Conversations with Kidney Vendors in Pakistan: An Ethnographic Study

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An Ethnographic Study

by Farhat Moazam, Riffat Moazam Zaman, and Aamir M. Jafarey

In theory, a commercial market for kidneys could increase the scarce supply of transplantable organs and give impoverished people a new way to lift themselves out of poverty. In-depth sociological work on those who opt to sell their kidneys reveals a different set of realities. Around the town of Sarghoda, Pakistan, the negative social and psychological ramifications of selling a kidney affect not only the vendors themselves, but also their families, communities, and even the country as a whole.

Until lions have their own "story tellers,"
tales of a lion hunt will always glorify the hunter.
—African Proverb

The growing concern about the shortage of kidneys available for transplantation has led some physicians, economists, and bioethicists to call for monetary inducements and "regulated" organ markets as a way of expanding the number of kidneys obtained from living, unrelated individuals.[1] Proponents of a commercial model for organs formulate their arguments in the language of supply and demand. They believe that "scarcity" of commodities—in this case, kidneys—can be addressed through the use of market forces. In this view, a vendor is an autonomous agent with the freedom to make choices, including the decision to sell a kidney, and depriving impoverished people of the option to sell a kidney makes their bad situation even worse.[2] In contrast, those opposed to the idea of organ sales believe that such practices lead to exploitation of the most vulnerable people in society for the benefit of the privileged. Concerns are also expressed about the negative repercussions of organ commerce on altruistic donations and integrity of the medical profession, and the weakening of efforts to initiate and sustain deceased donor programs. The potential for increased complications in recipients receiving bought kidneys is another consideration.[3]

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These debates are taking place against the backdrop of expanding organ commerce and tourism. Private health care institutions located particularly in Asian countries are advertising "transplant packages" with kidneys bought from the most economically deprived individuals. In a business that runs into millions of U.S. dollars annually, such kidneys are being transplanted not only into nationals but ever more frequently into citizens of affluent countries who travel to the host countries specifically for this purpose.[4] Despite the increasing awareness of the international organ trade, there is a surprising paucity of original research and scholarly work on this issue. In his presentation in May 2007 at the Second World Health Organization Global Consultation Meeting on Human Transplantation in Geneva, Yosuke Shimazona said he had found only 309 "relevant" documents, of which 243 were media reports, in a review of the previous five years' worth of literature. He emphasized the need for "further medical and social scientific research," without which he thought this "global health issue" could not be addressed effectively.[5]

One of the crucial missing pieces in the literature is in-depth sociological work on the vendors—the men and women who opt to undergo nephrectomy for money—and the on-the-ground realities that frame their decision. Very little is known about the sociological and psychological effects on vendors and on the families and societies they belong to when faced with a situation in which the only way to address financial difficulties is to sell a kidney. The most outspoken anthropologist to focus on this issue is Nancy Scheper-Hughes, who provides ethnographic accounts of kidney vendors from countries as diverse as South Africa, Israel, Moldova, the Philippines, and Brazil.[6] A handful of empirical studies from India, Iran, and the Philippines also venture beyond the medical paradigm and quantitative data to explore the psychological repercussions on kidney vendors and their kin.[7]

No studies of this nature have been undertaken in Pakistan, a country that came to be known as one of the largest "kidney bazaars" in the last decade. Almost all publications dealing with organ transplantation focus on medical issues, and especially on the morbidity and survival rates for the recipient and occasionally the donor.[8] In Pakistan, except for one recent survey of the socioeconomic status of vendors, it is not health care professionals but the local media that have tried to establish direct contact with vendors, often leading to sensational news reports and documentaries.[9] The only detailed ethnographic study available on kidney transplantation in Pakistan, published in 2006, deals with related, living donors and their families and does not focus on organ trade.[10]

The primary objective of our ethnographic study is to broaden what we believe to be a reductive and largely utilitarian international debate on organ commerce and regulated markets that considers the issue as a matter between two individuals—a recipient and a vendor. Such discussions generally highlight the predicament of those patients who wait for years to be transplanted, and often die while waiting. This is understandable, as many supporters of kidney commerce, of one variety or the other, are concerned with the care and welfare of such patients and consider themselves their advocates. In contrast, the would-be providers of these kidneys for transplantation appear as faceless individuals merely exercising their right to sell an organ. Very little is known about the experiential and psychosocial dimensions associated with the decision to sell a kidney or about the possible ramifications of the decision for families, communities, and perhaps even the ethos of the societies in which they reside.

Our aim is to turn the light on those who sell kidneys. Our research provides a "thick" description of the lives of kidney vendors and their families in Pakistan, people who stand at the center of organ commerce and yet have remained largely invisible.[11] We attempt to open a window into their lives, to capture through their narratives what it "means" to them and their families when circumstances compel them to sell a kidney, and the ways in which this act affects connected existences. We hope to clothe with flesh and context a global discourse on organ commerce and trade that has mostly employed a narrower, philosophical language revolving around autonomy, choices, rights, and competing interests of abstract individuals.

Kidney Commerce in Pakistan

Systematic kidney transplantation in Pakistan began in the late 1980s in the absence of a national law to regulate it.[12] Initially, because there was no deceased donor program (still the case today), the majority of transplanted kidneys were donated by family members, but by the late 1990s kidneys donated by kin had been almost entirely replaced by kidneys bought from unrelated individuals from villages located around major cities. By 2003, most kidney transplants were undertaken in private hospitals in the cities of Punjab. With middlemen working closely with hospitals, economically disadvantaged people from villages became the main source for the approximately two thousand kidneys transplanted annually in Pakistan.[13] Due to regional geopolitical events, there was a concomitant increase in kidney transplantations undertaken for citizens of countries from the Middle East, Europe, and North America, providing a lucrative business for private hospitals in Punjab.[14]

Although occasional cases of kidney selling or "stealing" have been reported in the press from other parts of Pakistan, the systematic practice of "kidney tourism," as it has become known, has remained limited to private hospitals in Punjab.[15] Several reasons may have contributed to this. One has to do with poverty. Punjab is the most densely populated province of Pakistan, and with its rich, fertile agricultural lands has often been called the "breadbasket" of the country. Wealthy *zamindars* (landowners) own large tracts of agricultural lands and orchards that are passed from one generation to the next. In this feudal system, large numbers of laborers and workers are needed to tend the lands and take care of cattle. Together with their families, laborers live and work on these lands for wages ranging from Rs. 3,000 to Rs. 4,000 (approximately $50 to $60)

The international debate on organ commerce generally highlights the predicament of patients who die while waiting for transplantation. In contrast, the would-be providers of kidneys appear as faceless individuals merely exercising their right to sell an organ.

per month. In addition to meager salaries, the only other benefits provided to laborers include accommodation (often one room) on the lands, a quantity of grain from harvests, a set of clothes, and one pair of shoes.

Workers accumulate debts in the form of loans taken from *zamindars*, and these loans are impossible to pay back. Even if a portion of the debt is paid off, further loans become necessary for new expenses, including health emergencies, marriages, and deaths. As long as the debt persists, and in spite of the fact that bonded labor is a crime in Pakistan, the worker and his children remain effectively "bonded" to the *zamindar* and are unable to leave. Punjab also has many brickmaking factories that draw laborers from rural areas of the province; they, too, are provided daily wages insufficient for their needs. Laborers on the farms and kiln workers from factories are among the poorest in Pakistan, and many vendors are drawn from these two communities.

