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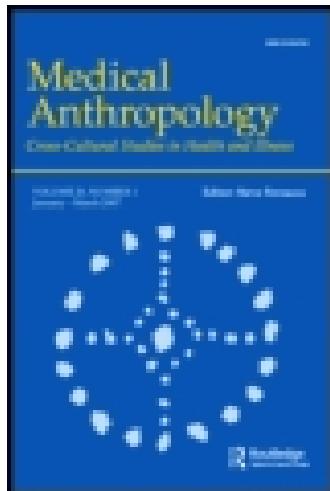
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GENDERING THE GIFT OF LIFE: FAMILY POLITICS AND KIDNEY DONATION IN EGYPT AND MEXICO

Megan Crowley-Matoka and Sherine F. Hamdy

Running title: Gendering the gift of life

Press teaser: How does gender shape living organ donation in Egypt and Mexico in ways we might – and might not – expect?

Bionotes:

Megan Crowley-Matoka is Assistant Professor in the Medical Humanities and Bioethics Program and the Department of Anthropology at Northwestern University. Her research focuses on the messy entanglements of biotechnology, clinical uncertainty, medicalization, and shifting forms of subjectivity through two primary ethnographic projects, one focused on organ transplantation in Mexico, and a second on the political and moral economies surrounding pain in American biomedicine.

Sherine F. Hamdy is Associate Professor of Anthropology at Brown University. Her book *Our Bodies Belong to God: Organ Transplants, Islam, and the Struggle for Human Dignity in Egypt* (University of California Press, 2012) analyzes crises in medical, religious, and state authority in Egypt through an ethnographic focus on organ transplantation in Egypt. Her current project, co-authored with Soha Bayoumi is on the role of physicians in ongoing political upheavals in the Arab world.

Keywords: Egypt, gender, living donors, Mexico, organ transplantation

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In this paper, we demonstrate how living kidney donation is a particularly gendered experience. We draw on anthropologists' contributions to understanding the globalization of reproductive technologies, to argue that kidney donation similarly endangers and preserves fertility, thereby both unsettling and reifying gendered familial labor. Based upon fieldwork in two ethnographic sites –Egypt and Mexico -- we examine how kidney donation is figured as a form of social reproduction. In both settings, kidney recipients rely almost exclusively on organs from living donors. We focus on how particular gender ideologies – as evident, for example, in the trope of the “self-sacrificing mother” – can serve as a cultural technology to generate donations in an otherwise organ-scarce medical setting. Alternatively, transplantation can disrupt gender norms and reproductive viability. In demonstrating the pervasiveness of gendered tropes in the realm of transplantation, we unsettle assumptions that the “family” as the locus of pure, altruistic donation.

Keywords: Egypt, gender, living donors, Mexico, organ transplantation

Although kidneys are less obviously gendered than other body parts, our ethnographic research reveals the ways in which living organ donation is replete with gender ideologies: from sacrificing mothers who ‘birth again’ through donating their kidneys, to men who fear the effects of kidney extraction on their virility, to a nun for whom kidney donation is imagined to endanger her vows of chastity. Worldwide gender inequality tends to privilege male recipients while exposing women disproportionately to the risks of giving or selling their kidneys (Simmons, Marine, and Simmons 1987, Cohen 1999, Moazam 2006, Scheper-Hughes 2007). Recent critical work in sociology and bioethics has begun to explore how gendered structural and ideological formations -- from economic dependency to notions of care work -- can exert greater pressure on women to serve as living donors (Shaw 2014, Zieler 2009, Biller-Adorno 2002). Building on this work, we turn to the *generative* possibilities of gendered ideologies of living organ donation, by remaining attentive to cultural logics and structural hierarchies that privilege different bodies, as well as the material constraints and conditions of those bodies and the biotechnologies that intervene in them. Toward this aim, we take two distinct ethnographic sites, Egypt and Mexico to reveal the uncanny entanglement of organ donation with situated life projects and family politics. We demonstrate how gendered understandings of bodies, fertility, and sexuality powerfully – but not uniformly – shape the ways in which people make sense of and experience living organ donation.

Our approach is informed by anthropologists of assisted reproductive technologies who have marked how the rapid expansion and diffusion of medical technologies have led to new clinical and social practices, as well as new arenas of social science research (Inhorn and Birenbaum-Carmeli 2008:178, see also Franklin and Ragoné 1998, Ginsburg and Rapp 1995, Strathern 1992). In diverse settings where new reproductive technologies are readily accessed by infertile couples, single mothers, and non-heteronormative couples, anthropologists have demonstrated heterogeneous and complicated social effects. In some instances, the ability to make biogenetic offspring outside of heterosexual relations has liberated women from constricting notions of their roles as primarily tied to their fertility. In other instances, the availability of new reproductive technologies has only reified the imperative of women to be mothers, as well as for women to

disproportionately bear the bodily burden of invasive fertility procedures. Building on this body of nuanced insights, here we take gender as a powerful -- and to date, under-utilized -- analytic for exploring the variable social effects and social demands of organ transplantation.

