in its ambitions for international renown. The development of an advanced national program for organ transplantation has also fulfilled a crucial domestic need as the number of renal patients grew. During the eight-year war with Iraq (1980-88) battle injuries and chemical warfare exposure left many soldiers with kidney failure. In more recent years the two leading

causes of kidney disease, hypertension and diabetes have been on the rise and have been attributed to stress and poor dietary habits typical of developing nations (Hamer and Nahas 2006). Rather than sending patients to foreign countries such as Germany and England for expensive transplantations, as was the case in the early years of the revolution, the procedure could be performed with an impressive success rate at university hospitals in larger cities across the country.

However, the rapid advancements in renal surgical procedures and tissue-typing rested on the existence of willing kidney donors. When in the late 1980s kidney transplantation between strangers became possible, those unable or unwilling to request an organ from a family member looked to willing strangers who would consider giving one of their kidneys in exchange for an affordable fee. But the desperation of patients, many of whom belonged to lower income families, coupled with the unpredictable and at times steep demands of individuals willing to donate, gave rise to what Iranians have called a “market” (*bazaar*) for kidneys (though it is arguable to what extent this sphere of exchange complied with the strictures of a commodity market). To accommodate kidney patients who were struggling under the crippling conditions of dialysis treatment, unemployment, and financial scarcity, a nonprofit-organization called the Kidney Patient Foundation stepped in to regulate payment. The accomplishments of Dr. Simforoosh and countless other renowned medical scientists and practitioners would not have materialized without the interventions of this essential non-governmental organization.

The Kidney Patient Foundation (KPF), a non-profit NGO was founded in 1980 in Tehran, gradually expanding to over 120 offices across the country. Despite its legal and

financial independence from the state, the KPF has played a critical role in forming and implementing policies for kidney patients recognized by the Ministry of Health and Medical Education (MOHME). What is today a deeply entrenched and indispensable institution was at first a patient support group made up of dialysis and transplant patients who shared their experiences and know-how with new members. The group was spearheaded by a newspaper journalist, Mr. Zahedi¹ who was himself twice a transplant recipient. Gradually the group grew into an active advocacy NGO run by numerous volunteers (many of whom were kidney patients), employed staff members, and many nephrologists and urologists who provide services to thousands of patients with kidney disease. With the active participation of prominent medical doctors and the relentless advocacy efforts of Mr. Zahedi, the KPF has garnered significant clout to lobby the government for medical services. For example, the KPF advocated for kidney disease to gain the official status of a “special” disease (*bimariy-e khass*), alongside other chronic conditions like thalassemia and hemophilia, which would funnel a significant number of subsidized health services to kidney patients. Not only would the transplant be fully paid by the state, but all medications directly related to renal disease would be offered to patients free of charge.

In the early 1990s, when many kidney patients in need of a transplant struggled to pay willing donors, the KPF advocated for the state to step in and mitigate expenses. In 1997, MOHME agreed to allocate a budget to award each kidney donor a fixed amount of one million tomans, which in light of soaring inflation rates has significantly depreciated in value. This means that patients have to make a much greater contribution to supplement the donor’s payment, an amount that is officially declared by the KPF. To garner interest in

¹ I have chosen a pseudonym for the director of the KPF to protect his privacy.

donation and yet maintain the affordability of transplantation for a larger swath of the population, the KPF announces a rate every year that rises with inflation, increasing from less than a million tomans in the late 1990s to 15 million as of 2015. Of course, it is not unlikely that more money will be exchanged in individual cases, an issue that I will address in depth in subsequent chapters.

The KPF has also advocated for other procedures and regulatory measures that primarily aid kidney patients, while also accounting (many would say insufficiently) for the welfare of donors. For example, to prevent organ trafficking, donors and recipients are required by MOHME policy to be of the same nationality. All foreigners seeking a transplant in Iran must be accompanied by a donor with shared national citizenship. A patient from Saudi Arabia, for example could only receive a transplant from someone with Saudi Arabian nationality, while an Iranian residing outside of Iran can travel to Iran to receive an organ from a fellow Iranian. This also means that Iranians can neither donate to nor receive organs from Afghan immigrants that constitute a majority of over two million refugees in the country. Other measures grant organ donors free health check-ups up to one year after surgery, and exempt male donors from military service. In turn, kidney donors must meet certain requirements: donors, who can be male or female, must be between the ages of 20 and 40, and have spousal or parental consent. Both male and female donors must submit a notarized signature by their spouse, or in the case of unmarried donors, a signature from their fathers. Paid donors are also not allowed to have patients with end-stage kidney disease in their immediate family, a measure meant to encourage family members to reserve their healthy kidneys for potential donation to blood relatives. Furthermore, all donors must undergo extensive medical examinations, which include among others, testing

for HIV, Hepatitis B and C, as well as undergoing a kidney sonogram and a CT angiography that determine the organ's anatomical and vascular normality. Lastly, all donors and recipients must be matched through the KPF waiting list. If a potential donor opts out after being matched, then he or she can no longer re-enter the donor list – all requirements that aim to prevent potential donors from seeking the most lucrative exchange.

The culmination of these regulations has resulted in a much shorter wait for kidney transplants in Iran than is the case in, for example, the United States, where paid donation is prohibited and most organs from unrelated donors come from cadavers and brain-dead individuals. This has often been touted as one of the most important outcomes of permitting kidney sales. In the US, if one does not find a donor among family or friends or an “altruist” living stranger, then the wait can take nearly four if not more years.² In Iran, the wait can be a little over a year, if not less; though celebratory reports on what is now called the “Iranian Model” often claim that there is no waiting list at all (e.g., Ghods and Savaj 2006). If a patient chooses non-living donation, then much like the US the wait can take much longer than a year. This would be the case for those who could not afford the payment, and those who would not accept an organ from a living person on moral grounds. As one young female patient from an affluent family who lost function in both kidneys during her pregnancy exclaimed, “I could never take something so precious from someone who has yet to appreciate its worth.” These patients have to wait for individual hospitals to identify a cadaver, or usually in Iran, a brain-dead organ donor, a process that can be unpredictable and time consuming. Despite MOHME and KPF's impressive and ongoing campaign for promoting brain-death organ donation that has resulted in massive

² For full statistics on organ donation and transplantation in the United States, see: <https://www.kidney.org/news/newsroom/factsheets/Organ-Donation-and-Transplantation-Stats>

popularity, the lack of centralization and effective routinization of the process thus far has meant that living unrelated donors are still the primary sources for kidneys.

The routinization of organ transplantation, including the exchange of money would not have been possible without the approval of Islamic legal authorities. Since the Islamization of the public sphere and the institutionalization of jurisprudence after the Islamic Revolution (1979), Shi'a Islamic jurists have played a critical role in paving the way for the normalization and legitimization of various biomedical interventions, such as in-vitro fertilization, sex-change operations, and so on. Likewise, to preempt ethically grounded disruptive measures by policy actors, in the routinization of transplantation and its attending practices (such as paid donation) members of the KPF sought fatwas from high ranking Shi'a jurists. By the 1990s, after a process of debate and deliberation a majority of these jurists opined that Islamic law allowed transplantation as well as the exchange of monetary payment.³

The regulation of these monetized donations has had important ramifications: it has made the transplant process transparent and routine; surgeries are performed free of charge within well-equipped public hospitals; exchanged payments remain within a range not too far in excess of permitted amounts; transplant remains affordable for a large segment of the population; and most importantly, organ trafficking involving non-Iranian donors and recipients is largely prevented. Nevertheless, this does not mean that what is exchanged between donor and recipient – what is lost and what is gained – is always fair. In fact, the so called Iranian Model is mired with moral anxiety, such that the very people who

³ By the late 1990s, brain-death was accepted by a most jurists as “real death,” making the passing of parliamentary law (2002) allowing organ removal from brain-dead patients legally permissible.

have advocated for its implementation have chosen to keep it largely outside the realm of public moral scrutiny.

Questions, Approaches, and Anthropological Engagements

This dissertation is about a public policy and the controversial exchange it fosters in Iran. The exchange is of “problem-solutions” mediated by kidneys and cash – of patients wanting to overcome a problem of disease and impairment in exchange for relieving a problem of financial distress. It is also about the formation of medical policy amidst moral uncertainty and incoherence, and the emergence of moral reasons amidst bureaucratic strictures. In this dissertation, I examine kidney selling both at the level of the exchange – where I analyze the experiences of kidney givers and recipients – and at the level of institutional and bureaucratic process, legal and scientific reasoning, and practical and ethical negotiation. The inquiry is guided generally by an interest in understanding the following questions: How did Iran come to be the only country to permit and regulate paid kidney giving? How did Shi’a jurists come to be the only religious figures to sanction organ “sales”? How has the policy been sustained despite widespread moral tensions and in the absence of a cohesive moral justification? Moreover, what are the motivations, rationalizations, and moral sensibilities that guide and shape people’s experience of giving a kidney for cash? And lastly, is this exchange like a commodity sale?

The research is based on over twenty months of ethnography between 2011 and 2013⁴ that included in-depth fieldwork at the KPF, operating rooms where I observed

⁴ Archival and media research conducted since 2013 has also importantly contributed to this research.

kidney transplants, dialysis wards, and research centers in Qom where I spoke with influential jurists to understand the formation of fatwas permitting organ sales. I further interviewed patient advocates, nephrologists, urologists, and social workers, as well as young aspiring middle class men and women seeking to sell their kidneys. I also incorporated textual and visual analysis of Islamic legal texts, Iranian medical journals, health magazines, newspaper articles and cartoons, as well as films and television serials. My analysis draws on scholarship in the anthropology of public policy, the anthropology of transplantation, morality and everyday ethics, as well as economic anthropological engagements with exchange and commodification.

Anthropological engagements with public policy are of two kinds: those that primarily study policy impacts and those that take policy formation as their object of analysis. In the first mode, anthropologists have contributed to policy research by documenting the failures and unintended effects of social policies implemented by local governments, international institutions, and non-profit organizations (Dalla Costa and Dalla Costa 1995; Mullings 1995). Notable ethnographies have charted the new subjectivities and even biologies produced by public policies, particularly as modern medical conglomerates increasingly whirl the wheel of biopolitical governance (Foucault 1990) (see Briggs and Briggs 2004; Petryna 2004; Nguyen 2004).⁵

In the second mode, policy itself, and not only the consequences of its implementation, takes center-stage as anthropologists unravel the politics and mechanisms

⁵ For example, Adriana Petryna (2004) shows how Ukraine's political attempts to identify and quantify the effects of radiation in the aftermath of the Chernobyl disaster gave rise to a 'biological citizenship' as radiation exposed citizens self-identified as 'sufferers' and made demands on the state for financial and medical retribution. Vinh-Kim Nguyen (2004) advances the concept of 'therapeutic citizenship' as a form of biopolitical citizenship to draw attention to the congeries of therapeutic technologies, knowledges, practices and politics that construct treatment options, systems of claims to therapy and individual subjectivities (see also Briggs and Briggs 2004 on "sanitary citizenship": 10)

of policy production and unearth the multi-layered, contingent, and often messy networks, and the authoritative and partial knowledges that bring policies into being (Shore and Wright 1997, Greenhalgh 2005, 2008; Shore et al. 2011, Wedel 2011). This new mode of engagement with policy draws heavily on Foucault's concept of governmentality (Foucault 1991a) and notion of power as diffuse and decentralized. Rather than taking policy as an objective entity, this analytic approach treats it as a *process* by which a constellation of elements are linked and come into relations of coproduction (Nielson 2011). As Cris Shore and Susan Wright state, policy in this way is treated as "a social and political space articulated through relations of power and systems of governance" (1997: 14). And so policy is investigated through the series of relations that constitute it and the "assemblage" of "heterogeneous, often incommensurate elements that come together for a period of time" that brings together ethics and values, knowledges and discourses, policymaking procedures and practices, formal and informal institutions and political actors (Greenhalgh 2008: 13).⁶

It is in this second mode that I approach my examination of Iran's policy for paid kidney donation. Rather than focus narrowly on evaluating the consequences of the policy, I analyze the non-linear and ad hoc processes by which the policy itself was imagined as a problem solution, and concretized and sustained through everyday practices within and outside the bureaucratic space of the KPF. The assemblage of policy elements that figure into my analysis include: key policy actors and "experts," such as the director and social worker of the KPF, Islamic scholars, and medical doctors; institutions such as the KPF,

⁶ A popular term for this assemblage that makes a policy situation possible is Foucault's "dispositif" or "apparatus" (Dreyfus and Rabinow 1983: 121; Rabinow 2003: 50-51). See for example, Gregory Feldman (2011), and Birgit Muller (2011).

hospitals, and Islamic research centers; bureaucratic spaces and objects, operating rooms, urban streets and building surfaces where kidney advertisements are inscribed; technical knowledges of medicine and Islamic jurisprudence; and importantly, the moral discourses including both Islamic and bioethical; and everyday ethical deliberations and contestations that both enable and challenge the policy's existence.

In this dissertation, moral encounters with the exchange of an organ for cash make up an important component of the analysis. I treat the ethical deliberations of policy actors, their unwritten moral assumptions and sensibilities, as well as the moral paradigm in which the exchange is imagined and lived by kidney givers and recipient-patients as formative of the policy's constitution and performance. Anthropologists have shown how particular "problematizations" – the discursive and non-discursive practices that constitute something as an object of thought (Foucault 1989; see also Dean 1999:27)⁷ – are both enabled and enabling of certain moral perspectives. Gregory Feldman shows how a citizenship policy in Estonia that marginalized half a million Russian speakers was rendered moral and pragmatic by the problematization of minorities as potential threats to the sovereignty of the nation state (2005). Susan Greenhalgh thoroughly demonstrates how China's One Child policy was rationalized and moralized once it was cast as a modern and scientific solution to economic sluggishness and "backwardness" (2008). James Ferguson (1990) and David Mosse (2005) also show how different problematizations in the policy context construct the moral and the "real."

⁷ Susan Greenhalgh adopts the phrase "policy problematization" more concretely in reference to the three-part policy process of: the formulation of a problem, development of a solution, and the evaluation of the costs and benefits of the imagined response (2008: 10).

Examining the moral dimension of paid kidney giving in the Iranian context is tricky, especially from a policy perspective. This is primarily because of the relative invisibility of the program to the general public, and the opacity of its constitutive components even to policy actors. This makes it difficult to discover the problematization underlying the policy. Though it is widely known that kidneys are sold in Iran, a fact that regularly surfaces in alarmist newspaper articles and in television dramas, the way in which it is regulated and effectively legitimized by the state through the administration of the KPF is unbeknownst to most. During the course of my research, I was shocked to find that even Islamic jurists held a hazy idea of the role of the KPF in monetizing kidney giving, despite the fact that most high-ranking jurists have issued fatwas on the matter. Similarly, the public, as well as administrators and medical doctors affiliated with the KPF are largely unaware that the issue has been taken up by jurists, and that fatwas explicitly permit the “selling” (*forush*) of kidneys. So unlike Iran’s brain-death organ donation program that has relied on an extensive and ongoing public discussion on the medical nature of brain-death and its status in Islamic law, and has been actively advocated in the media, the act of selling kidneys remains on the margins of public discourse. Even policy documents do not directly address the issue of sales. When some form of compensation is referenced, often it is the words “award” or “gift” that are invoked. In fact the Islamic legal literature is the only place where kidney “selling” is directly and unequivocally addressed, albeit as a technical legal matter. But even there, discussions of organ selling are marginal to discussions of brain death and transplantation in general.⁸

⁸ I also found that individual’s moral positions towards kidney sales were variable and strongly influenced by their personal encounters, observations, and experiences. So a family member of a dialysis patient was much

In short there are no cohesive formal moral justifications or rationalizations of financially incentivizing kidney giving. Although problematizations do exist, they are fragmented, contextually-specific, and do not add up to a cohesive whole. In light of the morally tenuous nature of the program, and the absence of a formally articulated ethical position on the matter, I find that a processual approach to capturing emergent everyday “moral processes” (Kleinman 1998; see also Brodwin (2013) on “everyday ethics”) is critical to demonstrating the tentativeness and contingency of the moral stakes that both render the policy viable and yet challenge its existence in myriad ways. How do these moral processes hinge on the encounters and “lived experiences” (Kleinman 1998; Biehl et al. 2007 ; Kleinman and Fitz-Henry 2007: 52) pertinent to transplantation? How are they restricted and enabled by bureaucratic and institutional strictures?

Examining moral processes in conjunction with the development and implementation of policy offers a fresh perspective on anthropological engagements with organ transplantation. Since transplantation became a routine medical procedure, anthropologists have rigorously studied its social and ethical ramifications, and the ways in which the substitution of an organ with that of another living or dead person (or animal) tests multiple boundaries of self and other, subject and object, nature and culture, and life and death (Fox and Swazey 1992; Ohnuki-Tierney 1994; Joralemon 1995; Sharp 1995; Hogle 1999; Sharp 2000; Lock 2001; Cohen 2003; Lock 2003; Scheper-Hughes 2003; Sharp 2007). But when it comes to assessing policies regulating transplantation, the literature has largely adopted the first approach mentioned above to studying policy, in that the policy is

more likely to condone kidney sales than an employer who could imagine his worker as one day considering the exchange.

taken for granted, and what is evaluated is the aftermath of the policy – the consequences and shortcomings of its implementation.

For example, Lawrence Cohen (1999, 2003, 2005) demonstrates how India's transplant law allowing non-related kidney donation only in exceptional circumstances fails to impede kidney sales, since the exception has effectively become the norm, where organ sellers are presented as altruist donors to administrators who choose to turn a blind eye to the exchange. Similarly, Nancy Scheper-Hughes (2003) and Monir Moniruzzaman (2006) show the failures of international and local laws against organ sales in their elaborate ethnographic accounts of global organ-trafficking. Scheper-Hughes (2003) follows the path of organs across countries such as Moldova, India, Romania, Brazil and South Africa, where the impoverished fall prey to organ brokers who circumvent local regulations and persuade them to supply their kidneys to wealthy patients. Cohen (2005) describes such organ sellers as "operable" and "bioavailable" and their recipient counterparts as "supplementable" subjects. Likewise, Moniruzzaman (2006) exposes the dark underbelly of kidney transplantation in Bangladesh, where he claims illegal organ sales inflict violence against impoverished sellers, effectively rendering them "living cadavers."

While powerfully exposing a grim reality often obscured from the view of medicine in the West, this body of literature has the effect of either casting the perpetration of violence and exploitation against the poor as a problem of corruption or as a matter inherent to a transplant technology animated by neoliberal logics. In the former case, corruption among medical doctors, administrators, and organ brokers, and the failures to adequately implement prohibitive laws is to blame. In the latter, exploitation becomes an

unintended but inevitable and inherent component of a biomedical intervention that has produced a desire, if not need for the body parts of others, and of a neoliberal logic that imposes a market ideology on biotechnological practices of healing (Sunder-Rajan 2006; Everett 2007). As other anthropologists have argued, this is made possible by a tendency in biomedicine (rooted in a Cartesian mind/body, subject/object dualism) to objectify and fragment the human body so that it can be flexibly made available for manipulation (Fox and Swazey 1992; Lock 2001).

In these analyses, then, we have a number of “logics” interlocking to form an inflexible system inexorably generating violence and exploitation: there is first the logic of transplant technology itself with its tendency toward objectifying and fragmenting the body; then there is the neoliberal logic of instrumental calculability and profit-maximization that exploits the poor and renders their bodies alienable on a global market; and finally there is the impersonal, efficiency-obsessed but corruption-prone logic of state bureaucracies which reduces the disadvantaged to cogs in the state machinery. If moral thinking enters this picture at all, it is in the critical anthropological intervention of exposing and deconstructing these logics, perhaps calling for something else to take their place.

A processual approach that takes moral reasoning on the part of policy actors seriously, as I accomplish in this dissertation, has the advantage of showing the contingency of all such mechanisms. Transplant actors are no longer reduced to being either the unthinking servants of biotechnological objectification or the calculating agents of neoliberal and bureaucratic rationality. They come into view as simultaneously calculating *and* moral, as subjects placed within structures that are larger than themselves

and agents who are capable of reasoning, initiative, and transformative action. The transplant “logic” then loses its inexorability and becomes one contingent possibility among others in an open future. This is so particularly because a processual approach can capture change and the emergence of new moral sensibilities as actors encounter new events.

In the chapters that follow, I expand this processual approach to an investigation beyond the formation of the policy and the moral processes of policy actors, to the exchange between kidney giver and patient and the “intersubjective” (Husserl 1999) experiences it occasions.⁹ Anthropologists of transplantation have analyzed how the intersubjective experiences surrounding the transplant procedure are fluid and shift through time (Sharp 2001, 2006). Lesley Sharp reveals the shifting experiences of the self in relation to the donated organ of the deceased throughout the various stages, events, and encounters involved in a transplantation (1995; see also Sharp 2001). Anthropologists have also shown how their moral consequences can vary from one society to another (Ohnuki-Tierny 1994; Lock 2001; Sanal 2011; Hamdy 2013; Crowley-Matoka 2016). For example, while brain-death has been largely accepted as real death in North America, Emiko Ohnuki-Tierny (1994) and Margaret Lock (2001) show how widespread attitudes towards the constitution of personhood and its relationship to the body, as well as an understanding of death as a socially determined event have made brain-death organ donation unpopular in Japan. However, when it comes to transplantation procedures that

⁹ For more on “intersubjective experience” in anthropology see Good et al. 1992, Kleinman & Fitz-Henry 2007, and Lock and Farquhar 2007.

involve the transfer of payment, attention to process is lost and every exchange is reduced to ostensibly universal market logics and mechanisms.

In this dissertation, by a processual approach to exchange, I mean treating the giving of a kidney for cash as a temporally extended process that begins before the event of the transplantation and beyond the transfer of money. That is, the exchange is not collapsed into a single moment when a payment or agreement for a payment is made. This method allows us to comprehend the myriad contingencies that affect the nature of the exchange and the moral outcomes associated with them. In the fourth chapter, I offer an extensive critical analysis of how the gift-commodity binary has been taken up in anthropological investigations of bodily exchange, and how a processual approach can offer an alternative to theories of commodification (e.g. Sahlin 1972; Gregory 1980, 1982; Hyde 1983; Appadurai 1986; Parry 1986; Carrier 1990, 1991; Thomas 1991; Weiner 1992; Weiss 1997), even when monetary payment is involved. A critical advantage of this approach is that it enables sensitivity to context-specific attitudes and sensibilities towards the process of transplantation, commodities, and market exchange that may depend on a host of social, religious, and economic factors. In a parallel way to the processual analysis of policy formation, this approach to exchange questions the inexorability of the commodity “logic” of alienation, objectification, and exploitation that dominates analyses where the sale of body parts is concerned, rendering such commodification as one possible outcome among other modalities of exchange.

In the section that follows, I explain the emergence and development of my research questions and methods, as well as the conditions of possibility that allowed the research to take on its present form.

People, Places, and Methods

The seed of this research was sown upon my encounter with a documentary film – “Iran Kidney Sale,” made by the Swedish-Iranian filmmaker, Nima Sarvestani. In the years after its release (2006) it was frequently watched and shared by many who understood it as demonstrating Iran’s social and economic deterioration as it was believed to reveal how the so called “children of the Revolution” were compelled to sell their body parts to survive. The film closely follows both kidney sellers and buyer-patients through the process of matching at the KPF, meeting in person, negotiating payment, and undergoing transplant surgery. One character is a young divorced woman who needs to pay back private loans and support her sisters. Another is a 23 year old man, married and recently unemployed who cannot afford to maintain a respectable livelihood in the capital. In the film the words “buying,” “selling,” and “price” are pronounced anxiously alongside “donation” and “gifting.” Within the bureaucratic space, the monetization of the exchange appears mundane and routine, and yet the anxiety it instills in the sellers is apparent. While the female seller clearly states her lack of benevolent intentions, the young man eventually builds a strong friendship with his 27 year old female recipient who like him comes from a family of humble means.

This documentary was my first exposure to kidney sales in Iran. By the end of the film, I was overwhelmed with a conflicted visceral reaction, which was at once that of sorrowful revulsion and intrigued empathy. What was so unfavorable about a person receiving payment for giving an organ that could drastically improve the life of another person? Did it matter that an affectionate bond could be built between donor and recipient?

Did it matter that the donor was compelled by financial need? How about the recipient's conditions of severe physical and even financial distress? Was this exchange really a "sale"?

In 2008 I embarked on preliminary research in Tehran to investigate kidney selling. Who were the kidney sellers? Why was Iran the only country allowing it? What did the process entail? I visited the central office of the KPF, the same location that was depicted in the documentary film. Not all the same people still worked there. On the first day, I walked up the stairs and entered the social worker's office. A nearly 50 year old woman who had taken the position shortly after the recording of the film greeted me. She received me with the same stern incredulity with which she approached other visitors, but one that was coupled with curiosity and intrigue. Weeks later I gained permission from the director of the organization, Mr. Zahedi to observe and ask questions.

In the months and years that followed, my continuous presence in the KPF office as a researcher became a means through which the social worker could actively engage her own ethical questions, reactions, and theories. Our relationship developed into an intellectual partnership where we reflected on our encounters with potential kidney sellers and patients, as well as our own experiences and findings outside the walls of the organization. Similarly, the KPF director willingly participated in numerous interviews, where I not only inquired about the history, policies, and day-to-day activities of the organization, but also candidly expressed my always evolving reactions to what I observed.

Mr. Zahedi had grown despondent over reactions to the documentary film. He had allowed the filmmaker unfettered access to an organization he was profoundly proud of. But the questions the film had elicited from Iranian transplant surgeons and other medical professionals were troubling. Was the KPF really fostering a "market" for human kidneys?

Was the organization a glorified, bureaucratic meat shop, they had asked. Mr. Zahedi hoped that I would not betray his trust, and that I would tell the “story as it really was.” To that end, he generously facilitated my research. He often shared contact information of key policy actors, such as transplant surgeons and KPF personnel, and made personal phone calls that made the hump of first encounters surmountable. He also allowed me continued access over the years, even though he was aware of my apprehensions about the paid donation program. It is no wonder that the KPF became the locus of my ethnographic research. It was not only where I could meet kidney sellers and patients, and observe their interactions with one another and with KPF personnel, as well as gather critical information on the implementation and development of the policy, but it was also where I could share and partially test my emerging ideas about various aspects of kidney selling with the very people who were involved in its actualization.

The rapport I was able to build with the director of the KPF as well as with transplant surgeons allowed me the opportunity to expand my research into three public research hospitals in Tehran. I spent multiple sessions inside dialysis wards where I observed and interviewed patients in attempts to comprehend the at once corporeal, emotional, and very social component of undergoing treatment: spending over twelve hours a week depleted of strength and connected by needles and tubes to a blood filtering machine – some old, faulty, and weak, some new and efficient – while being nursed by medical staff – some wise and judicious in their demeanors, calm and yet spirited, others rigid, technical, and aloof. I also spent hours in hospital courtyards where children chased pigeons in the gardens, in marble hallways where the sick were guided into examination and lab rooms, and in waiting rooms where restless families nervously thumbed through

prayer beads. I also observed two transplant surgeries between living strangers from inside the operating room. Though not every component of these observations have in their specificity been central to my analysis in the chapters to come, they have informed my inquiry in general, as they constituted an important part of the assemblage of spaces, technologies, corporeal and affective experiences, and other human and non-human factors that shaped, enabled, and limited Iran's living donor transplantation program.

Since the policy relied on fatwas by notable Shi'a jurists as a mechanism for garnering ethical legitimacy and impeding serious disruptions to its implementation, I attempted to understand not only the legal reasoning behind the fatwas, but to unravel the circumstances, events, and assumptions that made this reasoning possible. I began by studying the text of the fatwas as well as various Islamic legal discussions of transplantation published in various journals and websites of the *howza* seminaries. I also familiarized myself with basic methods and principles in Shi'a jurisprudence to decipher the mechanisms through which the fatwas had been formed. This is of course the typical approach adopted by scholars of Islam, to explain fatwas through jurisprudential rationality as conveyed in texts. However, I was also interested in the "micro-politics" of the making of the fatwas – that is, the formal and informal processes, the enabling discourses and framings of the problem, as well as the pragmatic institutional factors that contributed to the jurists' opinions. To achieve this, I traced a portion of the exchanges between the KPF and jurists, and then visited research centers in Qom to speak to legal scholars, seminary students, and jurists. My visits were made possible by relationships I had forged with former seminary students who were pursuing graduate degrees, as well as professors and administrators at a research university in Qom. The rapport I was able to

build through these relationships allowed me access to research centers, one of which was founded by a high-ranking jurist with fatwas permitting organ selling. In my personal encounters with legal scholars and jurists, I was able to communicate some of my research findings about the policy and what I had gathered about the experiences of patients and kidney givers. It was through the communication of these ideas and gauging the responses they elicited that I was able to further decipher the assumptions and legal blind-spots that partially shaped how jurists came to permit kidney sales. And in this way I realized how contingent and flexible their rulings were.

When I embarked on examining the opinions of Islamic legal authorities, I was hopeful that I would be able to organize my own moral position on selling kidneys. Likewise, my probing into the logics and rational sensibilities of KPF personnel, as well as the ethics of the social worker were indeed efforts to satisfy my intellectual inquiries, but inquiries that were significantly configured by a non-academic desire to identify a definitive stance: is it ethical to allow strangers to exchange money for an organ? What I found was that the opinions of these authoritative figures were highly contingent and prone to contradiction. Furthermore, they were largely based on partial understandings of what the exchange entailed, how it affected the experiences of patients, and most importantly the experiences of those young men and women who sold their kidneys.

During the course of my research I had the privilege of conducting in-depth interviews with several kidney patients, their family members, and kidney sellers. These lengthy conversations were critical to my conceptualization of the exchange as a dynamic process of problem resolutions that could not be reduced to a market commodity exchange. No doubt this perspective would be further enriched had I the opportunity to interview a

greater number of individuals, particularly kidney sellers, after they had undergone the transplantation surgery. But as I quickly realized, some of those who had sold their kidneys were reluctant to revisit their decisions, and would find often subtle ways to avoid meeting me. Unwilling to burden kidney sellers to whom I was a complete stranger, many of whom would go so far as to change their mobile phone numbers to erase their traces, I had to rely on my networks of friends. They would identify and introduce their own friends and acquaintances who would be willing to speak to me, individuals for whom I would be little more than a prying outsider. But such willing individuals were few. In turn, I was compelled to extend my analysis beyond the narratives of patients and sellers after the surgery to my observations on the streets around the KPF, where illicit advertisements were inscribed on walls and trees, where potential sellers met other sellers, spoke of their ordeals, hopes, and desires, and where they encountered the family members of patients who desperately tried to take donor-matching into their own hands. I introduced myself as a student researcher and asked questions when they appeared receptive. Most were forthcoming, and in return I offered what inside knowledge I had of the workings of the program. My close observations of over a hundred exchanges between the social worker at the KPF and visitors were also an important resource for tapping into the mindsets and sensibilities of kidney sellers and how they forged a relationship to the exchange on which they were about to embark.

The Chapters

In the second chapter that follows, I examine the desires and aspirations, alongside conditions of financial fragility that compel some young men and women to consider selling

a kidney in Tehran. The data emerged from months of listening to potential kidney sellers explain their conditions and motivations to a social worker at the KPF. Against the common perception of kidney sellers as the rural indigent or urban slum dwellers, those who walk through the doors of Tehran's KPF are often educated and either come from, or see themselves as tantalizingly close to, a middle-class lifestyle. In this chapter, my aim is not to lay a claim to representing the profile of Iranian kidney sellers, for those whom I examine consider undergoing the procedure but may not ultimately do so. Rather, I view the middle class aspirations of potential kidney sellers as a window into important social and economic trends in post-revolutionary, and more specifically post-war Iran that make the giving of a kidney to overcome a bout of financial hardship a viable and reasonable option.

In the third chapter, I visit the counselor's office at the KPF, where a social worker tasked with facilitating kidney donation attempts to dissuade most of those who walk through her door. I reveal the day-to-day grit of encountering individuals who are considering kidney selling, from the perspective of a social worker who fundamentally opposes the KPF's role in its encouragement. Building on Paul Brodwin's ethnography of "everyday ethics" in a mental health clinic in the US, I suggest the notion of an "emergent ethics" that develops out of everyday encounters, moral decision making, and embodied experiences, in a context where a coherent and dominant moral rubric is absent. That is, given the lack of discussion on the morality of Iran's program for paid kidney donation either within or outside the KPF, the social worker operated under a bureaucratic directive that was detached from any particular organizational ethos. Therefore, she actively sought to establish a set of principles of her own that would guide her interactions and tactics of

dissuasion with her clients. Fortunate to spend extended periods of time in the social worker's office over a period of four years, I was able to apply a processual approach to charting her ethical deliberations. That is, I was able to position her evolving concerns, reactions, and tactics in relation to what she witnessed and what she experienced emotionally and corporeally, and in relation to the limitations as well as the possibilities the bureaucratic space and its material artifacts afforded her. In this chapter, I demonstrate how clashing ethical visions (that of the KPF director and the social worker) were enacted in the bureaucratic space of the KPF, without entirely subverting the aims of the organization, thereby furthering one of my goals for the dissertation: to shed light on how the Iranian program for paid donation has been sustained despite the moral uncertainty that permeates its implementation.

In the fourth chapter, I delve into a critical component of the Iranian program for transplantation – the religious sanctioning of kidney selling. Like many other “progressive” fatwas by Shi'a Islamic jurists, the permissibility of organ selling has befuddled scholars outside of Iran who have limited their analysis to Shi'a doctrine. In this chapter I demonstrate that the rulings of Shi'a jurists must be viewed in light of the role the institution of jurisprudence has been afforded in making policy after the Islamic Revolution, and the practical and medical assumptions that inform their decisions. I examine the chronological and analytic order by which the issue of kidney selling was examined, and highlight the medical imaginary fostered by a relationship of trust in medical authorities in post-revolutionary Iran that informs jurists' opinions. In doing so, I demonstrate the extra-legal components that critically contribute to making fatwas and policy in the Islamic Republic. Moreover, by charting the contingencies that enabled the

permissive fatwas, I reveal another contributing factor to sustaining the program of paid living kidney donation, despite the absence of a coherent ethical discourse.

In the fifth chapter, I suggest that the commodity lens may not be an adequate analytical framework for understanding paid kidney giving in Iran. Drawing from my observations of kidney sellers and patients within and outside the KPF, as well as interviews with KPF personnel, several kidney recipients and their relatives, as well as an extensive conversation with a young kidney seller two years after his transplantation, I present an alternative conceptual model for understanding this exchange that treats the transaction as a temporally-extended bilateral donation. I then expound on the multiple temporal, material, and social parameters that position the exchange within a spectrum of equitability.

In the concluding chapter, I draw connections between the analytic and ethnographic findings in the previous chapters to further elaborate on the enabling conditions for the emergence and continued implementation of Iran's living kidney donation program.

Chapter 2: Almost Middle Class

“Do you realize this is a serious surgery?” asked the social worker. She was addressing a young man, 25 years old, and a mobile-phone shop owner from the suburbs of Tehran. She tilted her body to the left, drawing her right index finger along about five inches on her side, “it involves a large incision all the way from here to here, and then...”

“That’s it?! All along I thought it was at least this big!” he interrupted, as he held his two index fingers an exaggerated 10 inches apart.

Not “Bare Life”

In the wider anthropological literature, “kidney sales” conjure up woeful images of the rural poor and urban slum-dwellers lured by organ brokers to exchange the “organ of last resort” for temporary financial reprieve (Scheper-Hughes 2003). Anthropologists have pointed out that the flip-side of life-saving transplant technologies has been the flow of biological matter from the bodies of the disadvantaged to that of privileged patients. Organ trafficking has been condemned as the dangerous side-effect of neoliberal trends of growing economic inequalities, and the retreat of states from their responsibilities of care, coupled with the fragmentation and objectification of human bodies – giving rise to what Scheper-Hughes has bombastically called a form of “modern-cannibalism” (ibid). In this chapter, I will present an alternative explanation for organ selling in Iran, wherein instead of the “vampire” conditions of neoliberalism (Cohen 2005), middle-class aspirations and egalitarian national welfare policies emerge, alongside conditions of financial hardship, as important contributors to people’s decision to sell an organ.

The heightened attention to exploitation in conditions of structural violence and extreme poverty that drive kidney sales in places like India, Bangladesh, China, Brazil, and elsewhere, have no doubt been crucial to rallying medical professionals and the international transplant community to instate roadblocks to organ brokering. However, such narratives have left little room for understanding the constellation of conditions that drive certain people to sell an organ, beyond conditions of economic desperation. Organ sellers are portrayed as passive victims, desperate to feed their families, or escape crippling conditions of debt (Scheper-Hughes 2003), and in turn exploited by the predatory practices of neoliberalized governments and medical institutions. They are reduced to “bare life” as “operable” subjects, and made increasingly “bioavailable” by advanced immunosuppressant technologies (Cohen 2005). Recipients on the other hand are represented as affluent beneficiaries of state predation, those who have the privileged means to “supplement” their bodies with the bio-matter of others (ibid, see also Cohen 2011). To the extent that sellers are seen as victims, this literature sees no necessity in trying to understand the sellers’ motivations beyond a need to survive: their imaginations, their processes of decision-making, the complex web of anxieties and fears coupled with the desires and aspirations that structure their choices.

But how can we think about kidney selling under socio-economic conditions wherein those who are “operable” and those who are “supplementable” are hardly differentiable? That is, when a significant portion of those in need and able to acquire kidney transplants belong to similar, if not occasionally worse off conditions than those considering to sell. Such is the case in Iran, where the state’s welfare policies have included subsidizing transplant operations, which are free of charge. Furthermore, the regulation of

compensation has ensured that sellers can rarely expect a hefty payment only affordable to affluent patients. Finally, kidney sellers in Tehran (who constitute the majority of sellers in the country) hardly fit the profile of the destitute villagers or indigent slum dwellers often represented in the literature.

During my fieldwork in Tehran, I found that those contemplating exchanging a kidney for payment were frequently (not always) men and women in their twenties eager to achieve or retrieve a middle-class lifestyle, one that was tantalizingly close either as a recent experience disrupted by failed entrepreneurial efforts, or as something envied in close kin and friends. In other words, many kidney sellers were those on the cusp of a middle class created through the haphazard privatization and liberalization drive initiated after the end of the 1980-88 war with Iraq.¹⁰ In this scenario, the decision to sell is hardly about being reduced to bare life, but rather about meeting the standards of an imagined middle class lifestyle: satisfying a young wife in a new marriage, securing a lucrative business venture, escaping the pitfalls of making a poor investment, saving face in front of family and friends, and securing the achievements of a respectable, upwardly-mobile social existence as promised by a developing and modernizing Islamic Republic.

Another aspect of the literature on organ sales is the critical perspective on transplant surgery. The focus on “supplementarity” – or how some people have been able to secure longevity through the acquisition of organic form from others (Cohen 2011: 31), has meant that biomedical practice has been cast as a predatory enterprise, facilitating the exertion of power of one group over another. But what if we dissect the conditions that

¹⁰ One striking example was that of an ambitious 24 year old man who expressed interest in selling a kidney for 20 million tomans to add to the other 20 million he had already saved, because in his view, “a responsible man” intent on marriage should have at least 40 million in savings to begin a respectable life.

have enabled (not merely subjected) certain people to perceive themselves as amenable to being operated on? One of the striking features I observed among those considering kidney selling in Tehran was their trust in biomedicine as quotidian and taken-for-granted, and a concomitant trivialization of the invasive surgical procedure involved in kidney transplantation. These sellers were only mildly concerned about the outcomes of the surgery and regularly saw themselves as able to control and manage their health before and after the operation. This, I argue, emerges not simply out of the predatory practices of a global biomedical enterprise and discursive practices that may obscure the side-effects of medical procedures. Rather the relationship of trust towards biomedicine in Iran cannot be separated from the Islamic nationalist-revolutionary modernizing project that has heavily invested in building a strong biomedical infrastructure accessible to a wide swath of the population, including the more disadvantaged among them.

In this chapter, I focus on two interrelated topics: 1) the reasons and desires that guide certain people towards seeking a quick and discreet method of acquiring capital in Tehran, and 2) the “medical imaginary” that makes the removal of a kidney in exchange for payment a viable option for doing so.

Who are the Kidney Sellers?