But poverty in Pakistan is not limited to Punjab, so undoubtedly other factors are also at play behind the province's flourishing kidney trade. Following Karachi (population fifteen million people) in Sindh, Lahore and the "twin cities" of Rawalpindi and Islamabad in Punjab are the next most populated cities in Pakistan. Over the last two decades, there has been a movement in Pakistan to privatize health care, and it has been most pronounced in larger cities with affluent populations. Kidney transplantation, because it is a lucrative service, is of obvious interest to private sector institutions that have resources and trained transplant physicians. Sindh, the other province with an expanding private sector, has not experienced systematic development of organ trade and tourism, however, perhaps because of the influence of the Sindh Institute of Urology and Transplantation, a public sector institution in Karachi that performs large numbers of kidney transplants but accepts only family donors. SIUT draws patients from all over Sindh and to some extent from other provinces of the country.[16]

The Study

Selecting and gaining access to subjects. Our selection technique consisted of purposive sampling of kidney vendors considered most likely to provide rich, in-depth information.[17] Subjects were selected from *deras* (clusters of dwellings) around the town of Sargodha, which is known as a hub for vendors. It was suggested to us that vendors are easily reached through middlemen in the organ trade, but we decided to not take this easy route because of ethical concerns about working with people we saw as part of the organ trade circle. We were uncomfortable about the integrity of the middlemen and uncertain about mechanisms they might employ to convince vendors to meet with us. We also believed that the nature of the information we required would be more reliable if we entered local communities, with the help of their members, and met subjects in their own surroundings rather than having them brought to us. This required locating reliable contacts through phone calls to nongovernmental organizations and acquaintances in and around the area and a visit to Sargodha to meet relevant people.[18]

Process and methodology. Our research team consisted of two physicians from SIUT and a clinical psychologist from another university in Karachi, and the research proposal was approved by the Ethics Review Committee of SIUT. The study was carried out during three field visits to the site in 2007, each lasting from four to five days.[19] Our interactions with vendors and families took place within or in the vicinity of their houses or their work sites, and a community member was always present to introduce us. Verbal consents, and all interviews, were undertaken in Urdu or Punjabi (the local dialect) by one of the three primary researchers. To avoid intimidating participants, no tape recorders were used. We believe that for all these reasons, most vendors and their families were relaxed and willing to speak with us frankly and at length. No monetary incentives were offered, but participants were told that we would check their blood pressure and screen their urine. Anyone judged to need further examination would be provided referral slips for physicians in Sargodha, and treatment and medications would be provided free.

A questionnaire was used to record factual data, and open-ended questions were employed to encourage vendors to talk about the nephrectomy and their perceptions of life since surgery. Attempts were made to record the exact words, terms, and often rich analogies used by the interviewees. The two female researchers in the team met separately with male vendors' wives and female family members. The Self Reporting Questionnaire developed by the World Health Organization was administered by the psychologist to screen for

psychiatric problems. A brief test (twenty items) translated in Urdu and consisting of simple yes and no answers, the SRQ has been used and validated in rural and illiterate communities in Pakistan in screening for anxiety and depression. A score of seven to eight or above was selected as significant, as sensitivity and specificity have been found to be above 70 percent at this level.[20] Blood pressure readings were obtained with a manual sphygmomanometer, and a "dipstick" urine examination was used to test for the presence of sugar, protein, bilirubin, and blood.

Limitations of study. The number of subjects we interviewed is relatively small. One reason for this is that during one visit, we discovered that another research team had arrived in the area a day earlier for a survey of kidney vendors. This team was having vendors brought to their base, and some were from *deras* we were scheduled to visit. Vendors who said that they had been "tested" by the "other doctors" were not interviewed. A second reason was the design of our study, which involved time-consuming drives to *deras* and dependence on community members for entry into sites. Nevertheless, given that we were looking for depth and richness rather than breadth of information, we believe we were able to achieve our objectives and gain important insights not reported before despite the small number of subjects.[21] By the end of our third visit, we were recording repetitions in the themes that emerged from the subjects' narratives, suggesting that we were reaching a saturation point in the collection of information.

The other issue, discussed below, was the disconnect we found between our notion of privacy and what we encountered in the field. We discovered that *deras* represented a social "community," members of which often joined in the narratives of our subjects to offer their own comments and impressions. Our concern that this would influence some of the responses was allayed when we found that those interviewed in relative seclusion gave similar information, using identical phrases and idioms. An advantage of the "group encounters" was the opportunity to gauge the general ethos of the communities we met and the ways in which their members—vendors and nonvendors—related to one another. The lack of privacy, however, proved a hurdle in administering the SRQ to screen for anxiety and depression, and also in conversations held with some vendors' wives in the presence of their husband's family, especially the mother-in-law. Asking people to leave during our conversations with vendors would have been culturally inappropriate and might even have aroused suspicion, and asking people to leave during conversations with wives could have had bad consequences for them later.

Table 1
Demographic Data

Total vendors interviewed	32 (one couple interviewed twice)
Vendors less than 19 years old	2
Vendors 20 to 40 years old	27 (age unknown for 3)
Currently married	27
Illiterate	29 (grade five: 2, grade four: 1)
Number of children per family (range)	1–11
Time since vending	• <1 year: 18 • 1–3 years: 9 • >3 years: 5
Other vendors in extended family	• Yes: 16 ○ 1 family member: 8 ○ 2 family members: 6 ○ >2 family members: 2 • None: 6 • Not established: 10
Vendors referred to physician for proteinuria and/or hematuria	3 (none presented for follow-up)
Vendors referred for psychiatric assessment (based on SRQ assessment of 20 vendors)	10 (none presented for follow-up)

Site and Demographic Data

Our interviews were conducted in *chaks*, clusters of houses and a few shops, or in *deras* consisting of the *zamindar*'s lands with rooms for farm workers and their families. Access to many *deras* involved traversing dirt or gravel paths, sometimes on foot, through lush fields and orchards. Some of the rooms in which the laborers lived had neither electricity nor running water, in contrast to the *zamindars*' well-built concrete residences. The hospitality with which vendors and their families met us was striking, as was their willingness to speak with us frankly. *Charpoys* (all-purpose beds consisting of a wooden frame with jute ropes strung between the four sides) were placed under trees for us to sit on, and we were offered tea or water even in the poorest households. The only hostility we experienced came from a few *zamindars* who joined us as we were conducting interviews and wished to know who

we were and why we were there. On the other hand, some *zamindars* requested that we visit their houses and examine them or their family members. Their presence would lead to a temporary pause in the vendors' narratives, to be resumed once they left.

All families in and around the *dera*, vendors and nonvendors alike, would converge upon us and pitch in with comments and additions to what was being related to us at the time. We found the notion of "privacy" of information to be an alien concept; we were in communities in which everybody seemed to know the details of each other's families and experiences, including the amount of money promised, and received, for a kidney. People filled in the details of each others' stories and sometimes prompted one another about dates and months of surgery and even the ages of their children. Our interactions with vendors and their families often ended up being "group encounters." When we met vendors and families within the confines of their rooms, neighbors and friends would often walk in to see what was happening and sit on one of the *charpoys* to offer their own opinions about selling kidneys. To administer the SRQ, the extent of privacy we could manage in many cases was a move to the most distant *charpoy*.

Our attempts to take consent were generally met with uncomprehending looks, followed by protests that this was unnecessary and that they were glad that doctors from the "big city of Karachi" had traveled all that distance to speak with them. Nevertheless, after explaining the particulars of our study, all subjects were told that they were under no obligation to speak with us and were free to refuse. None did.

Demographic data. We interviewed thirty-two vendors (one couple was interviewed twice), four of whom were female, with age range of nineteen to forty-two years. Except for three individuals who had attended school until grade four, the rest were illiterate. The majority, twenty-five vendors, had sold a kidney within the last two years, and twenty-seven had done so to a hospital in Rawalpindi run by a retired colonel of the Army. (See Table 1.) All except two had sold a kidney to pay off debts owed to *zamindars*; a majority was either still in debt or had accumulated new debts. None reported receiving the total amount they had been promised, and almost all had to pay Rs. 10,000 to Rs. 20,000 to the middleman. (See Table 2.) None of the vendors questioned directly, except one, would recommend selling a kidney to anyone else, including those who had managed to pay off their debts.

Table 2
Debt and Monetary Transactions
US $1 = Rs. 60 to Rs. 75 (range over last three years)

Average debt before vending	Rs. 130,000 (Range Rs. 45,000 to Rs. 200,000)
Average money promised for kidney	Rs. 160,000 (Range Rs. 80,000 to Rs. 175,000)
Average money received	Rs. 103,000 (Range Rs. 70,000 to Rs. 155,000)
Money paid to middlemen	Range Rs. 8,000 to Rs. 20,000
Status of debt after vending	• 17 persistent/reaccumulated • 13 paid • 2 not established

Among the thirty-two vendors interviewed, three had elevated blood pressure readings or blood or protein in their urine—significant findings in anyone with one kidney. All were provided referral slips for a physician in Sargodha. Due to difficulties with privacy, administration of the SRQ was possible with only twenty vendors. Of these, ten (including one woman) had sufficiently high scores, or symptoms judged sufficiently worrying, to be referred to a psychiatrist in Sargodha. Of these ten vendors, two were considered to be possible suicidal risks, and one reported attempting suicide with sleeping pills obtained from a local doctor.

Based on our subsequent communications with Ali, our primary community contact, and the Sargodha physicians, we learned that none of the vendors we had referred for follow-up visited the physician or the psychiatrist. As we were concerned that the noncompliance might be due to the cost of travel, we made arrangements, through Ali, to rent a van for them, but this, too, failed. Those that Ali managed to contact were either unwilling or afraid to ask the *zamindar* for a day off from work.