In both Mexico and Egypt, kidney recipients rely overwhelmingly on organs from living donors,¹ as cadaveric transplants are far less available. In both countries, the division of labor is gendered such that women are more likely to assume the responsibility of both social and biological reproduction. Our ethnographic research in these two sites revealed how ideas that link women to motherhood, fertility, and purity make women in some cases more readily available to the call of organ donation, and in other cases more protected from it. Below we elaborate on three different tropes that emerge in fraught intra-familial dynamics around organ transplantation. First, we show how reproduction serves as a crucial idiom in which to understand the organ donor in similar terms to a birthing mother -- or, alternatively, as one who withholds an expected gift. Secondly, we demonstrate that with spousal donation, organ donation can be figured instead as a gift that binds the marital couple, or one that tears it asunder. Finally, we show how organ donation is sometimes posed as a potentially dangerous threat to female purity, sexuality, and fertility.

Throughout, we are attentive to the potential of medical technologies to simultaneously disrupt and reinforce gender hierarchies. Considering cases from Egypt and Mexico together enables us to see with greater nuance how the politics of gender and reproduction operate powerfully but heterogeneously in the face of organ donation. By analyzing two different ethnographic sites with their own cultural and historical specificities, gender ideologies, religious traditions, and political economies, we are able to both attend to cultural specificity and work across it to identify broader points of convergence and disjuncture in global transplant practice. In distilling and overlapping these local discourses and practices, we seek to provide a strategy for examining the operation of ideas about gender, family, the nature of giving, and the goals of human flourishing in shaping how transplantation is practiced and experienced around the world.

MATERIAL MATTERS IN ORGAN TRANSPLANTATION: THE CULTURAL TECHNOLOGY OF ‘THE FAMILY’

In this essay, we draw on long-term ethnographic research conducted separately in Mexico and Egypt (Crowley-Matoka 2005, in press; Hamdy 2012). The research in Mexico was carried out in the city of Guadalajara between 1998-2010, with the most intensive period of fieldwork conducted at the turn of the millennium. Transplant activity in Mexico at that time was concentrated primarily in the two key public healthcare systems where ethnographic

observations and interviews were conducted, one a social security-based system (*Instituto Mexicano de Seguridad Social*) and the other a public charity system (*Secretaria de Salud*). These public healthcare systems, a fragile legacy of Mexico's revolutionary past, have come under increasing pressures of privatization under widespread neoliberal reform since the structural adjustment policies of the 1980s (Homedes and Ugalde 2006). Yet these public institutions continue to provide both basic and tertiary level healthcare for a majority of the Mexican population. Operating in a context long dominated by single-party rule under the *Partido Revolucionario Institucional*, these public systems were the site of political maneuvering and sometimes criminal profiteering, leaving them chronically under-resourced. Deeply vital nonetheless, these were the public institutions where patients diagnosed with end-stage renal failure could try to gain access to limited services for subsidized dialysis treatment and kidney transplantation. At the time of this research, scarcities of both resources and specialized expertise made it often difficult even to diagnose renal disease, much less treat it. For those patients who managed to enter treatment, approximately 90 percent in the region studied were on dialysis of some kind and 10 percent had received kidney transplants -- and more than 80 percent of those transplants relied on living donations from family members (Crowley-Matoka in press). Public health officials, however, were eager to increase transplantation rates both as a mark of prestige and as a way to reduce the astronomically high costs of dialysis.

Egypt similarly experienced structural adjustment programs and neoliberal reforms, most notably since the early 1970s under President Sadat's 'Open Door Policy'. These led to increased privatization and the abatement of state expenditures on health care, leaving public health system unreliable, overtaxed and under-resourced, despite the state's rhetoric regarding universal health

care coverage. The ethnographic research conducted in Egypt's dialysis clinics and transplant wards took place in Cairo and the provincial Nile Delta cities of Mansoura and Tanta (2002-2004). Patients with end-stage renal failure received state-subsidized dialysis treatment. If they were willing and able to manage significant bureaucratic hurdles, and could procure a kidney from a willing donating family member, they could undergo a transplant at the expense of the Egyptian Ministry of Health. However, in the mid-1990s, the Egyptian Nephrological Society estimated that only three percent of patients with end-stage kidney failure received kidney transplants (more recent data are not available), and the majority of kidney transplants (between 70 and 90 percent) used kidneys bought from willing sellers in Cairo's thriving black market (Hamdy 2012).