Between the summers of 2011 and 2012, I observed hundreds of men and women seeking the services of a social worker – Ms. Zarrin,¹¹ at the central office of the KPF. I was permitted to sit in Ms. Zarrin’s office, often behind a desk adjacent to her as I observed her interact with various visitors. I quickly learned that the older visitors were usually the

¹¹ I have used a pseudonym for the social worker at the KPF to protect her privacy.

family members of kidney patients – either recent transplant recipients, or patients close to being, or already on dialysis treatment. Ms. Zarrin’s task was to guide them through the bureaucratic process of obtaining welfare services offered by the state and the KPF itself. Certain government banks offered a two million toman loan to fund the expenses of kidney disease, and pharmacies offered extra subsidies on drugs. Of course, with the proper paperwork, the transplant operation performed in a public university hospital would also be free of charge. I occasionally assisted kidney patients’ families in completing the forms and identifying the institutions near their homes from which they could obtain various kinds of assistance. The social worker’s office was also the depository for various donations of foodstuffs such as rice, cheese, and occasionally dates (particularly during the month of Ramadan), but most importantly – meat that Ms. Zarrin would dutifully and unobtrusively distribute after assessing her visitor’s level of need. There were also swimming pool vouchers, half-price coupons for men’s suites, and even free packets of coloring books and toys for children. Many of the visitors were struggling financially, and looked to such services for some relief.

Usually, in any given day half of those who made their way through Ms. Zarrin’s office sought aid, while the other half were there to either inquire about or initiate the process of selling a kidney. These latter visitors were often very young, mostly in their early twenties and only occasionally in their thirties. Initially, I assumed that I could identify sellers by various markers of financial deprivation, and even expected them to be worse off than most families of patients.¹²

¹² Though all kidney sellers completed a form that stated their socio-economic status, including their income, level of education, and number of family members, I did not always have access to this information. My

In the minds of the general public the person most likely to be pressed to sell a kidney is the “*kargar*”, typically a poorly-educated blue collar factory or construction laborer who struggles to survive in the city and constitutes one of the most vulnerable members of urban society. While it was not uncommon for members of this socio-economic class to solicit the aid of the KPF as patients (that is, kidney recipients) or their family members, I rarely found them among kidney sellers. When I brought this up with one dialysis nurse, she suggested that those in conditions of long-term economic deprivation had adopted other ways of making ends meet. If such a person sold a kidney, she claimed, the compensation would hardly be enough to remove them from that long-term condition of poverty, especially if they had large families to support.

While I am not in a position to test the veracity of such a claim, I can state that from what I witnessed, kidney sellers in Tehran were frequently (but not always) among those who had fallen into a sudden and unexpected condition of need requiring a quick, short-term solution. This abrupt change in circumstances could be due to a sudden accident, business failure, or loss of one’s social safety-net due to migration, familial death, or abandonment. Of course, those attempting to sell their kidneys also included drug addicts who could no longer maintain employment and had no other recourse but their bodies to support themselves. But although I commonly heard from ordinary people that they thought many kidney sellers were addicts,¹³ they did not actually comprise a significant portion of kidney sellers. The personnel involved in the process of transplantation,

assertions are not based on statistical data, but on my personal observations that nevertheless coincided with the opinions of the social worker at the KPF’s central office in Tehran.

¹³ Some kinds of drug abuse (especially short term) do not damage the kidneys, and can therefore go unnoticed in medical examinations necessary for donation.

including social workers, lab workers, and medical doctors, normally turned away anyone who was either visibly addicted or whose laboratory tests revealed traces of narcotics. That is, if potential kidney sellers with drug problems managed to sell, they typically did so by successfully concealing their addiction. The *assumption* that sellers were addicts was unsubstantiated by actual observation.

According to my observations as well as the accounts of Ms. Zarrin who drew on six years of experience at the KPF (2006-2012), the most common scenario among those who were in a difficult financial bind and considered themselves to be “desperate” was one where a member of the family was in danger of going to debtors’ prison. Once, a young twenty-five-year-old man appeared in Ms. Zarrin’s office during a short leave from prison. He had injured a pedestrian while riding a motorbike he had failed to insure. He owed the victim over thirty million tomans, and hoped to sell a kidney to offset some of his debt. But more typically, indebted sellers had made faulty investment decisions and owed their lenders large sums of cash. If they failed to amass the necessary funds, they too would land in prison.¹⁴

What was most remarkable was that significant number of individuals in far less severe circumstances saw selling a kidney as a means towards upward mobility, or as a way of relieving a bout of financial hardship that threatened their previously comfortable life and often their marriage. I was frequently dumbstruck by young and stylish men and women whose appearance belied a condition of poverty. Clad in upscale clothes, carrying chic briefcases and hand purses, Ms. Zarrin often joked that they appeared to be far better

¹⁴ In chapter three, I describe the stories of two people with such circumstances, one a man who had been swindled by his business partner, and another a woman whose husband owed blood money, and didn’t have a second kidney of his own to sell.

off than either of us. And indeed many earned salaries higher than Ms. Zarrin. Though some of these individuals may not have ultimately sold a kidney, my interest is in why such individuals would even consider doing so as a viable option.

For example, a 24-year-old married man whom I will call *Sahand* shared the following story about his interest in selling a kidney:

“I was once a student at one of the best universities, and because I was one of the top students, a steel company recruited me before I even graduated. I did very well and advanced quickly at my job. One day another company approached me and suggested that I start a branch in my home town. I eventually found someone to partner with, because I didn’t have sufficient funds to acquire an office and equipment. I did really well. Within a single year I earned 48 million tomans¹⁵. It was wonderful. I got married. We did well. But then I got swindled and lost all the money. I worked on another project and earned another 17 million. But then I lost that too. I invested the money, but got defrauded each time. Basically, my life with my wife is on the brink of falling apart. You’re a woman, you understand. She say’s ‘you’re an engineer, you’ve been working for a few years now. How come you can’t afford a car? How come we can’t afford to travel?’”

Sahand had not spoken to a doctor yet. But he assumed a transplant surgery was a relatively safe procedure, with potential side effects that were likely negligible given that transplantation was a conventional treatment for dialysis patients and that selling an organ was legal and routinized. It took Ms. Zarrin about thirty minutes of counseling for Sahand

¹⁵ At the time, this would have been approximately forty thousand dollars.

to reconsider his decision. She explained that selling a kidney was not a reasonable solution for a young and educated man who had already once managed to amass significant wealth, not least because the consequences of undergoing an invasive surgery may not be as benign as he had imagined.

Another young couple considered selling their kidneys after they were cut off from their social support systems due to their decision to marry against their parents' wishes. Thereafter they struggled to maintain a middle-class lifestyle in the capital:

The couple looked to be in their mid-twenties. The young man's piercing gray eyes and tasteful attire grabbed my attention. Judging by his appearance alone one might have expected him to belong to an upscale neighborhood in northern Tehran. He rested his left hand on his restless knee, his right thigh close against his wife. She too was also dressed elegantly in a brown manteau, her face only subtly embellished with makeup. But unlike her husband her demeanor was remarkably aloof.

"We were told to see you to for a donor's form," said the young man almost in a gentle whisper. When Ms. Zarrin inquired about his reason for selling a kidney, he explained that he had fallen in love with the young woman and married her despite his family's unrelenting disapproval. He tilted his head towards her and said, "I love my wife. My parents didn't agree with the marriage, but since I knew they were being unfair, I married her anyway." After a brief pause he continued, "My father is very wealthy, but he disowned me when we married, and so now we need money to start our life together."

"Which one of you wants to do this?" asked Ms. Zarrin.

- "I'll do it... Either one of us could I suppose," said the young man.

- "Have you spoken to a doctor?"

- "No."

At this point Ms. Zarrin turned to his wife, "Do you want to have children one day?" The young woman nodded without uttering a word. Quickly, the young man turned to her with wistful eyes and declared, "I won't let you give your kidney."

Moments later he explained that they were concerned about the lab fees and whether they would be reimbursed for the expenses they would incur.

- "No, you have to cover these costs yourself and there's no guarantee that you'll be able to donate...Do you understand what it means to have your kidney removed? It means you can't be exposed to direct wind, you can't lift heavy objects for a month. You need to take time off from work to recover. Do you have a history of diabetes?"

- "No."

- "Do you have high blood pressure?"

- "Yes."

- "How are you going to give a kidney if you have high blood pressure?"

- "I'll take medication. I'll control it."

- "If you can't control it now what makes you think you can do so later? Do you realize that blood pressure is a leading cause of kidney failure?"

- "But they say you can live with one kidney."

- "Well you can, but you increase your chances of needing a kidney yourself." The man grew restless and resumed shaking his leg rapidly. He glanced to the right and the left before he lowered his head. At this point I turned to his wife and asked, "What would you do if this option didn't exist at all?"

She responded evenly and without hesitation, “I would get separated. Financial difficulty is not a minor issue these days.”

Visibly struck with grief the young man turned to me and uttered, “I would never leave my wife. I love her.”

Moments later, Ms. Zarrin disrupted the heavy silence with a reminder of the health risks involved. “Do you need a form today?” she then asked. “I guess we’ll think about it some more,” he said. And as they rose from their seat, he turned to his wife one last time and asked in disbelief, “You really would leave me?”

In both of the above stories, we see young individuals seeking to improve their lives – in terms of material comfort or marrying someone they love – by relying on their own capacities and strengths, even if this means striking out on their own and alienating their social networks. If the young engineer in the first story had relied on the appropriate social connections in his business ventures, he would have been far less likely to fall prey to crippling fraud. In the second story, the very reason the young man found himself in dire financial straits was that his wealthy father had disowned him because he disapproved of his marriage. That is, in both stories, individual desires and ambitions were placed above social attachments with their attendant responsibilities and demands. Failure was occasioned first by the neglect of social connections, and secondly by the conflicts that emerged between husband and wife, two individuals who found themselves unable to reconcile their desires and commitments.

This valorization of individualist aspiration was enabled by decades of haphazard economic liberalization after the end of the eight-year war with Iraq. During and after the presidency of Ali Akbar Hashemi Rafsanjani (1989-1997), Iran underwent a zigzag process

of liberalization while also maintaining a commitment to welfare policies. Increased interest in and support for entrepreneurship coincided with a proliferation of discourses of self-mastery and success that emerged in the late 1990s and early 2000s. These discourses have been most palpable in the explosion of self-help books, 12-step guides for self-improvement, and motivational speaking success-gurus. They have also coincided with the proliferation of private and public gymnasiums, public parks packed with outdoor fitness equipment, and the rise of medical programs on state television that educate both a general and professional audience on recognizing symptoms and managing their personal nutritional and healthcare needs. The result has been the normalization of a global neoliberal biopolitical subjectivity that treats success as directly tied to an enterprising self, an abundance of material wealth,¹⁶ and the discipline to care for one's health and external beauty. Such an idea of success starkly contrasts with the notion of the "good life" vigorously propagated in the early years of the Islamic Revolution and throughout the eight years of war with Iraq (1980-88) – one that was achieved through egalitarianism, charity, and the fulfillment of religious and social obligations in accordance with an Islamic ethics. But even if conceptions of the good life underwent drastic changes through postwar economic liberalization, this did not take place at the expense of public health and welfare programs, as has occurred in many other countries transitioning away from socialism.

In the first decade after the 1979 Islamic Revolution, Iran's social and economic policies centered on protecting and fulfilling its revolutionary promise of establishing

¹⁶ One notable figure is Dr. Alireza Azmandian, an Iranian engineer educated in the United States, who has established a "success-conglomerate" based on what he has named the "technology of thought," a self-help system emerging directly out of ideas that the New-Age author, Rhonda Byrne put forth in her book "The Secret." Hosting massively populated motivational speeches, training courses for "entrepreneurs and managers," and offering an array of self-improvement books and audio and visual recordings, Azmandian has held a profound role in normalizing and popularizing a neoliberal discourse of success in Iran.

national independence and advancing the welfare of the “dispossessed” (*mostazafin*) (Behdad and Nomani 2009). These two interrelated goals required untethering the strings to “imperialist” powers, strengthening local educational and scientific institutions, and expanding public infrastructure and health services. Diplomatic ties with the United States were severed and public universities, research centers, hospitals and clinics were revitalized, all with a revolutionary commitment to building a model Islamic nation state. Medical and scientific progress and the welfare of the population, namely those “disinherited” under the monarchic regime, became markers of the revolutionary state’s success. A statement by Dr. Naser Simforoosh, known as the “pole” of urology in Iran for his significant role in developing transplant science (and policy), is telling of the revolutionary commitments that for many were instrumental to the advancement of the sciences. In the introductory remarks at the International Urological Conference in Tehran in 1987, he declared:

“Attention to the advancement of science is one of the most fundamental goals of Islam, and therefore that of the Islamic Republic. Despite the imposition of a violent, unequal, and oppressive war against the sapling of a new revolution – the Islamic Republic of Iran – the new sciences have met the highest expectations of our committed scientists for they do not view science as a material instrument, rather they consider attention to it as divine obligation. And it is such that in our ideology, medicine (*pezeshki*) is considered worship.”

Moreover, after the revolution, banks and various private enterprises were nationalized, and property and financial assets were seized from capitalists and affiliated members of the Pahlavi monarchy, and subsequently funneled into building revolutionary

foundations that would offer services to the poor (Harris 2013: 67). For example, the wealth of the Pahlavi Foundation—which held the assets of the monarch and his family members—along with the seized assets of dozens of millionaires, comprised the endowments for the Mostazafan Foundation (Abrahamian 2008) that was legally tasked with providing aid in the form of various services including monthly pensions and low-interest loans to the poor¹⁷. Another para-governmental organization, the Imam Khomeini Relief Foundation, alleviated rural and urban poverty –offering basic health services, social security, and financial assistance for education. The Construction Jihad, initially comprised of volunteers, mobilized revolutionary commitment to construct rural infrastructure – building roads, clinics, schools, and irrigation canals, as well as bringing piped water and electricity to dispossessed regions (Keddie 2003: 286).

One of the major achievements of the Islamic Republic was the expansion of access to health services in urban and especially rural areas that I argue have contributed to an atmosphere of trust in medicine among the Iranian population. This involved developing and upgrading the medical infrastructure, instating heavy state subsidies on pharmaceutical drugs, regulating hospital fees, and providing insurance coverage for a large segment of the population. For example 90% of pharmaceutical drugs in Iran are produced domestically at a fraction of the global market price. Furthermore, patients with chronic conditions such as those on dialysis fall into the category of “patients with special diseases” and are entitled to further subsidies.

¹⁷ Today, the Mostazafan Foundation is the largest commercial enterprise in Iran after the National Iranian oil Company, and as a *bonyad* (foundation) is exempt from state financial auditing. In 1982 it owned “203 manufacturing and industrial factories, 472 large farms, 101 construction firms, and 238 trade and service companies. (Keshavarzian 2007: 167-8). According to the foundation’s official website, it is now active in 207 production and service companies, including those within banking, tourism, and telecommunications (www.irmf.ir).

In 1983, Iran established the National Health Network (Heshmati and Joulaei 2016) that offered primary health care throughout the country with a primary focus on rural areas, which at the time comprised a little over 45% of the population.¹⁸ “Health houses” were established in remote areas, where *behvarzan* health workers that were recruited from the local communities relied on their intimate knowledge of households to collect data, offer effective health education, provide family planning and disease control services, immunizations, and essential perinatal and postnatal care –all free of charge. As a result the gap between major health indicators in rural and urban areas was drastically diminished. For example infant mortality rate in rural areas dropped from 12% in 1974 to 3% in 2000, and in urban areas from 6.2% to 2.8% (Mehryar 2004). The national family planning program resulted in the normalization of contraceptive use, such that by 1996 more than 74% of married couples were using them (ibid). When it came to non-preventive therapies, the majority of the population could take advantage of one or more public health insurance policies. (See also Harris 2010, 2013). Therefore, in addition to advancing an impressive family planning program (that is just now undergoing a reverse process), Iran has been successful at drastically reducing the rates of transmissible and infectious diseases, previously common in rural areas. (However, chronic conditions like hypertension and diabetes, the two leading causes of kidney disease and most common in the urban population are on a rise.)

While the inconsistent economic liberalization strategies after the Iraq-Iran War contributed to important cultural shifts and the normalization of wealth-seeking and entrepreneurship, they did not significantly overhaul medical welfare services. For example,

¹⁸ By 2014 this percentage had dropped to approximately 27% (<http://data.worldbank.org/>)

the current reformist president Hassan Rouhani has supported the continued privatization of public firms, but also initiated a popular national health care program that has expanded insurance to the five or more millions previously without coverage and also implemented significant improvements to health service access. Although it is likely that this program will be discontinued in the next few years due to the major budgetary pressures it has occasioned, it is demonstrative of an ethos of public welfare that is still a formative component of the republic's revolutionary ideology and the public's sense of entitlement to and trust in biomedical healthcare.

When it comes to social sensibilities and desires, the post-war era saw significant transformations. In the early years after the fall of the monarchic regime, the revolutionary ideology pushed forth an ethos that was both anti-Western *and* Islamic—not only in the sense of abiding by religious codes of conduct, but also in the importance it gave to social responsibility, charity, and austerity. The circulation and public consumption of many western brands, films, and music were banned. Conspicuous displays of wealth were heavily frowned upon and made synonymous with an aristocratic sensibility and support for the old monarchic regime. Lipstick and thin pantyhose were deemed not only immodest, but self-indulgent; women's outerwear were for the most part long, loose, and plain, with little stylistic variation. Gray and navy suits became formal male bureaucratic attire, and a permanent short stubble beard came to signify self-denial and modesty. Films and television dramas valorized the good household made up of pious, modestly dressed members who lived in austere homes furnished with little more than rugs and *poshti* back pillows, but who were bound together by faith, respect, compassion, and selflessness. The model family was pitted against the aristocratic household that drove foreign automobiles

and lived in lavish villas, where extravagance and materialism bred selfishness, defiance, and social apathy. This ethos had to do not only with a revolutionary Islamic ideology, but a “sacred defense” paradigm (Behrouzan 2015: 410) that advocated for a somber social climate in solidarity with the soldiers and their family members during the war with Iraq.

At the time of my research some three decades after the revolution, one found a vastly different and markedly liberal social, economic, and political ethos operating in Iran. This was an ethos that had emerged alongside, and at times in opposition to the revolutionary ideology, yielding a climate that some scholars have called “contradictory” and symptoms of an ongoing clash between “tradition” and “modernity (See Karimi 2013). Commercial advertisements which were once exclusively for national enterprises like banks became ever more present in everyday life, taking over massive billboards, buses, television screens, and impressive ad-books dropped at every door. Clothing emerged in a bewildering variety of styles, colors, and levels of modesty. The domestic fashion industry that was inspired both by foreign trends and “traditional” Iranian patterns and symbols flourished as did the appetite of Iranian consumers for trendy products that would mark them off as belonging to the *ba-kelas* (classy) social strata. As Farhad Nomani and Sohrab Behdad (2006:97) have argued:

“The Islamic state that once wanted to establish an Islamic economic justice, viewed profit making as an antisocial preoccupation, and regarded foreign investment and borrowing as satanic acts, is now promoting trickle-down economic policy, encourages profit-making investments, and tries its best dancing to the tune of foreign investors ... How successful the state has been in pursuing these policy objectives is a different issue. What matters is that the Islamic-revolutionary

discourse has changed and if the high-rise luxury apartments in the skyline of Tehran reflect anything, the “oppressed” (mostazafan) are “out” and the “arrogants” (mostakbaran) are back “in,” all thanks to the Bonyad[-e] Mostazafan, the largest real estate developer in the country.”

The transformation in the Islamic-Revolutionary discourse is most palpable in serials broadcast on state television. No longer are consumerism and entrepreneurship presented unexceptionally as indications of aristocratic avarice, rather they’re often taken-for-granted aspects of a middle-class life-style. Nevertheless, this normalization of consumerism has not been without concern over the social anomie that the struggle for upward mobility and the failed aspirations of many, particularly the younger population, has engendered. A common theme in these serials is to depict the dangerous predations of loan sharks feeding on desperate desires for financial security in an environment of panic-inducing inflation and rampant unemployment. We can see these filmic depictions as symptoms of the very same conditions of economic uncertainty that propel thousands of Iranians to seriously consider the option of selling a kidney.

While the liberalization of the economy since the late 1980s has improved living standards for many Iranians and helped revitalize the middle class, these processes have been accompanied by economic insecurity and widespread unemployment compounded by a population boom. Iran has hardly ever experienced inflation rates below 15% since 1979. In the first decade after the revolution, the aftereffects of revolutionary turmoil, a crippling eight-year war, US sanctions, and an oil price collapse in 1985 and 1986 brought ruinous effects on the economy, with inflation rates hovering on average around 20%. Inflation only

worsened once Rafsanjani's economic development and liberalization program took effect, rising from 23% in 1992 and peaking at 50% in 1995. From 2000-2004 inflation dropped to an average of 15% (Azizi: 2006), though everyday experiences of inflation were much higher.¹⁹ This environment of economic uncertainty was exacerbated by lack of steady employment for millions of Iranians.

Without adequate public and private opportunities for employment, the informal sector emerged as the go-to sphere for economic activity. Even those employed at stable office jobs will often seek "free sector" (*kar-e azad*) opportunities to supplement their income. While the middle class has experienced significant growth – tripling in size between 1986 and 1996 – the largest social class in Iran is the "fragmented petty bourgeoisie" who cannot afford to hire waged employees. Even the capitalist class which has grown by 740% from 1976 to 2006 is dominated by small business owners with one or two employees (Behdad and Nomani 2009). Behdad and Nomani see this as an indication of a "petty bourgeoisie orientation" among the capitalist class. The commonness of work in the informal sector and the success of some in amassing incredible wealth under conditions of economic instability and high inflation rates have consistently pulled more participants into the informal sphere (*ibid*).

Arang Keshavarzian (2007) has argued that with the progressive growth of the informal economy in postrevolution Iran, previous modes of evaluating reputations and building trust within the traditional marketplace (*bazaar*) went into decline. Partnerships in the informal sector may be more temporary and carry higher risk as they are not bound

¹⁹ While increase in the price of bread, which is mandated by the state, reflects formal inflation rates, streets all over Iran are always abuzz with concerned conversations about the uncontrollable rise of prices in everyday consumer goods, especially imported products.

by networks of mutual trust and responsibility through which reputations are built and assessed. As Keshavarzian shows, the rate of bounced checks and associated lawsuits has grown significantly alongside the expansion of the informal sector. Many of my interlocutors who were considering selling their kidneys had typically failed (or were defrauded) in ventures in the informal sector, and their vulnerability was compounded by their youth and lack of experience, on one hand, and their inability to rely on family support networks on the other. The latter failure had to do either with abandonment due to disputes over marriage, or a cutting off of relations that came with migration to Tehran from smaller towns.²⁰ We will encounter several stories of financial hardship rooted in these conditions in chapters three and five.

Medical Imaginary

“I have five kids. The last one I delivered with a *cezarian* (cesarean-section). He’s definitely the smartest of them all. Of course, because when he came out there wasn’t all that pressure on his head. There wasn’t pressure on his brain. That’s why children these days are so much smarter – they all come out with beautiful round heads.”

-Wife of a deceased kidney recipient

²⁰ Zohreh Fanni (2006) shows that in 2001 the vast majority of economic opportunities were concentrated in Tehran. More broadly, the number of cities has increased as has the population in the cities due largely to rural-urban migration, with over 60% of the population living in urban areas. Over 15% of the population lives in the capital alone, where welfare facilities are also more readily accessible.

So far we have seen that those who consider selling their kidneys are on the one hand buoyed by postwar promises of prosperity on the basis of individual ambition and entrepreneurial spirit, and on the other hand caught up in the treacherous conditions of an informal economic sector plagued by instability, high risk, and dearth of social support mechanisms. Dire as these circumstances may be, they still do not provide an adequate explanation for why the sale of kidneys should present itself as a viable solution. For a more nuanced picture, we need to understand the “medical imaginary” that grounds and motivates sellers’ decision making.

As I have already explained, the national health care system in Iran is heavily subsidized, such that even highly specialized and high-technology procedures are accessible to a wide swath of the population. Even though Iran underwent economic restructuring starting in the late 1980s, it did not suffer the same kinds of drastic transformations undergone by countries like Egypt where the World Bank and the International Monetary Fund imposed rapid privatization of public institutions, leading to a severe deterioration of public services (Hamdy 2013). The partial liberalizing transformations in Iran did not entail the dismantling of the public health system or social safety nets. While various spheres of life were commercialized, individualist consumer desires were promoted, and neoliberal fantasies of personal success and upward mobility became widespread and even morally acceptable, none of this occasioned the withering of welfare programs such as public health insurance, pensions, and drug and healthcare subsidies. In fact, as public hospitals competed with private ones for patients, their standards of care grew rapidly, making many public hospitals, especially those in the capital, preferred destinations for receiving medical treatment.

We might think of Iranians' attitudes towards biomedical interventions in terms of a "medical imaginary" characterized by trust and enthusiasm. Mary Jo Del-Vecchio Good suggested the concept to explain how we *think* about biomedicine, and how the moral and affective dimensions of our ideas drive the biomedical enterprise:

"[People] invest in the medical imaginary – the many-possibility enterprise – culturally and emotionally, as well as financially. Enthusiasm for medicine's possibilities arises not necessarily from the material products with therapeutic efficacy but through the production of ideas, with potential although not yet proven therapeutic efficacy." (Del Vecchio Good 2001:397)

In her analysis of clinical narratives of cutting edge and experimental therapeutic technologies, Del-Vecchio Good identifies what she calls a "biotechnical embrace," an experience of enthusiasm and openness towards these interventions that characterizes the attitude of both patients and medical practitioners. She writes that the promise of future possibility fuels the medical imaginary and in turn, "drives the political economy of hope as well as our society's investment in medical adventures and misadventures" (2007: 367). Likewise, Lesley Sharp develops the idea of a "transplant imaginary" to explore the moral thinking, sentiments, and ethical desires that underlie and push forth the highly-experimental science of bioengineering and xenotransplantation (2013). She explains, with concern, that the "celebratory qualities" attributed to "scientific inventiveness" (Sharp: 2013: 3), coupled with the scientists' desire and hope for saving lives, contributes to overlooking patient suffering and life post-surgery, in turn pushing the advancement of highly experimental procedures forward while "black-boxing" the experiences of the patients they are meant to serve.

A comparable moral economy can be identified among the community of Iranian scientists and medical professionals, one that is also coupled with a nationalistic desire to advance Iran's medical modernity. During my observation of kidney transplant surgeries in Tehran, I noticed a remarkable air of triumph and excitement in the operating room, as the transplant team eagerly watched the chief surgeon suture the severed kidney of a stranger to the ureter of the patient, awaiting the critical propulsion of the first stream of urine into the rehoused organ. Once, I saw the resident firmly pat his chief surgeon on the shoulder as he shook his head with a combination of awe and relief. It appeared as though we had all witnessed the miraculous – even if it was a routine procedure that the surgeon would perform a few more times that same week. The imaginary that emerges out of and shapes such events in the operating theater seeps into the public imagination in myriad ways, not least by the media.

While Del-Vecchio Good (2001, 2007) and Sharp (2013) focus on experimental and high-technology procedures, I want to apply the concept of a medical imaginary to reflect on the public attitude of embracing invasive biomedical interventions as inevitable and quotidian aspects of everyday life. Those Iranians who have not already gone under the knife for a cesarean-section, rhinoplasty, or vasectomy, often foresee that they may one day undergo these or other elective procedures. I was often surprised by how casually my interlocutors spoke about having to undergo various surgeries, say for a painful disc herniation or carpal tunnel syndrome. I was even more perplexed at how frequently medical doctors prescribed such procedures before considering less invasive therapies. This topic is worthy of in-depth research in its own right, but I will offer a few comments in what follows.

Let us take the example of cesarean sections. Along with rhinoplasties, C-sections are among the top ten most common invasive biomedical procedures performed in Iran (Akbari Sari et al. 2012). This major surgery in the abdomen and uterus runs multiple risks for both a mother and newborn, from painful recovery, infections, adhesions, and blood clots for the mother, to respiratory problems and difficulty nursing for the child. While the WHO indicates that 10-15% of deliveries are likely to require a C-section to prevent more serious outcomes, almost 42% of deliveries in Iran are by C-section, one of the highest rates in the world and second only to Brazil with a rate of nearly 46% (WHO 2010).²¹ The rate in Tehran is even higher at a staggering 66% (Azami-Aghdash et al. 2014), with some hospitals and clinics reporting rates of over 90%.

The prevailing attitude among my interlocutors was that C-Sections were a technologically-mediated, and therefore safer, “cleaner,” more predictable alternative to vaginal birthing. Many of the young women from the capital with whom I spoke and who had yet to deliver a child themselves, explained that after watching horrific videos of vaginal deliveries, they knew they would not be able to tolerate the pain. But for those with imminent births, there were other practical concerns to take into account as well, such as whether they would be seen by the same medical specialist they had so carefully selected and built a relationship with through the course of the pregnancy. Would they be able to trust the substitute medical team? What if labor occurred in the middle of the night and the hospital was short-staffed? One pregnant woman who had preferred vaginal delivery throughout her pregnancy ultimately opted for a planned C-section days before her expected date of delivery, because she feared she would not be able to make it to the

²¹ “The Global Numbers and Costs of Additionally Needed and Unnecessary Caesarean Sections Performed per Year: Overuse as a Barrier to Universal Coverage” WHO Report, 2010.

hospital in time given the often insufferably heavy traffic in Tehran. A study published in 2011 based on 26 in-depth interviews of health care providers, including midwives, obstetricians, and hospital directors, concluded that at the institutional level, medical staff preferred C-sections for the ability to control the timing of the delivery, because vaginal births were assumed to be unwieldy, unpredictable, and more prone to complications for which troublesome law suits could ensue (Yazdizadeh et. Al 2011). Other reasons included the profitability of C-sections and lack of adequate training of midwives and medical students in vaginal births. But underlying many of the social and institutional reasons for preferring a technologically-mediated invasive surgery can be explained by Del-Vechhio Good's notion of the "biotechnical embrace," where even the certain risks of biomedical procedures are deemed to be safer and more controllable, or perhaps inevitable, compared to less invasive, none-technologically mediated interventions. My interlocutors commonly considered the rejection or interrogation of that which is enabled by "science" to be "backwards" and unmodern. In one conversation, when I insisted to a seasoned obstetrician based in Tehran that I would personally prepare for a vaginal delivery unless a C-section was absolutely necessary, she looked at me with perplexity and asked, "But why do you insist against a simple surgery? We perform them all the time with no complications!" That I, a Western university-educated person would take such a position was especially dumbfounding to her.

When it comes to cosmetic surgeries, Iran also holds a remarkable lead. It is informally claimed that Iran has the highest rate of cosmetic rhinoplasties,²² which usually

²² "The beauty obsession feeding Iran's voracious cosmetic surgery industry," *The Gaurdian*: <https://www.theguardian.com/world/iran-blog/2013/mar/01/beauty-obsession-iran-cosmetic-surgery> (accessed June 2016)

involve the shaving of the nasal bone for size reduction and shaping the cartilage for an upward pinched tip. In a study carried out in the city of Kerman among 320 female high school students, more than half of the participants said that they would like to undergo cosmetic nose surgery (Arabi Mianroodi et al. 2012). It is likely that the numbers would be the same if not higher in Tehran. Many Iranians speak of nose operations as a rite of passage, a procedure regularly planned right after school and before college entrance when young boys and girls who had heretofore attended gender-segregated schools will share the next four years of their lives in proximity to the opposite sex, with opportunities to impress potential future partners.

Given how commonplace and taken-for-granted invasive procedures like C-sections and rhinoplasties have become, it should come as no surprise that surgeries in general provoke little anxiety or resistance. This attitude can help us understand the brief anecdote with which I began this chapter. The social worker Ms. Zarrin told a young prospective kidney seller that the operation to remove his kidney would leave him with a five-inch scar. In response, the man flippantly retorted that all along he had assumed that the scar would be at least ten inches long. In another case, Ms. Zarrin told me that a young woman claiming to want to sell her kidney to help her financially troubled brother was in fact trying to raise the funds to pay for a rhinoplasty for herself. In chapter three, we will see that Ms. Zarrin deployed a variety of tactics to overcome what she considered to be a trivialization of the surgery on the part of these and other potential kidney sellers. These tactics commonly involved manners of drawing attention to the inescapable corporeality of her interlocutors and attempting to shock them into an embodied realization of the dangerous risks they were about to take.

“I had nine abortions”

A woman in her twenties casually walked into Ms. Zarrin’s office. She was dressed in typical work attire – a black manteau and a tight-fitting black *maghnaeh* covering her hair. She laid her black messenger bag – one not unlike many sold along the sidewalks of Tehran – on her lap and expressed matter-of-factly that she was there to “sell a kidney.” She was assertive and unshy about her misfortunes.

“Are you married?” asked Ms. Zarrin. “No I’m divorced” she said with alacrity, and continued without pause: “I married young and then I divorced. Also my father’s dead. I had a very problematic relationship with my husband. We didn’t get along.” The young woman unabashedly declared her legal emancipation from her male relatives probably in anticipation of follow-up questions about spousal/paternal consent. As an adult without a spouse or a living father, she was an autonomous agent able to sell a kidney without family approval.

Ms. Zarrin allowed a perceptible silence to envelope the room. She then switched her distant bureaucratic voice to a tender tone. “Is that a crystal on your tooth? It’s pretty,” she said. “Is it *in* your tooth?”

- “No, it’s on my tooth!”
- “It doesn’t ruin your tooth?”-
- “No, I’ve had it for two months now. There’s a special glue for it.”
- “Ah yes... It’s pretty.”

With her smile still wide open showcasing the crystal on her upper right canine, she explained, “I had a smaller one before. But I liked it so I got a bigger one.” Ms. Zarrin smiled warmly.

- “So, it’s interesting...you divorced. How come?”
- “Well, it was so many years ago. When I was fourteen, I had many problems. My mom and dad and my [paternal] aunt came together and gave me to a boy. But what does a fourteen year old understand in our day and age? So they gave me to a boy who was *dehati* (rural) and a sheep herder! He didn’t know anything about life. And I was a city girl.”
- “You lived in the city?”
- “Well yes, I’m from a town around Tabriz, and he was *dehati* –from a village. He knew nothing about caring for a wife and child. I was a child myself, I didn’t know anything. I have another sister, older and married. And me, well they did this to me, and then I contracted malta-fever and landed in the hospital and so on, and then I had a child. And after my illness I divorced him and gave him the child.” The young woman narrated her affliction story like an oft-recounted tale.
- “So you divorced. What have you done since then?”
- “Well I did different things here and there. At first I was a videographer.”
- “You knew how to do that? You got married at fourteen, when did you get a chance to learn to film?”
- “I learned on the job. I went to a women’s photography studio. I did this and that, and then I eventually started filming. After three to four years I left the studio and started filming independently. People who knew me gave me jobs.”
- “So you’re an artist!”
- “I wouldn’t say that! So then you know, a boy came into my life and destroyed everything. One day he’d promise marriage, the next day he’d say his brother

won't let it happen. All these promises. And well, I was young – at the peak of that age when you want to depend on someone and you fall in love. I grew dependent on him, and couldn't leave him. We got into a temporary marriage. At that time, my mom had issues, she had psychological issues, she was getting therapy, and would often kick me out of the house. My dad didn't have much control, even on his own life. He was sick too. He passed away just a year ago. My mom would always complain about me wearing make-up, doing this and that. I was moving around from one house to another. And for this I lost my reputation. So I lived in this boy's house."

- "This boy had his own house?"
- "Well no, he rented one. And then I kept getting pregnant, and he would abort it." Her voice faded into a solemn tone for the first time. "I've aborted so many of his kids, I swear I can barely walk now. I can barely walk up two stairs. I had nine abortions. Nine!"
- "For how long did this go on?"
- "Four, five years."
- "Why didn't you use protection?"
- "Well, I can't take pills because of my health."
- "But you're a young woman; you know there are many ways of preventing pregnancy."
- "Well he wouldn't use protection."
- Ms. Zarrin sighed in visible frustration. "So, in conclusion?"
- "He took away my honor."

- “How did he take away your honor?”
- “Well, he made me stand out. Imagine in a small town, everyone knows you. Everyone knows you keep aborting babies. And we were in a temporary marriage, he wouldn’t support me, and I’d go here and there to provide for myself. A small town, all the stories and things people say...”
- “He wouldn’t give you money?”
- “No, and my mom kept kicking me out, so I had to live with this boy. Whatever he did, I accepted.”
- “And you’ve left him now?”
- “Yes. I’ve been living in Tehran for the past year. I work here and live in a dorm.”

The young woman explained that she worked for a company cleaning houses from 9am-5pm. She earned 600 thousand tomans of which she paid a fourth to the dorm. She complained that the work was too exhausting and there was little she could do with the money she earned. She claimed that with the five to six million she would collect from selling a kidney, she could put two million down for a deposit on a “decent home” in her own town and have enough to pay rent and get by for a while. “So you aren’t afraid given your nine abortions?” asked Ms. Zarrin. “I don’t care if I live or die!” she retorted, and with that blocked any attempts at using her health as a dissuasive tactic. Ms. Zarrin found an alternative.

- “Yes, but they won’t accept your kidney.”
- “But they don’t know.”

- "You're right that they don't know about the abortions, and I certainly won't tell them. But after the examinations, they won't let you do it. I'm sure you know this already."

- "Yeah. But you know we have *three* kidneys."

- "Oh? And how do you know that?"

- "When my dad was at the hospital they did a sonogram before his operation and they told him he had three kidneys. And they asked him how many sons or daughters he has. He said he has two daughters; they said they have three kidneys too."

- "Well before you think I have a bias, let me tell you that those people who have three or four kidneys, their kidneys together barely work as well as one kidney."

- "That's right, because they're smaller. But I don't care if I have two or three kidneys."

- "How did you hear about this in the first place?"

- "I've been thinking about it for years. I delayed it for various reasons. I even got my blood type before. A friend of ours left to Tehran thirteen or fourteen years ago. People were asking where he was. He had just left his wife and children. Everyone waited and waited. And when he came back, they said he's ill, he needs to rest. He was recuperating at home. We found out later he had sold his kidney. He had gotten two million for it. Back then, that was a lot of money! Just one month in bed and he got two million!"

- "How is he now?"

- "He's great! He's very happy and lively. He's chubby too. He even had another child. He paid the deposit for a house. He got a really nice house."

- "Okay, well one issue is that this will be much cheaper in your own city, but regardless once you pay the lab fees they won't take your kidney. The doctor will tell the patient this kidney is useless for you."

- "But what if they do the sonogram and they say my kidney is fine."

- "But it will cost you 500 thousand tomans."

- "But what about insurance? I have Social Security Insurance."

- "It'll still be 320 thousand. You have 320 thousand?"

- "Well that 320 thousand will become five, six million for me."

- "Well you go ahead and obtain that money, and you'll do the test, and they'll say what I just told you. And then that 320 you borrowed will be another problem for you. You don't think about all this, do you? This is how you get into trouble. So you go ahead and you borrow 320 thousand, then you come here, and after the exam they tell you what I've told you, and you won't be able to sell your kidney, and then what do you do? You'll have to give into another one of those marriages with your lender – it's not like anybody puts a free hat on the grave of his own father! Either you have to give into a marriage like that, or you just create some major mental burden for yourself when you should be thinking of something else, like getting a job. Now it's still up to you. Whatever you think is best. I'm just informing you."

Ms. Zarrin leaned back, tilted her head towards the window looking off into the distance:

- "It makes no difference for me. You can do what you like."

Irritated and impatient, the young woman had been incessantly rubbing the handle on her bag between her thumb and forefinger. “Then how do they do it?!” she pleaded. “How do others sell? They come here and you tell them no, you can’t do it?”

- “If like you they had nine abortions and a birth – that’s ten pregnancies! Do you know what that means? In every pregnancy your kidneys become partially damaged. This may be a small effect each time, but for some it may be a greater effect. Haven’t you heard of pregnant women who lose a kidney in the process? Have you ever heard that? Now for that person it was a major damage. In your case, you may have had small damage done each time. It may be bad for you, and it may be harmful for the recipient. If the doctor informs the recipient, they wouldn’t want your kidney. Because such a patient only has one or maximum two opportunities in their whole life to have a transplant. If I only could transplant once, and had to pay for it too, I would try, for example to find a kidney from a young man of 24, 25, not a woman who has had multiple pregnancies or births.”

Moments later the frazzled and disappointed young woman dropped her head, grabbed her bag as she slightly leaned forward, thanked the social worker for her time, and dragged her feet out the door. How are we to understand her story?