Vendor Narratives and Conversations

Through open-ended questions about vendors' perceptions of lives after selling a kidney, several overlapping patterns of symptoms and changes in "self image" could be identified. Many were psychosomatic in nature.

Issues related to the incision. All vendors, including those with a nephrectomy done over three years ago, complained of symptoms related to their surgical incision (pain, spasms, pricking), even though an examination revealed well-healed surgical scars. One vendor was still afraid *tankey na tut jan* (that the surgical stitches would break). Many also complained of tiredness, generalized *kamzori* (weakness), *chukkar* (dizzi-

ness), and shortness of breath while working. All expressed an inability to work as hard as before, a perception confirmed by family members with whom we spoke. One vendor explained his tiredness by saying that *jism may khoon nahin hay* (my body has no blood in it). A common complaint was *hun wazan uthanay day naal dard* (lifting anything heavy now gives me pain), a significant issue for those involved in manual labor.

The "half" man syndrome. A second cluster identified—and related to the left flank surgical scar—was a heightened sensitivity to or constant awareness of the left half of their bodies. Many vendors described pain, numbness, or a burning sensation in the left arm and shoulder or the left side of the abdomen. Some also had left-sided headaches. With these symptoms came a sense of emptiness. Pointing to the left half of his body, one vendor told us that *mehsoos hota hay kay khalee jaga hay* (I feel that there is an empty space here), and that he was now an *adhoora banda* (incomplete or half a man). This curious sense of feeling "half," being "empty," somehow having been transformed into an "incomplete" person, was among the most common statements we heard. One young man pointed to the uncapped pen in a researcher's hand and said that he was now *adha* (half) like that pen; replacing the cap back on the pen, he said he was "like that" before surgery.

One vendor said that following the nephrectomy, his *mardani taqat kum ho gayee* (sexual potency has decreased). In another case, a mother told us that by selling his kidney, her son had *zulm kitta* (done injustice) both to himself and to her, as she had wanted grandchildren and thought she might not get them now. The belief that losing a kidney somehow makes a person incomplete, lessens a man's sexual power, and reduces a woman's childbearing capacity was also reportedly expressed by some family donors in an earlier study conducted in Pakistan.[22]

Fears about the remaining kidney. Another related cluster of complaints revolved around profound anxiety—persistent *khof* and *fikr* (fear and concern)—at being left with one kidney. Different phrases were used—*dil pay bojh* (weight on my heart), *chaubees ghantay fikr kay hun ikon gurda, maira saath kee hoyay ga* (I worry twenty-four hours that I have only one kidney, what will happen to me), *dil ghabaranda* (my heart is restless, not at peace), and following nephrectomy *hun himmat nahin raee* (I have no strength/will left). One man said that if someone *uchi awaz nal bolay* (speaks to me in a loud voice) he became terrified, adding that *fikr say adha kay ikon gurda* (fear that I have only one kidney has made me half the man I was).

Two individuals used interesting ways to express the changes they felt in themselves and the sense of vulnerability connected to having one kidney. One said that *pehlan tees meter dee chalang laganda san, hun sochna parda ay* (before I could leap across thirty meters, but now I have to pause/think about it). Another described himself before and after he had sold a kidney—*pehlan mein sher san, hun mein bakri an* (before I was like a lion, now I am like a she-goat).

A sense of hopelessness. Fifty percent of those administered the SRQ revealed profound levels of anxiety and a sense of hopelessness about life. Although we had no means of assessing their status before the nephrectomy, vendors perceived these feelings as originating following it. An intelligent, middle-aged vendor named Chachu (paternal uncle) made an insightful observation. He said that those who sell kidneys *zehan tay tenshun laga lainday hein; nafsiatee asar bohat honda ay* (suffer from tension in their minds; there is a great psychological effect on them), and this was why he never let it enter his mind. Others reported insomnia, crying spells, loss of appetite, and a lack of *sakoon* (peace) in life. Many said that *dil na lagda* (my heart is not into anything) and that they *muk gaya* (were finished/destroyed).

One man who sold his kidney without informing his wife—who said she would have stopped him—informed us that he felt *hun zindagee dee koi lor nahin; na wajood raya na sihat* (now I have no need for life; I have neither my body left nor my health). He added that *kam nahin honda, mein baikar ho gaya hun* (I cannot do any work, I have become completely useless). Another vendor who had been unsuccessful in clearing his debts sat staring into space and used the frequently voiced word *baikar* (useless) for himself. He said that *marnay ko dil chahda ay* (my heart feels that I should die) and that he no longer experienced any *khushee kay lumhat* (moments of happiness/pleasure) in his life.

Feelings of regret. One female vendor, an assertive young woman, told us she did not regret selling her kidney and added that "what is done is done." Such comments were exceptions, however; more commonly we heard words, even from those who had paid off their debts, such as *afsos* (deep sadness, feeling sorry) and *pachtana* (regret, remorse) at the act. Different but overlapping reasons were given for this. One set related to the fact that despite selling a kidney and incurring the perceived harm, they remained under debt. A common statement was *gurda bhee gaya tay poora faeda bhee na hoya* (my kidney is gone and yet I have not reaped the benefit I wanted). Others stated that *qarza tay utar janda kisee taranh, par gurda na baichna chahda see* (the debt could have been paid off somehow, but I should not have sold my kidney).

Some subjects expressed remorse connected to a religiously grounded perception that there was an intrinsic "wrongness" in selling an organ. One man described the kidney as a *naimat* (blessing) from God, and others said that selling a kidney was *Allah tala kaa gunnah* (sin in the eyes of Allah), *a buraee* (wrong, evil act), or *accha kaam nahin* (not a right/good act). One vendor described the money ob-

tained from selling a kidney as *haram* (something strictly forbidden in Islam). We interviewed one man in our car by the side of the road, where he worked in a gas station (in addition to the work on a *zamindar*'s lands) to try and pay off his persisting loans. He wept as he spoke of his sense of hopelessness and said that he thinks of God all the time and asks for His help.

Two vendors among those we interviewed expressed feelings of profound shame at having sold a kidney and had concealed the act from various members of their families. One of them had told his wife that he had surgery for a kidney stone and was convinced that she would leave him if she discovered the truth. He had also not told his parents, for fear that the *biradari* (extended family) would find out, and he was miserable because *sub say dhoka kiya hay* (I have deceived everybody). In the case of the second vendor, his large extended family blamed his wife's influence on him and openly expressed their animosity toward her when she was present. The vendor himself was contrite that his act had resulted in shame for the entire family, and he added that people in the community made fun of those who sell kidneys.

Those we questioned directly said that they would not recommend that anyone sell a kidney. In answer to our query as to why they had themselves sold a kidney, the most common words they used were *majboori* (a word that arises from the root *jabr*, which means a state that is beyond one's control) and *ghurbat* (extreme poverty). One man expressed anger at his younger, unmarried brother, who had also sold a kidney despite his advice that *das saal zalil ho ja par gurda na day* (even if you have to suffer humiliation for ten years, do not give your kidney). He said that he had done it for the sake of his children and added—perhaps as a salve to his conscience—that at least he had "not killed anyone." Another vendor's advice to others was that *bhookay raho, gurda na do* (stay hungry if you have to, do not give your kidney), and a female vendor compared selling a kidney to *apnee nilami* (auctioning herself).

Feelings toward hospitals, physicians, and recipients. Although we asked no direct questions on this issue, some vendors offered unsolicited opinions about the hospitals and physicians involved in transplantations. One woman said that the doctors in the hospital where her husband sold his kidney were "nice," but the usual comments tended to be quite harsh. Except for three individuals, none had returned to the hospitals for follow-up. One man bitterly described the hospital as *sub karobar hay* (it is all a business) and said he would never return. He characterized those connected to the hospital as *kasaee* (butchers) and said he hated the place because *sub jhootay hein* (they are all liars). Some said that the hospitals were too far away and the cost of the fare beyond their means.

A sense of being victimized and deceived by the medical profession was expressed in general terms, and none knew the name of the surgeon or other physicians in the hospital. (All, however, were familiar with the names of middlemen.) Hospitals and staff were described variously as *sub choree da kaam ay* (in a business of theft), *sub daqa shahi ain* (all are the kings of thieves), *dhokay baz* (those who deceive others) and destroy lives like *phansee ka phanda* (a noose for hanging people). One female vendor described her experience in the hospital as one in which they *khoon choos litta; murda bana kay ghar bhaij dainday hein* (sucked out all my blood; they send us home after turning us into corpses).