In our field settings, patients suffering from end-stage kidney failure and their family members did not always readily assume transplantation was a safe or even desirable treatment. Such wariness toward seeking transplantation contrasts with the US, where there is an ever-increasing demand for transplantation and its provision is an assumed medical good (Sharp 2006). In part a product of the constrained resources that made health generally more precarious in our field settings, local reservations regarding transplantation also drew on culturally dominant religious traditions (Catholicism and Evangelical Christianity in Mexico, Islam and Coptic Christianity in Egypt). These religious frameworks offered common counter-narratives to the promises for medical salvation held out by transplantation. In Mexico, religious sensibilities informed hopes about the possibilities for cultivating miraculous intervention in human life. In Egypt, religious discourse fostered acceptance of irremediable difficulties and human mortality as the will of God.

Sharply distinctive in terms of their cultural worlds, political histories, and economic landscapes, Egypt and Mexico nonetheless both represent settings where patients and clinicians were acutely aware of the limitations of their resources as compared to an imagined and idealized US medical setting and sometimes skeptical about the moral status of transplantation. In both places, kidney transplantation was the most common transplant procedure and has enabled countless patients in kidney failure to survive independently of dialysis machines. Critically, in both places the vast majority of kidneys came from *living* donors.

The overwhelming dependence on living donors is a material condition of transplantation that the pioneers of transplant medicine in the US sought to avoid. At the inception of transplant medicine, pioneering clinicians were concerned about the risks posed to living donors by undergoing a major surgical procedure solely for the benefit of another person (Fox and Swazey 1974, 1992, Hamdy 2013). Cadaveric donation was (and still is, among many leading international transplant clinicians) regarded as ethically preferable to living donation. In North America and other places where the majority of transplants occur with cadaveric organs or tissues, transplant committees attempt to identify and exclude potential living related donors who seem to be under family pressure to donate (Simmons, Marine, and Simmons 1987, Lock 2001). Blocking donation by a family member who appears ‘pressured’ to donate is a decision made when cadaveric transplantation remains an alternative option -- albeit one with a potentially lengthy waitlist. Yet cadaveric transplantation is not readily available in the majority of places in the world where kidney transplantation is practiced, Egypt and Mexico among them, partly because cadaveric procurement relies on highly developed infrastructure and communication programs, and because of an ideological shift in the definition of death (Lock 2001).

Thus, in many places in the world, including our two ethnographic sites, a family member willing to donate an organ -- even under pressure -- is often deemed preferable to no organ at all (Moazam 2006, Manderson 2011). Hence organ transplantation is fundamentally a *family matter*, and in many cases, we found that ideologies of gender and family were explicitly leveraged to enable kidney transplantation. In both settings, transplant program staff often referred matter-of-factly to taken-for-granted understandings of the cohesiveness, size, and collective (rather than individual) orientation of the family in their cultural settings as advantages that generated more living donors than could be found in many other countries. As one Mexican transplant surgeon put it: “We may not have cadaveric donors, we may not have operating rooms or money or all the medications that we need, but our people will do anything for their families, we can get more live donors than you’ll ever see in the States...That’s what keeps us going.” We cannot, of course, take such representations at face value. In practice, families in Mexico and Egypt, like everywhere, are much more diverse, complicated and often conflictual than such imagery portrays. Yet we are interested in how such idealized ideological notions of family serve as a useful tool -- a cultural technology -- in making sense of, and hence making possible transplantation in these settings.

In Mexico, this ready availability of and reliance on living familial donors was not simply regarded as an unfortunate consequence of a minimally operating deceased donor program. At times, the availability of living donors could engender a sense of cultural -- even ethical -- pride as a redeeming resource that mitigated the overwhelming constraints they otherwise faced. Mexican transplant professionals were acutely aware of the stigmatizing stain on national identity that black markets in living organs have left in other settings (see Cohen 1999, on India),

and thus referenced an idealized notion of ‘strong’ Mexican families as the critical resource enabling their transplant efforts. Local transplant staff at times posed *la familia mexicana* in explicit contrast to settings dominated by organ *selling*, as well as in contrast to what they imagined to be the colder, more individualistic ethos of settings like the US and Western Europe, where familial organs were understood to be less readily available. In Egypt, familial organs were similarly understood as an inescapably necessary resource enabling local transplantation. Yet in this context, these material conditions were more likely to engender uneasiness about the possibilities for exploitation inherent in the intersection between the gendered hierarchies of family life and the transplant endeavor. Such distinctive responses emerge from the complex nexus of organ donation and life project concerns about fertility, marital stability, biological reproduction and the social reproduction of the family unit, to which we now turn.²