On the one hand, we could read this narrative as an unfortunate account of a desperate young woman forsaken by her family and community, forced into an inappropriate marriage, and later abandoned to engage in an uncertain relationship with an abusive man who repeatedly impregnated her without so much as meeting her basic financial needs. Having lost her reputation she is compelled to migrate to the capital where

she has to succumb to house-cleaning and living by herself in a women's dormitory. Ultimately, she is driven to sell a kidney to pay for independent housing and secure a chance at some sort of financial stability. Read in this light, this is yet another instance of structural violence, a tale of desperation and sacrifice, and that of a state policy exploiting a vulnerable population.

Alternatively, this is the story of an aspiring woman with an entrepreneurial spirit who is determined to secure her independence. Though it is likely that what she narrated was exaggerated or deliberately crafted so as to impress or appease the social worker, the point is that she deemed the story to be an appropriate justification for her decision to sell a kidney. In taking the narrative seriously regardless of its authenticity, we can decipher the moral imagination and structures of desire, as well as the medical imaginary that brought her (and many other young men and women in Tehran) to this same decision. It is likely that she was not in fact married to a sheep herder, but to someone she perceived to be beneath her status. Perhaps she did not have nine abortions, but felt violated in an unstable temporary relationship. Maybe she never worked as an independent videographer, but spent some time in a studio. None of this contradicts the fact that her decision was one of many strategies for securing her independence and becoming a prosperous member of the middle class.

In trying to dissuade her, Ms. Zarrin had to reckon with the fact that the young woman already had ideas about her body, the medical establishment, and welfarist public health policies that encouraged her that selling her kidney would not create major problems, and may in fact present a more attractive possibility than continuing life as a house-cleaner. From a young age, she had been familiar with the mental health

establishment which was aiding her mother. Her father was receiving some sort of treatment through which she had acquired knowledge about his kidneys (he had three) and thereafter about her own kidneys (that she had three, and that they were smaller than normal). Again the point here is not that this knowledge was accurate, but that she claimed to know about kidneys and how they function, and she based this claim on interactions with the medical establishment. Moreover, she was operating with the assumption that her social security health insurance would pay for her laboratory tests. That is, there would be little or no overhead costs for her decision to sell. Finally, her experience with pregnancy complications and hospitalization for malta fever provided a familiarity with public health institutions that reduced her fear of any adverse consequences from transplant surgery. It further helped that one of her acquaintances had gone through the same procedure and seemed to be thriving as a result.

If this young woman was “operable,” then, it was not because a neoliberalizing economy had rendered her body available as “bare life” for the exploitation of the privileged. Rather, she was operable because the liberalizing economy had constituted her as a subject with aspirations for upward mobility and desires for a middle class lifestyle that could be achieved through independence, resolve, skilled labor, and scientific knowledge of her body, its functions and capacities. Furthermore, she was operable because “operability” had been rendered cheap, safe, and even desirable in a medical imaginary made prevalent by a modernizing welfarist state. For Ms. Zarrin the social worker, dissuading potential kidney sellers largely had to do with countering precisely these assumptions. She had to convince them that selling a kidney was not cheap, that it

was not safe, and that it would not bring them a happier lifestyle. It was not just structural violence that made her work difficult, but the conditions of social welfare and prosperity.

Conclusion

During a visit to the KPF in the summer of 2009, I came across a bizarre article pinned to the wall outside the social worker's office. It was titled: "Selling kidneys for the GoldQuest pyramid scheme!"²³ The article reported on police shutting down an office of the network-marketing company GoldQuest International. The Hong-Kong based corporation with tentacles extended across the Asian and African continents, began its operations in Iran in 2000 amidst the haphazard liberalizing of the economy and the growth of entrepreneurship and consumerist desires. Facing severe crackdowns in the years that followed, it was accused of exploiting students and "gullible men and women" aspiring to supplement their income with simple unskilled labor, which in this case involved investing in "limited edition" gold coins and accruing commissions on new recruits as part of a typical pyramid marketing structure. According to the article three of its company leaders were arrested for operating an illegal business. But most interestingly, they were also accused of encouraging new members strapped for cash to sell a kidney for funding a venture with the company, and to subsequently purchase a replacement organ with their profits. I found the proposition jarring –and yet in an unexpected way neatly capturing significant elements of the phenomenon of kidney selling.

The same socio-economic conditions that have made quick-cash ventures such as GoldQuest's pyramid scheme increasingly popular in Iran, have also propelled thousands of

²³Fars News June 29, 2009.

Iranians to seriously consider selling a kidney for cash. Inconsistent, and haphazard economic liberalizing after the death of the leader of the Islamic Revolution, Ayatollah Khomeini, and the conclusion of the Iraq-Iran war, along with a shift in ideological, cultural, and moral attitudes towards wealth accumulation and consumerism, left many with a burning desire for upward mobility. And yet, crippling inflation rates, high unemployment, and a growing but vulnerable informal economy, brought about by years of war, international sanctions, and the state's gross mismanagement of the economy has left many in a severe financial bind. For many, especially young adults, aspirations for a modern middle-class lifestyle fostered in part by the state's revolutionary ideology of egalitarianism, and a modern public education have failed to become realized. Rapid migration from villages and small towns to larger metropolitan cities, especially the capital, has often resulted in disconnection from familiar social support systems. Ambitions for financial and social independence have left many of the aspiring young adults in a constant struggle to accumulate wealth rapidly so as to withstand the perils of an uncertain future. But for those who fail, and who lack, or have been cut-off from a social support system, the kidney becomes a potentially significant financial asset that is believed to be an easily accessible, discreet, and obligation-free means of redeeming or achieving a respectable life. But of course, this can be so, when an invasive transplant surgery is trivialized, so much so that one could imagine the removal of the kidney to be as straightforward as removing a part of a vehicle. Too often I heard from a potential kidney seller that if they were to experience an ailment in their remaining kidney, they would simply purchase a replacement organ at a future time when their finances were in order. But the mere fact that someone wanting to sell a kidney to escape financial hardship would imagine

him/herself as a potential recipient of a transplant surgery, which was also taken-for-granted in the GoldQuest leaders' suggestion to its members, is telling of a particular welfare system operating in Iran. The accessibility of high-technology medical procedures that have been made possible by the Iranian state's medical modernization, its ongoing welfare policies, and public education programs, have shaped the medical imaginary such that biomedicine and its often highly invasive interventions have become a quotidian aspect of life.

Finally, I will conclude with a provocation relevant to ethical discussions of kidney selling. As I have tried to offer an alternative heuristic for examining this phenomenon, one that sees desire and ambition, egalitarianism, and welfare (rather than simply exploitation and structural violence) as important components of the social matrix that constitutes certain subjects as potential kidney sellers, can we consider an alternative paradigm for evaluating the morality of such an exchange? In the chapter five, I will attempt to achieve this by offering a concept of "bilateral donation" and mutual-care as an alternative to the theoretical straitjacket of "commodification."

Chapter 3: “Lizard Ruses” and Bureaucratic Ethics

“You weigh too much”

December 2011. At the counselor’s office on the second floor of the Kidney Patient Foundation (KPF), a nervous young man knocked on the open door and stepped in.

- “Excuse me, I’m here to ask about kidney-selling.”

Ms. Zarrin, a fifty-year-old social worker, acknowledged him with a nod and gestured to the seat across her desk as she casually continued a long-winded phone conversation. She twirled the handset coil around her index finger and with her other hand shuffled around various objects on an already unkempt desk. A few minutes later, Ms. Zarrin rested the handset on the switch hook and turned to the young man.

- “How old are you?”
- “25.”
- “Single or married?”
- “Single.”
- “Will your father consent?”
- “He’s passed away.”

The phone rang again.

- “Did you bring his certificate of death?”
- “No, but I can.”
- “And how much do you weigh?”
- “95 kilos.”
- “You weigh too much.”

Ms. Zarrin picked up the phone. A few more minutes went by as she consoled a client who appeared to have problems coping with dialysis. At length she set the phone down and turned to the man once again:

- "So..."
- "Well I think my weight is normal. 90 kilos is normal."
- "You said 95."
- "But I think I'm 90."
- "You can't tell me what you *think*."
- "Well, won't they weigh me?" He was clearly impatient.
- "Yeah, after they take your 500 thousand tomans for the lab tests! They'll take your money first and then tell you they won't take your kidney. I don't want you to waste your money like that."

The young man muttered that he was helplessly drowning in debt.

- "I'm under pressure in every way. I'm really under pressure, otherwise I wouldn't do it. You're a counselor that's why I'm telling you this."
- "Everyone's under pressure. But they don't all..."
- "Not like me," he interrupted. "When my dad died, my family fell apart. You know, we're not the type of family that does this sort of thing [sell a kidney]. But I've just lost it. There's nothing else I can do."
- "What's your job?"
- "I was in garments."
- "But not anymore?"
- "I quit that to start a tourist agency."

Ms. Zarrin rested her chin on her fist and stared at him with wide inquisitive eyes and a faint affable smile that faded into a smirk.

- "What were you doing at the tourist agency?"
- "We started an agency with one of my friends. That's how I got ruined. My friend stole people's money and ran away, and now he's left me with all this debt."
- "What agency was that?" asked Ms. Zarrin, checking for the story's veracity.
- "*Mahtab. Ajans-i musafirati-yi mahtab*, around *Inqilab*. You know behind that pharmacy?"

She paused for a moment, then resumed her questioning:

- "But, with what kind of expertise did you start an agency?"
- "Well we had the expertise. *He* had the expertise. The garment shop really wasn't paying off. I invested in the agency, and then I went on one trip, and when I was back, all the money was gone. I paid off some checks, one million, two million, ten million!" He broke into a nervous chuckle. "But after that, I've just lost it! I'm not the kind of person who would write bad checks. And these checks haven't bounced yet, but they will. I have no options *khanum duktur*."

Ms. Zarrin leaned back in her chair and instructed the man to check his weight at the clinic across the street and return the following day to receive further instructions. But perhaps there was another way to put a hitch in his plans. Without pause she followed her sentence with another question:

- "Tell me, why did your father pass away?"

- “Heart attack, khanum duktur, heart-attack.”
- “High blood pressure?”
- “Yes, yes.”
- “Well then! You definitely cannot do this,” she proclaimed victoriously. “Since your father had high blood pressure and you’re overweight, tomorrow you’ll also develop hypertension. That is, as soon as they remove your kidney you will have hypertension. Hypertension is genetic.”
- “But my other two brothers don’t have hypertension. You know, I really don’t like doing this. I had thought about it before, and really hated myself for it, but I really have no options khanum duktur.”
- “It’s not about what you and I like. It’s about the necessary conditions. Since your father had hypertension, you’ll definitely develop the same problem.”
- “Well that’s okay khanum duktur.”
- “It’s okay if you develop hypertension?!” She raised her voice to highlight the young man’s imprudence. “Well, you’ll give that kidney to someone else, and that *badbakht* [unfortunate person] will develop hypertension too!”
- “Seriously?”
- “Uhum.”

The man appeared flustered. He shifted in his chair, and then grabbed his elbow defensively.

- “Well you know, I came here yesterday and I talked to this other lady and she said I could do it, though she *did* discourage me. So then I got scared and I left. But she said I met the requirements, there wasn’t a problem.”

- “Well we *can* tell you the requirements... and you said who will give your consent?”
- “My mother.”
- “Okay.” She began listing the conditions impassively: “The price [*qaymat*] is seven million. The patient gives six, the state pays one and it takes one to three months.” She paused and stared at him awaiting his response.
- “Okay, so isn’t there a form of some sort? Something, so I know what I need to do?”
- “I’ll give you a form in time. Don’t rush.”

The young man leaned forward and rested one hand on the edge of Ms. Zarrin’s desk.

- “Can you please give me the form or *something* before I change my mind again?”
- “The form is just your first name and last name – nothing special.”
- “Well, do you have any brochures, then?”
- “Sure, we have brochures.”
- “Maybe if I read them, I’ll go ahead with it before changing my mind again.”
- “But it’s a very simple and *rational* thing.” Her voice began to rise. “You’re a high risk person, and you are fat [*chaq*]!” She paused. “Are you 26 now?”
- “Yes.”
- “You’re 26 and you’re 95 kilos. Definitely by the time you’re 30 you’ll be 100 kilos. So you’re a *very* high risk person.”

The young man was clearly embarrassed.

- “But if they take my kidney my weight will come down!” There was a long heavy pause. “Isn’t that true?”

- “No, that won’t lower your weight, and even if it does that’s different from having the [overweight] *condition* that you have.” She turned to face me. “Does your weight drop if you give your kidney?”
- “Well, I don’t know,” I answered. “I suppose if you fall ill afterwards that may be a reason to lose weight.”
- “See?” she said sharply, “Only if you get *sick* you might lose weight. You’re very high risk. Understand?”
- “Well... can I at least have your card?”

Ms. Zarrin handed him her card, as he rose from his chair.

- “Thank you khanum duktur.” And he left the office as apprehensively as he had entered minutes earlier.
- “*Be salamat* [in good health]. Good bye.”

As the man left the room, Ms. Zarrin turned towards me and protested:

- “He started a tourist agency! And what did he know about a tourist agency? I used to work for one. Back then it was considered a serious *job*, you needed real skills!”

This chapter takes an in-depth look at the Kidney Patient Foundation, the non-profit organization at the heart of paid kidney giving in Iran. My central concern will be to examine the complicated ways in which contrasting ethical visions are entangled with bureaucratic procedure, and the ways both of these are enacted in everyday practice. On the one hand, as we will see, the KPF instituted certain policies to secure the welfare of prospective kidney recipients while creating what administrators considered to be ethical

conditions for organ donation. The bureaucratic guidelines and procedures for registering and matching donors and recipients were meant to guarantee these ethical conditions. On the other hand, in actual practice, many prospective kidney givers interacted with a seasoned social worker who was fundamentally opposed to kidney sales. As we see in the ethnographic vignette above and in more detail later, the social worker attempted to dissuade donors by making tactical use of the bureaucracy – including ad hoc policies and micro-procedures she instituted herself, as well as creative use of documents and registration fees. What comes into view here is not simply a clash of two solidified ethical visions (that of the administration and the social worker), but rather the continual evolution of an *emergent* ethical practice informed by face-to-face encounters with prospective donors, an embodied understanding of “impairment” (*naqs*), and a recognition of material constraints as well as limits to knowledge. I will argue that we can fruitfully examine the social worker's dilemmas, the various tactics she deployed, and her reflection on these practices, in order to gain insights into the ways in which bureaucracy may be appropriated in the service of ethical action. These will have implications for the way we conceptualize the "everyday ethics" of biomedical care, a topic to which I turn in the chapter's conclusion.

Ethics in Friction

When Mr. Zahedi officially registered the small support group he had created for kidney patients as a non-profit NGO in 1980, he envisioned that the organization would grow into a much needed advocacy center for patients on dialysis and those who had received or were waiting for a kidney transplant. Mr. Zahedi was himself a two-time kidney

recipient – once from a cadaver in London and another from his mother. “The first one was a piece of junk,” he told me. “Back then, they’d give us foreigners the useless organs, so I ended up receiving another one from my mother.” Supported by a growing group of nephrologists, urologists, and other transplant recipients, the KPF developed into not only a center for disseminating information that would aid patients through the difficult process of acquiring care and treatment, but a patient advocacy and lobbying group that would pursue patient interests on a range of issues – including for example subsidized drugs and securing loans. As the organization expanded to over 120 offices across the country, it effectively fashioned itself as a non-governmental arm of the Ministry of Health, regularly meeting with government officials to plan and collaborate with public hospitals. It would collect funds from the government as well as corporate donors and individual philanthropists to support its various projects. It would organize annual conferences, publish an impressive journal, offer training for peritoneal dialysis, and eventually construct a clinic equipped with a tissue-matching laboratory, a dialysis ward, and offices for various medical specialists providing subsidized healthcare. As the hub of kidney patient advocacy, it would be instrumental in promoting the nation’s transplantation program, including both living and brain death donation.

Besides serving as a crucial advocacy center, the organization operated as a bureaucracy, deeply embedded in the governing of patient access to public health services such as dialysis and transplants. It would do so by creating a national database of patients and generating identification cards marking patients as legitimate recipients of specialized health benefits. But most critical was its oversight and management of living organ donation, a procedure that would only be handled by the KPF rather than by hospital

administrations. Every patient seeking a government-funded transplant operation in a public (usually university) hospital would have to obtain an approval letter from the KPF. As such, the KPF became the locus of both policy development and implementation, as it advocated for patient affairs, fashioned new regulations, refined old ones, and facilitated the various bureaucratic procedures necessary to govern the affairs of those patients it sought to support.

All of the KPF's activities were animated by a single ethical imperative: The improvement of health and living conditions for patients with chronic kidney disease. In practice this posed challenging questions of policymaking and implementation. As a transplant recipient who had to maneuver through medical institutions both in Iran and England (where many patients were sent by the Iranian government to receive transplants during the Iraq-Iran war), Mr. Zahedi considered himself to be well-equipped to tackle the multifarious challenges facing kidney patients by drawing from his personal travails as a patient, and his knowledge of best practices abroad. He frequently boasted, for example, that the brain death organ donor cards the KPF distributed were near replicas of the cards he had seen in England.

The KPF's practices were also informed by major ethical debates in the international transplant community. Mr. Zahedi was familiar with these debates through participation in international conferences and close collaboration with domestic medical experts and academics. Some of the ethical considerations around organ donation were directed at protecting donors. For example, the KPF instituted regulatory measures that required donor-recipient pairs to be of the same nationality so as to prevent international organ trafficking. In practice, this protocol has not only prevented the sales of Iranian kidneys to

wealthy foreigners (a challenge that some other countries in the Global South have had difficulty overcoming), but also precluded refugees from Iraq and Afghanistan from selling to better-off Iranians. Other measures have been informed by concerns for recipients, such as a commitment to ensuring equitable access to kidneys by keeping compensation amounts low enough that they would be manageable by patients on the lower economic rungs of society.

As prominent as Mr. Zahedi has been in fashioning protocols for regulating patient affairs, his visions and practices emerged through collaboration and friction with various actors within the government and the very organization he governed. Not everyone within the medical establishment agreed with his vision for living and brain death transplantation. While state bodies relied heavily on his expertise as an advisor, his very public and bold complaints about patients' problems also landed him in hot water with officials who accused him of tarnishing the state's reputation as a trustworthy guarantor of public welfare. Mr. Zahedi's ability so simultaneously manage collaborative efforts and frictions ensured that his organization continued to wield influence and further its various programs.

Within the walls of the KPF central office in Tehran, a similar dynamic of collaboration and friction challenged the mission of the organization while also giving shape to its bureaucratic procedures. Between 2006 and 2012, the KPF employed Ms. Zarrin, a social worker of great fortitude, to facilitate the matching of living organ givers with patients. Ms. Zarrin found a significant chunk of her daily work routine to collide with her ideas of what was "good to do." So even though she was tasked with facilitating the process of transplantation and keeping the number of donors sufficiently high to meet the

demands of a growing waiting list, Ms. Zarrin directed most of her efforts at turning sellers down. For this she was regularly rebuked by her boss Mr. Zahedi, who saw the dwindling number of donors as a threat to the purpose of his organization –providing moral and material support for end-stage kidney patients. And so, in Ms. Zarrin’s words, she occasionally had to “loosen the sack” to let some prospective donors get away with selling and keep the administrators downstairs content. “But the numbers are still lower than they were before I got here!” she mischievously proclaimed.

In the remainder of this chapter, I focus on Ms. Zarrin’s moral conundrums, tactical maneuvers, and self-reflections. As a counselor with possibly the highest number of face-to-face interactions with young Iranian men and women seeking to give their kidneys in exchange for a solution to their financial problems, Ms. Zarrin’s tactics played a subtle but significant role in forming the terms through which paid kidney giving took place. Her experience also provides a rich and nuanced portrait with which we can deepen bioethical conversations about the ethics of financially-incentivized organ donation, and biomedical care more broadly.

I am primarily interested in three aspects of Ms. Zarrin’s practice. First, I am concerned with the way her encounters with prospective kidney givers shaped her moral vision. At the most basic level, these encounters led Ms. Zarrin to conclude that the majority of candidates for kidney donation suffered from “cultural poverty” (*faqr-i farhangi*), a concept I will explain in depth later in this chapter. As a result of this cultural poverty, Ms. Zarrin considered prospective donors to fall into two camps: Those who wanted to sell their kidneys for frankly silly reasons (such as an extravagant material lifestyle), and those who had legitimate and serious difficulties but did not recognize that selling their kidneys

would only compound their problems. She had honed her tactics of dissuasion to provide ethical responses to these groups, even as these tactics themselves provided experimental sources of insight about her interlocutors. Second, I focus on the lived, corporeal experience of impairment that informed Ms. Zarrin's ethical outlook. As we will see, Ms. Zarrin believed that this corporeal experience provided a kind of wisdom that could not be reduced to "information" handed out in brochures or divulged in the customary exchanges of counseling sessions. As a result, she believed that for prospective kidney givers to make proper decisions, they needed to be moved to realize the gravity of their choice in *corporeal* terms. Her actions therefore took on a performative quality that exceeded the referentiality involved in imparting information. Third, I examine the ways in which Ms. Zarrin tactically and creatively deployed bureaucratic procedures and materials in the service of an ethical objective, indeed in the service of constituting herself as an ethical subject. Ms. Zarrin called these tactics "the ruses of a lizard" (*marmulak-bazi*), and we can only understand them against the backdrop of a fragmented bureaucratic ethos and the contingent temporal, spatial, and material conditions that both restricted her ability to act according to the moral rubrics she carefully fashioned, and afforded her significant pockets of autonomy. My understanding of Ms. Zarrin's emergent ethical outlook grew in part out of my observations of her tactics of dissuasion, which provided openings for conversation and self-reflection.

In situating Ms. Zarrin's practices within bureaucratic contingencies, I attempt in part to achieve one of the central aims of this dissertation – to demonstrate how the volatile ethics of organ donation comes into tension with the messy grit of everyday policy-

work to produce a program that has been sustained for nearly two decades, while continually being called into question and even threatened with overhaul.

Emergent Ethics

Morality and *ethics* are terms that are often used interchangeably, although it is generally understood that they are not equivalent. In ordinary parlance “ethics” usually refers to rules and codes of behavior formed and enforced by institutions, whereas “morality” is relegated to the more intimate and less structured sphere of an individual’s values. These diverging meanings are commonly assumed in bioethics literature as well as anthropological discussions of biomedicine. For example, Kleinman (1998) differentiates *ethical discourse* (such as that of bioethics) from *moral processes* primarily in terms of the coherence that ethics aims to achieve. Kleinman says of *Ethics* (with a capital E) that it “is an abstract articulation and debate over codified values... [it] is reflective and intellectualist, emphasizing cognition (more precisely, in today’s jargon, rational choice) over affect or behavior and coherence over the sense of incompleteness and unknowability and uncontrollability that is so prevalent in ordinary life” (1998:363). Such Ethics is generally constructed in institutions responsible for forming guidelines for policymakers and practitioners engaged in implementing biomedical procedures. For Kleinman, *moral processes* are about practical encounters with specific everyday events. They are highly situated and contingent positions. In this paradigm, discussions about the goodness of incentivizing organ donation in order to benefit an ailing population of end-stage renal disease patients would constitute *ethical discourse* on organ donation, whereas the day-to-day decisions a medical doctor or social worker makes in determining the goodness of a

particular decision by an individual over whether or not to sell a kidney is treated as a moral process.

For Paul Brodwin (2013) *everyday ethics*, like Kleinman's moral processes, has to do with making choices between professional directives and what tactical, embodied wisdom acquired through practice prompts one to do. The purpose of Brodwin's intervention is to make possible an "imaginary conversation between two groups who rarely come into conversation with each other," the frontline staff of a community psychiatry outreach team, and policymakers who contribute to bioethical literature on Assertive Community Treatment (2013: 180). Unlike much of the recent anthropological scholarship that attends to the ways in which individuals take up ethical projects of self-making (Faubion 2001; Laidlaw 2002; Hirschkind 2006; Zigon 2008; Mahmood 2011), Brodwin is interested in actual moral decisions, the circumstances that elicit them, and what they can contribute to a broader ethical discussion.

There is, nonetheless, an important similarity between the context within which Brodwin approaches everyday ethics, and those within which scholars draw on Foucault's deliberations on ethics as "techniques of the self." In both, the moral codes or social guidelines from which individual agents derive their ethical decisions are, if not treated as static, taken for granted as transparent and readily accessible for emulation and personal adaptation. Foucault, for example, writes about morality as publicly expressed codes of conduct that institutions impose on members of society to determine the scope of permissible actions and their values (1991b) Similarly, Jarrett Zigon speaks of a *moral landscape* that is constituted by three spheres of the institutional, public discourse, and embodied dispositions (2008). At a moment of ethical reflection or moral breakdown, or

what Foucault calls “problematization,” these various spheres come to inform a new mode of being, a new embodied disposition (Zigon, 2008:165). Likewise, in Brodwin’s work there is both a strong ethos and set of protocols to which clinicians are committed and that guides their actions. Though clinicians may disagree with what the shared ethos or protocol compels in a certain event such that they adopt an alternative course of action (the practice of everyday ethics), these actions are limited in scope and are rarely formative of a larger moral rubric.

The question that arises is: How do we talk about morality and ethics with respect to a practice for which there is no clear and conclusive public or institutional moral standpoint? How do we write about individual ethical reasoning and decision-making when the moral landscape is uncertain, contested, and in flux? As I demonstrate throughout this dissertation, moral positions on kidney selling are everywhere volatile, such that few advocates hold resolutely supportive and coherent positions on the act *in practice*, even though the policy rests on both bureaucratic and jurisprudential support. So how do we describe moral encounters without relying on how agents creatively adopt positions already given by preexisting moral rubrics?

I suggest a concept of *emergent ethics* that is informed (though not determined) by everyday encounters and everyday ethical decisions, and that is produced in the absence of a dominant *moral rubric* (Deeb and Harb 2013) that would guide individual action. In this way emergent ethics can be seen as a site of experimentation in the face of a problem that is new, one that causes a moral breakdown (Zigon 2007, 2008) that cannot be adequately resolved through easily-accessible moral codes. It is characterized by transience and the possibility of a nascent construction that emerges from *everyday ethics* but exceeds it in its

insistence on coherence, even as it falls short of the systematicity of a formal high-order “Ethics.” It is thus ambiguous and unsettled, built through spontaneous moral responses to specific circumstances, but refined and re-interpreted through ongoing experience.

Anthropologists have persuasively demonstrated how ethical agents such as individuals interested in cultivating pious virtues borrow from a variety of moral rubrics and registers that are at times in conflict with one another (Deeb and Harb 2013; see also Scheilke 2009). This has been largely achieved through conducting in-depth interviews and sifting through the competing moral discourses at play in subjects’ explanations of their underlying reasons for acting a certain way in a particular context. In analyzing emergent ethics, attending to subjects’ accounts of their own reasoning is important, but observing practices gains increased salience as these constitute the experimental ground for the production of ethical visions and for reflection on emerging ethical logics.

In what follows I situate the formation of Ms. Zarrin’s ethical ideas about incentivized organ donation in relation to her unique encounters with clients during the course of her employment at the KPF. I could have gathered extensive information about her positions on the subject through a series of interviews without attending to the ways in which her moral ideas emerged from day-to-day interactions. However, I was afforded the privilege of spending substantial time over a number of years observing Ms. Zarrin as she reacted to her client’s demands and their accounts of financial distress. I was able to take careful notes on the tactics she used to experiment with her developing moral ideas, and the ways in which they were modulated based on the type of client she was dealing with. When I asked Ms. Zarrin to reflect on the overarching principles that guided her decision to act a certain way towards a particular client, she would narrow the vast field of ideas that

occupied her mind to the particular cases at hand or the encounters most immediately observed. It often appeared as though she actively produced an articulation of her moral ideas, a piece of her evolving ethics of organ donation, as a result of my spontaneous intellectual provocations. For this reason, a cumulative, processual approach to her developing ethics enabled by numerous encounters allowed me to gather a much more intimate understanding compared to what I would have gained if I had relied exclusively on interviews in a shorter period of time. Furthermore, attending to Ms. Zarrin's actual tactics of dissuasion demonstrates the ways in which her moral ideas were confronted with institutional limits that restricted her actions, and how in turn those restrictions contributed to the gradual development of her ethics.

Hanging out in the Office

Between 2011 and 2012, Ms. Zarrin's office was my default research site as I awaited various opportunities for interviews and observation. Despite my frequent visits, I always felt apprehensive about being welcomed in. After being away for an extended period of time, Ms. Zarrin would usually receive me with an excited hand wave and smile that would quickly fade into a displeased "Where have you been?" Then, after a few weeks of regular visits, she would grow unnerved by my presence and candidly ask that I pursue my research interests elsewhere. Our relationship was a precarious friendship, as we tried together to make sense of the moral encounter with the "kidney seller" while holding vastly different positions in relationship to the subject. I was a researcher there to only observe what transpired, driven by intellectual curiosity, free to arrive and depart as I pleased and most importantly free from any ties to the bureaucracy. Ms. Zarrin on the other hand was a

paid employee, committed to fulfilling her duties, while also pressed by her conscience to take responsibility for the well-being of clients considering selling their kidneys. It was this contrast between our positions that so starkly highlighted Ms. Zarrin's limitations and frequently agitated her about my presence. "You come and you remind me of what I'm doing here. But I can't just go away like you – I need this job," she told me on multiple occasions. This was while she was also visibly disgruntled by my lengthy absences. It appeared as though my presence and the autonomy with which I could distance myself from difficult situations reminded her of the restrictions her position as a paid employee imposed on her. On the other hand, our ongoing discussions and my inquisitiveness about her ideas created a sense of empowerment – an empowerment to actively contribute to an ethical discussion, a welcomed break from being a marginal agent in an organization with which she could not always align her moral compass.

During the many long hours I spent in her office, I struggled to get into her head and make sense of the reasons and affects that elicited her responses to paid kidney giving. I would sit in a corner of the office behind a desk with a notebook and pen in hand. Ms. Zarrin would explain to the visitors that I was a student researcher. Sometimes she would ask me to help with mundane activities like help someone fill out a loan form, hand out donated swimming pool vouchers to kidney patients, or install a Persian font on the dilapidated office computer. On occasion, she would ask me to talk to a kidney seller and carry on what she had been doing as she momentarily stepped out of the office. When I could, I would ask the visitors to explain what problems had prompted them to try to sell a kidney, and tried to identify alternative solutions for them. On one occasion, a young man of twenty-three who felt as though he had lost his reputation in his fiancé's household

asked if he could bring the young woman to talk to me after we had already held a lengthy conversation about the recent loss of his family's wealth and his desperate desire to throw a "dignified" wedding and provide a suitable home for his bride. "Maybe you can get her to understand my situation better. Then maybe I won't have to go ahead with this," he told me. There were rare instances when a client, usually a male seller, would ask that I leave the room so he could speak privately to Ms. Zarrin. But on most occasions, clients ignored my presence (until Ms. Zarrin herself brought me into the conversation), as if I were another staff member sharing office space with the counselor. Often there were 10-15 minutes between one set of clients and the next. I would use those opportunities to take notes on Ms. Zarrin's reflections on what had transpired, the tactics she had used, and the broader concerns on which she based them. Simultaneously, Ms. Zarrin strove to comprehend my interpretation of my observations and her actions. "What did you just write in your notebook?" was a common refrain. I would read her the contents of my notes and try to explain how it all helped me make sense of what kidney selling in Iran was about. I would also bring her news from what I had gathered in my research outside her office. Finding an articulation of the moral reasons for resisting financially-incentivized kidney donation became a mutual endeavor, one that was primarily informed by Ms. Zarrin's encounters with her clients, but was also directed by my intellectual provocations.

Before delving into the everyday emergent ethics of Ms. Zarrin as they developed in her office on the second floor, I will try to capture the broader bureaucratic space of the KPF that made her actions possible and intelligible, albeit contentious.

The Bureaucratic Space

Midway through Farhang street in central Tehran, I was always assaulted by a broad swath of illicit handwritten and printed “kidney sale” advertisements posted on the walls of homes and abandoned plots²⁴ before reaching a building with a yellow brick façade marked with a large white sign with Persian text announcing the Kidney Patient Foundation central office, founded in 1359 (1980). By the gate, a guard (*nigahban*) occupied a small kiosk. He asked wandering visitors about their business and, like most office guards, operated as a front-desk man, directing individuals to the proper personnel and their places in the building. Despite the myriad signs plastered on walls, visitors almost always sought oral confirmation of directions within the bureaucratic space. The common practice of asking rather than reading has necessitated the proliferation of *nigahbans* dispersed across larger buildings, particularly in hospitals, to sort and direct visitors through space and often to explicate the befuddling list of bureaucratic instructions. In the case of the KPF, only one such *nigahban* served this purpose, which meant one could often identify first-time visiting kidney givers by their slow and uncertain pacing of the corridors and the gentle mumbling of “Where’s the social worker”?

The *nigahban*’s kiosk was separated from the main building by a small courtyard where one could usually see iron beams and bricks presumably left over from a construction project piled near a small decrepit ambulance. Above the steps to the building, a narrow corridor led to a staircase to the second, third, and fourth floors. A piece of letter-sized paper with “The Counselor’s office” and a printed arrow pointed to the second floor. This was the first destination of anyone aiming to obtain or give a kidney or receive

²⁴ I will analyze these advertisements at length in chapter 5.

financial services from the KPF. On the way up the stairs, colorful posters adorned the walls highlighting the significance and nobility of kidney donation. One poster depicted a lifeless girl in a dialysis bed, presumably waiting for a healthy kidney beneath the text “Gifting a Kidney is Gifting Life.” Another poster announced March 13th as World Kidney Day, an international event the KPF claimed as its brainchild. Each poster carried the emblem of the organization – a tilted square with two hands in the center holding a severed kidney and dangling partial ureter. It was never clear to me whether the hands were offering the gifted kidney or cradling a precious bounty just received. Either way the emblem denoted the kidney as an isolated standalone rather than a paired organ connected to a body.

On the second floor a door led to a waiting area with two office rooms, a tiny kitchen, and a locked bathroom. One office belonged to Ms. Zarrin and the other to Mr. Bazzaz – a former transplant recipient and one of the founding members of the KPF whose coarse and penetrating voice I occasionally heard, but whose face I seldom saw. Mr. Bazzaz was a middle-aged heavy set man with salt and pepper hair and grey stubble who always seemed to drag his feet – his black slippers making gnawing sounds against the stone floors. I never observed anyone besides him enter or leave his office and it never became clear to me what his position was at the KPF. He would come and go as he pleased, always locking the door behind him and rarely exchanging a greeting or looking past Ms. Zarrin’s door. Early on I was instructed to always close and lock the outer bathroom door because Mr. Bazzaz detested foul odors. “He’s a transplantee. He says that’s the reason he’s sensitive to smells,” Ms. Zarrin explained.

In the waiting area where Ms. Zarrin’s clients awaited her attention, a tattered black faux leather sofa sat against the wall. There were no decorations, but an old carpet frame

with a Qur'anic verse hung above the sofa. Across from them was a worn out wooden desk, occasionally occupied by interns or a staff person operating as a temporary secretary on an especially busy day. Mr. Zahedi, the KPF's director, once noted to me that the old and broken furniture demonstrated the non-profit nature of the organization. "We don't want people thinking we are profiting from their predicament," he proclaimed. An attractive office would be a sign of excess and wastefulness. But if this particular KPF building had managed to keep up an austere appearance, the newly constructed Shafa Clinic across the street threatened to undermine it. On more than one occasion I heard a disgruntled visitor speak with contempt about the organization's alleged profit-seeking, gesturing to the brand new furniture and polished marble floors (which are in fact nearly ubiquitous in newer private and public medical treatment settings across the country).

Against a wall in the waiting hall stood a bookcase with dusty glass doors, packed with outdated pamphlets and booklets – mostly translations of English educational booklets on transplantation and dialysis belonging to the early days of the KPF in the 1980s. By Ms. Zarrin's door across the waiting hall there was usually a small wire cart filled with donated medication for dialysis and transplant patients. Some were from transplantees who no longer needed their supplements and others were from family members who had lost a loved one post-transplant or during dialysis. Ms. Zarrin removed the expired medication once in a while and left the rest in the cart to be used by other patients. On the second floor, across from the counselor's corner was the accounting office and the publishing room where articles for the organization's *Shafa* magazine were edited. One floor above it was a room where nurses trained patients and their families to administer peritoneal dialysis at home.

On the first floor, at the end of the narrow hallway on the right, a door led to a wide room with seats across the wall and a glass barrier separating visitors from staff workers. The staff collected clients' paperwork, provided kidney patient identification cards, and managed a large database of KPF members: Dialysis and transplant patients, as well as patients on the kidney waiting list who were matched with living kidney donors. The personnel moved sluggishly and spoke in low monotonous voices (appearing much like the typical indifferent and listless Iranian bureaucrat). They had little contact with patients and kidney givers outside of short exchanges through the glass.

The management's office was tucked away to the left corner of the hallway on the first floor and consisted of several rooms. One was occupied by a young female secretary. The largest belonged to the KPF director and it was the space where he conducted most of his affairs, including meetings with board members, philanthropists, and Health Ministry personnel. When Mr. Zahedi was not in his office in the Shafa clinic across the street, he could usually be found downstairs in this room.

In the absence of routine staff meetings and speedy internet communications, the primary mode of transmitting information from one compartment of the organization to the other was through intercom phone calls, the ad hoc transmission of hand-written notes and letters from management to staff members, and, when necessary, physical movement through the office.

Ms. Zarrin's office was not always on the second floor. In fact, when she was hired as a social worker in 2006 she occupied one of the smaller rooms adjacent to the director's office. She was tasked with guiding kidney patients through the process of obtaining loans and other financial services dedicated to patients with "special diseases" such as subsidized

medication.²⁵ She would also meet with small-scale financial donors and manage the allocation of donated funds. Mr. Zahedi on the other hand was responsible for larger philanthropic funds from patron private companies and wealthy donors. Before long, Mr. Zahedi requested that all prospective kidney donors meet with Ms. Zarrin first so that she could determine their needs, distribute some necessary forms, and guide them to the appropriate personnel downstairs. Soon crowds of people began to congregate in the small hall space between the social worker's room and the director's office. Eventually, Ms. Zarrin was moved to the room upstairs where she shared a hall-way and its amenities with the reclusive Mr. Bazzaz. Across the hall there was only the office of the accountant, who mostly kept to himself. So with this added privacy, Ms. Zarrin had much greater flexibility in how she interacted with her visitors. Clients could now be seated in the waiting room prior to individually meeting Ms. Zarrin away from the gaze of management.

This spatial bifurcation meant that the only person with substantial face-to-face exposure to the young men and women opting to give their kidneys in exchange for cash was the social worker, while management busied itself with the affairs of the KPF's primary clients – the kidney patients. At times kidney patients or their relatives stopped by in the director's office to side-step a protocol, most often to plead for a higher spot on the organ waiting list. It was not uncommon for him to comply, for example in the case of a mother who implored Mr. Zahedi to expedite the matching of her son with a donor, because on top of coping with her husband's chronic kidney disease and her own debilitating cancer treatment, she could not manage a son on dialysis. But unlike patients and their kin, kidney givers seldom had occasion to meet with the director. Exceptions included situations when

²⁵ End-stage renal disease is one of three "special diseases" for which the Ministry of Health has allocated various financial and therapeutic services. The other two are hemophilia and thalassemia.

a kidney giver wanted KPF approval for donating to a patient of his own choosing (a demand that to my knowledge was never granted) and when someone desired to donate despite failing to meet the KPF's age and family consent requirements.²⁶ Overall, Ms. Zarrin was the person with the most contact with kidney givers. With the autonomy afforded by spatial isolation from management and other staff, she could more freely experiment with various tactics to talk her clients out of selling their kidneys.