We detected little curiosity, or sympathy, toward the recipients. Vendors who managed to meet recipients in the hospital did so with the expectation of getting additional money and were disappointed and angry when this did not happen. In one *dera*, a young man casually mentioned that the "Arabi" (word for people from the Middle East) who had gotten his kidney died four days later. When another said that his kidney, too, had gone to an Arabi, a man in the group remarked "but they managed to save this old man and he didn't die." This was followed by loud laughter from everybody. This indifference and even disdain toward recipients contrasts with the emotional and psychological connection that altruistic donors often say they have with the recipients of their kidneys. To the vendors, the recipients of kidneys were affluent and often faceless strangers who had bought an important part of their bodies, often for less money than was promised.

All vendors expressed an inability to work as hard as before. A common complaint was *hun wazan uthanay day naal dard* (lifting anything heavy now gives me pain), a significant issue for those involved in manual labor.

Conversations in the *Zanana*

We met separately with some of the wives and female family members of male vendors. The women were friendly, curious about us, and very willing to speak with us. All of them had noticed that their husbands were quieter now and had less capacity for physical work. Their responses included anger and frustra-

tion, but also sympathy and concern for their husbands. Our most detailed encounter took place in the *zanana* (living area for women) of one *dera*, where we met the wives of three brothers who were all vendors. This was a small, one-door room that was furnished with two bare *charpoys* and rapidly filled with women and children, relatives, and neighbors, all crowding onto the *charpoys* with us.

Razia's husband had sold his kidney in 2005, but she said that they were still in debt. She added that her husband had not told her about his decision to sell a kidney, or she would have tried to stop him. The couple has two living sons and a four-year-old daughter, but Razia has had seven miscarriages, all handled at home by the local *dai* (midwife). A large part of the money from the sale of her husband's kidney had been spent for these expenses and the births of her children. She lifted her shirt to show us a small bandage saying that she had just had emergency surgery without which the doctor had said she would die. She told us that they now also owed the surgeon Rs. 12,000.

Razia said that before his surgery her husband *khush rehnda, hun chup, chup ay. Bus pay rehnda tay sochda rehnda ay* (used to be a happy man, but now he is very quiet. He just lies around; he is always thinking). He was no longer able to work like before, and when he did not work she fought with him (said with a laugh in which the other women joined). Razia added that he was in pain, could not sleep, and often walked around at night.

Shehnaz, the wife of another brother and married at the age of fifteen, had also not known about her husband's nephrectomy until after it had happened, and she, too, was unhappy that he had undergone it. Shehnaz said that he used to be a happy and talkative man but had now become very quiet. He was always worried about what would happen to the family if he died. Shehnaz said, "When he says this I tell him that if he dies I will die with him."

In another *dera*, we spoke with a smiling, plump woman married to her cousin, who had sold his kidney. She said that since the surgery, her husband was quick to get angry with his children, but that he apologized afterward. As they were still in debt, she said that she was thinking of selling her kidney, too, but that her husband was not ready for her to do so. Another woman also reported that her husband became much angrier now, could not work as hard, and worried constantly that his remaining kidney would stop functioning. She poignantly described her husband by saying *oda wajood dard karda ay* (his entire being hurts now). Another vendor's wife, heavily pregnant, described her husband as *banda kaam da na reya* (the man has become useless; he can do no work), adding that it would have been better to stay hungry than to sell a kidney.

We spoke with Chachu, a middle-aged kidney vendor, and his wife Bibi in a *dera* while sitting on *charpoys* and sharing the shade of a tree with several black buffaloes tethered close by. Chachu had paid off his debts by selling his kidney and a cow. He now worked on *dehari* (daily wages), and Bibi was employed as a domestic servant in the household of a *zamindar*. Bibi, who was sitting close to one of us, offered her views *sotto voce* while Chachu was being interviewed. She said they were no longer in debt, but that Chachu *pehlay hor banda see, hun hor ay* (was a different man previously, and is now a different man), that he was now *adha* (half). She said selling a kidney is not a good thing but *majboor see* (they had no choice) as they wanted to free their children from the *zamindar*. Bibi said that before he sold his kidney, Chachu used to smoke a *hookah* occasionally but had now become a chain smoker.

Boota and His Family: A Case Study

We have chosen to present the story of Boota and his wife Nazeeran, whom we met twice, constructed through our field notes. To us this couple presents a microcosm of the experiential realities shared by so many others we met, snared in the ebb and rise of a tide of unending debt, inexorably sucking in other members of the family, vendors and others alike, in different ways. Their story also highlights the complete control of *zamindars* over the lives of vendors and their families, succinctly expressed in the words of a vendor when he said *apna kuch nahin hay* (there is nothing that is ours).

June visit. When we first reached Boota and Nazeeran's *dera*, the *zamindar* had expressed reluctance to our meeting them, telling Ali (as we waited in the car) that "there is nothing wrong with them; they do not need to be seen by any doctors." Ali, who knows the *zamindar*, had tried to "soften him up" and suggested that we try again the next day. On that visit, the *zamindar* was nowhere in sight, and Ali led us to the little room where the family lives. Later, while we were speaking with Boota and his wife Nazeeran, Ali suddenly left the room. He told us on the drive back that he had seen the *zamindar* walking up and had gone over to keep him busy in conversation until we completed our interviews.

The room in which Boota and Nazeeran live with their six sons and two unmarried daughters (three other daughters are married) was reached by walking along a dusty dirt track leading away from the main residence. We walked past a water trough for cattle and saw several black buffaloes belonging to the *zamindar* tethered under a tree outside Boota's room. The only furniture in the small, windowless room with one door consisted of three bare *charpoys* laid out parallel to one another, with one piled with a jumble of clothes. A wooden shelf on the wall facing the door was lined with what appeared to be the family's pots and pans. In the height of summer in Punjab, a small portable fan whirred in a corner, battling ineffectively against the heat and swarms of flies that buzzed around

Those we questioned directly said they would not recommend that anyone sell a kidney. When we asked why they had themselves done so, the most common words they used were *majboori* (a word arising from the root *jabr*, which means a state beyond one's control) and *ghurbat* (extreme poverty).

the sparse, dingy room. Outside the door, in the distance, we could see the *zamindar*'s acres of lush green fields and his orchards, the trees heavy with ripening fruit.

Boota and his wife welcomed us into the room with smiles and ushered us to one of the *charpoys*. Naziran sat down on the *charpoy* facing us, while Boota squatted on the floor near the door. Their oldest, married son (not the vendor) and a silent, unmarried young daughter took their place on the third *charpoy* in the shadows behind us. The second son—unmarried and twenty-seven years old, who had also sold a kidney—was away at work, and we did not get to meet him. Throughout our conversation, in which the married son sometimes participated, shabbily dressed, barefoot children of different ages drifted in and out of the room. Our efforts to get the "consent" of the family were met with protests from Boota and Nazeeran; they said they were so pleased that we had traveled all the way from Karachi just to talk with them, there was no need to ask their *ijazat* (permission) as we were their *mehman* (guests). There were repeated offers of tea from Boota that he said he would make with the fresh milk of the buffaloes tied outside the room. When we declined politely, he offered to dilute the milk with water to make it digestible for our (city) stomachs.

Boota was a thin, gray-haired, quiet man who looked worn out and older than the age ("approximately forty") he gave us. Nazeeran (who did not know her age) was stockily built and talkative. Both were illiterate. Boota said that they had sold their kidneys because they were in debt for Rs. 200,000 (approximately $3,500) borrowed from the *zamindar*. Nazeeran said she was the first to sell her kidney, and that she did it about two years ago. She was accompanied by her second oldest son, who sold his kidney to the same hospital seven months later, and Boota had done the same about a year ago. Boota said he had been promised Rs. 104,000 for his kidney but had received only Rs. 70,000 and had to pay Rs. 10,000 to Khalid (the middleman). He said that he also had to travel to Rawalpindi at his own expense to get "tests." The son added that from the money, they also had to pay a *jurmana* (penalty) to the *zamindar* for something one of his brothers had done. Boota said that they were still in debt, and the two buffaloes they had bought with the money obtained from selling kidneys had also died.

The couple's description of the kidney trade was identical to what we heard from other vendors. The system worked like a well-oiled machine built on a nexus of middlemen, small courts, and hospitals and staff. Boota, Nazeeran, and their son were first taken by Khalid to a *kutcheri* (a small court) near the Rawalpindi hospital for *kaghazat bananay day liyay* (making out papers). A man in the *kutcheri* asked them if they were giving their kidneys *khushee say* (happily), and "we said yes." They were asked to put a thumb print on a piece of paper, but they said they did not know what was written on it. *Shanakhtee* cards (identification cards for Pakistani citizens) were also made for them, but the hospital retained all the papers.