THE EXPECTED GIFT: MOTHER AS GIVER AND WITHHOLDER OF LIFE

In many places, including Mexico and Egypt, mothers represent the most iconic – and seemingly least troubling – form of living donor (see also Lock 2001 on Japan, and Simmons, Marine, and Simmons 1987 on the US). Many Egyptian patients in kidney failure explained that it was only a parent (and most likely the mother) from whom they would be happy to receive a transplant; otherwise, the unbearably unpayable debt would too heavily weigh upon them. Likewise, in Mexico, transplant staff, patients, and family members alike made frequent reference to the idea that, as one transplant surgeon put it: “Of course if the mother can donate, she will – it’s only

natural that she would want to be the one.” This positioning of kidney donation as an expected extension of maternal duties was so commonplace that it featured as a joke. In a presentation to a large audience of healthcare workers during a national conference on transplantation in Guadalajara, one nephrologist playfully remarked: “So you tell a family that the patient needs a donor, and what do you think happens? Everyone starts sidling away and looking expectantly at the mother, of course!” The observation provoked knowing laughter among the conference crowd. Similarly in Egypt, where for over thirty years there has been heated debate over the ethics of ‘tolerable risk’ for organ donors, there was no question that it was only ‘natural’ that a mother would risk her life to try to save her child. Thus when the popular Egyptian television figure Shaykh Sha’rawi claimed that it was wrong to donate an organ because the “body belonged to God,” his adversaries had only to demonstrate that he “even denied the right of a mother to donate an organ to her child” to expose the absurdity of his position (Hamdy 2012:138).

In both settings a common framing heard around the transplant wards captured this naturalized linkage between mother’s bodies and organ donation: “My mother gave me life once, why wouldn’t she do so again if she could?” Drawing a resonant analogy between giving birth and giving a kidney, mother’s bodies were explicitly envisioned as the source of life from which both fully formed babies and organs could be extracted. A child carried within a woman’s womb was understood in these settings to take its physical materiality from her body -- a notion that was mobilized in the context of organ donation so that taking one more organ from that same source was rendered an organic continuation of that bodily intimacy and interdependence. This logic of fleshy continuity -- and responsibility -- underlay the understandings of a young Egyptian girl

Heba, born with only a quarter of a kidney. She joked that her mother *owed her a full kidney*. Heba also, though, quickly followed this joke with a defense of her mother, “But she didn’t do anything wrong while she was pregnant, like she didn’t take any medicines that she wasn’t supposed to -- it just happened.”

Yet for all their power, such naturalized symbolic connections between reproduction and living organ donation are hardly inevitable. In other settings, the relationship between motherhood and the needs of transplantation may be configured quite differently. Transplant surgeons from France, for instance, have described how staff are more likely to urge *fathers* to serve as living donors precisely “because mothers have already done their part” (Gauthier 2004).

Such fertile linkages between motherhood and organ donation not only referenced biological renderings of reproduction, but also conjured associations of spiritual compassion and self-sacrifice. Rendered most iconically in Mexico in the figure of the Virgin Mary, *la mujer sufrida* or *la mujer abnegada* (the suffering or self-sacrificial woman) gives endlessly of herself on behalf of her family and endures all with quiet grace. The deep familiarity of the figure of *la mujer sufrida* helped to render organ donation itself both biologically and culturally ‘natural’ in ways that seemed to stave off substantial public controversy about the risks of living donation, such as erupted in other settings, including Egypt. In making living organ donation meaningful - and thus possible -- this familiar figure of the self-sacrificial mother was instrumentalized, operating as a kind of cultural technology that both enabled the transplant endeavor and materialized it in particular ways.

Yet such images are never simple.³ The power of mothers to give life is coupled always with the power to withhold or even take it as well. In the context of Mexican transplantation, such darker feminine potentials emerged in the way that a family's failure to produce a living donor was frequently framed in terms of a *mother's* injunction. Refusals by a sibling to provide a kidney, for instance, were often attributed to the mother's prohibition of exposing yet another child to medical intervention. Expressed in such maternal prohibitions was a stark but commonplace calculus, often based upon gendered understandings of economic and familial prospects. As Marta, a frail yet quietly forceful young woman who was diagnosed with kidney failure in her early twenties, unsparingly described the decision-making process within her own family: "Well, my parents didn't want anyone in my family to donate. *My mother said she would rather have one sick child than two.* And all my brothers will have to be responsible for their own families some day, so it wouldn't be fair... And I don't have any sisters. So, that's it, I'm on the waiting list" (emphasis added). In the Mexican context where organ donations from brain dead donors were scarce, this consignment to the wait list was -- as Marta knew all too well -- a likely death sentence.

Yet such calculations of risk and need and future potentials were complicated, and a mother's power to block a donation did not always hold. In one case, despite the mother's adamant opposition, one brother felt compelled to donate his kidney to his brother who lived close by in Guadalajara, having seen first-hand the painful deterioration caused by kidney failure. Part of his motivation to donate a kidney was fear about his inability to take on the financial and social burden of caring for his brother's family, were he to die. Organ donation thus comes as the consequence of specific calculations aimed to reduce impending loss, pain, bodily risk, and

financial ruin, within a complex rubric of familial obligations of care and support (see also Manderson 2011).

This terrible power of mothers -- both to sacrifice and to withhold organs -- emerged in a case that caused considerable commotion in a transplant ward in Cairo, Egypt, involving a young patient who had just received a kidney from his mother. Another patient in the unit explained what was going on:

This poor young man; he has just received a kidney from his mother. But while he was recovering in the operating room, he heard about his brother's desolation – his younger brother also has kidney failure. Now he knows he will never get a kidney.