How to Donate a Kidney

The procedure for men and women wanting to exchange a kidney for cash was as follows: Candidates would meet with the social worker on the second floor where they would be walked through the process of kidney donation. Ms. Zarrin would make sure that they were between the ages of twenty and forty and that they possessed the necessary documents: A photocopy of their birth certificate, an official card displaying blood type, a consent form from their father or proof of father's death for single donors, and a spousal consent form or proof of divorce for all others. These requirements were hand-written on lined paper and pasted on the desk in the waiting hall as well as on a flyer board in the stairway. After delivering their documents, candidates would be instructed to visit the Shafa clinic next door, or another clinic of their choice, to complete preliminary lab exams to determine their overall health. If everything was clear, they would proceed to enlist as a donor on the first floor of the KPF and wait to be contacted once a recipient with matching blood-type was identified. They would then carry out more advanced exams testing the

²⁶ For example, once an unmarried university student who had failed to acquire his father's consent had been granted special permission to sell his kidney to pay his university tuition.

function of their kidneys, heart, and lungs, as well as testing for hepatitis and other venereal diseases.²⁷

This was, of course, the official routine. In practice, during Ms. Zarrin's six-year tenure, sellers would find their way into her office and she would request that they complete a donor form and pay a five thousand toman "processing fee." Both of these were tactics she had devised as minor road blocks to make donors at least pause and consider their decision to vend a kidney. She would then ask the candidates what had brought them to their decision. When they appeared receptive to a conversation, she would tactfully attempt to guide them to change course and seek a different solution to their woes. At the very least, she tried to make them realize that it was unwise to have a vital organ surgically removed for temporary financial relief.

Ms. Zarrin's attempts were not always successful. There were those who declined her efforts at "counsel" by fabricating stories or simply refraining from sharing any personal information. After repeated efforts, Ms. Zarrin had acquired practical wisdom into who was least likely to be dissuaded. Those would be the people for whom she would invest the least amount of time. They would walk in, inquire about the requirements, or if they were already prepared, show their documents for approval and proceed with the medical examinations and eventual submission of their file to the staff downstairs. For Ms. Zarrin, it was inevitable that she had to let some people go. This was also necessary because ultimately she had to allow for a certain number of kidney givers to match patients

²⁷ The KPF required that donors cover the costs of these tests themselves, perhaps as a way of reducing their own expenses, and more importantly filtering uncommitted donors who were perceived as likely to opt out if they had not already made the initial investment. These tests were rather expensive, costing nearly one million tomans in 2012, which was equivalent to the "award" donors would collect from the state. This left many prospective kidney givers despondent. I often heard from them that if they could put together one million tomans, they would not need to sell a kidney in the first place and would use the money to placate their lenders instead.

on the waiting list, otherwise management would be alerted to the shortage of donors and potentially undercut her efforts to counsel away donors altogether.

Management was not unaware of Ms. Zarrin's principled opposition to kidney selling and her attempts at talking people out of it. Ms. Zarrin explained to me once that she framed her activities as a benefit for the organization in the form of counseling for sellers. It would garner legitimacy for a program that had frequently come under domestic and international scrutiny, she argued. So management and Ms. Zarrin shared an interest in counseling prospective donors while assuring that a certain number made it to the list. For management, the interest had to do with protecting the organization's credibility while also assisting in the treatment of suffering kidney patients. For Ms. Zarrin, it had to do with ensuring that fewer young men and women fell into what she called the "sick cycle of disease and poverty" (what she deemed to be the likely result of kidney selling) while also maintaining her employment.

"I could have married an engineer"

A couple with a toddler walked in and sat next to Ms. Zarrin's desk. The petite young woman was dressed in an elegantly trimmed black manteau, blue jeans, and a gray shawl that revealed thick auburn locks sweeping across her forehead. Her eyebrows were tattooed in a natural unobtrusive curve, unlike some of the popular upward slanting "devilish" shapes that made one look somewhere between fierce and permanently stunned. The young woman had dropped in the previous day alone. This time she brought her husband along. He was equally refined in dress and waggled the child on his lap while they waited for another client to leave the room. Both were just about twenty.

“So you’re back,” Ms. Zarrin said. The woman smiled shyly and handed a small toy from her purse to the little girl. “You know it’s better for your husband to do it,” Ms. Zarrin continued. She always challenged a woman’s decision to sell a kidney when she was married to an able-bodied man. Usually when the husband was present, this would elicit a reaction of protectiveness that Ms. Zarrin hoped would at least momentarily perturb the couple’s decision.

- “I don’t want her to do it. I’ll do it myself,” interjected the husband.
- “Well why do either of you want to do this?”

The young woman explained that the couple had fallen in love six years ago. Two years later, when she was only sixteen and he was barely a year older, they married against the vehement opposition of both their parents.

“My family is wealthy, but they’ve completely disowned me,” the woman claimed. Her husband quickly followed, “My family says they could have found me a pretty wife.” Ms. Zarrin and I gazed at his wife. I noticed her hazel eyes, and delicate features. “My family says I could have married a doctor or an engineer,” the young woman retorted. The man lowered his head and played with the child, gently lifting her arms up and down.

- “Why won’t you both get a job and work together?” inquired Ms. Zarrin.
- “Where can we work? There are no jobs. I want to find a job, but they ask you to bring guarantors. If I had a guarantor I wouldn’t be calling them!” exclaimed the husband.

He meant that if he knew of people who could vouch for his experience and reliability, he probably would have had better job opportunities in the first place. He lifted the child off

his knees and gave her a nudge in my direction. I reached into a box beneath my desk full of donated coloring books and pencils and handed her a packet. She marched back to her father and delivered the gift.

The wife complained, "My husband doesn't give in to work, and our families won't help us. He's had several jobs; he worked for a mechanic, but wasn't satisfied and wanted to start his own shop. That shop closed down, then he worked at a mine, but the company ended up being a fraud." No rebuttal followed from the husband. "All my friends have everything! The lives they have – houses, cars, everything! I was invited to my friend's house tonight. But I don't want to go. I can't stand seeing their fortune."

- "Where did the fortune come from?" probed, Ms. Zarrin.
- "Her father is rich. But her husband is an addict."
- "And that's a good life?"
- "Hah! Do you do this to everyone? Do you turn everyone down like this?"

The woman snickered as she grabbed the child who was now sitting on her lap and poking her chest. She lifted the shirt under her unbuttoned manteau and fed her. Ms. Zarrin immediately gestured to her breastfeeding and turned to me: "And she wants to sell a kidney!"

- "At least I can then live *well* for five, six years!" The woman responded in a half serious way, carrying a smile so as to preempt ridicule from Ms. Zarrin.

Ms. Zarrin answered with a disapproving silence. She turned to the husband and bit the inside of her lower lip in a show of suppressed condemnation. The child suckled, but no one spoke. When the woman covered her breast, Ms. Zarrin calmly asked them to take their

time and think about it. They walked out without a word, bouncing glances from the floor to one another.

Cultural Poverty

In our conversations about compensated kidney giving, I was struck by Ms. Zarrin's assertion that increased information could not help dissuade prospective donors because they suffered from "cultural poverty" (*faqr-i farhangi*). I was alerted to this for the first time when I suggested to Ms. Zarrin that I could help develop a brochure that would use prose and visuals to impart the basic knowledge needed for an informed decision about donation. I thought that such a brochure could facilitate her work, having observed numerous occasions when she provided her clients summary or lengthy explanations on the functions of the kidney, causes of injury and disease, and the biomedical consequences of a nephrectomy. I offered to work with her to create the content and produce the brochure with management's approval. But Ms. Zarrin was not interested. "They [management] won't let you do it. Where would you even get the funds to print all those brochures?" Her objection struck me as strange given the high-quality printed periodical magazines the KPF had produced free of charge in recent years. When I insisted that I would shoulder the responsibility, she finally told me that she simply found brochures to be ineffective. "What's the point?" she asked me. To make sense of her dismissive attitude, I had to put it in the context of what Ms. Zarrin had repeatedly brought up to me as a problem of "cultural poverty" and the notion of *information* it produces.

In Iran, the notions of "cultural poverty" and its ostensible solution "culture-building" (*farhang-sazi*) have gained widespread use in recent years in both state discourse

and everyday parlance. State officials regularly call for culture-building in an array of fields ranging from driving to internet use, from literacy to environmentalism, from religious mourning to brain-death donation. Ordinary citizens may complain about the “lack of culture” or “un-culturedness” (*bi-farhangi*) of someone who neglects to shower before entering a swimming pool, or someone who discards wet food in a recycling bin. In this usage, *culture* is not simply a matter of hierarchically-differentiated embodied dispositions toward certain tastes in the Bourdieuan sense. Rather, it has to do with the collection of knowledge, dispositions, and affects necessary for a *proper* (possibly technical) approach to a subject that may or may not be correlated with socioeconomic status. For example, to build a “culture of brain-death organ donation” (*farhang-i ihda-yi marg-i maghzi*), it was not only necessary for the medical establishment to disseminate correct knowledge about brain-death, but to promote the values and appropriate models of volunteering. Doing so could depend as much on imparting factual information as on producing positive images through soap operas, commercials, and emotionally-rich film narratives that could refashion popular desires and aspirations. Culture-building thus has a discursive component, a practical component, and a dispositional component. When culture-building aimed toward promoting a particular social practice or behavior is successful, it finds its manifestation in individuals’ embodied dispositions, and not only in the breadth of their knowledge.

When Ms. Zarrin declared that many of the kidney givers she encountered suffered from cultural poverty rather than poverty in its common-sense meaning of financial deprivation, she was in effect indicating why the dissemination of knowledge alone would be insufficient for *informing* her clients. Instead, what was needed was training in building

a culture of financial management and prudent urban living, something she was not equipped to provide in those scant moments she had with her clients. She explained it to me like this:

“You know like some lady walks in with a highlight hairdo that costs a hundred thousand tomans, or it could be some guy with some big gold chain. This is how they are. They spend on this sort of thing. See, I haven’t bought myself a new manteau [overcoat] in three years. Just to give you an example. If I want to buy a pizza or a sandwich that costs five thousand tomans, I think ‘forget it, I’ll buy a chicken and eat it in three meals. Or maybe I’ll buy a carton of eggs and have it over ten meals.’ I think about a lot of things – not just the finances. Why should I eat this fast food when it’s unhealthy for me, and I’d be throwing away five thousand tomans buying it. I’ll buy the chicken or the eggs instead, and they are much healthier. I calculate these things. For example, I may consider riding a cab home, but then I say forget it, ‘I’ll get some exercise, and I’ll walk.’ You see, I’m thinking of my health too! It’s true I may smoke, which isn’t good for me. But I think of these things too. But a couple comes in here to sell a kidney. They’ll come in with their child, and I see they’ve just eaten lunch. And the child is carrying the prize from his kid’s meal. So you can tell, they’ve eaten out at a *khush mund* [high class] restaurant, not just any place. So this person has just paid at least twenty thousand tomans for a meal for three people – at least. This is what I mean when I say it’s mostly *faqr-i farhangi*.”

On another occasion, Ms. Zarrin told me:

“The thing is lots of them don’t really *need* the money. They’ve just heard something about making some cash this way. As soon as you tell them you need your father’s

signature, they walk out. I mean, everyone needs money. I sure need money! The point is, they might think it's an easy thing to do. They think, 'I'll get some money and buy myself a car or something.' So what I'm saying includes that *bi-farhangi* [lack of culture] as well. Not being able to make proper decisions. Not having enough knowledge. Well, maybe he or she has [school] education, but not *ittila'at* [information]. And when I say *bi-farhang*, I don't mean *bi-kilas* (without class). I mean someone who doesn't make the right calculations."

This notion that making an informed decision required far more than the acquisition of technical information motivated Ms. Zarrin's fragmented and even at times medically-unsound remarks about weight, the relationship between pregnancies and nephrectomy, and so on. As we will see, these remarks were mostly tactics she used to elicit a particular response, an embodied sensation that would have the effect of "shaking up" her clients. In a way her sentences can be thought of as *performative utterances* rather than transparent acts of referential communication (Austin 1962). They achieved the purpose of not simply conveying facts but altering the attitude of kidney sellers. Often times this involved a sort of "presencing" of the body, and more specifically of the kidney, so that her clients could *feel*, even if just slightly, the bodily dimension of transplantation.

The Seller's Body

Let me return to the young couple who were both eager to sell a kidney to improve their standard of living. When Ms. Zarrin gestured to the young woman breast-feeding her child, she seemed to be underscoring her corporeality. She was in a way indexing the raw

corporeality of the kidney transplantation the woman was hoping to undertake – to concretize and make *embodied* what is often a distant abstract thought, a disembodied opportunity for capital gain. Like the milk that flowed through her breasts and nourished her child, she would give something of herself (an organ) to nurture her lifestyle. But unlike the milk, the kidney would not be restored and the gained wealth would satisfy her only for a short while. She desired a life of comfort with the material luxuries that her friends had acquired and that perhaps her family had imagined for her in a more appropriate marriage. But in pursuing this lifestyle, she would be sacrificing a primary resource more fundamental to the family’s well-being than any temporary gain from a meager six to seven million tomans. An invasive nephrectomy could put her at long-term risk and incapacitate her in the short term, preventing her from adequately caring for her child as she recuperated from surgery.

Ms. Zarrin often made remarks about her client’s bodies, for example by expressing concern over a person’s excessive weight or their “vulnerable kidneys enfeebled by pregnancy.” In the conversation I described in the opening of the chapter, Ms. Zarrin objected to the young man’s insistence on selling a kidney on the grounds that he was too heavy. Her concern was not merely about the challenges his heaviness may have posed for surgery in a nephrectomy. More importantly, she was concerned that the man suffered from what she called a “condition of being overweight” that rendered his body unsuitable for organ donation. Ms. Zarrin was aware that hypertension and diabetes were the top reasons for kidney failure in Iran, and that those with excessive weight were at the highest risk for both these conditions. “These people are young. They don’t understand that if they don’t have high blood pressure or diabetes now, they might when they hit forty,” she said.

One study purports that nearly fifty percent of the adult population are pre-hypertensive (this means they are at a high risk for hypertension) and a fifth to a fourth are already hypertensive (Janghorbani et al. 2008). Obesity is also on the rise and is a serious risk factor for developing both hypertension and diabetes (Re 2009).

However, it was not easy to convince someone in their twenties that donating a kidney was a poor decision because their risk of developing hypertension would in turn further their risk of facing renal problems later on in life. Immediate anxieties about perceived financial crisis overshadowed concerns about long-term harm. Moreover, many saw themselves as already threatened by uncontrollable factors with major consequences. When Ms. Zarrin tried to explain the risks of an invasive surgery, prospective donors were often quick to dismiss her concerns by claiming that that there was probably more risk in crossing the street or breathing the toxic car exhausts in Tehran. Moreover, many medical doctors seemed to agree that kidney donation on its own did not significantly increase the chance of kidney problems as long as the donors maintained a carefully-managed healthy lifestyle. But this necessity of maintaining a healthy lifestyle was rarely explained to donors, so that the oft-repeated message was that kidney donation was safe. One urologist at a prominent university hospital responded to my concern about the risks of donation by remarking that those people who developed kidney problems subsequent to surgery in Iran would probably have faced those issues regardless of donation. "Many people who opt for selling their kidneys don't really have the know-how to take care of themselves. They would probably develop hypertension, or diabetes, or even renal problems anyway," he said. Contrary to the doctor's opinion, this to me was an obvious reason why those already

lacking the resources for adequate healthcare should be deemed especially vulnerable to harm and in need of protection.

Since Ms. Zarrin often failed in her attempts to convince sellers that their excessive weight or their previous pregnancies posed a significant risk for their well-being post-nephrectomy, she would occasionally resort to claiming that the condition of “overweightness” would transfer to the receiving patient or that a woman’s kidneys had already been harmed by pregnancy. To what extent this was medically accurate was beside the point. In the limited time she was afforded with the clients, and in the absence of permission and training in proper counseling, this was a tactic she could use to remind sellers of the vulnerability of their bodily interiors, or at minimum to provoke prospective donors to rethink their decision. Ultimately, however, physical harm was not the biggest of Ms. Zarrin’s concerns.

Her Hysterectomy

“The issue isn’t just about risk [to health],” Ms. Zarrin told me once. “The simple fact that someone walks in to sell a part of his body, to provide for something – a necessity he already has the right to have – the fact that he has to do this, this is what bothers me. It’s not just about risk to their health. It’s the other issue that bothers me most. It’s true that we didn’t make him poor, but we’re creating another crisis – a social crisis.” “Have you seen cases of people having sold a kidney and then coming in with their own kidney problems?” I asked her. “I’ve seen maybe two or three. I know someone who lost his one remaining kidney. But even if there were more, they wouldn’t come to me if they had problems.”

Anyway, I'm more concerned about those who have little knowledge [about transplantation]. Emotionally, what happens to them?"

Over a year earlier, Ms. Zarrin had undergone a hysterectomy on the recommendation of her doctor. A few times, I noticed that she pressed her fingers onto her side near her pelvic bone. She explained that ever since the surgery she felt a sharp pain in the vicinity of where her uterus had been severed. Despite the ongoing pain she was reluctant to revisit the surgeon. She was anxious and terrified that she may have harmed herself by accepting an optional hysterectomy. The sorrow of knowing that she had willingly done this to herself was too much to bear. So she avoided confronting the issue altogether (In the fifth chapter we will see a similar attitude in a kidney seller who experienced pain a year after transplantation).

"Before my surgery, I hadn't given this much thought. But now I think this person will realize later what little they gained in exchange for their organ. He might become depressed. Even though I knew that the uterus of an unmarried fifty-year-old woman is useless, I felt empty and defective after my surgery. I repeatedly reproached myself for so easily giving in to the doctor's recommendation. All I had was a cyst, why did I have to remove the whole uterus? At the moment when he suggested it, I didn't give it much thought. He recommended it and I just said okay. Do you understand what I mean? And now I think, why was I so naïve? I can't explain what came over me. But after that surgery I felt empty and depressed. What will happen to these young people who sell a kidney?"

The Person They Become

The primary moral drive behind living kidney donation within the medical community as well as the general public is one that relies on a Cartesian mind/body dualism. Among those uncritical of transplanting a vital organ from a healthy living person to an ill body, the assumption that doing so poses negligible harm is an entrenched one. This is based on biomedical knowledge of the functionality of the paired kidneys and research on post-nephrectomy health outcomes of kidney donors. Within this biomedical paradigm, harm is treated as a physiological effect that is independent of the donor's economic class and other socio-cultural conditions that shape the *lifeworld* (Husserl 1970 [1936]) the donor occupies. Biomedical science purports that most bodies hold two kidneys, of which only a portion of one is necessary for normal bodily function. Moreover, that many are born with a single kidney and live "normal" and "healthy" lives is proof for them that having a second kidney is not vital. This is treated as a scientific –therefore objective and universally applicable – fact.

Any concern for the well-being of the donor outside of this anatomist view is relegated to the separate and more malleable realm of the mind. A person's attitude towards kidney donation, which may be shaped by social meanings attached to the act and that depends on the reasons for donation, are perceived to be of negligible concern, primarily because kidney giving is deemed to be voluntary and based on the kidney giver's personal cost-benefit calculations. Furthermore, mental or psychological distress among donors is generally considered to be less threatening or even real than biological harm. While significant harm to the body is seen as a threat to the individual's day-to-day functionality that requires medical intervention, drugs, and hospitalization, mental distress

is considered to be manageable and even treatable without interventions that would further strain the kidney giver's financial and bodily resources. Moreover, many prospective kidney donors in Iran (and probably elsewhere in the world) believe that the mental distress caused by whatever it is that motivates their decision to sell far outweighs the psychological harms that may result from the transplantation. I often heard kidney givers straining to explain that the pressures they experienced were too great to bear, and that selling a kidney was their only possible solution.

Anthropologists have long criticized the Cartesian mind-body dualism that is regnant in the medical sciences and significantly shapes modern public imaginations of the mind-body relationship (Csordas 1997; Jackson 1996; Shaw 2010). One angle through which this bifurcation has been renegotiated has been through phenomenology. In the paradigm of phenomenology, one does not subjectively experience a pre-existing objective world. Rather one occupies a *life world*— a *Lebenswelt* in Husserl's terms (1970 [1936]) that is the product of shared individual everyday *lived experiences*. One experiences the life-world as a *lived-body*, which means that our consciousness, our being in the world, is intermediated by the body (Merleu-Ponty 1962: 137). The body is not “just an object in the world but that very medium whereby our world comes into being” (Leder 1990:5). Being inflicted by a disease alters the lived-body and therefore the life-world one inhabits.²⁸ The

²⁸ This should not be confused with the notion of *illness* in the explanatory model of interpretive medical anthropology (Kleinman 1980, 1988; Helman 2001). In this latter approach, *disease* as the biological or mental dysfunctions diagnosed by medical practitioners is differentiated from what the patient feels and describes as her condition. Through narratives, verbal expression, and behaviors, the interpretive anthropologist can arrive at the psycho-social dimensions of a person's predicament. But as Mol (2002) explains, this leads to *perspectivalism* where the perspective of the doctor is contrasted with the perspective of the patient. Both are ultimately interpretations, and belong to the realm of meaning (2002: 11-2). The downside of this approach is that it reifies the separation between the body and subjectivity, and fails to account for how our bodies materially change as a result of what we feel, or how technologies mediate our experiences.

concept of embodied experience in phenomenology allows us to explain the way in which the body encounters the world of materiality and meaning, and how this encounter holds sway in the subject's lived experiences.

When Ms. Zarrin differentiated between harm to the person's physical body (in terms of contracting an infection post-surgery, developing hyper-tension, diabetes, or loss of function in the remaining kidney) on the one hand, and depression and feelings of emptiness on the other, she was in a way trying to articulate the manner in which the lived world of the kidney seller can change after the transplant, as his lived body changes. Of her own hysterectomy, she said that "after the surgery, my world was no longer the same as my previous world (*dunyam ba dunya-yi qablam farq kard*). I haven't been well for over a year." She then reflected on the kidney sellers after surgery:

"When they come in at first wanting to sell, they appear so placid and subservient. And then you see the same person after they are released from the hospital. They walk in holding their side like this [she put her hand on her right side and tilted to the left, her upper lip curled and eyes squinting]. That same person now shouts at 'the system.' He's not the same person anymore."

In phenomenology, the lived body is both the "body-we-are" and the "body-we-have," both of which come together in our *body-image*, a concept introduced by Merleau-Ponty. Body-image is tied not only to its visual appearance, but also its tactile, ocular, gestational and olfactory aspects (Weiss 1999: 162; see also Grosz 1994: 100). And so when the conditions of the body change, when an organ is removed from the body – leaving traces of its absence through a scar on the flesh and occasional stinging pain – so does one's body-image. Body-

image is also intersubjective – that is, it is shaped through our perception of others' perceptions of our body. Therefore, how a friend, family member, or imagined member of society perceives our body, shapes our body-image, and in turn how we feel and experience our bodies and the life-world we inhabit.

Our embodied experiences are further entangled in cultural webs of signification (Gooldin 2008). In Iran, selling a kidney is stigmatized for it signals a person's dire misfortune and an inability to recover through "normal" channels of employment and/or kinship. It can also be closely associated with another form of "body-selling" (*tan-furushi*) – prostitution – although without carrying the same moral valence of reprehensibility. But by linguistic contagion, the notion of kidney selling can at first elicit a visceral reaction similar to that provoked by any mention of prostitution. Referring to this very phenomenon, Ms. Zarrin once shared an exchange between her sister and her nephew. "My nephew has grown out his thick dark hair. He mentioned to his mom that he was considering cutting it short and selling the locks. My sister immediately shrieked when he said that. And think, this was just hair –something he would have discarded after a haircut anyway!"

Within this realm of signification where the selling of a body part – spare or not – is frowned upon, the donor's embodied experience of the world, the way in which the individual encounters the world through the operated body, is affected. This is not merely about the meaning the seller associates with the experience of a lingering pain, but also about how the way one lives in the life-world is constituted through that embodied experience. As Ms. Zarrin said, one is no longer the same person, and one's world is not the same either.

I should note that Ms. Zarrin did not assume that this was the case for all kidney sellers. After she commented on the distressed seller who shouts at a system that has perhaps failed to meet his expectations for adequate payment and/or post-operative care, she quickly pointed out that there are also those kidney sellers who end up marrying their recipients. Not all kidney exchanges operate within the same moral economy, and the consequences they bring to bear on the life-world of the seller are not identical. Nevertheless, for Ms. Zarrin the less auspicious outcome was more common and too grave to be dismissed.

Presencing the Recessive Kidney

As Andrew Leder demonstrates in his philosophical ruminations on embodiment (1990), one's being-in-the-world depends on the "body's self-effacing transitivity" (ibid: 15). That is the body, particularly the interior body, has a way of receding from consciousness until disease or interrupted function makes it present or made to *dys-appear* (appearance due to dysfunction) (ibid: 84). If this were not the case, one would be unable to navigate the world without being overwhelmed with consciousness about every operation occurring in the body-interior and exterior.

The kidney is a part of the *recessive* body, an organ that lies deep beneath the body-surface, and in the case of a healthy individual is nearly never the object of direct engagement (ibid: 53-4). Because of this, it was not uncommon for kidney sellers to demonstrate little knowledge of where their kidneys were located or what function they served. And even if they could, Ms. Zarrin noted that this would not be based on an actual experience of the kidney. For this same reason I frequently heard kidney patients complain

that you cannot know the worth of the kidney until it falls ill and you lose it. When Ms. Zarrin remarked on a seller's body, she desired in a way to make her/his body *present*, so that he or she could at least in a subtle way feel the consequence of transplantation. Her own uterus had (dys)appeared as a part of her lived-body only after her hysterectomy. Consequently, she searched for tactics to make the kidney present, so that they would *know* it and recognize its worth as the kidney patient did, before undergoing surgery. A few times she had been successful in persuading a young couple to visit a dialysis ward to comprehend what the loss of the remaining kidney could entail. In both cases that I was aware of, the couple rescinded their decision to vend.

Escaping a Zero-Point

September 2011. Ms. Zarrin grabbed a large piece of flat bread and some feta cheese from the fridge in her office and spread it on the desk. I brought out some sweet bread I had bought from the bakery down the street and we snacked as Ms. Zarrin shared the bleak story of a divorced friend she had visited in Shiraz over the weekend. Meanwhile, a short and stumpy man wearing thick prescription glasses stumbled into the room. His head was tilted downward and his pupils shifted quickly from right to left, too shy to focus his gaze on either one of us. He muttered a greeting to Ms. Zarrin as he rested a black duffel bag on the desk. Ms. Zarrin welcomed him with a smile and gestured to the food on the table, "Come, have some bread and cheese! What do you have for me today?" The man unzipped the bag and spread the goods on the desk. There were an assortment of men's cotton socks, nylon stockings, under-scarf bonnets, and knitted shower gloves. "You didn't bring those cotton gloves you usually bring," Ms. Zarrin exclaimed. She picked up a couple of bonnets

with plastic rhinestone details. “My mother’s pretty religious. She loves wearing these under her headscarf.” The man excitedly grabbed a few more bonnets from his bag. “I have them in lots of colors, w-w-w-why don’t you take a green one? A g-g-g-reen one would suit your mother,” he stuttered. Ms. Zarrin smiled as she emptied the bread crumbs from a plastic bag and walked to the fridge to grab a package of *nazri* red meat someone had asked her to distribute among kidney patients and transplantees. She wrapped the frozen meat in a sheet of newspaper and then the plastic bag and handed it to the man along with three thousand tomans for the bonnets. She then wrapped a chunk of the sweet bread in a napkin. “Take this for the kids.” I also purchased two pairs of socks before he bashfully thanked us and made his way out of the door. “He’s a member of the KPF you know. He had a kidney transplant back in 1999 after battling kidney disease since childhood. You can see how the disease affected his stature and his mental development. He has two small kids and can’t do much work besides street peddling.” In the days that followed, Ms. Zarrin distributed the remainder of the meat, as well as some sweaters donated by a shop owner.

Moments after the man had left, a woman clad in a black chador walked in timidly asking about “selling a kidney.” She sat down on a chair close to Ms. Zarrin.

- “Are you married?” asked Ms. Zarrin.
- “Yes.”
- “So, why are *you* volunteering to do this?”
- “My husband can’t give his. He only has one kidney.”
- “You know doing this isn’t good for women.”
- “I know. I’ve asked around.”
- “And you still want to do it?”

- "Yes."
- "How many kilos are you?"
- "87."
- "Well then you're overweight."
- "I went to the doctor a while back, and she also said I was overweight. But I lost weight, and I saw her again just now, and she said there's no problem. She figured out my blood type as well. She told me to come here."
- "She accepted 87 kilograms?"
- "Yes."

Ms. Zarrin paused and glanced out the window. The *azan* (call to prayer) projected from the mosque nearby. Its muffled sound reverberated through the room.

- "How old are you?" she asked.
- "31."
- "How many pregnancies?"
- "Two."
- "You don't want more children?"
- "No."
- "Well with two pregnancies already and your extra weight, this will be more harmful for you."
- "I know. I already know that. But I'll try to lose more weight." She pleaded.

- “But you see, you’re the overweight *type*. It doesn’t matter if you lose weight. You are the overweight *type* regardless. You are much more likely than me for example to get sick, to get hypertension, diabetes.”

The more Ms. Zarrin insisted on the woman’s unsuitability for kidney giving, the more desperate and imploring the latter’s voice grew.

- “Well I’ve given it a lot of thought, that’s why I’m here.”
- “Okay. So you’re ready for the tests?”
- “Yes. How much will it cost?”
- “Four hundred thousand tomans, but your insurance may cover some. Here you go. Please complete this outside.”

She handed the woman a form. As she stepped outside, a man who had visited Ms. Zarrin a day earlier walked in. It was an especially busy day, and Ms. Zarrin could not have her clients fill out the forms in her office as they usually did.

- “So did you find out about *azad* [free market] selling?” Ms. Zarrin asked the man with a smirk.
- “No,” he responded.
- “You insisted on it so much the other day, I was hoping you would bring the news of how it’s done! So you took my word for it?”

The man nodded and Ms. Zarrin proceeded to explain the procedure for donating through the KPF.

- "It's five million tomans, which you will receive after the surgery from the recipient, and one million you'll get from the state, but that will take time, like any bureaucratic process. So you want to do it?"
- "Yes."
- "You *do* realize that this is a vital organ. It's a main organ, not spare, useless, unnecessary, whatever it is they call it these days in the streets. It's an important organ."

The man confirmed his decision to go ahead with the process with short, simple, answers. He seemed impenetrable, but Ms. Zarrin also appeared too occupied by the woman she had just sent outside to fill out a donation form to further haggle with him. The man stepped outside with the forms, and the woman walked back in. She placed the forms on Ms. Zarrin's desk and took a seat.

- "Please stamp your finger here and write down a mobile phone number right there," instructed Ms. Zarrin as her eyes paced the form - *age, place of residence, list of dependents, income, history of illness...* "So how long have you been living in *Dawlatabad?*" she asked.
- "We've been there for ten years."
- "And before that?"
- "At my father's home," the woman responded softly.
- "So what does your husband do?"
- "He has a truck. He works his truck."
- "Well that's good, isn't it?" Ms. Zarrin asked encouragingly.

- “We have problems, lots of problems. I’m just tired, so tired.”

It appeared as though the woman’s coy and vulnerable demeanor exhorted Ms. Zarrin to further persist in her questioning.

- “So what problems do you have?” She inquired.
- The woman spoke softly. “He had an accident with his truck. Now we have to pay a large *diyah* [blood money]. My life has been destroyed. I’m extremely tired. I don’t want to exist anymore.”

The woman clenched her chador as her face crumbled into a frown and agitated smile – pain escaped her eyes as she struggled to maintain a semblance of calm.

- “So why doesn’t *he* give his kidney?”
- “He can’t! He was born with one kidney. My luck!”
- “Have you tried for a loan?”
- “I have tried everything. They all want three guarantors!” she exclaimed. “Where do I find three guarantors? They want to give you a five hundred thousand toman loan²⁹ and they ask you for three guarantors. But from where?”
- “But will this solve your problem? Just a few million from a kidney?”³⁰
- “Well, at least it will cover a corner of it. When you consider something like this, it means you’ve reached a zero point - absolute zero. I just want to salvage a small corner of my life.”

The woman’s voice grew more and more assertive as the initial shyness of expressing her family’s affliction wore off.

²⁹ At the time this was slightly more than a secretary’s one month salary.

³⁰ The *diyah* her husband owed was over forty-five million tomans.

- “But if you can’t pay the entirety of the diyeh, how will it save any part of your life?”

The painful reminder that even selling a kidney may not save the woman from her troubles was disturbing.

- “Don’t bother yourself [*khudato aziat nakun*]” Ms. Zarrin implored. “We are all living in this same reality. We are just trying here to think about different solutions.”
- “I can’t think of anything else. Nothing else,” the woman moaned.

Silence engulfed the office, and glances sauntered the room, as if the walls would eventually reveal something. With a calm and lowered voice, Ms. Zarrin tried to help the woman think through her predicament.

- “You say he had an accident with a heavy diyah. So say you get five to six million, and the recipient gives you another five hundred thousand as an added gift. I mean why would s/he give more, when s/he knows the payment we’ve set? Say s/he even pays for your lab tests too. It’ll be in total seven million or so. But this won’t pay off that hefty diyah. All it will do is leave you impaired [*naqis*]. I would like to prevent that. I mean, what else do *you* think could happen?”
- “At least I’ll come out of this zero point.”
- “Will you? They [the diyah seekers] aren’t going to accept just a little bit now, and say we’ll collect the rest later, will they?”

The woman lowered her head and her face crumbled once again, this time without the faint smile.

- “I don’t know anymore. My mind doesn’t work. I just want it to be over.”
- “But it won’t end. It’ll just start another problem.”

- “Please don’t empty my heart [*tu dilamu khali nakunid* - don’t cast doubt on my decision]!” The woman implored.
- “Our purpose is not at all to scare you. We just want you to have this information. So if tomorrow something happens to you, you know that at least someone else cared enough to tell you. Whatever you decide, it will be my duty to respect that.”
- “What can I say, this is the only thing I can do.”

Ms. Zarrin would not give up.

- “But if you do this, you still may not solve the problem.”
- “Inshallah, the rest will come together as well.”

At this point Ms. Zarrin realized that her line of argument would not work. She turned to me, her head slightly tilted, hinting that she was out of ideas and wanted me to step in.

- “Are you working right now?” I asked.
- “No I’m not employed. I used to work, but not anymore,” she replied.

Lacking in Ms. Zarrin’s tactics of persuasion, I was unsure why I had asked that question. Would I have tried to convince this woman that finding a job would be more suitable than selling a kidney? I shifted to the issue of bodily harm instead, but still was unable to sustain a line of argument.

- “When you spoke to the doctor, did he explain to you what the consequences are?” I asked.
- “Yes he did. He said you have to be careful. I don’t remember. I don’t remember this sort of thing. *Tavakkul bih khuda* [My faith is in God].”
- “Is there anything else you’d like to say?” Ms. Zarrin asked me.

- "I don't know. I suggest you take your time. Maybe that other way that you hope to obtain the rest of the money will be the best way to cover the entirety of the diyah. Do you want to think about it some more?" I asked.
- "I've been thinking about this for one year. I have been hoping for this to work for a year now. Even losing that weight was so difficult for me. I did everything I could to lose the weight. I was under so much pressure. I couldn't do anything else."
- "How much did you lose?" Ms. Zarrin asked cheerfully, in a subtle effort to brighten up the mood.
- "Twenty-five kilograms."
- "Wow! In how much time?"
- "Since Eid [seven months earlier]."
- "How?"
- "With diet and exercise."
- "That's incredible. I can't even lose two kilos!"

The woman's face brightened up and she pushed her head back in a show of confidence. A pregnant silence engulfed the room. If only Ms. Zarrin had the authority to prohibit the woman from selling her kidney, she seemed to think. Moments later, she reached for the forms on the desk and concluded the session with a final attempt to at least delay the decision a while longer.

- "We'll get back to you. In good health."

It was not clear if Ms. Zarrin had managed to dissuade the woman. Perhaps she thought that the woman would return home, gratified that she had made a serious attempt to escape the zero-point she was stuck in. Maybe she would wait for someone to contact her,

and when no one did, she would assume that she had been disqualified and move on with her life. She would achieve a sense of having made a serious effort for her family without losing a kidney and having to undergo the subsequent misery of giving up a vital organ without even being able to pay off the diyah. Or perhaps she would visit the clinic next door, obtain clearance for the tests from the doctor, return downstairs with all the documents and put herself on the donor list. Ms. Zarrin would probably never know.

Ruses of a Lizard

When the woman stepped out of the room, Ms. Zarrin was visibly flustered. We were both moved and troubled that such a calamity had befallen the woman and that selling a kidney was the only solution she could foresee. “Look, we don’t have the resources to spend this much time on everybody. We just can’t. I can’t to do this for every person who walks in,” Ms. Zarrin snapped in frustration. She then proceeded to tell me a story about a master’s student from the University of Tehran who had dropped in the previous day, another case of failure to dissuade a seller.

“He was an engineering student from a farming family. He had a tumor three years ago and had surgery. He said he managed to acquire an exemption from military service for this. He wanted the money to leave the country. I said, ‘where do you want to go?’ He said, ‘I’m thinking of either Sweden or America.’ I said, ‘but this won’t be enough for you to do that.’ He tells me he has something like a scholarship. He just needs money for the preliminary expenses. I said, ‘but it’s such a waste [to give up your kidney for this].’ He said he’d seen a doctor – and Elham, I want you to pay close attention to this sentence – the doctor said, *‘you just might not become an*

Olympic champion if you do this.' This is what the doctor says. So I ask the boy, 'what do you think of this? Do you think he would say that to his son, to his daughter, his own brother? Or did he just say that to you?' So the boy says he doesn't have the patience for this kind of argumentation. So I said, 'why did you come here then? You step into a counselor's room. I assume you want to talk.'"

Ms. Zarrin released a loud sigh of despair. "It was an interesting case. You know, for me as well. He just shrugged his shoulders and left."

- "So you gave him the form?" I asked.
- "No, actually the room was crowded. I told him to go downstairs, tell them I have the form. I said just go, you don't need anything."
- "But can they go ahead without the form? Don't they need to stamp their fingers here?"
- "Well these are all *inhibiting factors*. Filling out the form is one thing that forces them to pause. Maybe they'll think about it again. And the fingerprint - when they're putting their finger in that stamp, it makes them think that this is serious, that I need to listen to what she says. I'm responsible. Maybe they'll think twice."
- "So these are all new requirements?"
- "Yeah, I implemented them. I don't know. These are just things that cross my mind."
- "Is it effective?"
- "I think so. I really think so. For a lot of people, as soon as they fill out the form, they pause and say 'okay then, let me think about it, I didn't know it's like this.' They might leave and not come back. There are just so many cases, so many who come in

that there isn't much more that you can do. At least *I* can't think of anything. You know when I go home, before I go to sleep, that's usually when I start thinking of what tactic [*taktik*] I can use the next day. What might work on some people might not work on others. Like maybe I can convince someone that their weight will cause them problems, but for someone else you have to use another tactic. Like this morning this young man asked me if giving a kidney would harm him. It didn't seem like he really wanted to hear the truth, and even so, he'd probably see some doctor, like the one who told that boy he can't be an Olympian, he'd talk to a doctor and they'd tell him he'll be fine. So I said, 'if you didn't need the kidney, why then would God put it in there in the first place? His wisdom is greater than ours!' Would this work? I don't know. But it was something I thought of last night. Every night I lie in bed and I think of what happened that day, and I come up with a sentence — something I can say that'll shake them up. You know, to really think about it."

Ms. Zarrin's use of the term *taktik* in reference to the way in which she artfully dealt with her clients brings to mind Michel de Certeau's (1984) notion of *tactic* as differentiated from *strategy*. For de Certeau, strategies emerge from positions of power, while tactics are "the art of the weak." As Robert Desjarlais elaborates, "The difference between strategy and tactic hinges on the spatial and organizational capacities of different social actors" (1997: 183). Those at the locus of institutional power and autonomy plan and strategize, while those in the margins must rely on ruses and "the good and bad tricks of rhetoric" (de Certeau 1984: 39 in Desjarlais 1997: 183). Similarly, Ms. Zarrin never used the term *ravish* (method), or *istiratiji* (strategy) in this context. In fact she despondently referred to her

ways as *marmulak-bazi* (the games or ruses of the lizard). In the social hierarchy of the KPF – an institution consisting of nephrologists, surgeons, and administrators – Ms. Zarrin was a dispensable member. Moreover, her intentions with regards to dealing with kidney sellers threatened to come into conflict with what the organization expected of her, further shoving her into the peripheries of power. Her practices of dissuasion, that is, could never be more than tactical. Nevertheless, the very spatial, temporal, and material features of the bureaucracy that were supposed to facilitate the matching of donors and recipients could turn, in Ms. Zarrin’s hands, into instruments for turning people away. They became tactical tools with which she could develop an emerging ethical vision and craft her own ethical subjectivity.