We asked if they had also "signed" any papers in the hospital. Boota said that he had put a thumbprint on a paper, adding that the man (he did not know whether he was a doctor) had said something to him about *maut aur hayat* (death and life); he could not recall exactly what was said. We learned that although "discharge slips" routinely list a hospital stay (for "nephrectomy done") of six to seven days, potential vendors often live in a hospital room for many days prior to surgery. Several were housed together in one room (there were separate rooms for males and females), and they slept on the floor until a recipient was found. The hospital provided food for this period, but the cost was deducted from the kidney money at the time of discharge.[23]

Boota said his kidney was given to a man from Karachi, who told him that *aap kaa aur hamara khoon ub aik ho gaya* (your blood and mine are now the same), but he did not give Boota any money. (Nazeeran told us in a matter of fact voice that the woman who received her kidney had died four days after the operation.) Despite three kidney sales within two years, the family had been unable to pay off the debt to the landowner, so they continued to work for him. Boota was worried about how they would marry off two of their daughters. He complained of weakness of his left arm since surgery and said that he urinated with *kum* (less) pressure. (His urine dipstick screening revealed traces of blood and presence of protein.) Coming close to tears, he said that since selling his kidney he has been experiencing *baichaingee saray wajood ich* (restlessness in his en-

tire body/being). He could not sleep well and said *khof lagda ay* (I feel afraid). When we asked what he was afraid of, his son said that Boota wakes up in the night screaming that *koi mein lay janda ay* (somebody is coming to take me away). Boota told us that he prays to Khuda (God) that *behtar kay mein mar jawan* (it is better that I die).

Nazeeran wept on and off during the interview. She mentioned general physical complaints—she felt *kamzor* (weak) all the time, had pain in the incision site and all over her body, and suffered from "gas" (bloating). When questioned about the kidney sale, she said the debt still remained, so *kee faida hoya* (what was the benefit)? She also said that when she sold her kidney, it was as if *apni nilamee kittee* (I auctioned myself). Like many other vendors, Nazeeran said that *assan log udhay log an* (we are like "half" people), and *hun zindagee dee kee lor ay* (now what is the need/use of living)? When we inquired if she had ever contemplated suicide, she wiped her eyes with her *dupatta* (long scarf that covers the head and chest), saying *majboori ay, zinda tay rehna ay* (I have no choice, I have to live), a reference to the fact that suicide is a grave sin in Islam.

Nazeeran vividly described her experience in the hospital and appeared to be suffering from flashbacks. She said that during her hospitalization, she had observed many other vendors after they had undergone surgery, and she described them as *pharaktay* (trembling/tossing/turning from side to side) in their beds, and said that she often woke up terrified that she was about to have surgery. The son confirmed that both his parents had insomnia, and he had occasionally come across them weeping at night. In view of the parents' bad experiences, we inquired why a son (brother of the son speaking with us) had also decided to sell his kidney. The son who was present responded that it was because of *mai-baap da zor* (pressure from the parents). He added that as they were still in debt, the family was considering that he also sell his kidney; the parents did not refute his statement.

As Boota's urine was abnormal and his SRQ score 11, we gave him referral slips and impressed upon him the importance of seeing the physician and the psychiatrist. He promised that he would do so. Nazeeran's urine screen was normal and her SRQ was 14, and although we did not refer her, in retrospect we believe that she, too, would have benefited from a referral to the psychiatrist. As we drove away, we asked Ali if he knew Boota and his family. He said that he knew them well, that they were in debt but they tended to "exaggerate." He thought that their current debt was probably about half of what they had told us and that he was aware that the others in the family were under pressure to sell a kidney.

November visit. Ali had to teach classes in his college during our second visit to Boota and Nazeeran, so our contact person was a young vendor named Raza who seemed to have taken a liking to us. An illiterate but articulate and bright man in his early twenties, a bit of a nihilist and a cynic, he has involved us in lively discussions on what he considers to be the "meaninglessness" of life. Raza said he knew a family of vendors and directed the driver to the Sahab Town *dera*, which included the elaborate house of a *zamindar*. Situated across a narrow dirt road in front of the house was the rest of the *dera*—a straight row of half a dozen small rooms for the *zamindar*'s workers that opened onto a dusty, common courtyard with a few scraggly trees. Raza led us to a covered area in front of the *zamindar*'s residence, and the ubiquitous *charpoys* appeared out of nowhere. We watched a thin, gray-haired man walk across the dirt road from the workers' quarters to where we sat, and much to our surprise, it turned out to be Boota. He was soon joined by Nazeeran, and both greeted us like long-lost friends. Almost immediately, Boota began to insist that we have tea with them, reminding us that we had not done so in our last meeting.

While we spoke with the couple, Raza left to see if he could locate the son who had sold a kidney (he did not appear this time, either). We learned that since June, no other member of the family had sold a kidney. We thought Boota and Nazeeran looked less anxious and teary-eyed than the last time, although on questioning they repeated some of their previous symptoms. They told us that they were still under a debt of Rs. 200,000 but were now working for a "nicer" *zamindar*. We asked how they had managed to convince the previous *zamindar* (from whom they had taken the loan) to allow them to leave his employment for that of another. Boota said that Haji, their present *zamindar*, had "bought" the debt from the last one, and so the family had moved to Haji's *dera* four months ago. We asked if Boota had gone to see the doctors as we had recommended. Nazeeran said that the *zamindar* had refused to give them time off, so they could not go to Sargodha. Boota was still spilling protein in his urine when we checked, and so we again lectured him about the importance of follow-up. We also gave a referral slip to Nazeeran for a psychiatrist, coupling it with a similar lecture, but were pessimistic about either of them following through on our advice.

Suddenly we heard a commotion and shouts from the direction of the workers' quarters. Boota and his wife sprang up and ran across the dirt road. We asked what seemed to be the problem and were told that their daughter Maqsooda was having a *dora* (the colloquial term for an epileptic fit) again. This young woman had earlier been sitting quietly in the enclosure where we were speaking to her parents, but had then walked away. Together with Raza we hurried across the dirt road and saw Maqsooda, a good-looking young woman perhaps in her late teens, lying supine on a bare *charpoy* in front of one of the rooms. She was sur-

rounded by a crowd that included men, women, and wide-eyed children. Her eyes were closed and several women were holding her arms firmly pinned down as she writhed and twisted and turned her body from side to side. Boota was at the foot of the bed holding on to her legs and at the same time trying to pull down her shirt to cover her lower abdomen and thighs. We heard him say, "Maqsooda, *Kalama parh, bus Kalama parh* (recite the Kalama [a verse in the Quran])," and this refrain was taken up by others in the crowd.

As we walked up, we saw Maqsooda's lips moving and her eyelids beginning to flutter. We were confident that we were not witnessing a seizure of any kind. One of our team members (a female) told the women to let go of Maqsooda and the crowd to move back, then sat down next to her and asked her to open her eyes. "I am a doctor, and I have very good medicine that will make you feel better." Maqsooda opened her eyes and watched as we checked her pulse and examined her. We asked if she was hurting anywhere, and she silently pointed to her left flank (the site of her parents' incision sites). Boota said that Maqsooda had been having "pain in her kidney" and frequent *doras* such as the one we had just witnessed. On examination, we could detect no physical abnormalities, and we were convinced that what we had just observed was a display of conversion reaction symptoms manifesting as a "seizure."[24]

By the time we had her swallow a paracetamol (analgesic) tablet, Maqsooda was smiling, sitting up on the *charpoy*, and ready to talk. We reassured her that there was nothing wrong with her kidney and suggested that perhaps she was just tired. Maqsooda told us that she worked all day for the *zamindar* (a young man with a wife and one young child), washing dishes and cleaning the house. Boota added that she often returned home very late at night, a fact that did not seem to perturb him or Nazeeran. To diffuse the situation further, we asked if people wanted us to take their photographs. The family and all the members of the *dera* milling around now clustered around a smiling Maqsooda. Laughing children clambered up onto her *charpoy* for the picture-taking session.

For those inextricably snared by lack of financial resources, selling a kidney has become "routinized" as an unpleasant but mundane act, and physicians are increasingly seen as organ purveyors complicit in this business.