You see, the mother had reasoned that her older son was already married and had a child. She thought to give her kidney to him so that he could support his family.

When the older one heard that his younger brother was upset, he was so distressed that he almost rejected his [new] kidney. . . . That poor mother! Two sons in need, but only one kidney to give!

The mother's body, with "only one kidney to give" and two sons in kidney failure, made visible the clear limit to the available resources that could be garnered to fight off disease. Her life project of achieving the social and biological reproduction of her family unit met the limitations of her material body. As the only viable donor in the family, the mother was expected to 'choose' between her two sons, and she chose the one who was in a better position to secure his own natal family. Meanwhile, the son who would receive the kidney faced not only the medical and surgical risks associated with the transplant, but also the social risks of familial disruption,

guilt, and strained relations with his brother. In the face of life-threatening illness, people were forced to make decisions valuing some lives over others, always with uneasy consequences.

Men who suffered end-stage kidney failure in Egypt in their late twenties and early thirties, an awkward life stage, stated wistfully that they had ‘no-one’ to gift them kidneys. Yet for similarly-aged women in need, mothers often rushed to donate kidneys to enhance their daughters’ chances at marriage, reproduction, and a ‘normal life’. Mothers hastened to overcome potential stigma that their daughters with kidney disease might bear, particularly its adverse effects on marital prospects. Yet in uncertain economic straits with high unemployment, the stigma against men with kidney disease could be even higher. With more expectations on men to provide for their families through gainful employment, there was no guarantee that a transplant would improve a man’s marriageability or employment prospects. In both our fieldwork settings, we observed many young men who felt the sting of their mothers’ denial.

In the end, the image of mothers as a ‘natural’ source of kidneys for transplantation is both symbolically overdetermined and materially consequential, but also considerably more complex than a simplified story of transplantation as yet another means of gender exploitation. Women who defined themselves first and foremost as mothers in both settings often expressed pure elation and relief upon news that they could donate their kidneys to their sick children. In such donations, the convergence of cultural norms and mothers’ stated life projects of achieving both biological and social reproduction of their family unit were paramount, and happened to coincide with and enable the demands of organ transplantation. Yet, as we have seen in that maternal calculus of “I’d rather have one child die than two,” the life projects of mothers could also work

in powerful ways to withhold kidneys from the transplant endeavor. Moreover, the effects of imagining the kidneys of mothers as an ‘expected’ form of the gift of life may extend beyond the bodies of mothers themselves in important ways. In Mexico, those deep resonances between particular understandings of women’s reproductive capacity and the capacity to ‘give life’ through living organ donation not only feminized but also naturalized living donation more generally. Such gender-based forms of naturalization could serve to render the transplant endeavor writ large more culturally legible, and materially practicable -- it is this sense that we might see culture leveraged as a kind of technology. But as we further explore, such associations between women’s bodies and the risks of organ donation could also work to quite opposite effect – undermining rather than underwriting the drive to extend transplantation.

THE GIFT THAT BINDS – OR CAN TEAR ASUNDER: HUSBANDS AND WIVES

It was ‘common knowledge’ in both Mexico and Egypt that ‘of course’ wives were more likely to donate kidneys to their husbands than the other way around. Constrained by a still-widespread gendered division of labor, in which women within the domestic sphere usually played the role of nurturer and caregiver while men worked outside the home to provide for the family, wives in both settings often contributed bodily to what seemed a common-sense move to secure the family. Gabriela, for example, was a careworn woman in Mexico faced with an ailing husband, five children and no employment of her own outside the home, who described the constrained

terms of her decision: “Of course I gave him my kidney, he was sick and getting sicker, and if I didn’t donate, he would have died. Then how would my kids and I have survived? Who would take care of us?” Such wifely sacrifice to the husband in service of the family was simply a more material, bodily version of the more general gendered patterns of care-giving and familial commitment regarded as commonplace in Mexico. As one seasoned transplant nurse bluntly observed, referencing her decades of work on the kidney wards: “Look, if it’s the husband, the wife stays and takes care of him and the whole family supports him and helps pay for the treatment. But if it’s the wife who gets sick, he just leaves and the support falls apart.”⁴

Acutely aware of such structured dependencies, patients sometimes expressed cynicism when discussing transplants between spouses. One Egyptian woman, divorced during the course of her dialysis treatment, sullenly related that there are men who think their lives are “worth more” because they are men. “If he were the one sick,” she said, “I would have given him my kidney.” Not only did he not do this, but tiring of all the treatment and expenses, he divorced her, a fate not unfamiliar to young women on dialysis. Such all-too-familiar gendered forms of economic dependency and bodily vulnerability clearly play out in the practices of organ-giving and organ-receiving.