Forms as Impediments

Forms are the quintessential component of every bureaucracy. In Iran, carrying a *pushah* or folder containing documents and forms is the obvious sign of being embroiled in a bureaucratic process. Leaving a bureaucracy without having either turned in or collected a form is like not having entered one at all. The form has been studied in the humanities and social sciences as an artifact of modern knowledge (Riles 2006; Wheeler 1969), and the primary activity of the bureaucracy with significant material and symbolic power (Gupta 2012; Hull 2012). The form is afforded authority and legitimacy as a technology of rational bureaucratic processes for its transferability, facelessness, and permanence (Wheeler 1969:5). Importantly, it has a way of *enacting* (Callon 2006; Law and Urry 2004; Moll 2002) the very bureaucratic objects it serves to document. In the opening of this chapter, we saw how the first prospective kidney giver withdrew from the social worker’s office with one

final request, that he be given a form before he once again changed his mind about making a crucial decision about his body. One is not a donor without having a piece of paper documenting the fact, and once a donor form (even an empty one) is physically held in one's hand, one can viscerally feel the initiation of a bureaucratic process of *becoming* a kidney giver. The form can turn an abstract idea about selling a kidney to solve a financial predicament into a real, practical process with spatial and temporal dimensions. Obtaining, filling out, and submitting a donor form can be seen as not just a mundane component of the bureaucratic process, perhaps necessary for one to achieve the goal of becoming a donor, but one that concretizes the idea and can thus propel the subject of the form to move forward with the task at hand. This is precisely what the first prospective giver was hoping for, to be pushed by the inertia of the form. In the case of the woman who considered selling her kidney to pay off the blood money her husband owed, completing the form could have afforded her the gratification of having taken a real step to rescue her husband and her family. Ms. Zarrin hoped to grant her that gratification, but by asking her to wait to hear back from the KPF, possibly hinder or postpone the remainder of the process.

This quality of concretizing and actualizing an imagined possibility can also have the opposite effect, of stopping a potential kidney giver in his tracks. The lightness of an abstract thought is given weight when one is confronted with the form. It is this aspect of the form that Ms. Zarrin relied on to bring to reality what she deemed as just an abstract thought for some of the youth who entered her office. Perhaps they would think twice before it was too late, she hoped. Surely, a potential donor would encounter more such artifacts in the process, if not in the social worker's office, then most certainly at the Shafa

clinic where he would be tested for health. But perhaps it would be too late then. This was one of the reasons Ms. Zarrin came up with the idea of demanding personal and family information from anyone who attempted to sell a kidney. In effect, the form had no other bureaucratic purpose. It was not necessary for one to complete a form in order to complete the lab tests, to obtain a blood type card and to place one's name in the donor database downstairs. Ms. Zarrin never actually turned in the forms to any other personnel or her supervisors. They were stacked in binders that she kept in her office under careful protection. In this sense, the donor forms were "bureaucratic" artifacts in the Weberian sense only for the *potential* of being replicable, portable, and permanent. It was the symbolic power the forms held as an instrument of documentation – an instrument through which people left traces of themselves and selectively exposed aspects of their private lives – that prompted some people to pause and rethink the idea of selling a kidney.

Ms. Zarrin explained to me that she had managed to obtain approval for distributing and collecting these forms for the potential they held for future use. She had persuaded the director that the data in the forms could provide crucial statistical information on the socioeconomic profile of kidney donors. This data could then potentially be used to quell the anxieties of the opponents of kidney selling who felt that sellers were not being accounted for. Keeping documents and statistical data on things like age, income level, and sex indicated bureaucratic discipline and competence, and could further the organization's legitimacy and credibility. After all, "What kind of an organization doesn't keep track of their clients?" asked Ms. Zarrin. Though Ms. Zarrin obviously appreciated the potential of the forms as a source of data for future analysis, that was not the day-to-day purpose they fulfilled in Ms. Zarrin's routine encounters with clients. On an everyday level, filling

out a donor form constituted a crucial tactic for slowing down the process for potential kidney givers. The temporal dimension of physically penning in the blanks in the form provided the advantage of allowing Ms. Zarrin to use the content of the form as a means to initiate a conversation about the candidate's decision to sell a kidney. The time it took for a person to do so also gave Ms. Zarrin the opportunity to construct the appropriate sentences to achieve the desired effect of changing a seller's mind.

Bureaucratic forms also serve the social function of disciplining the activities of personnel by leaving records of the client-employee encounter (Gupta 2012). The almost instantaneous transportation and permanent recording of forms through digitization and file-sharing in computer networks and distribution through the internet imposes significant control on the activities of employees. However, in the case of Ms. Zarrin, the donor forms were not transported outside of her office. The dilapidated computer in her room was disconnected from the internet, and she did not maintain digital copies of her forms anyway. Even the contact information of financial donors which Ms. Zarrin personally accumulated through the years was carefully recorded by hand in a large personal phonebook that she kept to herself. "These are relationships of trust that I have built over the years, with people who trust *me*, not so and so in the KPF who has never exchanged a word with them. I can't distribute this information and risk losing that relationship with the donors. Too many of my patients rely on their assistance," she told me. The lack of visibility of her activities due to the immobility of papers afforded Ms. Zarrin a degree of autonomy within the bureaucratic space to act in accordance to her own ethics.

Conclusion

In 2006 a documentary titled “Iranian Kidney Bargain Sale” found an audience on youtube and social media. It depicted the stories of three kidney sellers as they registered to be matched with patients and then underwent transplantation. The documentary showed a character named Mr. Seifi (whom Ms. Zarrin had been hired to replace) as he mediated the financial transactions between seller and patient. Ms. Zarrin had heard of the film, but had not seen it. One day, per her request I brought the CD and my laptop and together we watched a scene where Mr. Seifi negotiates a price between a young seller and an even younger patient. This scene perturbed Ms. Zarrin. She commented, “Maybe what Seifi is doing is better – handling the transaction like that. But then, what I do is more systematic. I don’t know. Someone needs to study this.” Minutes later, she wiped the tears that had joined the sweat above her cheeks and half-jokingly said “Elham, leave already. I don’t want to lose my job. I don’t have another source of income. You show me this film, and... I too am like Seifi [a broker for organs]. I didn’t want to be him. I didn’t want to be another Seifi.” She then tilted her head forward, scooping her face in her palms, and pressing her eyelids as if to hold back more tears.

Everyday, Ms. Zarrin responded to her moral intuition that individuals should not have to sell a body part in exchange for financial relief. It was not the act of buying or selling the kidney that she deemed unethical per se. What was problematic was that an institution intimately affiliated with the state should legitimize and incentivize the act, in turn encouraging many who otherwise may not have done so to consider selling a kidney. Every day, the bureaucratic space and position she inhabited brought her face-to-face with various ethical decisions – whether to confront a seller, how much effort to exhaust in

reasoning with or provoking a client, and what tactics of dissuasion to employ. Perhaps the limited time she was allowed with clients, coupled with her perception of their youthful callowness, impelled her to rely less on reasoned persuasion than on rhetorical maneuvers and quick routinized tactics like demanding that a form be filled out, stamping a finger, paying a small application fee that would concretize and render embodied the abstract notion of severing a kidney for financial gain.

These everyday choices and encounters relied on and were animated by an ethics – as in a set of moral reasons and guidelines – which was continually in the process of formation in reaction to these very daily encounters. From everyday ethical encounters and circumstances, and in the absence of a shared institutional ethos, she developed an emergent ethics that was not based on abstract notions of autonomy, beneficence, harm, and so on, but was rather ad hoc, cumulative, and provisional in its formation, and therefore deeply textured with everyday practice. A processual approach that contextualizes the development of emergent ethics is important, as it identifies the loci from which moral concerns arise, and can therefore inform how ethical responses can be adjusted to new and different contexts.

For this reason, in this chapter I attempted to couple Ms. Zarrin's ethical concerns with particular affective and material events, as well as the spatial and structural organization of the KPF as a bureaucracy. Although I share many of Ms. Zarrin's concerns, and must admit that my proximity to the events she intimately experienced shaped the contours of my own ethical thinking with regards to kidney donation, I do not want to suggest that these principles should be universalized. That is why for this kind of emergent ethics to develop into Ethics with a capital E, it must be carefully situated within the

everyday limitations and conditions of possibility within the landscape from which it emerges. A look at an ethical agent's tactics (or strategies depending on the context) can achieve this by simultaneously revealing the moral logics, principles, and concerns motivating action, while also pointing to the spatial and organizational capacities of a social actor that may affect the way in which those moral logics are made actionable. As Foucault and others have extensively stated, freedom is the necessary condition for ethical action. And so, paying attention to the range of possibilities available to a social actor, and the way in which she may carve out pockets of autonomy and freedom to act morally (or at least attempt to do so) is crucial to examining emergent ethics. At the same time, as I have shown, Ms. Zarrin's ethical decisions were fundamentally shaped by a recognition of constraints. These ranged from the impositions of a bureaucracy to which she was committed as an employee, to her time limitations, and finally to the limits on her own knowledge which seemed to play a part in her "giving in" to a fraction of her clients who seemed really to have no good options before them.

Paul Brodwin writes that *everyday ethics* has to do with the acts of ethical decision making that emerge in the "familiar landscape of [everyday] practice" and in the "collision zone between the desirable and the possible" (2013:179, 29). In the context of bureaucratic institutions, everyday ethical sensibilities are provoked by blockages in work and a breakage between an ethical agent's own moral demands on the one hand, and the messy, practical requirements of the work space on the other. Ethical responses are characterized by a choice between day-to-day bureaucratic routines and directives, and a subject's own notion of the moral (ibid: 19). Brodwin argues that careful ethnographic description can reveal the "micropolitics of work" that give rise to everyday ethics in sites

of “moral breakdown” (Brodwin 2013: 57; on moral breakdown, see Zigon 2008). By understanding everyday ethical actions, he says, we can gain insights into the shortcomings of normative ethical discussions and the regulatory practices they motivate.

Applying Brodwin’s analytics of everyday ethics brings me to reflect on the contrasts between the bureaucratic condition of the clinicians he describes and that of Ms. Zarrin at the KPF. Brodwin writes that in everyday ethics, “what the person achieves is often evanescent and insignificant, even from the standpoint of the local work group. A hallway discussion, a staff-room debate, a push to alter the standard procedures for future cases – the real-world result of everyday ethics rarely go further” (2013: 20). In the case of the clinicians Brodwin describes, as is the case in most established institutions with defined and strongly enforced procedural guidelines, the range of possible actions are narrow, and though at times choices are made outside protocol, they are nevertheless most often within the bounds of behaviors that further the goals of the organization. Brodwin uses the notion of *ethos* to capture the more implicit collective ideals of an agency. “The ethos involves a shared set of emotional attitudes that exert a compulsive force. An ethos thus functions as an implicit demand to pledge loyalty to the institution, its standard recipes for action, and the ideals woven into ordinary gestures of work” (2013: 56).

In the case of Ms. Zarrin, although she did not possess full autonomy, her actions were consistently against the preferences of the KPF’s director. She dissuaded donors when in fact her task was to facilitate the process of kidney selling. But most importantly, the moral bewilderment that Ms. Zarrin exhibited throughout the years in which I observed her actions was indicative of the ethical uncertainty underlying incentivized kidney donation within the KPF and without. The lack of a coherent ethos at the organization,

particularly one to which Ms. Zarrin could adhere, pushed her to fashion her own moral rubric, enabled by routines she managed to formalize within the organization, as well as through her moral reflections on how things should be, or could have been had “people chosen to see what she saw.” Ms. Zarrin was interested in turning her day-to-day observations and challenges into a theoretical commentary on organ selling, a principle-based system for approaching kidney sellers that would not only guide her own decision-making, but would contribute to a broader discourse of organ donation.

How can a consideration of Ms. Zarrin’s emergent ethics contribute to bioethical discussions? I suggest that it does so by insisting that bioethicists should not separate the practices they evaluate from the ongoing ethical considerations in which they are entangled. For Paul Brodwin, the everyday ethical decision making of his interlocutors revealed the fault-lines in bioethical judgments. Similarly, I argue that bioethical considerations should be reframed not as experience-distant reflections on practices out there in the world, but as engaged exchanges with actors whose ethical lives we take seriously as intelligent, reflective moral subjects. Rather than relying on the work of anthropologists to describe what goes on in a given situation so that they (the bioethicists) can then construct normative ethical positions about the situation (or worse, engaging in arm-chair consideration of disembodied thought-experiments), I argue that they need to take seriously the ethical wisdom of the actors directly involved in these situations and entertain the possibility that they may even learn something by joining them in serious and open conversation.

Chapter 4: Making Fatwas for Policy

“[Shi’a rulings on kidney transplants and sales] shouldn’t surprise you. Because through Shi’a jurisprudence we may reach conclusions that neither Sunni jurisprudence nor the jurisprudence of westerners can reach. Because, you see, our jurisprudence is extremely rich. We have numerous sources and principles [*qava’id*] that don’t even exist in their jurisprudence. Now one issue is that of cloning. In the case of cloning [*shabih-sazi*], though there is some disagreement, most of our jurists state that it is without a problem. Cloning! Now all over the world this has been prohibited. Christians, Sunnis, all have prohibited it! Now the question you raised should be answered, and we have to see what the reasons and principles pertaining to it are and what conclusions we reach with them, regardless of whether the world agrees with it or not.”

Ayatollah Mohammad-Javad Fazel Lankarani

How could kidney sales become routinized in Iran? What role did the state’s Islamic character play in this routinization? The short answer is that the establishment of a policy and bureaucratic procedure for compensated kidney donations depended in large part on successful attempts by a number of key policy-actors to secure favorable fatwas from high-ranking Islamic jurists. But this opens up a larger question: Just what is the relationship between fatwas and policymaking? What kind of authority do fatwas enjoy when they have policy implications, and what sets these fatwas apart from other Islamic legal opinions that are addressed to situations that have nothing to do with policymaking?

A fatwa is a legal opinion provided by a jurist after a process of discovery and interpretation of Islamic law. This process is contingent not only on the jurist’s interpretation of the sources of Islamic law, but equally on the jurist’s understanding of the

problem at hand and the premises upon which it lies. My aim in this chapter is to explain how jurists' *fiqhi* (Islamic jurisprudential) principles converged with medical assumptions to legalize the sale of kidneys. Here, I suggest studying fatwas processually with attention to the extra-legal components that inform their formulation. This means attending not only to the fatwa, but the question or set of questions that elicit the fatwa, and importantly, the "problematizations," framings, and assumptions within which the questions are embedded. This means attending to the actors and institutions that pose the questions and the processes of abstraction that result from the translation of knowledge from one field of expertise, such as medicine, to the expert field of jurisprudence, as well as the practices of abstraction inherent to the formation of those fatwas with policy implications.

Before I delve into fatwas on kidney sales in Iran, it is pertinent to situate the fatwa within a field of Islamic bio-governance. And here, by *Islamic* I mean a highly contingent application of Islamic mores as understood and deemed relevant by Shi'a jurists and state actors, which is as dependent on the sources of law as it is on the pragmatics of governance. I will then expound on the intimate relationship between law and medicine since the Islamic Revolution to illustrate some developmental trends in jurisprudence that I argue have been instrumental to the formation of permissive fatwas on kidney sales.

The authority of Shi'a jurists in Iran is typically understood in the form of a top-down vector that originates from the clerical establishment and extends over every other domain of social life. This is an idealized view enshrined in the official ideology of the Islamic Revolution and shared in Western popular and scholarly imaginations of the "clerical regime." In this chapter I demonstrate that contrary to this misleading image, fatwas – often treated as the ultimate expression of Islamic legal authority – can in fact be

strategically prompted and mobilized by various experts and institutional figures to further their particular policy objectives. Furthermore these latter actors may not only critically shape the content of new fatwas – by configuring the problem for which a fatwa is sought and supplying expert knowledge – they may also purposefully calibrate the scope of a fatwa’s authority depending on the discursive and practical contexts in which it is evoked. Far from implying that maraji’, the highest ranking Shi’a jurists and sources of emulation, function as pawns in the hands of experts and other policy actors, I suggest that the highly technical and arduous process of forming what I call a *policy-oriented fatwa* is a thoroughly dialogic one that is significantly shaped by a host of social and political influences.

In what follows, I analyze the process by which fatwas on kidney selling were prompted by the non-profit Kidney Patient Foundation (KPF) to show how the selling of kidneys became permissible (*jayiz*) despite the widespread social stigma surrounding the act and the moral ambivalence by which it has been treated by the same organization and group of actors that advocated for the fatwa in the first place. Furthermore, I argue that in this instance the fatwa served much less as a means for morally persuading the public than to facilitate the bureaucratic process for implementing a policy for incentivized organ donation that was seen as a practical and temporary solution to a complex and difficult problem. For this reason the fatwa was never publicized, nor made the subject of ethical debate.

Fatwas and the Islamic State

The term *ijtihad* literally means “self-exertion.” In the context of Islamic jurisprudence, it refers to the arduous interpretive process of discovering and deriving

legal rules from the sacred sources (Weiss 1978). While certain obligations such as the duty to pray, fast, and pay religious taxes (*zakat* and *khums*) are stated clearly in the Qur'an, other rules of conduct need to be carefully derived through the practice of *ijtihad*. The jurist qualified to carry out this task is called a *mujtahid*. When a *mujtahid* conducts *ijtihad* to derive a ruling on a particular matter, he reports his discovery in a *fatwa* (pl. *fatawa*).

While the above description is appropriate for both Sunni and Shi'i legal traditions, there are noteworthy differences in the practice of jurisprudence (Weiss 1978; Codd 1999) that I will partly address, with some simplification.³¹ All Muslims consider the Qur'an and the *sunna* – the tradition of the Prophet Muhammad – to be sources of *ijtihad*. The Shi'a additionally consider the pronouncements and living examples of the twelve sinless *imams* who are direct descendents of the Prophet to constitute part of the *sunna*. Furthermore, while analogical reasoning (*qiyas*) serves as an important legal tool for Sunnis, it is rejected by the Shi'a as too conjectural and subjective (see Weiss 1978: 212). Instead Shi'a scholars take *'aql* – intellect or reason – as their final source for deriving Islamic law, a concept that has over past centuries transformed in meaning and implication (Amir-Moezzi 1994) and is most regularly cited as the primary reason for difference between Sunni and Shi'a legal interpretation on contemporary matters.

There are also differences in the ethical force of *fatwas*. While in Sunni Islam, a *fatwa* is a non-binding legal opinion (Messick 1986), in Shi'a Islam they are binding. This has to do with differences in the historical evolution of the institution of Shi'a jurisprudence (Arjomand 1984; Momen 1985; Moussavi 1994, 1996; Walbridge 2001).

³¹ In this chapter, by Shi'a I am only referring to Twelver Shi'a. Moreover, I restrict myself to the dominant Usuli school of Shi'i jurisprudence.

Presently, the Shi'a juridical hierarchy positions the *marja'-i taqlid* (or just *marja'* - pl. *maraji'*), which literally means the "source of emulation" above all other mujtahids. Today there are over two dozen maraji' in Iran alone, and they are distinguished from other mujtahids by their advanced knowledge, which is in part embodied in the publication of a *risala*, a comprehensive compendium of rulings on topics ranging from religious rituals, trade, and marriage, to stem cell research and cloning. While the core of the risala consists of a body of rulings on pre-established issues shared among the maraji' (such as purity, obligatory worship, and contracts), the rest gradually accumulates as the marja' responds to questions – known as *istifta* which means a request for a fatwa – posed by his followers. According to Shi'a doctrine, each Muslim must choose a living marja' to follow in matters of practice. While Sunnis are free to switch from the legal opinion of one jurist to another (though they may not in fact do so, even when the ruling seems to put them in a disadvantage. See Agrama 2010), as a matter of doctrine the Shi'a must follow the opinion of a single jurist (though in practice, many heed the opinions of different jurists on different topics. See Clark and Inhorn 2011).

In contemporary Shi'i jurisprudence, fatwas are divided into three categories of ordinances: primary (*avvaliyah*), secondary (*sanaviyah*), and state (*hukumati*). Primary ordinances are those edicts that are judged by the jurist to be based on the "essence of the matter" (*zat-i mawzu'*) and that do not take into account secondary issues and exceptional circumstances such as conditions of necessity, harm, and great hardship. *Secondary* ordinances on the other hand are those rulings that account for exceptional situations such as urgency, fear, and illness. So for example, while the drinking of alcohol is at a primary level forbidden, at a secondary level it may be permissible if the health of an individual

depends on it. Another important difference between primary and secondary ordinances is in their durability. Secondary ordinances are temporary. As soon as the conditions necessitating a secondary ordinance become obsolete, the eternal primary ordinance takes its place (Mavani 2010:36). And so, secondary ordinances are the legal category by which rulings are made to accommodate fluctuating and variable circumstances arising with the change of time (*zaman*) and place (*makan*). In fact, in contemporary Iran, secondary ordinances are mostly discussed in the context of the state's ability to address the needs of a rapidly modernizing nation whilst remaining in alignment with Islamic law. All fatwas by maraji' fall under either the category of a primary or secondary ordinance. Moreover, the fatwa of a marja' is only ethically binding on the marja' himself and his followers or "emulators" (*muqallidin*, sing. *muqallid*).

The third category of fatwas – what is called a state ordinance – is conceptualized within the Islamic Republic as a fatwa that can only be decreed by the ruling jurist (*hakim*). Much like secondary ordinances, a state ordinance is situational, but unlike primary and secondary ordinances, a state ordinance is a verdict related to matters of governance that legally supersedes all laws as well as the fatwas of other jurists. That is, a state ordinance is not merely the announcement (*ikhbar*) of a ruling the jurist has discovered from the Shari'a that is binding upon all of his emulators – it is a command (*hukm*) that is binding on all members of the body politic, including other maraji'. It is argued that, although doctrinally more than one marja' may be qualified to decree a state ordinance, pragmatically, within the structure of an Islamic state, such a division of power could lead to chaos and is therefore avoided. While in theory state ordinances proffer great power to the ruling jurist, in practice Ayatollah Ali Khamenei (the current Supreme Leader) rarely takes advantage of

this prerogative. The most recent example of one of his state ordinances was in 2014 when he approved a term extension for the caretaker of the Ministry of Science until the cabinet's suggested candidate was approved by Parliament.³²

So what is the status of a fatwa in the Islamic Republic? I should begin by saying that fatwas do not carry legal force - even when they are decreed by the ruling jurist - unless they are issued as a state ordinance. Since the establishment of an Islamic Republic in Iran in 1979, the institution of *marja'iyya* gained a political dimension that was not entirely unprecedented, but was definitely more entrenched and divisive than ever before.³³ Although the Islamic Revolution effected a dramatic rupture, the post-revolutionary state continued a decades-old process of centralization and of proliferating bureaucracies. As Fariba Adelkhah has argued, "the *Islam* of the Republic contributes to social legitimation of state centralization" (2000:113). This has in turn entailed the dual process of the bureaucratization of various spheres - including the institution of the *maraji'* - on the one hand, and the penetration of the authority of the *maraji'* into the bureaucratic process, on the other. As such, the activities of institutions have grown increasingly entangled with the institution of jurisprudence, and the institution of jurisprudence increasingly sees itself in a supervisory role in relation to other institutions to ensure that their conduct complies with Islam. This has resulted in a shift in the role of jurists as interpreters of God's law to also include operating as important components of the policy and lawmaking process. This however does not mean that those highest ranking in the clerical hierarchy - the *maraji'* - determine policy with their fatwas. Rather fatwas play a complex and contingent role, and

³² Islamic Republic News Agency: <http://www.irna.ir/fa/News/81396003/>

³³ For more on the development of the institution of jurisprudence in modern Iran, see Amanat 1988.

their authority depends largely on the way in which external actors choose to mobilize and enforce them. In this way we can see the fatwa as a *technology of biopower* that can be flexibly and strategically deployed by institutions to discipline populations.

To illustrate this point, it is crucial to distinguish the fatwas of the maraji' from laws made in parliament, the opinions of the Guardian Council that vets parliamentary legislations, as well as fatwas issued by the Supreme Leader of the Islamic Republic. Since the Islamic revolution, the most overt effort at Islamization has been the consolidation of authority in the person of a single jurist. Ayatollah Ruhollah Khomeini put forth the notion of the "guardianship of the jurist" (*vilayat-i faqih*) over the affairs of the government in a series of lectures in 1970. Although the notion initially entailed the authority of a plurality of jurists, his stance eventually transitioned to the rule of a single "just jurist" (*faqih-i-'adil*). Within a decade this concept found its way to the Iranian constitution over the objections of a number of maraji'. The next effort was to purge the law of its non-Islamic components and to ensure that all future laws complied with the Shari'a. The Guardian Council, consisting of six jurists and six lawyers was instated in order to, among other things, oversee legislation produced in parliament with the power to veto those laws that were deemed to contradict the constitution or the Shari'a.

When controversial issues emerge that are without precedence in the constitution or the Shari'a, the six jurists seek recourse in fatwas issued by maraji' to determine the pertinent Islamic ruling. In practice, parliament often tries to secure supportive fatwas from the majority of maraji' before going forth with a piece of legislation, in order to avoid a veto from the Guardian Council. Due to the plurality of opinions from the maraji', the single fatwa of one marja' cannot be determinative of law or policy. Furthermore, although

the Supreme Leader of the Islamic Revolution has the sole authority to issue a state edict on matters of governance (the state ordinances I described above), Ayatollah Khamenei rarely takes advantage of this prerogative. Instead he may issue fatwas for his emulators that will also inform the decision of the Guardian Council but by no means are determinative of it. In other words, Khamenei often acts in such a way as to distinguish his role as Supreme Leader (with the power to issue state ordinances binding on everyone) from his role as one marja' among others (whose rulings only apply to his own followers). For example, although Khamenei has decreed semen donation permissible, the disagreement of most other maraji' has rendered it illegal. Nevertheless, despite this illegality, as Abbazi-Shavazi et.al (2008) explain, Khamenei's fatwa has afforded legitimacy to the actions of some doctors who choose to perform artificial insemination.

There are also instances where the Guardian Council will purposely remain silent on an issue, thereby allowing legislation to pass without conferring upon it its seal of approval. For instance, on the topic of brain death, after years of deliberation outside and within parliament, and the decree of permissive fatwas by Khamenei and various other maraji', the Guardian Council refused to take a stance, which allowed the law on "transplantation of organs from brain-dead patients and those whose death is certain" to pass, but without the explicit sanction of the Council (Sotoodeh 2012). As these examples demonstrate, the relation between the fatwas of jurists and policy is anything but straightforward.

What I wish to highlight is that the enforceability of fatwas becomes largely contingent on them being taken up by actors interested in their implementation. Their implementation requires that they be translated to guidelines and protocols. Within a system of Islamic bio-governance, the jurist often becomes dependent not on individual

emulators – but on *institutions* – the conduct of which is contingent on limited resources, managerial dynamics, the political-religious commitments of the actors involved, and so on. Moreover, today, fatwas most often function to supply legitimacy where moral certainty is lacking or where public support is tenuous. In the Islamic Revolution’s effort to make governance comply with Islam, the opinions of jurists as experts on the Shari’a have emerged as a weighty force – an authoritative seal that could ease the flow of activities through the tumultuous stream of bureaucratic policy work.

Jurisprudence and Medicine: Expert Knowledges and Islamic Biogovernance

When it comes to medical policy-making, fatwas can play a critical role in garnering moral support for novel or controversial medical procedures. Naturally, the attitude of jurists toward biotechnologies and biomedicine in general is crucial to the formulation of fatwas. In Iran, biomedical developments have been eased by an outlook among jurists of overwhelming trust and admiration towards medical experts and their field of knowledge-practice.³⁴ Likewise, the model of medical science informs the way in which the institution of jurisprudence constructs and imagines itself as an expert field.

“Though multiple knowledges exist and may be necessary for each person to learn, they are not all equal in value and nobility (*arzish va shirafat*). Among the various knowledges, the most valuable and honorable is the knowledge of religion which establishes the health of the soul and shapes his spiritual life... After knowledge of religion, the knowledge of medicine is the most valuable, which provides for the health of the human body. The Prophet -

³⁴ This may be less related to the unique nature of Shi’a jurisprudence than to biomedicine’s particular relationship with the modernization efforts of the state and its vigorous attempts to develop a “native” (*bumi*) medical education, as well as the active involvement of medical experts firmly committed to the ideology of the Islamic Republic.

peace be upon him - said, 'There are two knowledges: The knowledge of religion and the knowledge of the body.'³⁵ The reason for the worthiness of these two knowledges over other knowledges is that these two are related to human life (*hayat*), one to spiritual life and the other to material and bodily life. A doctor is one who deals with the bodily life of the human and seeks to reduce its ailments and suffering, and so has a highly valuable occupation. And the Muslim doctor, according to religious teachings, believes that he is a mediator and a vehicle for the healing that comes from God. Essentially healing is the act of God... And it is He who gave plants and objects their healing qualities, and placed a cure for every pain... And a doctor discovers the laws of God and their application in curing humans, and he is an instrument for the fruition of the law. He does not do so [heal] independently."

Hojjat al-Islam Khodadadi (2006)

The above passage is from the introduction to a compendium of medical fatwas issued by the late Grand Ayatollah Mohammad Fazel Lankarani. The published book is titled "Religious Rulings for Doctors and Patients" and is composed of 721 injunctions on a variety of issues, such as the legal status of golden tooth fillings, the touching of patients' genitalia, blood transfusions, brain death, surrogacy, organ transplantation, cloning, and matters pertaining to doctor liability and patient confidentiality. The introduction to the book reflects the pervasive Shi'a jurisprudential attitude of deference towards medicine as an expert knowledge and field of practice that nevertheless, must be disciplined by jurisprudence so as to ensure its conformity to God's laws. The medical doctor is bound by duties to the Creator, and it is the task of the jurist as legal expert to make those duties legible in the form of a fatwa. The Shi'a jurist first undertakes the process of legal discovery and interpretation, deciphering relevant laws from the four sources: the Quran, hadith

³⁵ Bahar Al-Anvar: 220/1 ج 52.

traditions, consensus (*ijma'*) and judicial reason (*'aql*), and then translates his findings to a set of simple instructions both comprehensible and feasible.

Since the Islamic Revolution both jurisprudence and medicine have enjoyed special attention from a state that has treated their advancement as a pathway to an exemplary *modern and Islamic state*.³⁶ The uniquely permissive fatwas by Shi'a jurists in recent years on a variety of medical procedures, such as in-vitro fertilization and sex-change operations and even embryonic stem-cell therapy, have opened a vast arena of medical practice and experimental research, making Iran one of the most liberal Islamic states when it comes to iatric procedures. This in turn has led to an influx of medical tourists from neighboring and Islamic countries, adding an important economic dimension to advancing medicine.

The evolution of an Islamic bio-governance has meant that jurisprudence and medicine have grown entangled in ways that have had formative implications for their respective developments. Since the Islamic Revolution, various schemes and initiatives were put into place to make medical practice comply with Islamic precepts, at times restricting and transforming the conduct of medicine. This in turn has compelled medical practitioners to make their knowledge and interests legible to jurisprudential reasoning (Najmabadi 2013), which has perhaps been most formative in the development of a so-called "Islamic bioethics" in Iran. Conversely, jurisprudence has also been impacted by this intimate relationship with medicine, which an Islamic bio-governance has engendered. This chapter will illustrate the crucial way in which medical reasoning and the interests of medical practitioners can influence jurists' rulings. But I would like to also briefly draw attention to a more subtle relationship that may illuminate important transformations in

³⁶ According to Schayegh (2009) medicine has played a formative role in the constitution of Iran as a modern society since the early 20th century, particularly since the Constitutional Revolution (1906-1911).

Shi'a jurisprudence, which may in turn shed light on the making of medical fatwas. This has to do with the way in which a medical imaginary informs the discursive formation of jurisprudence as an *expert* discipline.

I previously explained that according to Shi'a doctrine every Muslim must emulate a marja' on matters of religious law. However, this obligation is haunted by the "temptation" to rely on one's personal interpretation and reasoning. Prior to the Islamic Revolution the marja' was a charismatic leader whose elevated status depended on the veneration of his followers. Linda Walbridge (2001) writes that with the marriage of Islamic authority and state politics under the Islamic Republic, the grassroots charisma of the marja'iyya diminished as jurisprudence became increasingly institutionalized (see also Adelkhah 2000). In the early 1990s, the Association of Teachers at the Qom Seminary issued a list of seven state-endorsed maraji' who were recognized as either supportive of the Islamic Revolution or entirely apolitical. The utter disregard for the role of the followers in the marja'iyya and the involvement of state interests has in turn resulted in the gradual dissipation of regard for the institution as a whole.

As the popular authority of the marja'iyya has waned, the institution's supporters increasingly attempt to shore up its authority by defining it as a form of expertise comparable with that of medicine. A salient example is a lesson in the third-year middle-school religion textbook, titled "Rational Ways" (*ravish-hayi 'aqilana*). It asks students to imagine a "skillful architect who is an expert at building high rises. His abilities are so great that no one builds a high rise without consulting him." Then the text asks the reader to imagine that the skilled architect develops an excruciating headache.

“Could we expect that because he is a knowledgeable expert, he can resolve this problem on his own? Today with the scientific advancements of mankind, the various fields of knowledge have expanded to such an extent that becoming an expert in just one field requires years of studying and research. Therefore, it is apparent that no one can achieve expertise (*takhassus*) in all the fields of knowledge necessary in his life, and solve all of his problems without help from other experts (*karshinasan*). When we are ill, each of us sees a skillful doctor, and uses drugs based on his/her orders. We are not aware of the content of the medication we take, but we trust doctors’ orders, and do exactly as they say. This is the only rational (*‘aqilannah*) way.”

The lesson goes on to explain that there are individuals who dedicate years to studying and researching Islamic knowledge, “these people are called experts, *mujtahids*, or *faqih*s,” and the *mujtahids* whom others can emulate, like the skillful doctors, are the *maraji’-i taqlid*.³⁷ This comparison between the expert in jurisprudence and the expert in medicine is the most frequently deployed analogy in justifying the vital role of the *marja’*.

Similar analogies are adopted to argue for the further specialization of jurisprudence and the need for jurists to train in highly focused fields of expertise. In one of his well-known lectures in the early 1960s, Ayatollah Morteza Motahhari, an ideologue of the Islamic Revolution, proposed that training in jurisprudence be divided into the study of general jurisprudence, followed by tracks in specialized topics modeled after medical training and specialization (Motahhari 1989: 121-127). Others have drawn attention to the need for committees and collaborative communities similar to that of say, the *association of cardiologists* that would discuss emerging issues and work towards producing verifiable and consistent rulings (Ja’far Pishefard 2000) as opposed to the plurality of contradictory fatwas that have been common to jurisprudence. These analogies allude to the fact that

³⁷ Pages 21-23 of the textbook.

both medical and jurisprudential knowledge are treated as neutral, objective, and discernible only through a highly technical and impartial process of discovery by qualified experts. During a friendly discussion in Qom on the appropriateness of the clerical garb, a cleric and masters' student clad in a white turban and beige cloak remarked to me that without the garb, how else could society mark those learned in the science of jurisprudence? If a doctor removes his white coat in a hospital, how could you tell him apart from the patient or the janitor? Similarly, without his *professional* clerical attire, how would a passenger on the bus know to ask *him* his legal questions, rather than the likely untrained person next to him?

An Anthropology of Policy-Oriented Fatwas

When discussions of fatwas find their way to Western scholarship, it is most often the activities facilitated or impeded by fatwas that are of interest, rather than the reasoning or epistemological assumptions that guide fatwas themselves. When fatwas are the subject of investigation in themselves, scholars often rely on the formal knowledge and legal reasoning that jurists apply to arrive at their rulings (Moosa 1999; Moors 2003; Abbasi Shavazi et al. 2008; Clarke and Inhorn 2011;). Though such analyses are crucial to explaining how Islamic legal theory dynamically encounters and treats emerging technological and social phenomena, they invariably treat jurists as automated lawmakers who are governed by a strict legal logic. As Agrama (2010) notes, fatwas are thus studied as statements of doctrine divorced from the modes of engagement that structure their formation and practice.

It is also possible to study fatwa-formation as a contingent practice and to account for the everyday (extra-legal) components that (in)form the fatwa and its application. In order to reveal the ways in which various experts and institutions contribute to the development of fatwas, we need a *processual* approach that situates *istiftas* (requests for fatwas) within the wider social and biopolitical milieu and accounts for the dynamic process by which emerging issues are presented, construed, and processed by jurists.³⁸

Policy-oriented fatwas are prompted within a policy-making process, even if they do not necessarily translate to policy.³⁹ These fatwas often involve input from other experts and institutions, and their effects go far beyond the conduct of individual questioners. The involvement of other experts in practice means transferring and translating various kinds of knowledge, and making one form of expert-knowledge legible and actionable for other kinds of experts. Therefore, rather than thinking of the fatwa through concepts of *authority* (of the jurist) and *ethical agency* (of both jurist and fatwa-seeker), the policy-oriented fatwa must be examined as a technology of Islamic bio-governance. This framework requires us to attend to the practical interests and moral concerns of various institutions, and the strategic and politico-ethical status of the jurist within the Islamic nation-state.⁴⁰

As we will see further below, a crucial difference setting apart a policy-oriented fatwa from fatwas elicited in contexts free of policy considerations has to do with the kinds

³⁸ See for example Hoodfar and Assadpour (2000) and Najmabadi (2014:163-201). Other examples of processual approaches to the study of fatwas that do not necessarily contribute to policy include Agrama (2010) and Hamdy (2008)

³⁹ There are also individuated fatwas that may eventually be taken up by policy makers and have policy implications. I do not address this category of fatwas in this chapter, but believe nevertheless that examining the assumed subject in such fatwas and the assumed and/or real subjects of the subsequent policy can be crucial to understanding the logics and consequences of fatwa formation in Islamic states.

⁴⁰ Of course, this should not obviate the need for attending to affect, or to tactics of persuasion in understanding the ways in which a jurist may be persuaded to approach an issue from one angle rather than another.

of subjects each of these fatwas assume. Although the object of legal reasoning for both is an individual (and not society writ-large⁴¹), non-policy-oriented fatwas tend to deal with a real person in the flesh, a subject with multiple facets, some of which may become apparent to the jurist in the fatwa-seeking process. However, in the case of policy-oriented fatwas, the individual subject imagined by the jurist is a generic one, abstracted, depersonalized, and de-temporalized. Understanding the characteristics that are afforded to this abstracted individual can be crucial to understanding the outcome of a jurist's ruling.

To construct an anthropology of policy-oriented fatwas, we can turn to some of the analytic tools and methods provided by the anthropology of public policy. This burgeoning field has brought attention to the dynamic and contingent processes that allow certain modes of action to appear as the *best* or *only* solution to a problem, and the many actors that contribute to this process. One of the approaches developed in the anthropology of public policy has to do with studying the various *problematizations* out of which policy solutions emerge. By *problematizations*, anthropologists mean the way in which problem-spaces are processually carved out by a heterogeneous assemblage of people, knowledges and technologies; the way in which a set of conditions are framed and narrated as a “problem” to be resolved. These *problematizations* do more than lay out the contours and premises of the question, rather they present the discursive and material space within which solutions can be imagined, by forming the terms of the argument, and – more significantly but less visibly – by molding the scope of the thinkable, the practical, and the moral (Apthorpe 1996; Feldman 2005; Wedel et al. 2005; Greenhalgh 2008; Shore and Wright 2011;). Applying this approach to the study of the fatwa requires examining the

⁴¹ In the case of state ordinances that are only decreed by the Supreme Leader, society or the state is the object of analysis and legal reasoning, and not an individual person.

fatwas in relation to the istiftas (Khalid Masud 2009) that elicit them: the fatwa-seekers themselves, as well as the professional, institutional, and ethical stakes that motivate them.

To carry out such an investigation in practice can be quite challenging. One of the primary issues is that of restricted access and the simple fact that research often begins after the fatwa has been decreed, rather than in the process of its formation. To investigate the making of fatwas on kidney sales in Iran using this processual approach, I would have ideally had access to the (female exclusive) circle of seminary students that work with a particular marja' as a new istifta is presented. But in the absence of such a research opportunity and in light of the fact the fatwas were issued over a decade ago, my study of fatwa formation needed to take on the form of a sort of social archaeology – an unearthing of actors, networks, and texts, as well as the use of scattered information that could suggest the attitudes and approaches of jurists. I began by studying the text of fatwas. As legal *opinions*, fatwas are almost completely devoid of jurisprudential reasoning. To understand the reasons, I was warned that I needed at least two years of seminary education in legal theory (*usul-i fiqh*). In the absence of such a privilege, I set out to decipher the reasons through individual reading in specialized jurisprudential literature. I also visited Qom, the heart of Shi'a learning, to discuss the fatwas with scholars with an insider view, including a mujtahid who had completed a master's thesis on the legal positions on organ transplantation, and another researcher who had authored an impressive book on legal perspectives on brain death and transplantation. Most notably I had the opportunity to converse with a mujtahid on the cusp of becoming a marja' about organ sales and the fatwa-making process. A well-known teacher of graduate seminars on *dars-i kharij* and *usul-i fiqh*, Ayatollah Mohammad-Javad Fazel Lankarani directed a large research center in

Qom that was founded by his late father, a marja' who had ruled that the receipt of payment for organ donation was unproblematic.