The Vendor and Beyond

The vendors we met are among the most socioeconomically disadvantaged citizens of Pakistan, and in almost all cases had sold a kidney to pay off debts. Following the nephrectomy, almost all of them reported perceptions of significant deterioration in their physical health and an inability to work as hard as before, even as they mostly failed to escape the cycle of crushing debt. Similar findings have been reported in the handful of studies undertaken on paid, unrelated "donors" in India and Iran.[25] Our screening also revealed significant psychological repercussions, commonly expressed as a sense of profound hopelessness, a perception of the self as somehow halved and incomplete following the nephrectomy, and constant anxiety for the remaining kidney. The family members we spoke with, including the wives, confirmed the vendors' physical and psychological deterioration.

This contrasts with findings in an earlier, comprehensive study of family members in Pakistan who donate kidneys to kin. Within the norms of closely knit extended families, kidney donation was motivated by love for a family member, to fulfill religious obligations to help your own "blood" (which is rewarded by God), and to protect the socioeconomic future of profoundly interdependent extended families. Many donors reported heightened self-esteem and an increase in their stature within the family.[26]

An important aspect of our research on kidney vendors in Pakistan is that our empirical data suggests selling a kidney carries negative social, psychological, and emotional ramifications that extend far beyond the vendor to the immediate and extended family and also to the community. In this light, the arguments for organ markets as merely a transaction between two freestanding biological entities exercising their autonomy, seemingly in a vacuum, can be reductive and misleading. Through our time spent with vendors in the *deras* of Sargodha, and through their generosity and willingness to speak with us frankly, we were able to glimpse firsthand the realities on the ground of personal and collective existences, hopes, and disappointments, their "current pressures and uncertain prospects," and the ways in which many lives are engulfed when a family member sells a kidney.[27] Through our observations and through informal conversations with others we met, we were also able to observe subtle shifts in the values of communities

involved in organ vending, and—most disturbing to us—we could see how these practices serve to modify opinions about the integrity of medical professionals.

The vendor. When laborers in Punjab sell a kidney, they do so not on the strength of philosophical positions on ownership of or property rights to their bodies, or in order to exercise their freedom to make autonomous choices—the issues that form the core of international debates among ethicists, physicians, and economists. In the words of the vendors, they sell a kidney because of *majboori*—a word meaning lack of options, a situation over which one has no control—in order to fulfill what they see as obligations toward immediate and extended families in which they are inextricably embedded, and within systems of social and economic inequalities they can neither control nor escape. They sell kidneys in hopes of paying off loans taken to cover their families' medical expenses or to meet their responsibilities for arranging marriages and burying their dead. These are recurring expenses, and for most the debts rapidly accumulate again, even if they have been partially or completely paid back with the money from selling a kidney. Some sell kidneys in the hope that by paying off their loans to the *zamindar*, they can free their children from his employment and enable them to work on daily wages. Most are not only unsuccessful in freeing themselves from debt but are left in a worse situation because of the terrible price they pay in terms of their health.

The obvious paradox is that, despite these known consequences and although none said they would recommend that anyone sell a kidney, we met several families in which more than one member had sold a kidney. Perhaps the answer to this riddle lies in the dynamics of power structures and inequalities described by psychologists, historians, and political scientists, in which the psyche of the oppressed and the behavior of the oppressor perpetuate the cycle of oppression.[28] The families we met, engrossed in a struggle to survive from one day to the next, had little time left for imagining a "future" that includes the consequences of selling a kidney. This situation is compounded by a system in which *zamindars* exercise complete control over the time, mobility, and physical space of the workers. This was expressed succinctly by one vendor when he said *apna kuch nahin hay* (there is nothing that is ours).

The state of poverty and the restrictions imposed by the *zamindars*, which we witnessed repeatedly as we moved between *deras*, effectively limit the ability of the laborers even to imagine, let alone undertake, alternatives to selling a kidney to pay off debts or even to pursue medical help. Within these realities, the argument that preventing impoverished people from selling a kidney "ignore[s] the fundamental tenet of Western society—that people be allowed to control their own destiny"—appears parochial and cavalier.[29] And arguments that trumpet the "autonomy" of the impoverished to sell organs and equate it to the right "each of us" has to "engage in risky behaviors" such as "sky diving, volunteering for military service . . . and smoking cigarettes" seem cynical and out of touch with reality.[30]

The family, and kidneys as commodity. Our study also reveals how the vortex of poverty and debt sucks in others in the family beyond the vendor. Persisting debts lead to sometimes subtle, sometimes overt, pressure on others to sell a kidney. The resulting anxiety and guilt manifests in different ways, as demonstrated by the conversion reaction seizures we observed in Boota's daughter. These pressures were also evident in our meeting with Ahmed, the husband of a vendor. A slight man with noticeable tremors of his hands, he sat quietly as we interviewed his wife. Afterward, Ahmed said he had not been feeling well lately and asked us to examine him. He complained of pain all over his body, general weakness, and insomnia. He said that a doctor had told him after listening to his heart and lungs that his *gurday kharab hein* (kidneys are diseased/not working). Our detailed history and examination revealed nothing abnormal, but Ali told us later that Ahmed was being pressured to sell a kidney as the family still owed money to the *zamindar*.

Renee Fox and Judith Swazey, well known for their sociological, ethnographic study of the inception and evolution of the organ transplantation scene in the United States, criticize what they see as the medical profession's transformation of organ transplantation into something "analogous to a commercial industry." They note that "increasingly, organs are being thought of as 'just organs' rather than as living parts of a person," and that this "biological reductionism" carries insidious implications for how we see ourselves and how we relate to others. According to Fox, there is a "progressive routinization and profanation of organ transplantation" as a result of the increasingly "commercialized view" of organ transplantation, a specialty that began in a sense of awe and wonder among its practitioners.[31] Although they are commenting on highly educated transplantation professionals in the United States, we found some of their observations echoed in the way members of the illiterate rural communities of Punjab, driven by their dire circumstances, have come to see their bodies.

Among the farm laborers we met, living in regions where growing numbers of people have sold a kidney, there appears to be a resigned acceptance of the thought that their kidneys are a kind of commodity, the only material asset they possess in life, that can be sold to pay debts or cover expenses. For those inextricably snared by their lack of financial resources, selling a kidney has been "routinized" as an unpleasant but mundane act, and physicians are increasingly seen as organ purveyors

The vendors we studied may be specific to Pakistan, but their lives, and the circumstances in which they live them, reflect variations of economic disparities and social inequalities that are universal realities from which no country can be considered entirely exempt.

complicit in this business. The latter perception, profoundly distressing to us, was brought home to us on different occasions during our field visits.

Once when we had stopped to admire flowering mustard fields on both sides of the road, we were approached by a man accompanied by his pregnant wife and three barefoot children. As his wife stood by silently, he told us that he had eight children and was under debt to his *zamindar*. Having learned from our driver that we were doctors, he asked us if we could make arrangements for him to sell a kidney to pay back the loan. On another occasion, while walking through the narrow alleys of a settlement in search of a vendor's house, we stopped to ask directions from a man selling vegetables from a small pushcart. After providing directions, the man said that he could see we were doctors and inquired if we could help his friend sell a kidney. We found these encounters deeply disturbing.

The zamindars. We also observed a curious phenomenon that we came to label "vicarious kidney anxiety" among some of the *zamindars* who had vendors in their employment. They often asked us to check them for abdominal and back pain, which they invariably related to problems with their kidneys. In one *dera*, the *zamindar* requested that we examine his mother, whom we met in a room full of female relatives who had all gathered to be seen by the "Karachi doctors." As soon as we entered, a ten-year-old boy asked us if we had come to check his kidneys, too, followed by a woman who inquired if we had brought "machines" to test their kidneys. Another woman in the room was convinced that the pain in her abdomen was related to her kidneys, despite an ultrasound report she showed us that revealed normal kidneys. Before leaving the *dera*, we were approached by the *zamindar*'s cousin, who said his check-up in "a big hospital in Paris" was normal but that he was convinced his back pain was related to kidney disease. We had similar encounters with *zamindars* in other *deras*. The psychosomatic anxieties of the vendors seem to have seeped, as though through osmosis, into their employers.

The community at large. Throughout the study we also interacted informally with many people in the town of Sargodha and the areas in which the *deras* are located. Many were aware that laborers in the district sold their kidneys to private hospitals in cities and expressed mixed opinions about the vendors. Some considered the practice to be related to poverty and illiteracy of vendors—"they are too ignorant to know what they are doing to themselves." Some expressed anger at the government for not taking steps against poverty and leaving villagers open to exploitation. But many were far less sympathetic and tended to look with disapproval and disdain upon vendors and their families. We were told that "these people waste the money" they receive from selling their kidneys by using it for cell phones, extravagant weddings, and large dinners celebrating circumcision ceremonies for their sons. A few also expressed resentment at the vendors and "foreign TV and news agencies" that came to the area to make documentaries that give Pakistan "a bad name."