Yet the entanglement of familial relations and organ transplantation can be considerably more complex. Both Egyptian and Mexican men in kidney failure sometimes refused to ‘take’ kidneys from their wives, for fear that this might threaten their wives’ abilities to take care of their children, were they to die. In Egypt in particular, middle-aged fathers diagnosed as ‘acutely’ in need of new kidneys did not see the threat of their failed organs as a legitimate or justifiable

reason to intervene surgically in the bodies of their wives, siblings, or children. Such painful choices were made in medical contexts in which kidney transplants were not always successful, and were often seen as a high-cost gamble.

These choices also reveal an alternative configuration in which organ donation does not merely reinscribe gendered power relations or enable social reproduction, but may work to unsettle them. In Egypt, a common saying is that children ‘tie’ a wife to her husband, and in essence complete a marriage (see also Inhorn 1994). It was not uncommon to see young Egyptian women, not yet mothers, who were divorced after falling into kidney failure – the husbands unable to cope with the economic pressures of the dialysis treatment as well as the threats to biological reproduction that kidney failure posed. Well aware of this, women’s natal families often worked to ‘protect’ their daughters from kidney donation, for fear that it would impinge on their future prospects. Sometimes wives hoping to gift kidneys to their husbands met fierce resistance from their parents, from unstated fear that, if the husbands were to die anyway, their daughters would be less likely to remarry if ‘sick’ (from kidney extraction) or less likely to raise their children on their own. The kidney here becomes its own sort of social capital indexing health and productivity.

Highly attuned to such reproductive imperatives, women’s natal families in Egypt sought to block daughters from kidney donation, for fear that it would limit their future chances for marriage and children. Wafiyya related the difficulties she faced when insisting to donate a kidney to her husband Ali, then in his fifth year in kidney failure on dialysis. The disruption to their daily routine by Ali’s thrice-weekly dialysis regimen and inability to work posed an

unbearable challenge that she wished to end via donation. Yet Ali refused, on the premise that “the body belonged to God,” and that he feared being responsible for what might befall Wafiyya and her ability to mother their children. Wafiyya’s parents and siblings also fiercely resisted the idea that she might donate. The tacit, starkly pragmatic calculation underlying this resistance was the chance that the husband would die anyway, leaving Wafiyya both single-kidneyed and likely to remain single as a result.

Extended families, particularly in-laws, thus can play an important role in shaping the giving and taking of kidneys. For example, Iman, who lived in the Nile Delta city of Mansoura, Egypt, was diagnosed with acute kidney failure in her early thirties after her third pregnancy resulted in a premature and stillborn birth. When her husband offered to donate his kidney to her, his alarmed sister and brothers intervened, warning him not to “hurt himself.” Iman, knowing that her sister-in-law meant to imply that she was not “worthy” of such a tremendous sacrifice, herself came to refuse her husband’s offers: she could not, she felt, live the rest of her life ‘owing’ her husband (and husband’s family) the unrepayable gift of her husband’s kidney. She and her husband instead raised the funds to pay for a kidney – his sacrifice came in the form of liquidating his assets and savings, to pay a young man from Cairo in his twenties to part with his kidney. The young man wanted to raise the money necessary to get married to his fiancée; he also, later, used the evidence of his extracted kidney as a way out of mandatory military service. Iman’s sister-in-law made several comments about what a significant cost it was (about \$4,000) to pay a kidney donor, and about how terrible it was to surgically intervene in such a “young boy.”

The successful kidney graft enabled Iman to return home to care for her sons. She was acutely concerned about her body rejecting such a precious gift -- a common fear among transplant recipients, with clear social and personal resonances in the idea of rejection. Following the surgery, Iman adopted strange behaviors like refusing to take off her surgical mask for a month. Two years later, while watching a heated soccer match on television between his two favorite teams, her husband suddenly and unexpectedly died from acute heart failure. Iman told me that God had spared her from being “blamed” by her husband’s family for his death – it is certain that she would have been accused of weakening him by accepting his kidney. Now, years after his death, she still lived in an apartment unit in her married home, depending on her in-laws to raise her sons in their now fatherless world. In recounting her story, Iman questioned why her sickness would have given her own body priority over the other bodies with whom she was linked. Now she wonders: was she really any more at the brink of death than was her asymptomatic husband, who she ultimately outlived? If he had symptoms, would the resources for treatment have gone to him instead of her? The giving and taking – and sometimes refusing – of kidneys between husbands and wives were both conditioned by and constitutive of forms of relation among the wider family as well, who might later blame the organ recipient for putting the donor at unbearably high risk.