Qom: Arriving at the Research Center

It was pouring rain outside and my escape from the cab hadn't saved my chador from a few dips in the puddles outside the café. I lifted the slightly muddied bottom of the veil, gathered it to one side and reclined on the modern-baroque love seat next to Alireza. We were waiting for a group of graduate students from the University of Religions and Denominations in Qom. One of the students, Mr. Saremi, had arranged a meeting with Ayatollah Fazel Lankarani. Our rendezvous point was a duplex café that resembled many other modern cafés rapidly sprouting across urban spaces in Iran. I had previously associated such cafés with Tehrani cosmopolitanism and did not expect to find myself in one in Qom. Our friends wanted to introduce us to a venue markedly different from what we were used to seeing in this city of seminary students and pilgrims. Inside the café, there were no traces of the Persian embellishments and patterns of paisleys and vines, or the blue ceramic tiles typical of traditional (*sunnati*) tea houses. To our right was an open bar with hanging goblets and by the windows to the left were several baroque sofas in maroon and striped beige, facing tree-stump coffee tables. On the menu was an assortment of mochas, lattes, smoothies, shakes, cakes, muffins, toast sandwiches, the quintessential black tea, and non-alcoholic champagne (*shampayn*). We ordered tea and biscuits and waited.

Half a glass of tea later, our friends arrived. After several minutes of polite exchange I stood up to leave with Mr. Saremi to our meeting with the jurist. Alireza and I had

previously discussed whether I would have preferred for him to attend, and based on my previous encounters, I chose to relieve both the jurist from having to address me through my husband, lest he appear too forward or enthusiastic to converse with a married woman, and my husband from feeling compelled to respond on my behalf. The dynamic was different when I interviewed a jurist on my own. Our communications were direct and engaging, and that was what I was looking forward to. But in this case, Mr. Saremi was to sit in the meeting with me. The issue was much less about having a male guardian of some sort to supervise my interactions with the non-mahram⁴² jurist (as Mr. Saremi too was not mahram to me), than to have a person of the university witness the content and etiquette of the proceedings that was arranged personally by the president of the university. Should anyone raise a political or personal objection about the meeting between a jurist and an “American” female researching the controversial sale of kidneys, Mr. Saremi would be able to vouch for the event’s all-around appropriateness. Mr. Saremi was the essential liaison that protected the researcher, the jurist, and the university.

We arrived at the Immaculate Imams Center for Jurisprudence (*markaz-i fiqhi-yi a’immah-yi athar*), a research center founded by the Grand Ayatollah Mohammad Fazel Lankarani in 1998, and administered by his son whom I was expecting to meet. According to their website, the research center’s goal is to “educate scholars and researchers; train competent clerics and committed jurists who are aware of the requirements of the time; provide the necessary resources and the proper space for scholarship and in-depth research in jurisprudence (*fiqh*) and principles of jurisprudence (*usul*), in the comprehension of and responsiveness to novel problems and the critical examination of

⁴² In Islamic law, a *mahram* in relation to someone else is a person who cannot be married to that individual, due to being a close relative by blood or by law.

uncertain issues pertaining to fiqh; as well as the authorship and publication of scientific books and articles.” One could say that such a research center serves, in part, as an advisory arm for the institution of marja’iyya. The in-depth and technical analysis of various novel issues in the form of research papers and books and academic conferences inform the analyses of various jurists and students who are tasked with examining various sides of an issue and presenting them to the marja’ for consideration before a final ruling is determined.

The Immaculate Imams Center was an impressive edifice with a grand entrance of wide concentric stone stairs and tall marble columns holding the obtruding upper floors. The building was embellished with arched windows and intricate ceramic tiles with vibrant turquoise, jade, and golden colors and elegant geometric patterns and lattice-work, typical of many Iranian mosques and shrines. The magnificent marble entrance met us with a lofty wooden door as if to dominate the insignificant ego that is to witness the grandeur of the sacred knowledge produced inside. The center was the first and largest research center “specialized” in jurisprudence. The new building, inaugurated in 2010, was fully funded by the alms of the followers of the Grand Ayatollah Fazel Lankarani (without any government contributions), and consisted of numerous lecture halls, conference rooms, general and specialized libraries, and offices for affiliated scholars, who are either experts in jurisprudence, civil and constitutional law, or both. The center also has branches in Afghanistan, Malaysia, Syria and most recently London.

When we entered the building, Mr. Saremi approached an elderly doorman with an un-tucked gray collared-shirt and black slippers to explain our intention to meet Ayatollah Fazel Lankarani. “But he’s not here,” the doorman said. “It’s the night of mourning, and

surely Haj Aqa must be at the mosque. On the days of martyrdom he always stays for the post-prayer ceremonies.” It was a night of mourning? Luckily, I had opted for a conservative black maghna’ah, rather than the purple scarf which would have been quite inappropriate for the night of martyrdom of the fifth Shi’a Imam. Confused, Mr. Saremi left a message for the President of the university explaining our quandary, and retreated to a bench by the door.

As we waited for a call, I stepped into the main hallway and found my way to a library. On display were numerous books published by the center on specialized topics, like Islamic banking, feminism, brain death, cloning, and artificial insemination – each examined extensively (judging by their thickness) from a jurisprudential perspective. The varied collection is testament to the immense efforts of jurists to illuminate Islamic laws in a wide range of practices. Champions of jurisprudential scholarship declare that God’s laws of conduct encompass every aspect of life, but have till now only been partially deciphered – and so, as the sciences and fields of human practice expand ever-so-rapidly, so must jurisprudence keep up with its oversight and edification, highlighting the paramount importance of research centers such as this one.

Mr. Saremi’s phone finally rang. It was the university president who had managed to reach Ayatollah Fazel Lankarani. It turned out that our highly anticipated meeting had been rearranged instead with two researchers at the center. The elderly door-man walked us upstairs to a seminar room. Two men greeted us and gestured to the seats on the opposing side of a large conference table. Mr. Kamrani was an attorney working on topics in international law, and Mr. Setayesh was the author of a book on the jurisprudence of brain death. Mr. Saremi and I sat down with two empty seats between us. Mr. Setayesh who

would be the main presenter thumbed through a copy of one of his recent articles. He was already privy to the topic of my research and in addition to preparing a presentation, had put together a bag of books on various medical topics, including his own book as a take away gift. After a brief introduction extolling the breadth and versatility of Shi'i jurisprudence he carefully walked us through the jurisprudential questions that organ transplantation and sales present to the jurist. The path of juridical reasoning he sketched mapped neatly onto the schema I had developed from my readings of the jurisprudential literature and the explanations of other mujtahids and legal scholars to whom I had previously spoken.

As was the case in my previous discussions with jurists and scholars of jurisprudence, the issue was discussed dispassionately and purely from a legal perspective. Furthermore, the issue of "ethics" or what was right never entered the conversation until I challenged my interlocutors' legal claims with my on-the-ground findings that plucked the topic from abstract formulations and dropped it into concrete examples of what I had seen. The conversation would normally end with a recommendation that I take my concerns to the maraji' and test whether a reformulation of the issue based on my observations would alter their fatwas.

Meeting Ayatollah Mohammad-Javad Fazel Lankarani

About an hour into our meeting, Mr. Saremi received another phone call from the president of the University of Religions. Ayatollah Fazel Lankarani had offered to meet with us in case we found the conversation with his colleagues "inadequate." We could meet him at 8:30 pm at his home. I was exhilarated and humbled by the offer. No matter the richness

of our meeting at the research center, I could not pass up an opportunity to meet with an influential mujtahid who could very soon become a marja'. We left Mr. Setayesh and Mr. Kamrani and made our way to a residential area in Qom. The houses lined up on the street revealed little of their mediocrity or grandeur. Like most houses, they were inward facing, their exterior facades forming a long flat wall of marble slabs and bricks. At the door, a boy of about thirteen politely greeted us and invited us downstairs to the basement. We removed our shoes and trailed behind him. I pinched the chador and lifted it on both sides before my excitement consorted with the slippery marble to topple me over down the stairs. In the dry desert climates of Qom, Kashan, and Yazd, the floor beneath the street level is where families retreat in the scorching heat, as the lower floor can often be five to ten degrees cooler without need for air conditioning. But with modern air conditioners these cool havens are often rented as studios, or as in this case, morphed into a magnificent library and work-place. Perched along the walls were columns of book cases, loaded with hard cover books etched with golden calligraphy. In the center of the farther half of the room a large desk was covered with neatly stacked books. The other half was an area of conversation and hosting guests. There were sofas, cushioned chairs, and a coffee table which by now the young boy had covered with plates and an assortment of pastries and a large fruit bowl. "Ali, please come and offer fruit to the guests!" The jurist exclaimed to his son.

Ayatollah Fazel Lankarani was dressed in his clerical garb, including a white *'amamah* (turban). He warmly welcomed us and reclined on a sofa-chair on the other side of the coffee table. Mr. Saremi began with introductions. He explained where I lived in the US, that I was conducting research for a doctoral degree at the University of California, that

my husband was also an anthropologist, and that I had previously worked with the University of Religions and Denominations. He then briefly explained my interest in jurisprudential opinions on kidney transplants and sales.

The jurist slightly tilted his head towards Mr. Saremi and asked, “Does she want to know about the Islamic perspective or the Shi’a perspective specifically?” I responded before Mr. Saremi had the chance. “Since my research is on transplants in Iran, I am interested in Shi’a jurists’ rulings that contributed to the program on kidneys sales in Iran.”

Ayatollah Fazel Lankarani: “So this doesn’t happen in *kharij* (foreign countries)? If someone wants to sell his kidney, or will that it be donated after his death – that’s how it happens here – it is not possible there? “

EM: *“I do briefly address brain death, but I’m mostly interested in kidney sales.”*

Ayatollah Fazel Lankarani: “So you are saying that this doesn’t happen elsewhere?”

EM: *“Well, in America one can donate an organ, but can’t sell it. In many other countries, kidney sales do happen, but illegally.”*

Ayatollah Fazel Lankarani: “So donation is permitted, but sale isn’t??

EM: *Correct.* [I go on to explain that in the international medical community, it has been agreed that the sale of organs is not ethical.]

Ayatollah Fazel Lankarani: *“‘ajab (interesting).”*

EM: *“And in other religions, even among the Sunnis who allow donation, sales are prohibited”.*

Ayatollah Fazel Lankarani: “Have you seen my father’s fatwas on this?”

EM: *“Yes, and I have been interested in understanding the reasoning behind these fatwas.”*

Ayatollah Fazel Lankarani: “So what have you concluded?”

[I describe what I had learned about the jurisprudential principles relevant to transplantation and organ sales from my previous interviews, and expressed that I was interested in understanding the way in which jurists applied these principles and how they were informed by the opinions of doctors.]

Ayatollah Fazel Lankarani: "I was thinking that a similar issue would be that of sex change. Our jurists, Imam (Khomeini), and Aqa (his father), they all consider it permissible, and if you visit my website, you will see that there are over forty questions or so that I've answered on this topic. Though your question is a valid one, it [Shi'a rulings on transplants and sales] shouldn't surprise you. Because through Shi'a jurisprudence we may reach conclusions that neither Sunni jurisprudence nor the jurisprudence of westerners can reach. Because, you see, our jurisprudence is extremely rich. We have numerous sources and principles (*qava'id*) that don't even exist in their jurisprudence. Now one issue is that of cloning. In the case of cloning (*shabih-sazi*), though there is some disagreement, most of our jurists state that it is without a problem. Cloning! Now all over the world this has been prohibited. Christians, Sunnis, all have prohibited it! Now the question you raised should be answered, and we have to see what the reasons and principles pertaining to it are and what conclusions we reach with them, regardless of whether the world agrees with it or not."

In the remainder of this chapter, I will draw from my conversation with Ayatollah Fazel Lankarani, Mr. Setayesh and Mr. Kamrani, as well as other legal scholars, jurists and my examination of jurisprudential literature to explain the principles and concepts applied by jurists to evaluate the jurisprudential position on kidney sales. I further examine the relationship between fatwas and *alegal* policies, paying attention to the assortment of actors that partake in the latter's development and implementation. Here, by *alegal* policy I mean the protocols and category of regulated and routinized procedures that govern the actions of both governmental and non-governmental institutions and that do not fall under the purview of legislation. These policies are significant for how they

govern everyday action, but also because they can shape the discursive field from which laws later emerge. With the example of kidney selling, I hope to demonstrate the formative role scientific experts and actors within and outside the state play in the conclusions maraji' reach in their fatwas, and the contrasting ways in which such fatwas are later deployed to achieve different policy aims.

Fatwas Permitting Kidney Sales

In 1987, the Iranian urologist Dr. Simforush took a bold step and performed the first genetically-unrelated kidney transplant in the country. Immunosuppressant drugs had dramatically expanded the pool of potential donors, such that those reluctant or unable to obtain a kidney from a relative were able to look to the bodies of strangers for survival. Gradually, an informal market for kidneys emerged. The Kidney Patient Foundation (KPF), the only kidney patient advocacy group in the country, began loosely overseeing the monetary exchange and facilitating donor-recipient matching. By 1997 a full-fledged program for incentivized kidney donation had formed, with the KPF operating at the center of its administration as a de-facto arm of the Ministry of Health. As transplants became more common, some doctors and medical institutions grew concerned that the removal of an organ from one person and its implantation into another may defy Islamic law. If so, the program could be shut down or at least face harsh criticism. Soon the KPF sent out letters, and in some cases its representatives, including medical doctors and jurists, to several maraji' to appeal for permissive fatwas on transplantation. And sure enough, they succeeded.

It is noteworthy that few people among those I interviewed were aware that such fatwas existed. These fatwas are not hidden from view. They can be found under the header “sale” (*furush*) in most compendia of medical fatwas. But if not publicized or discussed in the media, the general public has no reason to know of their existence. And in this case, as I found out during my fieldwork, the KPF and its affiliated medical institutions as well as the Ministry of Health treated the facilitation of sales as a temporary solution and had no intention of making it a matter of public moral scrutiny. The fatwas were not brandished to promote kidney selling, they instead served the important purpose of proffering the necessary legitimacy needed for the program to discreetly continue its operations.

I came to know of the fatwas during an early interview with the president of the KPF after pressing him on the ethical justification for facilitating kidney selling. He responded that the organization was merely supervising the exchange of a “gift,” a financial reward for the gift of life, and not the sale of organs. He then handed me a large binder containing the archives of articles published in KPF’s *Shafa* magazine. Somewhere in there, he assured me, I would find an article containing the fatwas issued by several important maraji’ proving that the KPF’s actions were acceptable. This prompted me to further research the fatwas and ask, how were the maraji’ convinced that kidney selling was permissible?

In one early letter written in 1990 to Ayatollah Araki, the founder of the KPF – himself a transplant recipient – first introduces the organization and then explains what being on “dialysis” means: “A dialysis patient is someone who has fully lost function in both kidneys and whose blood must be filtered three times a week; and the only way to *save* such a patient is to give him a kidney” (emphasis mine). The letter then continues to state that another marja’, as well as Ayatollah Khomeini had allowed certain charity funds to be

granted to the KPF after being convinced of the “dire and unbearable conditions of these beloved patients.” Moreover, he declares that Ayatollah Khomeini had only a year earlier been asked about kidney donation, to which he had given a permissive fatwa. Only at this point does the author present this *istifta* (fatwa request):

“Please state your opinion about someone wanting to donate a kidney in order to save the life of another Muslim, whether it is during his life or after his death, considering that according to the science of medicine, donation of a kidney entails no side effects for the donor.”

We can find the brief response of the marja’ handwritten in the lower right-hand corner of the letter. It states, “With the assumption that the life of another Muslim depends on the donation of the kidney, whether alive or dead, then there is no problem.”

In another letter written at a slightly later date to Ayatollah Fazel Lankarani, the same *istifta* is followed with another question, almost in a post-scriptum kind of way: “If the donation of an organ is allowed, then is it also permissible for the donor to receive money for his donation?” The response is an unconditional permission.

In the letter to Ayatollah Araki, the president of the KPF presents a story centered on the predicament of end-stage kidney patients on dialysis. Kidney transplantation is presented as the sole solution to ending the patient’s “dire and unbearable condition,” which the letter indicates, has also been confirmed as such by other maraji’. By informing the reader about prior sanctions by none other than the Leader of the Islamic Revolution for not only transplants to be carried out, but for the KPF to make use of funds preserved for the most righteous of causes, the author establishes a weighty precedent of permission for transplantation, and also confers substantial legitimacy unto the KPF. And finally, after enlisting the support of other maraji’, he bolsters his position by employing the authority of

the “science of medicine.” Any concern for the permissibility of donation is assuaged by reassuring the reader that donation indeed causes “no harm” to the donor, a reliable fact verified by “science.”

What the narrative of this letter succinctly demonstrates is the way in which the problem faced by dialysis patients and its solution have been more generally framed. It also highlights how the issue of organ sales has been eclipsed by the issue of transplantation in the KPF’s narrative. Such *istifta* letters are usually not the first or only instance in which a new problem is brought to the attention of a *marja’*. An issue may be written about and debated by legal scholars and others with an interest in the topic for years before an *istifta* is finally made. My rather thorough reading of the jurisprudential literature, as well as the content of various *fatwas* reveals that the narrative presented in the letter is the primary mode in which transplantation and organ sales have been imagined and discussed, and that the deliberate attempts by medical doctors to persuade jurists has been crucial to the *fatwas’* formation.

In the section below I detail how jurists first assess whether transplantation is permissible, and only then determine the status of kidney sales. This order of evaluation is important, because as I will demonstrate it created the elisions necessary for kidney selling to appear unproblematic. We could say that the various layers of evaluation of kidney sales can be framed as three concerns: 1) Can a kidney be removed from the human body? 2) Can the removed kidney be implanted into another person? 3) Can the kidney giver be paid?

The Nephrectomy

In the first layer of evaluation, the jurist asks: Are humans owners of their own bodies? In other words, do they have such jurisdiction over their bodies that they may choose to detach a part of it?

There are extensive legal discussions on the nature of man's authority over his body: whether man is "entrusted" (*amanatdar*) with his body by God, or has "domination" (*saltanat*), or "ownership" (*malikiyat*) of his body – each of which entails authority with varying degrees of freedom and limitation. Though crucial to the discursive evolution of legal conceptualizations of the body, for the purposes of organ transplantation, the differences of opinion yield similar results – that man's authority over his body is limited to actions that 1) do not constitute a "violation of the dignity" (*hatak-i hurmat*) of the Muslim body, and 2) that do not cause the body "harm" (*zarar*).

The injunctions in Islam that pertain to the prohibition on the violation of the dignity of the Muslim body appear in the context of the mutilation or beating of the body after death. When early fatwas on transplantation prohibited nephrectomy on this ground, medical doctors argued that the removal of the organ was to save the life of a suffering patient, only with the noble Islamic virtue of the preservation of human life in mind. On this basis and by relying on several analogous traditions,⁴³ it was agreed that the severing of the organ was permissible since the transplantation had a reasonable purpose, and the value of saving a life outweighed the consequences of cutting the body. However given the weight of the prohibition on the desecration of the corpse, many jurists cautiously required that the primary prohibition be overturned, *only* under an exceptional circumstance of

⁴³ For example a tradition (*ravayat*) that stipulates that the cutting open of the belly of a pregnant mother is permissible if it is believed that the fetus can be saved.

necessity (*zarurat*). Usually, the condition of necessity is that the life of a Muslim must depend on the transplantation of the severed organ, and that no other organ (from an animal or non-Muslim) be available instead.⁴⁴ Moreover since the mutilation or beating of a Muslim corpse requires the payment of blood money, some maraji' cautiously stipulated that the surgeon, hospital, or the state pay an appropriate blood money for the severed organ that could be spent on the deceased (for instance, to pay his funeral expenses or for the repayment of his debt). As I have mentioned, such caution is relevant to the nephrectomy of a corpse (or brain dead body) and not a living person. As the living person consents to the removal of his or her kidney, the surgeon cannot be held liable and need not be penalized with the payment of blood money.

The second condition that the operation should not "harm" the organ giver is more tenuous, and rests on the expert opinion of medical doctors. Does the removal of a kidney constitute harm? If so, what is the extent of this harm? Is it substantial or is it negligible? Some like Khomeini have permitted kidney donation on the condition that it does not cause harm "worth tending to" (*zarar-i lazim al-mura'at*). Others state that the harm must not be "great" or "irreversible." Despite this cautious language, the assumption underlying the permissive fatwas is that a nephrectomy is indeed harmless or at most negligibly risky. For example, Ayatollah Makarem-Shirazi states in one fatwa on doctor liability, that "in the case that an individual has consented to removal of his organ and the risk of harm is low, but by

⁴⁴ A mujtahid once explained to me that the reason a non-Muslim corpse is favored for dissection or organ transplantation is that it is commonly assumed that non-Muslims do not hold a similar prohibition against cutting of the corpse as Muslims do, and therefore, doing so would not be considered a form of desecration. If the presumption is untrue in a particular case, he claimed, then the prohibition would hold equally for the Muslim and non-Muslim body. I have not yet confirmed if this is a matter of consensus among jurists.

chance harm is indeed incurred, then the doctor is not responsible; for example in the case of *removing a kidney*, where normally there is no danger” (emphasis mine).

At one point during our meeting at the Immaculate Imams Center, I asked Mr. Setayesh, “Who decides what constitutes too much harm?” He responded that this is a matter of *‘urf* or “common-sense.” There are voluminous discussions of what *‘urf* really means in jurisprudence, and what the parameters of resorting to it are. Often, *‘urf* is equated with the opinion of *‘uqala* – “people of reason” or “experts.” In most cases reliance on *‘urfi* concepts in jurisprudence allows for the malleability of the fatwa to changing opinions and approaches in varying times and spaces (*zaman va makan*). Making the fatwa ruling contingent on “harm” technically leaves the ruling open to change as new evidence for injury to the giver (or lack thereof) is found. But just as importantly, it transfers ethical responsibility to society, or the experts – rather than the jurist, who as I was repeatedly told in Qom cannot be held responsible for investigating technical issues that fall within the knowledge-realm of other experts. It is the task of medical doctors, or perhaps the individual who is affected to assess whether nephrectomy causes too much harm to the kidney giver.

The Implantation

At the second layer of evaluation lays the question of whether a severed kidney could be permanently implanted into the abdomen of another person. Initially Ayatollah Khomeini, like others, had prohibited transplantation on the grounds that a severed organ constitutes a “dead part” (*murdar*), which is ritually unclean and if touched by a Muslim, precludes the performance of religious obligations such as prayer. However, the prohibitive fatwas were

rescinded once medical doctors persuaded the jurists that the transplanted organ was both alive and incorporated into the body of the recipient, and therefore undifferentiated from his other organs. They argued that the blood that flowed through the kidney cleansed it of its foreignness and made it one with the rest of the body.

Of course no mention was, or is, made of the lifetime struggle the recipient's body undergoes as its immunity system strives to expel the invading organ carrying foreign antigens, only to be subdued by regular use of costly immunosuppressant drugs. The point was that the implanted organ was not dead flesh and should be legally treated like any other of the recipient's own organs. And so in this way, the kinks at the second layer of evaluation were also smoothed out. Now there were no juridical prohibitions on either the removal of the kidney or its transplantation. Only then came the question of sales. This order of evaluation is both an analytical order and a chronological one. That is, fatwas were first obtained for the permissibility of organ transplantation, and only later were fatwas requested on the issue of sales.

The Sale

At this final layer of analysis, the question is not, "Can a kidney be bought and thereafter removed and transplanted into a new body?" Rather the question the jurists answer is, "Now that a kidney has been removed for the legitimate purpose of being transplanted, can the owner of the kidney receive payment for it?" As such, concern for the intention of the organ giver as seller, is avoided and made irrelevant. Furthermore, the legal concerns are then about an already detached organ – not a vital organ lodged beneath a rib and layers of flesh, joined to the person by vessels and thick tubes that would cease to function only once

a person had agreed to sell a part of his or herself, and once the surgeon's scalpel severed it from its place. The nephrectomy was already addressed and permitted in the first step, and at that point the intention of financial gain did not inform the jurist's reckoning. I will return to the importance of this epistemological disjuncture after I explain the legal concerns that the jurists did address.

The primary concern of jurists in assessing whether an organ can be sold is whether it has *maliyat*, that is, whether it is perceived by *'urf* (common knowledge) to have a legitimate utility for which someone would be willing to make a payment. Even though explicit prohibitions exist in Islamic jurisprudence against the sale of bodily fluids such as semen, blood, saliva or parts such as bones, it is argued that the ban in the pre-modern Islamic legal texts stemmed from the lack of utility of such body items, besides say, in the illicit practice of sorcery (*sihr*). Now that reasonable utility exists for kidneys and blood, the jurists claim, there is no reason to deny that they do indeed have *maliyat*. And as mentioned earlier, the issue of authority or ownership of the body was resolved in the first step. If the person could consent to the removal and transplantation of the organ, then he must have sufficient jurisdiction over his body. And now that the organ is separated, there exists no other rightful authority over it than himself. Some explain that if the organ can be donated, then it can also be sold, since sale (*bay'*) – a giving with a return – and donation (*hibbah*) – a giving without a return – share the same parameters: that the item given must have utility and worth (*maliyat*) and must be under the ownership (*malikiyat*) of the giver. Ayatullah Fazel Lankarani explained in this regard:

“So *you* say he can donate. We say, what is the difference between donation and sale? If you can gift (*hibbah*) something, you can sell (*bay'*) it. What is the difference between *hibbah* and *bay'*? The difference is that in one there is a return, and in the

other there isn't. We say that both in donation and in sale, there is ownership. And whatever can be donated can be sold. Now we have to examine the reality of bay'. You can go to my website where I explain the premises of bay'. Some say that on the two sides of the exchange there must be something of utility (*mal*). Those who say this ask: Is the kidney a mal or not? So when you say you can donate your parts, well you can only donate your parts if you are the owner of your parts [and those parts have use]. If you aren't the owner, on what basis could you donate it?"

Like his father, Ayatullah Fazel Lankarani expresses no reservations about the ownership and salability of the kidney, and does not discriminate between altruistic donation and sale. From a legal perspective, he argues, there is no difference. However, some jurists hold the possibility that a kidney may not be a property fully owned by the individual, but may rather be a useful item at his disposal. For this reason they require, per caution, that the exchange of payment not be for the organ itself, but for the right of its use, or perhaps the process of transplantation that the giver must undergo.

Below, I present rulings by two maraji', Ayatollah Fazel Lankarani and Ayatollah Makarem Shirazi to the same istifta, to illustrate how the principles discussed in this schema form their fatwas.

Istifta: "Is the sale or donation of organs of the body for surgery and transplantation to another [person] permissible (such as in the sale of a kidney)?"

Ayatollah Fazel Lankarani writes:

"If the life of a Muslim depends on the transplantation of an organ from a deceased Muslim, and a non-Muslim replacement does not exist, then the severance and transplantation of the organ is permissible, and per caution the blood money (*diyah*) should be paid so that it may be spent on the deceased; but selling (*furush*) is not permissible. But before death, there does not seem to be a prima facie (*fi nafsih*) reason for not permitting sales, unless the danger of death or unbearable side effects (*avariz-i ghayr-i qabil-i tahammul*) exists – in which case it is not permissible."

This marja' first responds to the scenario of donation after death. Based on the prohibition of the desecration of the Muslim body, the marja' allows the nephrectomy only under the exceptional condition that the life of a Muslim depends on the transplantation. And in this case, the organ cannot be sold, as the only rightful recipient of the payment is already dead. As for donation while living, the marja' applies the legal principle of no harm (*la zarar wa la zihar*) in his ruling. While some jurists leave the interpretation of "harm" to common knowledge, the marja' in this instance explicitly defines harm as that which may cause death or unbearable side effects. So while Ayatollah Fazel Lankarani permits only the donation of an organ after death as a last resort, he considers the sale of the organ of a living person permissible as long as the act of transplantation does not risk a fatal or unbearable physical consequence. Ayatollah Makarem Shirazi responds to the same istifta in this way:

"The severing of an organ from a living person and the transplantation of that to someone whose kidneys have both decayed (*fasid*) is permissible on the condition that the owner (*sahib*) of the organ consents, and his life (*jan*) is not put into danger; and caution requires that if money is received in exchange, that it be in exchange for the permission to proceed with the taking (*giriftan*) of the organ, and not the organ itself."

For this marja' it is required that the life of the organ-giver not be put in danger, which effectively renders "harm" to mean loss of life. What differs in this fatwa is that the marja' prefers that the money be exchanged not for the organ itself, but for something else, such as for the release of rights over the organ. We find this caution as well in his compendium of medical fatwas, in which he responds to the question "What is the ruling on the buying and selling of organs for transplantation?" by stating that "It is permissible (*jayiz*), but it is

better that [the donor] receive the money in exchange for the permission to remove the organ” (emphasis mine).

What is apparent in both of these responses is that a concern for the condition of the organ giver, his reasons for selling, and the sort of social or psychological ramifications his actions may have are eclipsed by the purpose of the transplantation – to benefit a patient with end-stage renal disease. The extent of concern for the giver is in that he should not purposely cause himself death or irreparable harm, as this would blatantly defy the Islamic prohibition on harm to the self. That the phenomenon of persons, often young men and women between the ages of 20 and 25 being offered a monetary incentive by a state institution (the Ministry of Health) and the KPF to forgo one of their kidneys to potentially ameliorate a bout of financial crisis, should escape the imagination of the jurists as they conceptualize a ruling on organ sales is conceivable, given the context within which the “problem” of organ selling emerged *as a problem* to be addressed by the jurists.

Though the *istifta* presented above, or a slight variation thereof, is what can be found in the published fatwas of jurists – in fact often the compendia of medical fatwas only include an edited, de-contextualized version of multiple *istiftas*, or even just a subtitle such as “organ selling” or “transplantation” – the original questions on transplantation are far more elaborate. Such is the case when a novel phenomenon is to be examined for a legal ruling. Letters are delivered and meetings are carried out between jurists and concerned experts. And what information is communicated, and what is excluded in the presentation of an emergent problem is naturally paramount to the kind of answer that is achieved.

With the pervasive assumption that kidney donation causes no significant harm to the donor, the act of saving the life of another Muslim overshadows concerns for the organ

giver. This may be in part due to the conceptual separation of the intention to sell a kidney from the severing of the organ. That is, the altruistic donor and the kidney seller are collapsed into a single subject. As we saw in the *istifta'* letters, the question of sales emerged only after, but within the same framework in which a case for transplantation had been made. Concomitantly, the legal reasoning of jurists replicates this same fragmented conceptualization. An assessment of the permissibility of kidney transplantation is made (with the dead, or altruistic donor in mind), and then the legal status of the exchange of money for the already detached organ is ascertained.

It is no wonder that the most common scenario imagined when evaluating the permissibility of transplantation is the donation of an organ from a brain-dead body, or from an altruistic donor such as a relative (the same kinds of donors who have been examined by the medical studies that profess that no harm is done by donation). These two scenarios permeate public imagination as the only proper and legitimate forms of kidney giving. The media exclusively focus on the heroic deed of brain death donation in their public advertisements, medical programs, and even TV serials. On the other hand, the dark side of organ selling is often the fodder of alarmist newspaper columns that highlight the illicit brokering of kidneys, rarely revealing its formalized and institutionalized components. The KPF as an organization that encourages and facilitates kidney sales remains in the fringes of public imagination as a center where the unintended consequences of bureaucratic leakages and misconducts lead to the bodily exploitation of the poor. The reach of this imagination no doubt extends to the jurists in Qom. For example, Ayatollah Fazel Lankarani expressed to me that he had heard of some peculiar “companies” that brokered kidneys. The emergence of such companies could be the result of “some

taking advantage of the law [of God],” he claimed. The mysterious company, of which he spoke, was indeed the KPF, the non-profit organization that formulated the program for kidney sales to assist the thousands of dialysis patients it supports, and the very institution that elicited fatwas from the jurists.

It is also crucial to highlight the fact that these policy-oriented fatwas were elicited not by individual kidney donors or patients, but instead by medical doctors and KPF activists. These actors sought to legitimize and facilitate a policy they deemed to be practical and necessary – they were not merely looking for ethical guidance on a matter of personal import. Their involvement thus imbricates the fatwa within a biopolitical project, the target of which is a population of donors and patients, not individual moral subjects. With the exception of state ordinances, fatwas normally assume an individual *mukallaf* or (responsible subject) as their addressee. The result is that when a fatwa is policy-oriented, it often assumes the subjects of its judgment to be abstract individuals stripped of social context and temporality. In the absence of a real-life person enmeshed in various social and economic relations – say for example a young unmarried woman who decides to sell her kidney to pay rent in the city – it is the doctors and KPF activists who situate the subjects of their *istiftas* and come to speak for kidney givers and patients. As shown in the *istifta* letter, an end-stage renal patient is presented as a suffering Muslim, the life of whom can only be saved by receiving a new kidney, while the donor is reduced to an abstract subject with a spare kidney. We do not know *why* she will consent to a nephrectomy, nor do we know *how* she will be affected, besides the fact that according to “medical science” her body will be unharmed.

While the Western bioethical stance against the sale of irreplaceable organs such as the kidney is based on a social view that the permissibility of such an act can lead to the exploitation of the vulnerable (because donors will primarily consist of individuals with financial incentives), the Shi'a jurists separate the legal concern for sales from the first two legal concerns of organ removal and transplantation; only once the other two are permitted is the kidney's salability assessed. And I argue that it is this disjointed, legalistic reasoning that separates the incentive of sales from the removal of the organ itself that has produced fatwas that resemble the logics of free-market libertarians who argue for the permissibility of organ sales in the West. When this disconnection of financial incentive from organ removal occurs, many troubling concerns are elided. These include the fact that the primary suppliers of organs are those who have been sufficiently pressed in their finances to be compelled to sell an organ, that they are most vulnerable to falling victim to kidney failure in the future, and that unlike altruistic donors, they are socially stigmatized and therefore must hide themselves from society (including sometimes close relatives), causing a great deal of emotional stress and familial strain, which at times leads to increased marital problems and even divorce.

As an anthropologist who had conducted fieldwork among donors, it was precisely these concerns that I took with me to jurists, including Ayatollah Fazel Lankarani who is reportedly building his career to attain the position of marja' and fill his father's shoes. These jurists told me that if the concerns for exploitation of the young and vulnerable were indeed "scientifically" verified and revealed to jurists, then it was likely that a secondary fatwa would void the original fatwa in light of new and secondary concerns.

At a primary level, the question or istifta is raised as a matter of individual concern, for example one person wishes to remove his kidney, transplant it into a sick person, and receive compensation for this act. In this situation, wider social ramifications fall out of the purview of the jurist. The only concerns incorporated into the original assessment are those that are obvious to the jurist. Informed by the viewpoint of medical doctors, it turns out that what is most apparent to most jurists is the perspective that donation constitutes negligible risk regardless of the profile of the donor. At the third level of state ordinances, on the other hand, the concerns are that of the state, for example the well functioning of state institutions, or the image of the state in the international community.

It is at the level of the secondary ordinance that secondary evidence can prompt a marja' to decree a new and opposing fatwa. As jurists repeatedly stated, the response of a marja' is directly contingent on the way in which a question is posed and the assumptions embedded within the question. If the assumption is that the donation of a kidney does indeed constitute harm or presents significant risk, then surely not only the sale, but possibly the living donation of kidneys would be prohibited.

It is not as though concerns for the social problems around kidney selling escape the KPF or the medical doctors supporting and participating in the present donation program. Those involved in the program saw the increase of donors as a necessity in overcoming the overwhelming problems faced by increasing numbers of dialysis patients. In the absence of a sufficiently developed brain-death program, and with the challenges and complexities of maintaining a large population hooked to inadequate dialysis machines, regulating an already existing market for kidney sales seemed inevitable and the best course of action. Routinizing kidney selling without promoting it publicly or even discussing it as a

legitimate practice was what the president of the KPF called a “temporary solution.” At the time of my research, I was struck by the fact that very few people had heard of the fatwas permitting kidney sales. Even within the KPF organization, there were high-level administrators in branch offices in other cities who were unaware of these fatwas’ existence. In my conversations with medical doctors (practicing in fields other than urology or nephrology), college students, professors, and even seminary students and jurists, I found that many were aware of the prevalence of organ selling, but they thought of it as a largely illicit or untamed practice. Nearly everyone I spoke to was taken aback by the fact that fatwas expressly permitted the sale and purchase of organs such as kidneys.

Kidney selling is now being gradually replaced with the ethically-preferable transplantation from brain-dead patients, which – contrary to sales – has been heavily publicized and advocated by the KPF and state ministries. As for the permissive fatwas, there has yet to exist an entity or an individual invested in eliciting a secondary fatwa. After all, a change in course and a gradual move to reducing paid living donation and increasing brain death donation is already underway, and is not contingent on a prohibitive fatwa. The process of forming a new fatwa would bring under moral scrutiny the actions of many doctors and agencies so far involved in transplantations from paid donors, and would draw unwanted attention to a topic which has increasingly been the cause of moral unease. Few if any people see the need to elicit fatwas for reversing a policy that may not last very long in the first place.

Conclusion

By examining fatwas on kidney selling, I have demonstrated the way in which the rulings of jurists can be instrumentally deployed by actors and institutions within and outside the state to facilitate policy aims. Most importantly, I detailed the crucial role experts and organizations play in framing social problems and their solutions, and both the subtle and overt ways in which such input contributes to the formation of particular fatwas. Furthermore, I argued that even though fatwas are the closest approximation of what God mandates, they are not necessarily deployed as an expression of what is most ethical. While medical experts and the KPF persuaded the jurists that the removal and transplantation of an organ and the subsequent exchange of money did not challenge the principles of Islamic law, they did not entirely agree that facilitating kidney sales was a permanent solution that could withstand ethical scrutiny. For this reason they never publicized the fatwas, and instead strategically used them to facilitate the progress of a temporary solution to the kidney shortage problem. The fatwas showed that kidney selling was Islamically permissible, but did not necessarily prove that they were also ethical.

I have argued that medical doctors and the KPF were guided by practical interests to frame the issue of kidney sales in a patient-centered narrative, in order to encourage and support a trend of organ selling that had already been taking place and was seen by many as the most pragmatic and ready-at-hand solution to the rising number of government supported dialysis patients. The istiftas were embedded within claims to science and premises that anticipated the concerns of jurists. Jurists relied exclusively on the expert knowledge of medical doctors and approached the topic with the same narrow biomedical

perspective. The istiftas were driven by institutions and medical doctors and not the kidney givers and patients. In the absence of an intersubjective relationship with the very persons the fatwas would affect, abstract subjects were assumed without ties to family or community, and kidneys for sale were fashioned as already separated and ready for exchange. All other concerns, realities that would befall the kidney giver, were cast as a secondary matter – a matter with no advocates.

Perhaps another fact also influenced the outcome of the fatwas: The sale of kidneys, unlike a range of other issues (such as transplantation itself) provokes few jurisprudential concerns.⁴⁵ To illustrate, I will end with the closing remarks of Ayatollah Fazel Lankarani as we wrapped up our meeting in Qom.

“Let me tell you of an even more important matter [compared to kidney sales] with lots of interesting jurisprudential issues, and that is artificial insemination. See now the world is doing this; our country is doing it as well. But our maraji’ are of two camps. Some say at a primary level it is prohibited. I personally say it is forbidden too. I *proved* that if it is between husband and wife it is alright, but if you place semen from a unrelated person, then the issue becomes: Who is the father, who is the mother? And I wrote a book about this. If you look fifty years ahead, if a part of society, say even 10% are created this way, we will have a generation of persons whose fathers and mothers are unknown. They freeze semen, and maybe they make a mistake [about the identity]. The child doesn’t know who its mother is, who its father is, who its aunt is. You end up with a generation of people without identity! Now just compare this to the issue of kidney sales! (*Hala in kuja, mas’alah-yi furush-i kulliyah kuja!*) Now whether you have someone who wants to sell a kidney to make some money, someone who wants to buy it to save his life ... [his voice fades]. What I

⁴⁵ This may as well partially explain the dearth of jurisprudential discussions dedicated to organ sales.

want to say is that *that* issue [artificial insemination] is much more important! But
May God help you in whatever task you may wish to pursue, inshallah.