The International Debates

Is this study, conducted in the remote *deras* and villages of Punjab, relevant to international debates on kidney commerce and regulated markets for organs? We believe it is. The presence of power differentials within societies based on economic and social status is a global issue, one that is on the increase both within and among countries. The communities of vendors we studied exist in a milieu that may be specific to Pakistan, but their lives, and the circumstances in which they live them, reflect an extreme example of the variations of economic disparities and social inequalities that are universal realities from which no country can now be considered entirely exempt.

All studies to date clearly indicate that it is the most disadvantaged and the most vulnerable in any society who resort to selling a kidney, and that they do so only when they are left with no other alternatives to feed their families, pay off debts, or get health care. When we consider whether to legalize some form of kidney commerce, then, we should not overlook the fact that it is always the poor and the disadvantaged who end up exercising a "right" or "freedom" to sell their kidneys. Margaret Lock has called attention to this problem: in her comments on the "crisis" of organ shortages and the debate about instituting organ markets in the United States, Lock criticizes market proponents for "studiously avoiding any discussions of inequities, dissent, and above all, the lived experience of those at center stage."[32] To us, this reflects a failure of collective obligations toward the less fortunate and society's abne-

gation of responsibilities toward its most needy.

Although studies about social ramifications for those who sell a kidney are rare in academic literature, those that are available also reveal, as ours does, unequivocally poor outcomes for vendors.[33] Our study adds to this picture by providing insights into the psychosocial consequences of selling an organ that reach beyond the vendor, to the family and the community. The sale of a kidney by one family member can inevitably lead to subtle and not-so-subtle pressures on others to follow suit, and it carries with it the potential for the eventual stigmatization of individuals and of whole communities as organ "sellers." People always exist within families and communities, and it seems to us that our findings in the *deras* of Punjab would be equally pertinent, in varying degrees, to other societies. We believe that international discussions about organ commerce will remain reductive and shallow if they continue to be framed solely as transactions between two individuals, without taking into account the real possibility that there may be broader ramifications for families and societal ethos.

Equally important is that the Pakistani experience of kidney commerce over the last two decades confirms that the practice leads to the gradual erosion of altruistic donation. In the first several years following the initiation of kidney transplantation, the majority of organs in Pakistan were donated by family members driven by love and emotional connections with the patient. By the late 1990s, with the option of transplants with kidneys bought from unrelated donors, donation by family members dropped precipitously, as had also happened in other countries that introduced commerce in kidneys, including Iran, Israel, and Hong Kong.[34] In light of these experiences, we believe it is unrealistic to argue that certain societies would somehow remain immune to this phenomenon. As Gabriel Danovitch has written, organ vending "does not cohabit well with altruistic living donation."[35]

Finally, in our opinion, Anglo-American philosophical principles have exerted a disproportionate influence in discussions about organ markets. They have helped make a legalistic language, resting on rules and regulations, the dominant way of thinking about those markets. American proponents of kidney markets have long promoted this procedure-oriented approach, but recently some commentators in developing countries have employed it as well. The central premise is that the buying and selling of organs can be made ethical through proper monitoring and regulation.[36] Alexander Capron, commenting on the connection of social science and American bioethics, states that "bioethics literature is more concerned with who may decide than the morality of the decision, more often framed in terms of one's right to do something than in terms of what is the right thing to do."[37] The observation is certainly apt for the arguments that support organ commerce and regulated organ markets.

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3. S.M. Rothman and D.J. Rothman, "The Hidden Cost of Organ Sale," *American Journal of Transplantation* 6 (2006): 1524-28; F.L. Delmonico et al., "Ethical Incentives—Not Payment—for Organ Donation," *New England Journal of Medicine* 346 (2002): 2002-5; G.M. Danovitch and A.B. Leichtman, "Kidney Vending: The 'Trojan Horse' of Organ Transplantation," *Clinical Journal of the American Society of Nephrology* 1 (2006): 1133-35.

4. For some examples from India, the Philippines, and China, see S.S. Chattopadhyay, "A Kidney Racket in West Bengal," *Frontline* 20, no. 15 (2003); "Discount Kidneys for Sale in Living Donor Hotspot," *Gulf News*, April 19, 2008; Y. Yun and J. Da, "Illegal Kidney Transplant in Mainland Hospital," *Epoch Times*, http://en.epochtimes.com/news/6325/39692.html.

5. Y. Shimazona, "The State of the International Organ Trade: A Provisional Picture Based on Integration of Available Information," *WHO Bulletin*, http://www.who.int/bulletin/volumes/85/12/06-039370/en/print/html.

6. N. Scheper-Hughes, "The Global Traffic in Human Organs," *Current Anthropology* 41, no. 2 (2000): 191-211; also see N. Scheper-Hughes, "Keeping an Eye on the Global Traffic in Human Organs," *Lancet* 361 (2003): 1645-48.

7. A handful of surveys related to health and economic conditions of kidney sellers can be found in medical journals, but ethnographic studies involving in-depth interviews are a rarity. For examples of the former see M. Goyal et al., "Economic and Health Consequences of Selling a Kidney in India," *Journal of the American Medical Association* 288 (2002): 1589-93, and A.J. Ghods, S. Ossareh, and P. Khosravani, "Comparison of Some Socioeconomic Characteristics of Donors and Recipients in a Controlled Living Unrelated Donor Renal Transplantation Program," *Transplantation Proceedings* 33 (2001): 2626-27. The few academic publications about kidney vendors based on ethnographic field research include L. Cohen, "Where It Hurts: Indian Material for an Ethics of Organ Transplantation," *Daedalus* 128, no. 4 (1999): 135-66; J. Zargooshi, "Quality of Life of Iranian Kidney 'Donors,'" *Journal of Urology* 166 (2001): 1790-99, and J. Zargooshi, "Iranian Kidney Donors: Motivations and Relations with Recipients," *Journal of Urology* 165 (2001): 386-92.

8. S.A. Rizvi and S.A. Naqvi, "Kidney Transplantation in Pakistan," *Clinical Trans-*

plantation (2000): 381-82; S.A. Naqvi, "Community Involvement in Increasing Transplant Activity," *Transplantation Proceedings* 31 (1999): 3280-81; F. Jawad et al., "Problems of Donor Selection in a Living, Related Renal Transplant Program," *Transplantation Proceedings* 30 (1998): 3643.

9. S.A.A. Naqvi et al., "A Socioeconomic Survey of Kidney Vendors in Pakistan," *Transplant International* 20 (2007): 934-39. This is a questionnaire-based study, the only one to be undertaken by a team of health care professionals in the country. In comparison, the national press and media have been very active in reporting news stories based on meetings and interviews with vendors. See A. Mehdi, "Jobless Youths Offer Kidneys for Sale," *Dawn*, June 2, 2005; Z. Tahir, "Hundreds Deprived of Kidneys in Punjab," *Dawn*, May 27, 2007; A. Ansari, "Kidney Donor Has the Worst of Both Worlds," *Dawn*, July 10, 2007.

10. F. Moazam, *Bioethics and Organ Transplantation in a Muslim Society: A Study in Culture, Ethnography, and Religion*, Bioethics and Humanities, ed. E.M. Meslin and R.B. Miller (Bloomington: Indiana University Press, 2006), 28-30.

11. C. Geertz, "Thick Description: Towards an Interpretive Theory of Culture," *The Interpretation of Cultures* (New York: Basic Books, 2000), 3-32.

12. On September 4, 2007, after years of pressure, the government of Pakistan finally passed the Human Organs and Tissue Transplantation Ordinance, 2007. The ordinance requires all institutions, private and public, to register with and provide annual data to a national oversight committee, whose functions include periodic inspections of all transplant hospitals. See B.S. Syed, "Organs Trade Ordinance Issued," *Dawn*, September 4, 2007.

13. F. Moazam, "Organ(ised) Crime," *Dawn*, magazine section, August 27, 2006. This article gives an overview of the Pakistan kidney trade and lists some of the Web sites of hospitals in Punjab advertising "transplant packages" for foreigners at that time.