THE GIFT THAT ENDANGERS: PURITY, SEXUALITY, AND FERTILITY

Finally, in both Egypt and Mexico the entwined practices of giving and receiving a kidney were frequently caught up in gendered questions of purity and reproductivity. Although less pervasive than analogies with giving birth, in Mexico the bodily invasion required by living donation was sometimes likened to sexual penetration. For example, the transplantation hopes of Martita, a young kidney patient in Guadalajara, were thwarted by a particularly charged set of such preoccupations with purity. As she explained: “My sister wanted to donate. But then they told her at the convent that she couldn’t take her Orders if she donated an organ. They told her that she wouldn’t be pure any more, it would be like losing her virginity...She didn’t want to tell me, she told my mother. But I couldn’t let her give up her dream for me.” Here the physical act of opening up the body and removing an organ for donation was considered as echoing the act of (hetero)sex, with the donor’s body imaginatively penetrated both by the hands and instruments of the surgery, and by the desire and desperate need of the organ recipient. The sense of violation evoked in such imaginings of living donation has implications not just for women, however, but could also translate into fears of feminization among male kidney donors in Mexico, who sometimes expressed concerns about whether donating an organ might make them “less of a man,” rendering them impotent or infertile.

Within such purity and fertility-focused protective logics, young men in Egypt could be rendered comparatively vulnerable, as families rushed preferentially to shield their young, unmarried

women from the risks of donation. Such was the case for a 26 year old Egyptian man with mild mental disabilities, Saeed, who had hoped that his widowed mother would gift him his kidney. She had made numerous attempts to find a transplant surgeon who would agree to the operation, but all refused because of her dangerously high blood pressure. Though willing to risk herself, when Saeed's twin sister offered to gift him her kidney, their mother stood firmly in the way of such an operation. It was a contentious issue in the family. When the other patients in the dialysis clinic asked Saeed's mother why she would not allow the donation between sister and brother, she said matter-of-factly, "She's not married yet! A girl is not like a boy! If he had a brother, it would be okay!" Those listening nodded in understanding. Mothers and fathers in Egypt were more likely to gift organs to their daughters to ensure their marriageability and reproducibility, but for men, there was no guaranteed economic mobility or marriage prospects if they were to get a kidney. In contrast, these clear patterns of preferential protection of female fertility did not emerge in quite the same way in Mexico, where siblings were the most common source of kidneys for transplant and sisters were almost twice as likely to donate to brothers as brothers to their sisters. Instead, in Mexico familial donation discussions tended to center on the need to protect economic productivity – understood to be the primary purview of men. So Marta's mother's above-described unwillingness to run the risk of having two sick children rather than one was couched in terms of protecting her brothers who "will have to be responsible for their own families some day."

Yet familial investments in women's marriageability and fertility in the context of transplantation could produce its own forms of vulnerability. The story of one young Egyptian woman, Samira, captures the complex relations between kidneys, babies and the stability of both

marriages and physical health. Samira had received a kidney from her mother at Egypt's famous Mansoura Kidney Center three years earlier, and was re-admitted because her kidney function was deteriorating. Her mother had donated her organ to Samira as a straightforward and 'natural' step to achieving her life project of seeing her daughter marry, and 'complete' her own family. But Samira's own life project faced greater challenges. Rather than worrying about her kidney, all the questions she had for the doctor concerned her ability to get pregnant. The nephrologist's tone was uncompromising: "Listen. You cannot attempt to get pregnant. This will put both you and the baby at risk. You might lose your [grafted] kidney." Samira looked dejected. What the nephrologist did not realize was that Samira was in her second marriage. Unable or unwilling to bear the expenses of Samira's illness and dialysis treatment, her first husband, and father of her son, had divorced her, even while she and her natal family had made every attempt to find a new transplanted kidney for her so that she could resume her 'normal' domestic duties in her married household. By the time that Samira was able to get off Mansoura's waitlist, with her parents at her side as potential donors, her husband had already divorced her. When she was finally admitted to Mansoura for an operation, her mother was able to donate her kidney to her. A year after receiving the transplant, Samira re-married. But now she was afraid that she would lose her second husband if unable to bear him a child. The nephrologist shook his head in exasperation, complaining to the residents in English, "She is afraid she will lose her marriage without a child, but she will definitely lose her marriage if she loses her kidney!" The medical residents and attending physician seemed to blame Samira for her ignorance and simplicity, even though she was in a structurally difficult situation whereby women's bodies were expected to be reproductively viable in order to attain marital and financial security.

Similar double-binds between the will to maintain (one's own) life and the will to (re)produce it abounded in Mexico as well. Women who received a kidney often faced considerable difficulty in establishing or maintaining marital ties, largely because of doubts about their ability to provide children. Patí, for example, had been forced to endure an extended and uncertain period of engagement with her fiancée, imposed by his family's doubts about her suitability as a reproductive partner, and she worried about the constant strain placed on their relationship: "They always ask him why he can't find someone healthy. They are worried that I won't give them grandchildren. I know he loves me, he supports me in everything, but how long can he withstand such constant doubts?" And importantly, such threats to marriageability for transplanted women could pose risks to their newly-acquired kidneys as well. For in a setting where women were still more likely than men to depend upon a spouse for access to the most commonly (though not universally) available form of nationalized healthcare coverage, failure in marriage could all too easily translate into failure of the transplant itself. That is, for transplant patients who require life-long access to expensive immunosuppressive medications, losing access to healthcare coverage represented a dire health threat – to which women in Mexico remained structurally more vulnerable than men.