Chapter 5: Money and Mutual Care

Chicken Meat

On an especially loud and hectic day at the KPF, a man warily walked through Ms. Zarrin's door. His stained and bruised shoes, drab knitted-hat, course hands, and distressed tone spoke of a man who had long outgrown the youthful callowness of so many that visited the office. Ms. Zarrin occupied herself with some papers and gestured to one of the social-work interns to handle the situation. "Can I help you?" asked the intern.

- "I'm here for *donation* - for *selling* a kidney."
- "Do you have all your documents?"
- "Some of them, but first I want to know what the *price* is. I have a problem and I need twenty million."
- "The amount the recipient pays is six million. And the government pays another one million on top of it..."
- "But I need twenty million," he interrupted.
- "Alright, but the amount that is set is six million. You can't demand more than that. It's the same for everyone," she said evenly.

The man grew visibly agitated:

- "But that's useless for me. What am I going to do with six million? I'm here because I have a serious problem. I wouldn't be here; I wouldn't do this if I didn't have a problem. I need at least twenty million, maybe even more. I can't do anything with six million."

As his voice grew louder and more distressed, another intern explained that the rules stipulated that every donor receive a set amount. But the man had had enough:

“What rules? Who makes these rules? How dare you talk to me like this? How dare you talk to me as though you’re telling me the price of chicken meat? This is my kidney! It’s my body!”

The words “*ihda*” meaning *to gift* or *donate*, and “*furush*” — *to sell* are often used simultaneously to describe the paid giving of a kidney for transplantation. For example, alarmist newspaper articles alert the public that kidneys are being “sold” and that the “market” for kidneys is “hot” as “sellers” allegedly demand exorbitant fees from desperate patients in exchange for donating/gifting⁴⁶ an organ.⁴⁷ It appears as though the term “selling” serves to highlight the financial aspect of the exchange, while “gifting” refers to the actual act of giving the organ up for transplantation. Similarly, in conversations with the social worker at the KPF, men and women seamlessly alternate between the connotatively opposing words. Some shy away from framing the act in market terminology, only then to find themselves referring to the cash payment as the “*qaymat*” – *price* of the “gifted” kidney. Customarily, *ihda* is used in conjunction with the act of giving a human organ for transplantation, similar to how in English medical journals even the paid organ giver is regularly referred to as a “donor.” To sell is the exception, which is differentiated from altruistic contexts of brain-death donation and living donation of kidneys and blood – all highly publicized and morally desirable instances of giving from the body in Iran and the

⁴⁶ *Ihda*, the term used for “donation” literally means “to gift.”

⁴⁷ “Kulliyah giran shud” [Kidney Prices Increase], 12 December 2011

rest of the world. Despite the numbers,⁴⁸ the standard model of organ giving is that of altruistic donation, and not selling – hence the linguistic convention of using the term “ihda” in the context of giving transplantable organs, even when payment is involved.

At first it may seem as though the insistence on using *ihda* (*gifting*) instead of *selling* is both a matter of linguistic convention and an effort to cloak the common reality of selling with the purifying language of altruism and gifting. This would agree with the pervasive interpretation in anthropological scholarship on the commodification of the body (Scheper-Hughes, Tober, Sharp, Lock, and others), in which the language of gifting is seen as no more than a rhetorical effort at concealing a pernicious reality. Although this may indeed be the conscious or unconscious intention of many who simultaneously deploy the language of gifting and selling, such a formulation cannot explain the frustrated remark of the man who desires to give his kidney in exchange for at least twenty million tomans but is offended by the insinuation that a part of his body can bear a price tag like the flesh of animals sold by the kilo at the butcher’s shop. Nor can such a formulation do anything but dismiss those of my interlocutors who insisted that despite the exchange of money for kidneys, kidneys are not “sold” in Iran.

In an interview with the Iranian Students’ News Agency (ISNA) published in 2011, the director of the KPF lambasted an official from a public insurance organization for having stated that kidneys were being “sold” for over fifteen million tomans without the supervision of the KPF. The KPF director retorted that “by mentioning such things they practically claim that kidney buying and selling occurs. While in this country we don’t have anything called buying and selling of kidneys, rather this year the recipient pays an amount

⁴⁸ Nearly 75% of kidney donors in Iran are paid organ givers, compared to roughly 20% brain dead in xxxx in 200x.

of five million tomans for a donated kidney.” One must ask then, if exchanging cash for the removal and transplantation of an organ is not always an act of selling – and therefore by extension not an instance of the commodification of the kidney – what else could it be?

In what follows I will examine the medical anthropological approach towards the “commodification of the body” and the moral judgments that undergird this approach. I will suggest that the commodity lens may not be an adequate analytical framework for understanding paid kidney giving in Iran. Drawing from interviews with KPF staff, kidney recipients and their relatives, and particularly an extensive conversation with a young kidney giver two years after his transplantation, I offer an alternative model that treats the transaction as a temporally extended bilateral donation. I then expound on the material, social, affective, and temporal parameters that factor into evaluations of the fairness of the exchange.

Rethinking the Commodified Body

Anthropology has been acutely concerned with the commodification of the human body as the ultimate consequence of its objectification and fragmentation, particularly in the case of organ transplantation (Fox and Swazey 1992; Joralemon 1995; Koenig and Hogle 1995; Hogle 1999; Sharp 2000; Scheper-Hughes 2000; 2001; Jackson 2002; Lock 2003; Scheper-Hughes 2003; Sanal 2004; Sharp 2006, 2007; Kaufmann 2013). The definition of commodity employed in the literature usually carries the general meaning of that which is sold, or more accurately, that which is made commensurable in value with something else through exchange. However, the moral censure underlying these analyses of the “commodified body” is shaped more specifically by Marx, and later, Polanyi’s

morally-charged critiques of commodity relations under capitalist market conditions. Nancy Scheper-Hughes warns that under “late capitalism and the new global economy,” commercialized medicine has “divided the global society to organ givers and organ receivers” – the latter often the poor from the Global South who are sacrificed to meet the demands of the more affluent members of the Global North (Scheper-Hughes 2003: 5). Embedded in this literature is a pressing concern that impoverished people are being reduced to the capitalist value that can be extracted from their bodies. The fear is that human beings are increasingly exploited as market logics characterized by anonymity and self-interested calculation penetrate medical treatment and care (Fox and Swazey 1992; Lock 2001; Sharp 2000; Lock 2003).

This research has done much to understand the material conditions enabling biomedical practices both old and new.⁴⁹ It has also shed critical light on the social harms such practices may engender. Even so, the emphasis on the commodification of the body runs the risk of a sort of fetishization of the commodity. As Leach warns, “commodification” can serve as a meta-narrative, a teleological interpretation that anticipates the cause and trajectory of people’s interest in things (2005). And just as Parry and Bloch (1989) argued that anthropological literature had fetishized money by crediting it with an “intrinsic power to revolutionize society and culture” irrespective of cultural context and the nature of existing relations of production and exchange, the “commodified body” has been reified such that there is no space for analyzing the receiving of monetary payment for the giving of an organ through any other framework. According to the medical anthropological literature, monetary transaction is proof of the commodification of the body, bearing with it

⁴⁹ The commodity lens has extended its reach far beyond the topic of transplantation into a range of other reproductive and genetic practices (See Strathern 1992, Ragone 1994, Rabinow 1999, Finkler 2000).

all the injurious side-effects of creating “fictitious commodities” – those things that are not produced for market exchange but are nevertheless bought and sold, and subject to market mechanisms (Schaniel and Neale 1999) as cautioned by Polanyi seventy years ago (1944).

The problem with taking commodification as a static ontological fact when it comes to organ transplantation and kidney-selling is that it allows for only a very narrow analytic framework. Most importantly, it imposes liberal market logics on the exchange even when subjects themselves express altruistic motivations – such as a humanitarian effort to extend life to another person. Any articulation of gifting is inevitably treated as a rhetorical attempt to *redefine, mask, and disguise* the actual commodification of organs. Claims to altruism intermixing with financial motivations are inevitably dismissed as a sort of false consciousness. For example, Nancy Scheper-Hughes writes in the edited volume *Commodifying Bodies* (2003), “We have opted for a broad concept of commodification, encompassing all capitalized economic relations between humans in which human bodies are the token of economic relations between humans that are often *masked* as something else – love, altruism, pleasure, kindness” (2003:2). Later in the same volume she writes of commodity sales being “disguised as gifts” (ibid: 54). Similarly, in her analysis of semen donation in several clinics in the United States, Tober acknowledges the existence of both commodity and gift forms, and yet chooses to treat one – the commodity – as an ontological fact, and the gift as mere perception: “Despite the fact that semen transactions are commodity-mediated exchanges, women typically perceive this exchange as a type of gifting, and fantasize about how alliances with the donor could be forged in the future...” (2003: 142).

To articulate what are deemed to be the presence of both a gift-aspect and a commodity-aspect in giving bodily organs, tissues, or services, scholars largely rely on Arjun Appadurai's seminal formulation of the commodity as a "socialized thing" (1986). Working against Marx's production-centered notion of the commodity, Appadurai focuses attention on the cultural meanings, social contexts, power structures, and relationships that assign a "commodity potential" to things and allow that potential to be realized temporarily in a given "commodity situation." Rather than search for the inherent quality that makes a thing a commodity or a gift, Appadurai suggests following the social path through which objects are exchanged, which can render them a commodity at one point and perhaps a gift at another. Tracing the "social life" of the object can illuminate the ways in which the mode of exchange, which is manifested at the intersection of "temporal, cultural and social factors," (1986:15) can alter its commodity status. This approach has allowed medical anthropologists to focus on the rhetorical and material strategies utilized by the medical establishment as well as patients to make a commodity – an alienated, impersonal thing – out of a transplanted organ at one point, and a connected, inalienable organ characteristic of gifted things at another. For example, Lesley Sharp applies Kopytoff's notion of the "cultural biography" of things (which builds on Appadurai's framework of the "social life" of things) to explain how kidneys harvested from deceased patients can simultaneously be commodities and personalized objects. She analyzes the ways in which doctors and medical staff rhetorically objectify and "reify" organs as "mere muscles, pumps, filters, or bits of flesh" (1995:377) as they prepare patients for the transplantation process. However, as recipients experience a "rebirth" post-transplant and imagine themselves as newly constructed through the body part of an idealized donor, they

defy the transplant personnel's objectifying rhetoric and ascribe personalized traits to the organ. When patients meet relatives of their deceased donors, further personal attributes can be associated with the body part, and in turn, at times to their newly constructed selves. Using Kopytoff's framework of the cultural biography of objects (1986), Sharp states that "the organ itself may be viewed as embodying a biography of its own" (1995: 378) including the various phases of being recorded as a medical object for transplantation, to its inhabitation within the recipient's body as she experiences a new subjectivity that may transform in subsequent encounters with medical staff and relatives of the donor.

Despite its sophistication and nuance, Sharp's account of the experiences of transplant patients is similar to the examples I cited above in that she assigns to the transplant organ the *ontological* status of the commodity while treating the experiences of recipients with transplanted organs a matter of *perception*. She writes, "As I will argue, the recipient perceives the organ as an unusual object, one whose nature is rich and varied: it is perceived as simultaneously a thing and as an other. This odd configuration is at the heart of transplant ideology, where messages vary according to context (and audience)" (1995: 377). But then she writes, "...organs are indeed commoditized: price lists distributed to recipients, for example, reveal that their organs are bought and sold" (1995:377).

In general then, when organs are detached from their original bodies and money makes its way into their social lives, they are treated as commodities. The evaluations and reasoning surrounding their giving and receiving are analyzed through market logics. But what if we take Appadurai's fundamental question of "what is a commodity exchange" very seriously, and rather than taking for granted that the giving of something in order to receive money is inexorably an instance of commodity exchange, we consider that a certain

set of conditions can make it such that the exchange can be something qualitatively different even in the presence of the promise of immediate payment?

It may be useful to recall older debates among anthropologists regarding “bride-wealth” versus “bride-price” that questioned whether the making of payments to the bride’s family in certain societies was qualitatively the same as a commercial transaction (Evans-Pritchard 1931, Gray 1960, Gibson 1962). Evans-Pritchard argued that bride-price was a misleading term, because for one, despite the economic dimension, the parties involved did not see the exchange as a market exchange, and second, because the social events and circumstances surrounding the making of the payment differentiated it from impersonal market transactions (1931: 36, cited in Dalton 1966: 732). This can be the case despite the fact that marriage payments formally resemble those of commercial transactions within the same societies.

My insistence on rethinking the so-called “commodification” of the kidney in Iran stems from similar observations as those highlighted by Evans-Pritchard in the case of bridewealth. Even though in the words of patients and kidney givers, medical practitioners and the general public, the kidney is “bought” and “sold” at an agreed “price,” these same people either explicitly or implicitly indicated that this buying and selling was often different from the buying and selling of commercial goods. And though I was initially tempted to write this off as attempts to justify kidney-selling or to rid it of the negative connotations of the commodification of human parts, I was increasingly pushed to consider these claims seriously.

In Iran, giving a kidney for money is stigmatized, so much so that kidney givers try hard to hide their decision from family members and friends. But the stigma has much less

to do with the fact that the human body is being treated like a commercial good than with its signification of financial desperation and the failure to provide for oneself and family, as well as one's inability to secure support from familial and social relations. This is perhaps why in many ways the drug addict is the quintessential kidney seller: He is desperate for money, unable to secure a job, lacking in honor and credibility, and severed from his ties to family and community. Even though the actual reasons for giving a kidney are often very different, the image of the feeble addict haunts many who consider this as a way to resolve their financial problems.

Likewise, the general public's uneasiness over the prevalence of paid kidney-giving in Iran is primarily directed at what it signifies: Widespread poverty and the financial pressures afflicting the youth. I often asked Iranians of various socio-economic backgrounds and levels of education what their reactions were towards paid organ-giving. As I expected, the overwhelming response was negative. But to my surprise, the reason rarely incorporated a critical attitude towards the treatment of the body as a commodity. That is, it was not so much the ostensible commercialization of transplantation that aroused moral unease, but that there should be individuals under such a financial burden to consider kidney selling a solution. Concern for skyrocketing prices and the lack of support and resources for the poor far outweighed alarm over individuals being permitted or even incentivized to "sell" their body parts. On the other hand, those who had heard of young individuals selling kidneys to pay for a wedding or purchase a car blamed rampant materialism, superficiality, and misguided aspirations.

Such discursive framings of the phenomenon as an issue of financial difficulty on the one hand, and confused priorities on the other are also reflected in political cartoons. For

example, one widely-shared cartoon that I found on a public Persian facebook page called “Cool Caricatures” depicts a somber image of a father with patched up pants handing a loaf of sangak bread to his rejoicing children. The father’s two kidneys are hollowed out, illustrating the hefty price some have to pay to provide for their families. In another cartoon⁵⁰ a young man eagerly punches numbers in a calculator as his grandparents and baby sister watch with wide-eyed expressions. The young man’s speech bubble says, “Grandma, do you think if we put my kidney, plus your kidney, and mom’s and my sister’s and grandpa’s kidneys together, we can throw a great wedding to make all the neighbors gape in envy?”

The idea of “selling” a kidney has become so pervasive in the public imagination that it is reflected in and reproduced by everyday expressions that refer to the kidney as a final legitimate financial resource. It is not unusual to find a character in a TV comedy or drama plead in desperation that he is willing to part with his kidneys, to sacrifice his last possession, to pay for a child’s surgery. One may encounter people joking about having to sell a kidney if their business doesn’t pick up, or if an associate fails to pay back his debt. One can contrast this to prostitution, a form of *tan-furushi* (“body selling”) that is illicit, morally repugnant, and excluded from public humor. Kidney-giving, on the other hand, serves the vital purpose of relieving another’s suffering, an act so laudable that its value and significance cannot be easily and entirely diminished through the making of a payment.

What I wish to arrive at here is that the lack of a strong critical attitude towards the commodification of the kidney may point to other dimensions to the exchange that a narrow commodity framework obfuscates, aspects that can more adequately reveal the

⁵⁰ <http://www.hovel.ir/post/363> (accessed June 25th 2015)

boundaries between fair and exploitative exchange – a morally defensible instance of paid kidney giving and a morally reprehensible one. When I explained to my interlocutors that selling a kidney is illegal in the US and that Iran is the only country where it is permitted and routinized, I was always faced with disbelief and sadness. “Why should Iran be the only country where such a thing happens?” they asked. But when I probed further, I realized that they interpreted my remark to mean that only in Iran poverty pushes people to sell their kidneys. When I explained Iran’s uniqueness in this regard to a 21-year-old woman who had recently received a kidney from another young woman, she said, “I know I’m a kidney patient and I bought a kidney, but really why should a young person have to sell a kidney for money? What does a 22-year-old know about life to be able to decide to sell a kidney for a wedding? It’s painful that someone should have to do this. It’s different if someone donates to their daughter... You know, I think they [the government] did this to keep people quiet. You know, for people to have some way of making money.” I then clarified that if organ selling was legal in the US, there would be no dearth of individuals needy enough to consider the exchange. “Really?” she said with a chuckle. “Then do they [the US government] give them some sort of financial assistance instead?”

All of this is not to say that the selling of a kidney is never imagined as a commercial exchange, or that when it is, it is treated as unproblematic. In fact, as I will later demonstrate, the commercialization of the exchange haunts the entire process as a potential, from the moment prospective kidney givers contemplate the idea, through their personal encounters and monetary negotiations, to the transplantation itself, and sometimes even for years after the surgery. To treat the transaction as one animated primarily by a desire for financial profit, to ascribe a predetermined monetary value to the

kidney, to ignore or diminish the affective, humanitarian, and social aspects of the exchange, can all taint the transaction. For kidney givers in particular, these can all create feelings of exploitation and regret. But making a payment does not necessitate any of this in itself.

The Money is Not the Price

In a conversation in 2012 with the director of the KPF, we discussed the recurring topic of the ethics of organ selling. Besides explaining the practical circumstances that he believed necessitated the Iranian model, Mr. Zahedi insisted that what happened in Iran was not in fact *organ selling*, because the transacted payment was not the “price.” “We agree that buying and selling is happening – a bit,” he said. “Money is being exchanged. But the money is not the price.” Several years earlier he had made a similar claim when payment was set at five million tomans (one million from the state and the rest from the recipient). He told me that with the payment being so low, it could not possibly be treated as the value (*arzish*) of the kidney, and therefore those who gave their kidneys and were paid were largely motivated by an altruistic desire to “help their fellow countrymen.”

I had a similar conversation with a twenty-one year-old orphaned chemistry student named Sara who had received a kidney from a young woman who was in turn paid twelve million tomans by a philanthropist. Sara told me that the twelve million was definitely not the value (*arzish*) of the kidney. When I asked her if her kidney-giver had indicated any altruistic (*khayrkhahanah*) motives, she replied that irrespective of what the giver had expressed, it was indeed altruistic. “Because twelve million is really nothing,” she said. “I’ve

been through dialysis. I know how much a kidney is worth. A healthy person doesn't understand this. So twelve million is not the value of the kidney."

These statements are consistent with others I heard from many individuals whose lives had been entangled with kidney transplantation, as patient advocates, medical doctors, kidney givers, actual or prospective recipients, and their relatives. From the perspective of the receiving side, the value of the transplanted kidney as a life-saving organ is boundless. These were individuals who had undergone the often painful experience of dialysis and knew what it was like to be unable to eat and drink as normal. For them, the value of living with a healthy kidney was one they could not quantify. They would agree that the value of a life enhanced by a transplanted kidney is incommensurable with anything else. I once asked Ms. Zarrin, the social worker at the Tehran office of the KPF, whether she considered paid organ giving to constitute a sale given all of her grievances with the practice. She responded:

This isn't really selling. That person [giving a kidney] doesn't know this. S/he calls it a sale, but in reality it isn't. I mean, can you put a price on a part of the body, and so little at that? I always say this. I actually believe this. You can't put a price on it. You just can't. If they ask me, would I do it? I ask myself this a thousand times a day. Would I do this surgery? During those times when I've been so much in need, would I have done this if I had known about it? And these donors, they could do something else. They all know well that they can steal, or they can deal drugs, but they won't do it. A lot of them, you know, could steal if they wanted to – they could pull it off. But they don't; there's something in them that holds them back. That means this is a good person. Not all people can steal or deal drugs, but a lot of these people who sell, can if they want to. But they don't. Some might not do it [give an organ rather than steal] out of fear, but some you can tell, they are bold [*jasur*] – he comes in with a large scar on his face, you ask what happened to you and he says "I fell." You just

know this person could pull off any of this [stealing or drug dealing]. He's got the boldness but won't do it. I say this is a good person, a good person who is willing to put up with all of this. So when I put all of this together, I think this isn't a sale.

I then asked her to clarify what qualifies as a sale?

Like something that is worthless. Or maybe you could say, something material – something that you can put a price on.

These claims convey the idea that a human body part that is transplanted to relieve another of severe bodily harm cannot be made commensurable with any other object that one could obtain with the amount the recipient pays, or perhaps, as some would say, to any amount of money. This notion of selling as an exchange of two things of equal value, as occurs in a market, overlaps nicely with Marx's notion of "commodity exchange." In *Capital (Volume I)*, Marx defines a "commodity" as that which is produced by human labor for the purpose of sale and is exchanged in a commercial market. Under capitalism, the producer of the commodity sells his labor power to the capitalist. The capitalist extracts surplus-value from the labor through his control of the mode of production and the increase of labor efficiency. He then sells the commodity in the market at an "exchange value." With that exchange value other commodities of equivalent exchange value can be purchased, irrespective of the qualitative difference in the actual labor, both in kind and measure put into making the products. Capitalist money (also "general purpose money" (Bohannon 1959)) operates as a standard scale by which the exchange value of commodities can be measured and so allows for two qualitatively different objects to be treated as though they were the same. The worker in this system is alienated from both the commodity and the mode of production, since it is his labor power that is being sold to the capitalist and not

the commodity which he produced. Furthermore, in the market the commodity is made commensurable with other commodities of varying utility and methods of production, while the value (exchange value), or what we call the “price” of the commodity comes to be seen as an inherent quality of the commodity itself. The labor or the real social relations necessary in the production of the commodity are “mystified” and the price comes to be seen as the objective value of the commodity itself. Marx calls this “commodity fetishism” (*Capital Volume 1*. See also Harvey 2010: 56-62).

There is an ambiguity here that needs to be clarified. Sara the kidney recipient, Mr. Zahedi the KPF director, Ms. Zarrin the social worker, and others who were proximal to the experience of end-stage kidney disease, all argued that the transplantable kidney has no exchange value. On one level this would seem to agree with the claims of anthropologists and bioethicists who describe the payment for organs as instances of the commodification of the body. They too would agree that the payment made to an organ-giver is never equivalent to the life-saving value of the kidney. In the words of Karl Polanyi, the sold kidney is a “fictitious commodity” (2001[1944]), that is it is a thing not produced to be exchanged in a market, but is nevertheless treated as a commodity, alienated from its producer (in this case the person to whom the body belongs) and made commensurable to other commodities in the market. For this reason, just as Polanyi warned, the commodity-like treatment (*commodification*) of the body has serious social and moral consequences (ibid: 76).

As I stated earlier in this chapter, when it comes to organ giving and transplantation, medical anthropologists have taken the commodity status of transplant-organs as an ontological fact. Even when the gift-giving aspect of the transaction is acknowledged, it is

treated as an alternative “reading” by certain actors. For example, in a review article for the *Annual Review of Anthropology* (2000) titled “The Commodification of the Body and its Parts,” in which organ transplantation is dealt with at length, Lesley Sharp writes, “... two models of commodification may be at work simultaneously, one more akin to Mauss’s understanding of the symbolically charged gift and reciprocity (1967[1925]), the other to Marx’s notion of commodities as goods produced under the alienating conditions of capitalism(1971 [1887]). Thus different parties may offer competing readings of various goods of human origin. Where, for example, medical professionals may insist on the objectification of body parts, nonprofessionals may instead foreground understandings of kinship, body integrity, and selfhood, all of which may be embodied within an organ or other body fragment. Thus, Mauss and Marx can work in tandem, together generating a dialectical model of commodification as a social process”(Sharp 2000:292). That is, for example “a dead woman’s transplantable heart may simultaneously embody the essence of a lost love one, be transformed into a gift for a recipient in need, and be the coveted object of a surgeon’s desires.” Applying Appadurai’s notion of the social life of things (1986), the author acknowledges that the commodity is not a thing in and of itself, but is embedded in webs of social relationships and structures of power and meaning that make an object into a commodity, and the exchange of money for the organ is undisputedly a situation of commodity exchange.

In this formulation, the normative claim is that the body should not be treated as though it is commensurable with other commodities in a market, which is precisely what it would be when payment is made for an organ – be it by a hospital obtaining body parts from an organ bank or a patient paying a kidney giver. This is where the claims of medical

anthropologists diverge from the statements of my interlocutors. In the accounts I gave above of my interlocutors, the claim is not only that kidneys *should* not be deemed equal in value to the received payment, but that paying the giver was ontologically not an instance of a market sale.

Taking this claim seriously and allowing it to shape my own etic analysis may seem suspect, given that the market terminology of *furush* (sale) and *kharid* (buying) abound in speech about paid kidney giving, that Islamic jurists for the most part unequivocally discuss the legality of “organ selling,” and that even Iranian newspapers warn of an organ “black market.” Furthermore, there is no shortage of advertisements scribbled on walls around the KPF and hospitals and even the comment space on online websites that share transplantation stories, vying for a kidney “buyer” or a “seller” and promise a “negotiated price.” In what follows I will attempt to elucidate an alternative approach to analyzing paid kidney giving in the Iranian context by first examining the “market” status of the sphere of exchange in which living kidney transplantation occurs. I will argue that kidney advertisements are in effect an attempt to *escape* the perceived marketization of transplantation. I will then explain further why the “gift” and “commodity” model is insufficient, and put forth an alternative analysis of the exchange as “bilateral donation” that does not fit the profit-seeking, alienating, quantifying logics of the commodity market, nor a hybrid gift-commodity model as has been applied in for example garage sales where the insignificant funds paid are not treated as the market price of sold objects (Hermann 1997).

Kidney Advertisements and the “Market”

It is often remarked with alarm in newspaper articles, on blogs and web forums that there is a “black market” for kidneys in Iran. The face of the market is Farhang street in Tehran where the central office of the KPF is located and where thousands of advertisements cover the surrounding walls. Layers upon layers of inscriptions of phone numbers in Persian numerals and blood types in Latin letters stand out beneath peeling coats of paint – futile attempts by homeowners and the KPF to render them invisible. On these walls you see not only short advertisements, concise lists of words in the form of rental ads or car sales, but also (less frequently) statements beseeching the good will of a patient’s family to help a kidney giver overcome an urgent financial predicament. Though most of the advertisements are ambivalent hand scribbles in pen, marker, and even pencil, one will also find printed flyers containing a blood type, the word “selling” or “buying,” a date and a (usually temporary) phone number. A few times I even encountered large stenciled advertisements, boldly spray-painted over less conspicuous hand inscriptions. Similar advertisements are written on blogs and web forums in a virtual extension of the walls of Farhang street, often with more elaborate stories contextualizing the decision to give a kidney.

Advertising the buying or selling of kidneys is prohibited, though not illegal in Iran. That is, there is no law criminalizing the writing of advertisements. But a notice is posted outside the door of every KPF office declaring that advertisers will be “reported” and phone numbers written on their ads will be disconnected. Ironically, these same notices become surfaces for more handwritten ads. During the many visits I made to the KPF and the many hours I spent hanging around Farhang street, only once did I encounter a middle-aged man

nervously hiding what appeared to be a container of glue in his pocket, as though he had just finished pasting a flyer or sticker on a wall. It appeared as though for the most part, advertisements were stealthily scribbled, or in the case of bolder ads, plastered and painted on the walls in the darkness of the night so as to avoid the gaze of the KPF guard, the residents occupying the homes behind the walls, and street pedestrians. If the KPF has indeed reported and disconnected any phone lines, this has not deterred further advertising.

The KPF forbids advertisements because it says it wants to prevent the rise of a market for kidneys. Allowing patients to choose among a large selection of organ givers would hypothetically lead to the emergence of a commodity market where buyers can shop for the most desirable item at the most attractive price. In such circumstances, the age, athletic appearance, and even sex of the kidney giver may figure into assessments of the most suitable candidate. A typical advertisement might indicate that the “seller” is a young twenty-one year-old male, healthy, and with an athletic build – what many doctors tell patients would be the ideal candidate for transplantation.⁵¹ Furthermore, the selection of advertising patients in search of a particular blood-type could encourage kidney givers to shop for the most generous recipient, quickly raising prices and leaving few opportunities for poorer patients to gain access to a transplant.

To prevent such an outcome, the KPF keeps two separate lists: One for patients in need of kidneys, and the other for prospective donors who have undergone the necessary lab tests. While the urgency by which a patient needs a kidney can bump their name up on

⁵¹ While some patients expressed a preference for female kidney givers as they were assumed to have been less likely to smoke or use drugs, others were concerned that a female giver’s kidney may have already been somewhat harmed by a pregnancy, or would in the future be more negatively affected than male givers, should they choose to become pregnant.

the list, kidney givers are listed in the order in which their completed documents are presented to the office. The KPF will then match the top names on each list that have matching blood-types. Although it is not unheard of for a patient to reject a kidney giver – because, for example the giver is later found to smoke (a factor that does not medically disqualify a giver, but makes many patients uneasy) – KPF rules stipulate that a kidney giver who backs out of an agreement with a patient will be permanently removed from the giver list. The KPF operates as the central matching unit and formally refuses to accept kidney givers and patients who have independently found one another. That is, they would not be able to obtain a supportive letter from the KPF that is required by public hospitals where state-subsidized transplantations occur.

Although I had no way of ascertaining the extent to which these protocols were followed, I was told by several medical doctors that there was little advantage for a hospital or surgeon to defy them, since surgeons were paid by the state and not the patients, and especially since in recent years certain hospitals had threatened to revoke the medical licenses of doctors should they operate on a patient without a KPF letter of support. During my fieldwork I came across multiple transplant recipients who indicated that they had in fact independently found a kidney giver (all of whom had done so in the earlier years of the matching program), and many who claimed that in recent years they had initially attempted to do so, but had been prevented by the KPF. I personally witnessed a number of instances in Tehran between 2009 and 2011 in which the family member of a patient was engaged in an intense brawl with KPF staff for being refused necessary documentation because a kidney giver had been selected independently.

It is likely that KPF offices and even the central office in Tehran have not consistently implemented their own guidelines. It is also possible that stories of match-findings from the earlier years of the program are still alive and animating the drive for others to attempt the same. Furthermore, a deep-seated distrust in the reliability of bureaucratic systems frequently pushes individuals to take matters into their own hands, especially when organ givers are in a rush to resolve their financial problems (as they almost always are), or when kidney patients are made to wait longer than they had expected. The inability of many to comprehend and appreciate the KPF's insistence on centralizing and controlling match-finding, coupled with a general distrust for bureaucracies, results in a widespread assumption that the KPF practices favoritism and is financially interested in doing so. For example, I once met a man who had been standing on Farhang street in search of a patient and had not yet entered the KPF to inquire about the procedure. I explained to him the guidelines and encouraged him to speak to a social worker. As we walked through the hallways of the KPF's Shafa clinic across the street, the man let out a sigh while gesturing to the marble floors and cherry-finished hardwood doors, retorting, "And you say they're not making money off of this!"

In 2011 I spoke at length with another middle-aged man shuffling about on the street under the scorching summer sun in hopes of finding a kidney giver for his seventeen-year-old daughter. His thick *luri* accent and croaking voice made it at times difficult for me to decipher his words. He explained that in 2007 his daughter had received a kidney from a young brain-dead boy who had been suffering from a brain tumor. He emphasized that the boy's compassionate doctor-father and teacher-mother chose to "chop up their son and give away his parts to save the lives of others." But a year later his daughter's body rejected

the kidney and she was back on the waiting list. For three years the father had been visiting the KPF inquiring about a match for her daughter. "She's O+, and O+ isn't rare is it? How many times do I need to come in for them to find me someone?" While three years is longer than most wait to receive a kidney from a paid living giver, he admitted that his daughter had also experienced some complications that had pushed back the possibility of undergoing a transplant. However, it was not clear to what extent he attributed this to the delay in finding a match, or perhaps the fact that she had already received a transplant once and was likely to be considered later than those who were still waiting for their first transplant. Frustrated and confused, he intently gazed at every pedestrian pausing at the sight of a scribbled ad on the wall.

It is difficult not to stare at the walls. If one is in need of giving or receiving a kidney, it is perhaps even more difficult not to scribble a note. After frequenting the KPF day after day over the course of a few years, the walls seemed to me to take on a mystical quality, meshing into one long and narrow living surface (even growing sideways onto nearby trees and light-poles) that gradually shed its skin as the ink faded in the sun and rain, only to perpetuate itself with a call to its spectators to inscribe yet another advertisement. The wall not only summons patients and givers to inspect its surface, to carefully examine its crevices and trace the darker colored lines to distinguish the more recent ads from the outdated, but it also marks and differentiates the interested persons from the curious passersby for those (usually no more than two to four people) haplessly standing on the street looking out for a potential match.

With my writing-pad in hand, carefully noting the content and form of the inscriptions, I was regularly approached as an interested party. "Are you looking to buy or

sell?" I was asked. Once I explained my research interests I would inquire as to why they did not wait for the KPF to identify a suitable match. Besides hoping to secure a candidate quickly, kidney givers almost always expressed a need to obtain more money than what the KPF had announced and feared being matched with a patient who would be financially unable to accommodate them. At times the amount was in excess of just one or two million tomans, other times five or ten million. Although occasionally one could find an ad on the internet or on the wall asking for payments up to ten times the regulated amount, it would be highly unlikely that any patient would agree to such a payment given the likelihood that many other willing givers could be found for much less. When I once called the number on an internet ad by a young man requesting fifty-five million tomans for paying the *diyah* (blood money) in a case of manslaughter, the man explained that the victim's family had consented to receiving the payment at a later time, releasing him from the need to sell his kidney. He then remarked, "In reality no one will pay that much [fifty-five million]. At most they will pay ten or twelve million." This was at a time when the KPF had announced a payment of six million. He also mentioned that the only phone calls he received were from others who wanted to learn how to successfully acquire a similarly high payment. Furthermore, assuming that the KPF was successful at preventing such cases of independent match-finding from making it through the transplantation process, it was unlikely that a giver could demand a fee so much higher than the set "price," since an eventual disagreement and withdrawal by the patient could result in the giver being permanently removed from the list and failing to give a kidney altogether.

So far it seems that the regulation and standardization implemented by the KPF is aimed at precisely what it claims – a serious effort at curbing the marketization of kidney-

giving and preventing the sorts of transactions some still attempt on the “black market” of the street. The illicit advertisements modeled so accurately after other commodity ads that are found in newspapers and flashing internet pop-up ads, point to a similar conclusion. But examined closely, the attempt to independently find a match can be seen as an effort to attach a personal face to the blood-type, to allow the sharing of stories of financial difficulty, and to ultimately engage in an exchange that does not treat every giver the same way (as though the sameness of the organ warrants an equal and standard payment). This is an attempt to account for the unique problem that each individual hopes to overcome by resolving another’s problem of disease and suffering. The prospect of meeting face-to-face affords gives the opportunity to establish a social relationship and a personal connection revolving around a mutual interest in easing one another’s suffering. A few examples of advertisements that contrasted with the more common commercial form and instead resembled the kinds of interactions that individuals engage when they meet face-to-face can better illustrate my point.

One undated advertisement that I found in August 2009 was neatly written in blue marker ink on a white piece of paper with hand-drawn lines:

<p><u>HELP ATTENTION HELP ATTENTION</u></p> <p><u>I am in financial need for my mother’s knee-replacement surgery. Therefore I wish to sell my O+ kidney. I request altruists and those in need of a kidney to assist me in this God-pleasing cause.</u></p>

This advertisement acknowledges the altruism of the exchange on the side of the kidney patient who makes a generous payment to aid the giver in financing his mother's surgery. Essentially, the author is hoping to give another the opportunity to live life free of dialysis in exchange for his mother's ability to walk.

An online advertisement that I found in January 2012 states the following:

Believe me, I am stuck and in need. My problem is a matter of life, otherwise I would donate to you my friend who is in need [of an organ]! But we are both in need. And in my opinion your need is more dignified! My price is twenty million tomans, which I think is not much given the organ that I am giving and given the rate of inflation and the bad state of economic affairs in our country and the little value in our currency! Please, if you can afford it, contact me!"

Internet ads are far more likely to be elaborate, often containing the financial reason motivating kidney giving. The invisibility of writing from behind a computer screen makes it easier to do so compared to posting an advertisement on a public wall. In the example above, the author demonstrates the moral superiority of purely altruistic donation, but admits that his or her problem is grave and perhaps qualitatively similar to the need for an organ, since it too is a matter of "life." Furthermore, the ad indicates that the so-called asking "price" of twenty million is far less than the actual value of the organ, thus detaching the payment from the organ, and perhaps also hinting at a degree of altruism in the exchange. Finally, the ad acknowledges that the payment may be beyond what some can afford, demonstrating that the author hopes to acquire sufficient funds to resolve a particular problem that costs twenty million, rather than seek merely a fair and affordable payment for the giving of a kidney. Even though kidney givers often negotiate the amount

of the final payment with the recipient, as I will thoroughly elaborate later in this chapter, the payment is treated as a negotiation between what the giver *needs* and what we can think of as the recipient's "capacity for care." While the kidney giver offers what is within her or his capacity to improve the health of a patient – the giving of a kidney for transplantation – in return he or she expects the recipient to reciprocate with what is within his or her capacity to care for the giver – payment that will ease a financial problem.

Let us compare this with a situation where someone is selling a lightly used futon bed for one hundred dollars. A buyer may be interested in purchasing the futon for seventy-five dollars, perhaps because that is all she can afford, or because that is what she believes to be the worth of the commodity. She may even claim that someone else is selling a similar bed for seventy dollars, at which point the two parties engage in a negotiation where they discuss the quality of the bed compared to other futon beds sold in the area. The two parties ultimately settle for eighty dollars. In this situation, the paid money operates not only as a means of exchange and a method of payment, but also as a standard of value (Maurer 2006: 20). There is no effort to detach the price from the value of the commodity, to relate it to personal circumstances affecting the sale, and certainly no interest or expectation of a prolonged relationship of reciprocity and debt. The payment terminates the relationship, and profit is unproblematically figured into the motivation for selling. In contrast, in a kidney exchange in the Iranian context, givers and recipients generally do not attempt to justify a payment in terms of the value of the kidney, nor do they make comparisons to other kidneys of the same blood-type. The payment is explicitly stated not to be the value, and givers and patients are frequently engaged in long-term relationships of reciprocity. In this instance money serves as a means of exchange and a

method of payment, but not as a standard of value. (I will later explain that to treat the money as a standard of value, and therefore as a means of exchanging commensurable commodities, rather than as an index of the patient's capacity for care, is experienced by givers as unjust and exploitative. Furthermore, an interest in making a profit is treated as a morally repulsive exchange).

In my conversation with the man mentioned earlier who stood on Farhang street in search of a match for his daughter, I asked how much he was willing to pay for the transplant. He explained, "Something in a normal range. It depends on the other person. Right now I have seven million, but really what is seven million for a kidney? Some say ten million. I don't know. However much you give though, you have to also account for paying more on top later on. Tomorrow you'll have to help them out." He then added, "The person giving a kidney has a problem. They are either thinking of their honor [*abiru*], or want to pay for a wedding. They have some sort of plan [for the money], some sort of need. They come from a dignified family – not any person is willing to give a kidney. They come from a dignified family, such that they aren't willing to approach a brother for money." He then shared with me that his daughter had undergone a series of surgeries on her heart and gall bladder since a very young age and that he would do anything for her well-being. "And the other person, they become defective [*naqis*] after this. Right now I have seven million, but later on after my daughter's surgery, when I come to more money, I'll help them out. Maybe I'll give one million. I'll do what I can... You have to take care of them."