14. See Naqvi, "Socioeconomic Survey of Vendors," 936. Among the 239 vendors surveyed, kidneys from 69 percent were used to transplant non-Pakistanis. At the WHO Regional Consultation Meeting on Cell and Organ Transplantation held in Karachi in November 2005, nephrologist Nabil Mohsin presented data showing that following the drop in kidney tourism to India (with passage of the Indian Transplant Law in 1995) and then to Iraq (due to the Gulf war), patients from the Middle East were traveling increasingly to Pakistan for transplants; "Trend of Renal Transplant Operations—Living Related, Cadaver and Unrelated from Outside the Saudi Kingdom."

15. "Surgeon Accused of Kidney Theft Still at Large," *Dawn*, July 8, 2006; "Kidney Theft Victim Seeks Compensation," *Dawn*, July 30, 2006.

16. The Sindh Institute of Urology and Transplantation provides free care and has a good reputation. For a breakdown by provinces of kidney transplants done by SIUT, see M. Alam, "SIUT Set to Become Region's Biggest Transplant Center," *Dawn*, August 6, 2008. Of the 2,030 patient transplants done to date, 1,194 were from Sindh, 641 from Punjab, 127 from Balochistan, 57 from NWFP, and 11 from Azad Kashmir.

17. P.R. Ulin et al., *Qualitative Methods: A Field Guide for Applied Research in Sexual and Reproductive Health* (Durham, N.C.: Family Health International, 2002), 59-61.

18. Our primary contact was Ali, a young man born and raised in a *dera* near Sargodha and active in social work within local communities. A landowner who knew several vendors but employed none was also helpful. During our first visit to Sargodha we also contacted the *Naib Nazim* (deputy mayor) about our study due to safety concerns, as a few months earlier a member of our institution was assaulted while making inquiries about vendors. A general practitioner and a psychiatrist were also contacted for follow-up for vendors we judged to require medical attention.

19. The study was carried out during three field visits in April, June, and November, with each visit lasting from four to five days. Our second visit was delayed twice. The first delay occurred when Ali called to say that the harvest season in Punjab was not over and that vendors would have difficulty taking time away from work. The second delay was due to the May 12 face-off between lawyers and the government in Karachi, leading to violence that spread to other provinces, including Punjab.

20. For use of the SRQ in Pakistan, see K. Saeed, S.S. Mubashar, and I. Dogar, "Comparison of Self Reporting Questionnaire and Bradford Somatic Inventory as Screening Instruments for Psychiatric Morbidity in Community Settings in Pakistan," *Journal of College of Physicians and Surgeons of Pakistan* 11, no. 4 (2000): 229-31; D.B. Mumford et al., "Stress and Psychiatric Disorder in Rural Punjab: A Community Survey," *British Journal of Psychiatry* 170 (1997): 473-78; S. Ahmer, R.F. Faruqui, and A. Aijaz, "Psychiatric Rating Scales in Urdu: A Systematic Review," *BMC Psychiatry* 7 (2007): 59, http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2186345.

21. B. Glacer and A. Strauss, *The Discovery of Grounded Theory* (Chicago, Ill.: Aldine Publishers, 1967).

22. Moazam, *Bioethics and Organ Transplantation in a Muslim Society*, 164-67. Moazam's ethnographic research revealed that the reasons for reluctance to donate a kidney include a belief that the loss of one kidney somehow reduces an individual to *adha insan* (half a person). This "halfness" is believed to make one *kamzor* (weak) physically and sexually and make childbearing difficult for women. This is felt to be particularly problematic if the potential donor is unmarried, as it results in not getting an ideal "match" for marriage. In some cases, the fact that one has donated a kidney is not revealed to anyone beyond the immediate household.

23. This clarified a conversation we had had in Karachi with a man who said he was planning to have a transplant done in one of the Rawalpindi hospitals. He said the hospitals ran a "one-window operation": all you had to do was give a blood sample and they did the rest. According to him it was like a *gurda piri* (kidney market) there. The man was drawing an analogy to a *bakra piri* (goat market), where there are milling herds of goats that may be purchased for sacrifice.

24. *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., text revision (Arlington, Va.: American Psychiatric Association, 2004), 492-98. The seizure variety of conversion disorders presents as voluntary motor or sensory symptoms, suggesting a neurological condition as a result of stress or conflicts being experienced by an individual. Conversion reactions are "a way of expressing distress but, unlike malingering, are not produced intentionally by the subject." This variety is "more commonly reported in rural populations, [and] individuals of lower socioeconomic status." DSM notes that "The form of the symptoms reflects local cultural ideas and acceptable ways of expressing distress."

25. For the lack of economic improvement following the sale of kidneys by Iranians, see P. Khajehdehi, "Living Non-Related versus Related Renal Transplantation—Its Relationship to the Social Status, Age and Gender of Recipients and Donors," *Nephrology, Dialysis, Transplantation* 14 (1999): 2621-24, and A. Griffin, "Kidneys on Demand," *British Medical Journal* 334 (2007): 502-5. Khajehdehi found that 87 percent of the living unrelated donors remained in "economic deadlock" due to debt, unemployment, illness, and drug abuse. Griffin offers a good overview of reports about the transplant system in Iran and notes that despite inconsistent data, what is "true" is that "nearly all the donors are desperately poor men who do not want to be identified" due to fear of social stigma. For studies about quality of life and psychosocial repercussions on those who have sold a kidney in Iran, see Zargooshi, "Quality of Life of Iranian Kidney 'Donors,'" and "Iranian Kidney Donors: Motivations and Relations with Recipients." For a report on

Indian vendors, see Goyal et al., "Economic and Health Consequences of Selling a Kidney in India." A recent newspaper article reports an interview of 109 kidney vendors by the Philippine Society of Nephrology, revealing that "almost 80% of the villagers were just as poor as they were" before they sold a kidney. See J. Gomez, "Philippines: No Kidneys for Foreigners?" *Associated Press*, April 1, 2008.

26. See Moazam, *Bioethics and Organ Transplantation in a Muslim Society,* 137-145.

27. A. Kleinman, "Moral Experience and Ethical Reflection: Can Ethnography Reconcile Them? A Quandary for 'The New Bioethics,'" *Daedalus* 128, no. 4 (1999): 69-97.

28. For a landmark study on the economic conditions of laborers in rural Punjab, see M. Darling, *The Punjab Peasant in Prosperity and Debt* (Oxford, U.K.: Oxford University Press, 1925). For literature on the psychology of the oppressed in the context of male-female relationships, see J.B. Miller, *Toward a New Psychology of Women* (Boston, Mass.: Beacon Press, 1986).

29. A.J. Matas, "Should We Pay Donors to Increase the Supply of Organs for Transplantation? Yes," *British Medical Journal* 336 (2008): 1342-43.

30. Friedman and Friedman, "Payment for Donor Kidneys."

31. R.C. Fox and J. Swazey, *Spare Parts: Organ Replacement in American Society* (New York: Oxford University Press, 1992): 207-8; R.C. Fox, "Afterthoughts: Continuing Reflections on Organ Transplantation," *Organ Transplantation, Meanings and Realities*, ed. S. Younger, R.C. Fox, and L.J. O'Connell (Madison: University of Wisconsin Press, 1996), 252-72.

32. M. Lock, "Transcending Mortality: Organ Transplants and the Practice of Contradictions," *Medical Anthropology Quarterly*, *New Series* 9, no. 3 (1995): 390-93.

33. I. Sajjad et al., "Commercialization of Kidney Transplants: A Systemic Review of Outcomes in Recipients and Donors," *American Journal of Nephrology* 28 (2008): 744-54. In this literature search, the authors could find studies on vendor outcomes only from India, Pakistan, and Iran, all suggesting poor "medical, socioeconomic and emotional outcomes." Along the same lines, also see review article by V. Jha and K.S. Chugh, "The Case against a Regulated System of Living Kidney Sales," http://www.medscape.com/viewarticle/543585.

34. Danovitch and Leichtman, "Kidney Vending."

35. G.M. Danovitch, "Cultural Barriers to Kidney Transplantation: A New Frontier," *Transplantation* 84, no. 4 (2007): 462-63.

36. L.D. de Castro, "Commodification and Exploitation: Arguments in Favor of Compensated Organ Donation," *Journal of Medical Ethics* 29 (2003): 142-46. Castro, who is from the Philippines, argues for a market that "will freely determine the price of human organs in a market economy" that can, among other things, "monitor developments," "protect donors" against middlemen, and ensure that "organs are sourced legitimately." Also see A. Bagheri, "Compensated Kidney Donation: An Ethical Review of the Iranian Model," *Kennedy Institute of Ethics Journal* 16. no. 3 (2006): 269-82.

37. A.M. Capron, "What Contributions Have Social Science and the Law Made to the Development of Policy on Bioethics?" *Daedalus* 128, no. 4 (1999): 295-97.