What this demonstrates is the importance of caring for the giver, to reciprocate the opportunity to live a more healthful life with something qualitatively commensurable. In this example, the patient's father imagines that a prolonged relationship of care can

compare with the temporally extended experience of a healthy life post-transplant. He intends to engage in such an exchange irrespective of whether the kidney giver is one that he finds on the street, or by calling a number on a “for sale” advertisement, or most likely, through the KPF’s waiting list.

International bioethical discourse on organ donation promotes anonymous transactions in order to eliminate the possibility of the giver “harassing” the patient for ever more compensation. In the Iranian context, however, kidney givers and patients are allowed to meet and develop a relationship that can last for years beyond the surgery. Of course this does not always take place. When such relationships fail or are terminated prematurely, the giver may experience disappointment and regret, as we will later see in the case of one of my interlocutors.

In the example of the futon sale, I said that comparing the seller’s futon to comparable beds might be a legitimate method for assessing the appropriateness of the seller’s price. Indeed in commodity sales as Marx would have it, the exchange-value of an object is dependent on the average “socially necessary labor time” to produce the commodity. That is, the price is a function not of the particular use-value of the object, which would account for the idiosyncrasies of a particular producer’s process of crafting the object, but an abstract value that may bear no relationship to the actual producer and his labor (Marx 1971 [1887]). As Chris Gregory (1980, 1982) argues, unlike gift exchanges that create relations between subjects exchanging aspects of themselves, commodity exchanges only create relationships between things (See also Strathern 1990, Graeber 2001). The futon is imagined in relationship to other futons with similar function and appearance, and therefore its exchange value is dependent on the exchange value of those

comparable commodities. But when it comes to kidney “selling” in Iran, one observes a wholly different dynamic where kidney givers’ problems are treated as singular, even if kidneys belonging to two people have identical features of being of the same blood-type and belonging to equally young and healthy individuals. The following example can more clearly illustrate my point.

One afternoon, as I stepped out of the KPF’s door leading to Farhang street, I encountered two men standing next to one another engaging in casual conversation, each holding a large folder containing what were likely lab results and other papers for kidney giving. I drew myself near, unsure whether it would be appropriate to identify them as kidney givers so close to the KPF’s security guard who on occasion stepped out of his kiosk by the door and stepped into the street to tell off individuals posting ads and pursuing potential matches. Soon enough, one of the men interpreted my gaze in their direction as a sign that I might be interested in “buying.” As usual, I explained that I was merely doing research on the experiences and challenges of kidney givers and recipients. We then started a conversation about the circumstances that had driven the men to the KPF’s door and the amounts they were hoping to acquire. One man whose blood-type was B+ explained that he needed seven million to pay his debt to a business associate. Failure to do so could result in him being jailed until the debt was paid off. However, the other man with an A+ blood type was asking for eleven million. “My problem won’t be resolved with any less than eleven million. The KPF says the price is 6 million, but I need eleven million, and I need it very soon.”

What struck me as odd was that the two men standing next to one another were asking for vastly different payments. Though the different blood-types meant that they

could not be competing for the same patient, one would nevertheless expect that in a market structure, if one individual finds it fair to request a higher amount for a comparable object or service, it would be equally fair and surely profitable for the second person to demand an equally high amount. Or if one person's price were much lower, the other should feel the need to offer a competing low price. Even though comparisons were inevitable and undoubtedly influenced negotiations, kidney givers for the most part emphasized that their interest was in solving their problem, not in making a profit off a "spare organ." Some claimed that if they could not obtain the entirety of their requested payment they would most likely pull out altogether. Others were more flexible and would take an opportunity to make up at least a portion of their debt.

***Savab*, Problem-solving and Profit**

As I explained earlier, the kidney, with its vital role in drastically improving the life of an ill patient, cannot be made commensurable in value with a monetary amount. Even when the financial payment makes a substantial improvement in the kidney givers life, it is usually believed that there is still an excess that will never be completely reciprocated by the recipient. This excess can be recompensed by *khuda* (God) in the form of *savab*, the divine reward promised to human beings for their good deeds. That is, a divine transaction can make up for the inadequacy of the ordinary exchange between kidney giver and recipient. As Sara the twenty-one year-old organ recipient told me, "The person who gives a kidney has a reward with God. They're saving someone from so much misery. That warrants a reward with God. Just because they're receiving money, it doesn't mean there is no reward in what they do." Another middle aged woman I met in a hospital expressed

fervidly that she and her husband were not well off and could not continue to support her kidney giver as they would have hoped, and so she prayed for his well-being during her daily obligatory prayers. She appealed to God as an infinite resource to reward the giver for the ongoing benefit she gained from his action.

In Islam, every transaction, in fact every action is an exchange with God. The Qur'an itself uses the word *tijara* (commerce) to explain God's reciprocation of the deeds of mankind.⁵² Unlike the hostility to commerce in the Aristotelian tradition,⁵³ commerce or retail trade which was the occupation of the Prophet of Islam is considered a social necessity, and when practiced in accordance with Islamic law, is treated as a sacred profession. Every commercial transaction that is equitable and mutually beneficial and that does not distance one from the remembrance and worship of God can be a source of financial benefit as well as a source of divine reward. When one engages in a good deed, one receives divine blessings in return, and when one misbehaves, one receives divine punishment. In this reciprocal "commercial" relationship with God, some exchanges can be more profitable than others. The greater the sacrifice and the good will accompanying it, and the greater the benefit that results from the action, the greater the divine blessing. Since God is *al-karim*, (the Generous), his recompense is much greater than the recompense of man. This is the logic of sacrifice or denying oneself worldly pleasures in exchange for a far greater reward from God. Likewise, the more self-interested and materialistic one's motives, the less opportunity there is to profit in divine blessings. Therefore every short-term transaction with man is entangled with a divine transactional order (Parry and Bloch 1989) and requires a fine balance between worldly profit necessary for everyday

⁵² Quran, 35:29; 61:10; 9:111

⁵³ Aristotle, Politics, Book One, Part X

sustenance, and divine profit that guarantees one's welfare in this world and the hereafter. Since God's recompense is bountiful, the greatest profiter is one who chooses God's recompense over man's.

Even for those who are less devout, the ethic of not tainting a good deed with self-interest is very much a common moral disposition. Ms. Zarrin the KPF social worker once told me that she had an old but functional refrigerator that she wanted get rid of. A furniture broker had offered her fifty thousand tomans. Even though the money was not insubstantial for Ms. Zarrin, it was nowhere close to the value of the refrigerator. Ultimately, Ms. Zarrin decided to give it away for free, an act of charity, rather than trade. Even though Ms. Zarrin did not consider herself a devout person, the opportunity for reaping some form of non-material reward from the charitable act motivated her refusal to be paid. Similarly, kidney givers often lamented that they were not able to donate a kidney altruistically, and that their request for financial payment would reduce the merit and potential savab in their action. In recent years, with the tremendous publicity given to the donation of organs after death and the immense divine reward in doing so, organ donation has become a popular moral desire, one that inevitably informs moral valuations of paid kidney giving.

I once had a conversation about these themes with Samaneh, a thirty-three year-old mother of two who occasionally cleaned houses to supplement her husband's custodian salary. She related to me the story of her decision years ago to sell her kidney. "At one point when the kids were little, we lived in an empty parking space in an indoor garage. The place was filthy and we were breathing auto-exhaust all day long. I was desperate and wanted to sell my kidney to pay for a proper home. But my husband dissuaded me. He was

worried I would get sick. But now I want to donate my organs like they show on TV. My daughter wants to do the same. All of us, we all want to do this, to save someone's life. I want all my organs to be given away when I die."

I asked Samaneh what she thought of "selling a kidney." "No, it's not good. It's not good to sell it," she said. "If you can give a kidney then find someone who really needs it. You shouldn't do it for money when God will reward you so much for this. There is so much blessing in saving someone's life. Why would you ruin that?" "But what if you save someone's life and receive a payment as well?" I asked. She responded, "Well, let's say I have a son who wants to marry and I don't have any money. I can't get money from anyone, I have no option. I can find someone who really needs a kidney, and I can give my kidney and save that person's life, and I can say you give me some money for my child's wedding. Like I'd ask for five million, just enough to pay the costs of the wedding, not like ten million! Just enough for the wedding. And you know, say you don't want anyone to find out and you don't know anyone to borrow money from. In that case I think it's alright. You save his life and he helps you with your problem. But no, you shouldn't make money from it."

Here, Samaneh makes a crucial moral distinction between bilateral donations in which the parties to the exchange solve one another's problems, on the one hand, and making money or profiting from kidney giving on the other. While she sees the latter as a form of kidney-selling, something she finds morally objectionable, the former can be a justifiable last resort for inconspicuously obtaining money to solve a pressing problem such as paying for a son's wedding.

In the previous section, I explained how two men standing next to each other in front of the KPF requested vastly different payments in return for their kidneys, each

enough to cover the expenses of a distinct problem. Likewise, kidney givers for the most part differentiated between profiting from the exchange, and undergoing the transplantation to solve a dire problem, perhaps qualitatively not too different from the challenges of a sick dialysis patient. Even though the commercial language of buying, selling, and price were regularly invoked, and the exchange resembled a commercial transaction in form, the giving of a kidney was treated as an exchange of solutions to specific problems, not the sale of a commodity. One man who was desperate to find a match to pay back a twelve million toman debt repeatedly insisted that he did not want to make even one single toman off the sale. "All I want is to save my honor, and to protect my family. God is my witness that I don't want any profit. In fact I'm willing to show anyone my check, show them exactly how much I owe, and if they take care of that for me, I'll donate my organ to them without any expectations. I wish, I only wish that I could do something so rewarding and not demand anything in return. But I can't. For the sake of my dignity, my honor in the community, for the sake of my family, I can't."

One may ask how profiting or "making money" is any different from collecting money to solve a problem. Perhaps the answer rests in the fact that making a profit is what one intends to achieve in a commercial transaction, a commodity sale where the money paid is representative of the market value of the commodity. But to give a kidney should not be a market sale. To treat it as such would be to devalue a part of the human body. Some would even say that since the body belongs to God, and man has only been entrusted with its use and guardianship, it cannot be sold like a commodity. Furthermore, a commodity sale would obviate the need for engaging in a social and affective relationship between the organ giver and patient, a relationship of long-term reciprocity and gratitude,

a temporally extended giving-back to the kidney giver that would compare with the temporally extended benefit the giving of a kidney entails for the patient. It would also question the existence of altruistic motives to save the life of another that may exist prior to the exchange or throughout its duration. To profit would be to be motivated by self-interest, and therefore a significant loss in one's ability to accrue divine reward for an otherwise tremendously rewarding act.

Perhaps it is this distinction between paid kidney giving as an exchange of solutions and as kidney selling that can explain the fury of the man in the beginning of this chapter who compared his kidney to chicken-meat. Once the intern at the KPF informed him that he could only collect a set and pre-defined payment and not the amount he needed to resolve his problem, he was enraged that his body was being treated like a piece of meat sold for a set price at the market. While the KPF formally limits the payment in order to prevent the demanding of exorbitant fees and to make transplantation accessible to the less-privileged, they are also reluctant to enforce a strict limitation. Doing so, they seem to realize, would restrict people's abilities to attempt to fairly negotiate payments that would adequately resolve their problems. In this way, the so-called "black market" where kidney givers and patients attempt to secure private exchanges outside the regulatory practices of the KPF is actually the space in which individuals attempt, albeit not always successfully, to guarantee that their exchange does *not* become a commodity sale. This space of unregulated negotiation is one where givers struggle to ensure that their individual problems become differentiated from those of others.

A Failed Transaction

I met Hamid in the summer of 2013. A year and a half earlier he had given his kidney to a thirty-year-old nuclear engineer in exchange for six million tomans.⁵⁴ He was twenty-nine years old, married, and had a one-year-old child. He worked in a tiny men's designer clothing shop in the West of Tehran that was owned by a savvy entrepreneur several years younger than himself. We sat on opposing sides of the counter in the empty shop on a hot weekday afternoon. The shop was closed until a few hours later when the cooler evening air would invite shoppers in.

"I had a shop like this for six years, the one right next to this one in fact. That was until I took the stray path and fell into addiction. I couldn't think straight any longer. And in the 2009 protests [after the controversial presidential election], business went down in our area. I ended up closing the shop and taking high interest loans to pay my debt. All this, the addiction, I couldn't think properly anymore. I was stuck in a bubble of indecision. I fell deeper into addiction, so much so that I had nothing left. Not even one thousand tomans to pay for a cigarette. My wife almost divorced me. I became one with the dirt."

Just as his marriage was about to fall apart, Hamid quit his addiction and took up his mother-in-law's offer to live with her along with his wife for a year. "I had nothing. What was left of me, even my appearance was frightening to others. I had lost all credibility. I couldn't find a job and I didn't have the nerve to work here. This is how I decided to sell my kidney."

Hamid first approached a dialysis center on the outskirts of Tehran. "They told me you're not supposed to come here for selling, you know, donating a kidney." He was sent to the KPF to submit his documents and undergo the necessary lab tests. "I had no money left, so I had to borrow to pay for the exams. I got my blood type, B+. Now I needed a full check-

⁵⁴ Of which one million would be paid by the state.

up, and for every exam I needed to wait a month. They take time, for example you have to take a urine test at home, and then submit it to the lab, and then find out about the next exam.” In addition to the routine check-ups Hamid had to undergo an extra examination for infectious diseases because of a tuberculosis skin test that had presented positive when he was seven years old. “Finally I had to do this very expensive test called the angiography. I had already spent five hundred thousand tomans in those four to five months. The last test itself costs six or seven hundred thousand tomans.⁵⁵” Unable to pay the costs, Hamid approached the elderly patient he was matched with. The patient agreed to cover the expenses for both the angiography and tissue-typing, but later realized he had developed an ulcer and was unfit for a transplant. Hamid was then matched with a woman who refused his kidney on the grounds that he was a smoker. Then they introduced him to a thirty-year-old from Kermanshah. “Unfortunately, he had lost both kidneys. The poor guy was living on a third of one kidney, which was now also failing. He accepted to pay for the angiography, and the infectious disease doctor said my tests were fine, but that out of caution, the recipient should take a particular drug for three to six months. He agreed and we went ahead.”

This process took Hamid six months, which meant he had to renew some of his lab tests, which he quickly did at the expense of the recipient. The night before surgery the recipient’s father approached Hamid and promised to support him financially after the transplant. “But I wasn’t thinking of the money at that point. He brought it up himself.” Hamid then explained to me the emotional account of how his initial motivation to obtain enough money to move out of his mother-in-law’s home and support his pregnant wife had

⁵⁵ This would be equivalent to a few hundred dollars, and one tenth of what he ultimately collected from his recipient.

gradually transformed to an altruistic desire to help the patient. He explained that after beginning the process of kidney giving he had started a job and had been working for four to five months, and even though he was still very much in need he was no longer desperate. Moreover, his wife and in-laws had tried hard to dissuade him. "The issue of money went away in my mind. Instead there was this strong feeling, a humanitarian feeling you could say. That young man was about my own age. His kidneys were failing, and apparently dialysis wasn't working for him. He was just like me, so young. I wanted to do this, not just because of the money. I did need money then, but the money wasn't the only reason."

But Hamid was enraged. He felt used and discarded. The pain he experienced after the surgery was unexpected, and so was the cold shoulder he received from the recipient and the same father who had so generously offered continued support the night before the surgery.

"I don't know how to describe the pain to you. The recipient doesn't feel any pain. But the pain the donor feels, I take God as my witness, this pain, this pain, I compare it to the pain a woman undergoes during delivery. No it's a lot worse. I think they break your rib in the process too. For a long while, if you even sneeze, even a small sneeze, it puts such pressure on the operated part that it hurts a lot. Even breathing is difficult. For three days I had the most intolerable pain. And the nurses, they treat you like an addict. They say 'oh he wants more medicine because he's an addict.' As soon as the kidney is removed the donor isn't important anymore."

Hamid deeply resented being treated as though his act of sacrifice, which he later realized involved intolerable pain, was reduced to a scheme to make money. "I had almost changed my mind before the surgery, but because of that man, because he was so young, like me, I couldn't take back my promise." At this point, Hamid asked to take a break and smoke a

cigarette outside. “It doesn’t remind me of good memories. When you think of what you started off with, what you lost, and how you reached this low.”

The way Hamid explained it, the physical pain he experienced after the surgery was great, but it paled in comparison to the emotional pain of being neglected by the people for whom he sacrificed his body.

“And I told you about the patient’s father, how he said he’d support me. But for twenty days, no one even called me. No one called to ask me how I was doing. Finally, I was the one who called, to see how he was doing. And at that time my family had shunned me. I only had my wife. And my wife, with teary eyes, had tried to stop me, but I went ahead. I did it for the patient. In my heart I did it for him, and I was so sad that they didn’t even ask how I was doing. It isn’t just me. You see donors, with their horrible condition, with all their pain that even if they let out a single cough they can feel such pain around their stitches... and they just write them a check of five million and say good-bye. Goodbye?”

Not only did Hamid experience a discrepancy in the treatment and attention given at the hospital by the staff between himself and the recipient, but he also felt unappreciated by the people directly benefiting from his sacrifice. “I had told them I don’t want much from you, but I’ll be unemployed for twenty days, please cover that cost. They refused. I would have earned five to six hundred thousand tomans then, but they gave me two hundred and forty thousand instead. See you’re fully forgotten. There is no sign of the donor left. Everyone’s only focusing on the recipient.”

About six months after the surgery, Hamid encountered his recipient in person. “I saw him behind the shop window. And he was looking very well. When he was sick, you may not believe it, but he was maybe less than fifty-five or sixty kilos. He was very well when I saw him later. His weight could have doubled.” Hamid was relieved and pleased that his kidney had improved his health, and in return he expected an expression of gratitude. “I

was happy, but you know he didn't really acknowledge me. I mean you gave up a part of your body. If it had been me, if I had received an organ I would be thankful for years; I would visit them twenty, thirty times a year. But our encounter was just that once, and it lasted three to four minutes. That's it. He didn't even call. That was it, and now almost two years have passed."

At this point I asked Hamid whether his feelings of regret meant he would discourage others like him from doing the same.

"I would only warn him of the pain, and the difficulties after the pain, the limitations in your diet and so on. But I wouldn't prevent it. Because if someone like yourself stands in your presence and needs a new life, then you are affected by that, regardless of the financial issues. At that point the financial issues don't come to mind. I mean what is five million tomans? What can you do with it? Can you rent a home? Buy a motorcycle? Maybe you can buy a fridge? You can buy a nice suit for over one million! Is the worth of a kidney the same as five suits? Can you believe that? All those people aren't necessarily drug addicts. They have problems and need this money to solve them, and five million is not enough. I'm not saying you should take advantage of the patient, but you should get at least enough to solve some of your problems."

I asked Hamid if he thought it would have been better if the program for paid kidney giving never existed. "No," he responded,

"That's not a good thought. We are all human. When that human connection is created between two people, when you see that young person who needs you, you can't turn back on that. There's an emotional connection. But you see the amount is so little; it would be nice if someone, if the government or someone wealthy covered that amount so you didn't have to sell in the first place. That would be nice. But once you go ahead with it, you've gone that far and you see that person, then you think maybe God wanted this to happen. Maybe it was meant to be. If before that interaction occurs, someone offers to help you out, then you won't go ahead with it, you don't see the patient and you aren't involved with all those emotions. I promise

you that if a friend, a sister, a stranger, if you see them, if you've gone this far to give a kidney and you encounter them and you know you are saving them from an early death, then you will consent to do it. But before that it's a financial issue, there is no emotional connection and you may not go ahead with it. But when you have that connection even if you find the money, your heart will not consent. You think it's meant to be for you to share your life with them. It is nicer and more beautiful that the person be grateful. In Iran, you see when someone is brain dead, and a family member donates their organs, you see the patient's family consoles the donor's family. I say it's good that you appreciate the donor. Maybe the money isn't enough. You do something so the person doesn't become resentful. They could have said something. They could have been grateful. They could have called. That would have been more valuable than hundreds of tomans. This is my opinion. Others may not agree. This is just what I think."

Finally, Hamid remarked:

"A while back I needed some money to pay the down payment for a home. I asked friends if they knew of a loan I could get. One of my friends said 'why don't you request the amount from your recipient?' I thought about it and realized that not only would I lose the spiritual reward for what I had done, I would gain nothing else. I would belittle myself. Say I called and said could you give me five or ten million? Say he even does pay that amount to me, but in that case, all the emotional aspects would wither away. All of it would be destroyed. I've gone everywhere, asked everyone to find a loan, but I won't approach my recipient."

Between Fairness and Exploitation

Hamid's narrative of kidney-giving elucidates an exchange that failed to form into a bilateral donation and was therefore experienced by the donor as unfair. This was despite the fact that the recipient had paid the initially-promised compensation amount, and the fact that Hamid claimed his decision to give a kidney had over time become more about caring for the young engineer rather than financial gain. By reflecting on the causes of this

failure, we can illuminate the boundaries between what is considered to be a moral instance of paid kidney giving versus one that approaches an exploitative exchange.

For Hamid and others like him, the perception of equitability hinged on the commensurability (or lack thereof) between material and non-material gains on the one hand and the kinds of sacrifices each party endured during a temporally-extended period of exchange. For the kidney recipient, the gain is potentially immense – a transformed life detached from a dialysis machine, the ability to enjoy food and drink again, to travel, work, and so on. The kidney giver’s gain, on the other hand, depends on the kinds of possibilities enabled by a financial payment – perhaps the ability to afford a loved one’s surgery, to rescue oneself from debtor’s prison, or to open a small shop, all of which may be deemed qualitatively commensurable with living a healthier life as a transplant recipient. When it comes to sacrifice, the kidney giver must forgo an irreplaceable organ through an invasive surgery with moderate to severe post-operative pain, limitations to work, movement, and diet for a period of time, and long-term risk of complications and disease, in addition to a range of social and psychological ramifications. On the other hand, the organ recipient’s sacrifice can be largely reduced to the making of a payment. The more difficult it is for the recipient to put together the required funds, the more comparable the sacrifice to that of the kidney giver.

At the heart of what renders the two sides of this exchange (and arguably any other non-market exchange) commensurable with one another is the *temporal quality* of the gain and sacrifice. That is, a large discrepancy between the longevity of the gain and the effects of loss on each side can lead to an experience of the exchange as inequitable. Acquiring the ability to pay for your mother’s knee-replacement surgery (as was the hope of one

advertiser we discussed earlier) can be commensurable to receiving an organ, not only because they represent comparable improvements in health conditions, but also because the effects are similarly long-term. The same can be said for when the compensation allows a kidney giver to start a small business that can generate long-term revenue. The most ideal scenario is when the receiving party engages in a prolonged relationship of care that may range from finding employment for the giver or providing regular financial assistance, to fostering a friendship. Similarly, the sacrifice a family makes to put together the compensation requested by a kidney giver can have long-term consequences. Many families unable to procure sufficient assistance from their community of family and friends or charity organizations, particularly those from rural areas, have resorted to selling their homes or other significant possessions such as vehicles and carpets that they experience in terms of enduring loss.

Any discrepancy between respective gains and sacrifices can result in indebtedness, which for many can be rectified through a belief in abundant divine blessings, and also the gratitude of the other party.

What becomes blatantly clear in Hamid's narrative is that what he gained paled in comparison to his recipient's gain. Unlike many kidney givers, Hamid had not demanded payment in excess of the KPF's designated compensation, perhaps because of his increasing desire to help the young engineer, as well as the fact that it was less possible for him over time to identify a distinct, quantifiable financial problem. As he explained, despite his meager circumstances, by the time of the transplant he had resumed his employment and was offered support from his in-laws. Nevertheless, he could not neglect the fact that the paltry five million tomans he received amounted to just about five fancy suites at his

employer's shop and could hardly bring about any considerable or lasting improvement in his quality of life.

Similarly, what Hamid had to endure before, during, and after the surgery far exceeded what he had anticipated, and was incomparable to the negligible sacrifice the moderately wealthy engineer had made. Hamid had to spend substantial time and money on lab tests leading up to the transplant, suffered the contempt and disdain of his family members, and then endured excruciating pain after his surgery, not to mention the emotional distress of having put his health at risk.

What made the exchange most unfair for Hamid was the recipient's failure to ameliorate these discrepancies through an expression of gratitude. The patient's father had promised to "take care" of Hamid, but the family refused to even compensate him for what he lost in wages recuperating from the surgery. No one contacted him, inquired about his well-being, or expressed appreciation for what he had done. Every bit of pain radiating through his body, every bit of regret and resentment he endured in the year-and-a-half before our interview, could have been alleviated had the recipient expressed genuine appreciation, an act that could potentially transform the difficult exchange to one wholly worth making. Hamid had felt compelled to give of his body to a feeble young man for "humanitarian reasons" that did not obviate his need for receiving appreciation, for witnessing gratitude in his recipient's countenance, a reflected image of the sacrifice he had made that he could re-imagine and hold onto in moments of despair.

Even though the transaction had failed as a bilateral donation wherein each party would resolve comparable problems in one another's lives and create a relationship of mutual care, it still did not amount to a commodity exchange. No one was under the

impression that the payment was equivalent in value to the kidney, and despite the improper termination of a relationship between Hamid and the patient, Hamid held onto the belief that his action warranted a spiritual reward – one that may not have been experienced powerfully enough to preclude regret, but that he nevertheless was unwilling to diminish by making further financial demands on his recipient.

Conclusion

Anthropologists such as Nancy Scheper-Hughes and Lawrence Cohen position their work on organ transplantation against a particular bioethical discourse that is largely influenced by a formalist economic logic and that argues for the legalization of organ sales and the emergence of free or partially-regulated markets for organ giving (see for example Matas 2004, 2006; Becker and Elias 2007). The formalism of neo-classical economics amounts to a view of society as a collection of autonomous and rational actors whose every action involves conscious or unconscious selections among alternative means to alternative ends (Prattis 1982). In this formulation, actors are deemed rational in that they will always find the most efficient method of attaining what they want through cost-benefit calculations. When it comes to organ sales, it is assumed that kidney sellers are autonomous agents who will rationally choose an option that maximized their interests. To prohibit organ sales would be *paternalistic* and unjust, they claim, as it would remove a viable option for escaping a financial predicament. If individuals are aware of the risks of transplantation, they are fully capable of deciding whether the financial gains are worth the risk.

On the other hand, medical anthropologists alarmed by the penetration of such market logics into the “private” domain of the body argue – sometimes explicitly and sometimes implicitly through their critiques of the commodification of the body – that formalist economic reasoning fails to acknowledge the exploitation of the poor that a market in organs could foster, as has been the case in places like India (Cohen 1999, 2003, 2005, 2011), Bangladesh (Moniruzzaman 2006), Brazil, China, Israel, and so on (Scheper-Hughes 2000, 2003).

Their differences notwithstanding, the bioethical/economic arguments for permitting organ sales and those opposed to them within medical anthropology share a fundamental assumption – that the body has *already* been commodified through practices that fragment it, alienate its parts from the person to whom it belongs, and put it to medical use, all of which have important economic dimensions. Transacting money for an organ will always therefore be an instance of commodity exchange, in this view. The difference between the two debating parties is that the medical anthropologists find this morally abominable, while the formalist economists and allied bioethicists accept it as a mere fact that can have liberating consequences for the poor and life-saving potential for the sick.

The trouble with treating the body and its organs as already commodified and universally so (through various biomedical and biotechnological practices that fragment and atomize the body) is that it targets biomedicine and biotechnologies without situating them at the interstices of varying social practices that may in fact challenge the instrumentalist market logics that are believed to follow biotechnological interventions. This leaves few practical options for battling very real abuses like the exploitation of the poor through international organ trafficking, and leads to an endless debate that ultimately

boils down to ideological differences (“commodification of the body is destructive of social relations and individual perceptions of selfhood” versus “commodification of the body is liberating and an efficient solution to treating illness”). Furthermore, it precludes serious engagement with individuals’ personal claims to motivations that are irreducible to market rationalities.

In this chapter, I have demonstrated that even though unrelated living kidney givers in Iran are primarily motivated by the promise of payment, the transaction of money need not entail the commodification of the transplanted kidney. Kidney givers and recipients regularly engage in bilateral donations where the purpose is the mutual resolution of problems. Money in such a transaction becomes a medium of exchange and not a standard of value. That is, despite the ubiquity of a market language of “buying,” “selling,” and “price,” the compensation does not stand for a quantified value of the organ, since it is understood that an irreplaceable human body part with the potential to save the life of another is priceless. Furthermore, I argued that such bilateral donations are deemed as morally-defensible instances of paid kidney giving which can come under a range of threats. These include expressions of profit-seeking by organ givers beyond what would solve a distinct problem, and incommensurability between the gains and sacrifices of the two parties to the exchange. Moreover, immaterial compensation from the recipient in the form of genuine gratitude, divine reward, and a sense of spiritual achievement, can potentially rectify the inequity of the exchange.

Partaking in bilateral donation requires that the two parties have a way to meet, to learn of one another’s problems and needs, and to negotiate compensation commensurable with the kidney giver’s problem which at times may include a long-term relationship of

care, financial support, and friendship. For this reason, I argued that the illicit advertisements on the walls surrounding the KPF and elsewhere are not so much manifestations of a “black market” for organs as an effort by organ givers and recipients to escape the standardization and anonymization brought about by the regulation of kidney sales. This is also why in spite of its formal disapproval, the KPF office in Tehran did not attempt to forcefully hinder the informal exchange of payments between the parties in excess of the standard amount.

How can such a challenge to the underlying assumptions about paid kidney giving contribute to the ongoing bioethical debates between the proponents and opponents of kidney sales? The answer is that this approach allows us to escape the ideological debates over the morality of commodification and instead inquire into the conditions that facilitate or undermine bilateral donations, including the protocols instituted to regulate paid organ giving. It may very well be the case that appropriate social, bureaucratic, and infrastructural mechanisms can be developed to facilitate such exchanges in some places and not others.

In order to conduct such an assessment, it would be necessary to treat transactions between paid organ givers and recipients as temporally-extended interactions, and not merely as narrow moments of exchange. As I mentioned early on in this chapter, anthropologists frequently rely on Arjun Appadurai’s concept of the “social life of things” (1986) to explain how the body can be flexibly cast as an alienated commodity or an inalienable gift at different moments in its trajectory. In so doing, they recognize that things can take on varying identities in different *moments* of transaction, but neglect how an

exchange can itself acquire a lengthy biography that can facilitate or undermine different sorts of relationships between the exchanging parties. A kidney is only transplanted once, but the exchange relationship it enables can last a long time. This alternative approach makes it possible for us to understand the exchange of money for things in terms of a mutual attempt to offer solutions to one another's problems. Money here operates as a medium for the transaction, but not a measure of value.

Chapter 6: Conclusion

As I walked towards the KPF office in Tehran in the summer of 2013, I noticed a stenciled graffiti on a yellow metal door. It was written in English and in bold black letters, “ENJOY 50% OFF ONE ITEM.” The reference to a commodity sale was a commentary on the illicit handwritten advertisements for kidney sales shrouding the same metal door and extending onto surrounding brick walls and nearby shedding tree trunks. This was the first time I encountered a social commentary on kidney selling in Iran that incorporated an explicit critique of commodification. Besides a single political cartoon that had appeared on the internet depicting a customer in an “organ shop,” every other visual and textual commentary in Iranian social and political media seemed to target either rampant poverty or the misplaced priorities of those willing to forgo a kidney, say to throw a lavish wedding.

The graffiti on the yellow door was signed “Black Hand,” the pseudonym for an anonymous Iranian street artist who gained international renown as the “Iranian Banksy” in 2014. One of his popular images that was allegedly removed only hours after its completion had appeared on a wall outside a transplant hospital in northeastern Tehran.⁵⁶ It depicted a man in a suit and tie standing behind a podium with an auction hammer in hand, gesturing to a framed image of two kidneys in a faceless body. To the other side of the frame stood an eerie bald man, dressed in a tie and a long, black, butcher’s apron. Once again, the artist’s social satire targeted neither the kidney sellers nor the ailing economy, but the treatment of a human organ as a commodity – one that could be auctioned off or

⁵⁶ <https://www.theguardian.com/world/iran-blog/2014/aug/06/iran-banksy-street-graffiti-tehran-black-hand-interview> (accessed June 2016).

subjected to a fifty percent discount. Were these images heralding the emergence of a discourse of commodification that could undermine Iran's kidney selling program?

In the preceding chapters I investigated the moral formations and experiences emerging from Iran's program regulating paid kidney giving both at the level of policy, and the level of exchange. I presented a deep ethnographic analysis of moral encounters and rationalities in the bureaucratic space of the KPF, the Islamic legal space of policy-oriented fatwa making, and the space of exchange and mutual care between kidney donor and patient – in a way that demonstrated the policy's many contingencies and vulnerabilities. Furthermore, by adopting a processual approach I was able to account for how a heterogeneous assemblage of people, places, institutions, material objects, discourses, and moral sensibilities came together through time to build both durable and fragile relationships that made certain actions possible, while impeding others. In doing so, I offered an explanation of how Iran uniquely came to regulate kidney sales.

In attending closely to the practical and institutional contingencies of policy formation and enactment, its various opacities and the disagreements that weigh it down, I have aimed to understand how the wheels of the state turn, how things move forward more or less as planned, without having to invoke the specter of corruption, coercion, and centralized power. This is particularly urgent as recent scholarship on Iran has overwhelmingly focused on themes of resistance, rebellion, struggle, and repression (Olszewska 2013; see for example Varzi 2006, Mahdavi 2009, Khosravi 2008), an approach that has been developed at the expense of recognizing contingency and the complexities of moral agency.

In Chapter Three I showed that while the KPF is the site where this policy has been produced and implemented, it is also where a social worker actively discouraged kidney selling on a day-to-day basis for over six years. Ironically, the same KPF director who has organized and managed incentivized kidney donation since its inception has routinely and publicly complained about the financial pressures that compel some individuals to sell their kidneys, while also contending (in private) that in most cases what takes place in Iran is not really a “sale” (Chapter Four). The dual recognition that there were indeed disadvantages to organ selling, and that there was an urgent need to supply readily available kidneys for suffering kidney patients, came together with more mundane factors like the spatial bifurcation of the bureaucratic space and the tactful usage of bureaucratic artifacts (forms, stamps, etc.) to enable the social worker to fulfill her official duties while also adhering to her own ethical sensibilities. In turn, the selective hindering of kidney sales along with the enhanced tracking of donors through forms created a semblance of counseling and transparency that garnered legitimacy for the KPF, which in an indirect way contributed to the persistence of the program.

In Chapter Four, I demonstrated that many Islamic jurists in Iran have explicitly permitted kidney-selling, a fact that is largely unknown to the general public and even many involved in the implementation of the policy. I showed how the rulings were enabled by a particular medical framing of the problem of kidney shortage that trivialized organ donation, and furthermore that these rulings appeared only after an active and contentious process for persuading jurists of the Islamic legitimacy of transplantation. I also showed how the expertization of jurisprudence and its active involvement in policy-making since after the Islamic Revolution were instrumental to this effort. Nonetheless, the same jurists

and legal scholars insisted that if the “harms’ of kidney selling, be they physical, psychological, or social, were “proven” then a secondary fatwa could override the initial permissive rulings. But as I stated in that chapter, there may be little interest among policy actors in pursuing such “proof,” when doing so would bring moral scrutiny on a program that was perceived by most as a practical but temporary piece of bandage for a problem that was gradually being replaced with the more permanent solution of a national brain death organ donation program. However, such a cause could have been pursued by those outside the policy circle had there been a public discussion on the matter of kidney selling that did not see the act as an unfortunate but inevitable extension of poverty and/or youthful callousness.

Certain shared themes emerge across these chapters about the factors that enabled the creation and continued vitality of the policy. The most obvious is the lack of a public discussion on organ sales, a situation starkly distinct from the brain death organ donation program which was subjected to elaborate moral and legal discussion and was ultimately advocated through an active public campaign. The absence of a public discourse meant that no overarching rationale guided individuals’ thinking about whether encouraging kidney selling was ethically sound. Reactions to the phenomenon among experts, policy actors, and the lay public instead followed a logic of proximity: individuals’ experiential proximity to the conditions of kidney sellers or patients - through personal encounters or experiences with sickness and surgery - played a significant role in their moral attitudes toward kidney sales.

Another factor has been the medical imaginary or “biomedical embrace” that has rendered even the most invasive biomedical procedures to become proximal, quotidian

aspects of everyday life in Iran. In Chapter Two, I argued that if middle class desires and ambitions alongside conditions of financial instability and unemployment characterize many attempts to sell a kidney in Iran, then these factors also need to be coupled with a deep-seated trust in the authority of biomedicine in order to make selling an organ a viable option for achieving wealth. I argued that the welfare policies of the Islamic Republic and its medical modernizing projects made many medical procedures acceptable and routine among Iranians from various social and economic strata. In Chapter Four, I made the case that the relationship of trust and cooperation that has been fostered after the Islamic Revolution between religious and medical authorities has made Islamic jurists uniquely receptive to biomedical interventions. Many scholars of Islam have been perplexed by Shi'a jurists' permissive opinions on organ selling and other medical procedures such as stem cell therapy, sex change operations, and various assisted reproductive therapies. Ultimately, they have explained these "progressive" opinions in terms of doctrinal differences between Shi'a and Sunni jurisprudence (Clarke and Inhorn 2011; Saniei 2012; Tremayne 2015) What I demonstrate in this chapter, however, is that we need to look at the unique role of jurisprudence as an institution as it has been historically shaped in the aftermath of the Islamic Revolution. The expertization of jurisprudence modeled after the expertization of biomedicine, the cooperative relationship between "native-bred" medical practitioners loyal to the Islamic ideals of the state, and the role of religious authorities in overseeing and facilitating policy, have all been instrumental in making policies surrounding such medical interventions possible.

Lastly but perhaps most importantly, I contend that formalizing kidney sales in Iran would have been less likely to succeed had the exchange been generally evaluated as a

market exchange. As I argued in Chapter Five, the KPF director's claim that what occurs in Iran "is not really a sale," is not entirely without basis if we think of "sale" as a commodity exchange in a market transaction. In examining the interactions, verbal and material exchanges, as well as narrated experiences of kidney patients and sellers, I showed that even though the possibility of falling into a market transaction always haunts the exchange, the mere payment of money does not necessarily commodify the relationship. This could be because a "neoliberal imaginary" – one that overwhelmingly perceives exchange as an opportunity for profit seeking between rational maximizing actors – may not be operative in the Iranian context. This does not mean that market exchange is not rampant. In fact as I mentioned in Chapter Two, a spirit of entrepreneurship has been vitalized since the state's haphazard privatization schemes after the Iraq-Iran War. But just as privatization schemes in Iran did not spell the demise of welfare initiatives and an ideology of egalitarianism, they did not mark the domination of a liberal imagination that would make sense of monetary transactions overwhelmingly through the lens of commodity relations (as is the case in Western Capitalist societies). Perhaps it is this very disjunction that explains the tendency among anthropologists and bioethicists to equate transactions that involve money with commodification.

We can see this absence of a market-oriented logic in Ayatollah Mohammad-Javad Fazel Lankarani's explanation of an exchange between a kidney giver and a patient as imagined by a jurist evaluating the legality of the act at a "primary level." Someone in need of a kidney offers payment to someone willing to give a kidney in return for money that he needs – an exchange that is imagined to take place in the absence of society and government. What should be noted is that at this level, the market is also absent. The

existence of a market and any accompanying ill effects must therefore be proven and assessed at a “secondary” level. The market does not enter the imagination of the jurist by default. Its contours must rather be defined when it does exist, as a possibility and not a necessity.

It was for these reasons that when I came across Black Hand’s graffiti near the KPF and the transplant hospital, it struck me as a commentary that resembled, more than anything else I had encountered, a Western critique, one that appeared foreign to the moral landscape I had spent years unearthing. The English language and imagery both suggested to me that the commentary was directed at a Western audience, a hunch that was confirmed by the outsized attention that Iranian underground art began to receive around the same time.⁵⁷ Conversely, it could be that the artist was importing a Western critical discourse in order to offer commentary on a local social problem. Whatever its origins and intended audience may have been, however, the very existence of this graffiti suggests that other imaginations of the paid kidney program are possible, and yet new configurations of bureaucratic practice, exchange, and moral subjectivity may emerge.

⁵⁷ See for example Ajam Media Collections: <http://ajammc.com/2012/11/05/taking-back-the-streets-iranian-graffiti-artists-negotiating-public-space/> (accessed June 2016)

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