However, echoing the story of Samira above, even when transplanted women were able to secure a stable marriage relationship, reproductive expectations and their own reproductive desires could put them at risk in another way. Childbearing can put added strain on the transplanted kidney and, particularly for those women who do not (or cannot) undergo careful medical monitoring before and during pregnancy, can lead to losing the transplant entirely. Yet, such risks did not always dissuade women in a setting where transplantation was often centrally

understood as a means to achieving reproduction – at the same time that reproduction could become a means to maintaining the transplant. Forced to run such risks, women sometimes lost – and doubly so.

Women's decisions to run such risks for reproductive desires were not just a product of structural positioning and cultural expectation; they were also conditioned at times by transplant staff. For example, in Mexico reproductive hopes featured centrally in transplant program staff's efforts to incite the desire for a transplant in the first place. In a setting long characterized by both resource scarcity and pervasive political corruption, many patients in Mexico found the prospect of getting a transplant simply hard to trust, hard to align with the realities of their day-to-day lives. As a result, transplant program staff had to work hard to constitute the 'demand' for transplants in Mexico, finding strategies to actively draw patients into the transplant endeavor. A central feature of these efforts – in sharp contrast with the Egyptian nephrologists' uncompromising rejection of reproductive hopes described above – was a compelling discourse about the ability of transplantation to restore patients to a 'normal' health and life – a discourse in which reproductivity played a central role. In the words of one Mexican transplant coordinator, exhorting a roomful of kidney patients there for an educational session on transplantation: "With a transplant, you get your kidney and it starts working in your body, and you can have a normal life again. You can work, have a family, be just like any other person again!" Such sessions typically included an accompanying slide show, in which one of the first images was often a young woman tenderly cradling the baby she bore after receiving her kidney transplant. Through the circulation of such comments and images, organ transplantation was thus explicitly and

persuasively held out in this setting as a promise to secure one's own life goals of reproducing the family, despite the very real risks that such reproduction could pose for the transplant itself.

That heartwarming image of (transplanted) mother and child contrasts painfully with the experiences of those women whose post-transplant pregnancies put their life hopes, and even their very lives, at risk. In one case, Angélica, a middle class woman diagnosed with kidney failure as a newlywed, pursued the projects of obtaining a transplant and conceiving a child with equal fervor – for her the two were inextricably, necessarily linked. As she put it: “Well, that was the point, no? To have a normal life again...that was what the transplant was for, to be a real wife, a mother, that was why we suffered for the transplant, to achieve a life again...But of course, that's not how it ended for me.” Not long after her longed-for daughter was born, Angélica's transplanted kidney began to fail, and before her baby's first birthday she was forced to return to dialysis treatment. Angélica had found dialysis difficult the first time around, and now, weakened by transplant surgery, childbirth, the physical process of rejecting her kidney – and by all of the commonplace strains of new parenthood – she became virtually bedridden. Eventually, recognizing that she could no longer care for the child she had so desperately wanted, Angélica sent her daughter to live with her sister. Such losses – of both kidney and child – were particularly poignant given that reproductive hopes had been so persuasively held out by transplant staff as part of the promise of transplantation.

CONCLUSIONS: ORGAN TRANSPLANTATION AS SOCIAL REPRODUCTION

Close, comparative attention to the workings of gender in these two settings reveals how organ transplantation figures as a peculiar form of social reproduction of the family unit. In both Mexico and Egypt, people consciously articulated the importance of female self-sacrifice and of protecting women's purity and fertility in ways that rendered certain family members more or less available to the call to donate a kidney. In some instances, as for example, in the trope of the 'self-sacrificing mother', gender ideologies could serve to generate donated organs in an otherwise organ-scarce medical setting (Crowley-Matoka and Lock 2006). Alternatively, family members could draw on gendered tropes about motherhood and female fertility to *impede* a transplant, if it was understood to be potentially disruptive to reproductive hopes and viability.

All-too-familiar patterns of exploitation clearly mark living donation in many ways, yet are not merely reproduced in predictable fashion through the medium of this biomedical technology. And while patterns of organ giving and organ receiving do indeed both rely upon and reify gender inequalities, they may also expose -- or even incite -- disruptions in taken-for-granted flows of power that can serve to unsettle not only those gender hierarchies, but the transplant endeavor itself. Thus what emerges from our combined ethnographic material is hardly a straightforward story of gendered oppression through the medium of transplantation. By focusing on gender in settings in the global South, we seek not to suggest that women in these societies are more or less vulnerable to patriarchal conditions from which women in the US or other more

economically privileged settings are exempt. In fact, men and women in our research samples donated kidneys in nearly equal numbers (Crowley-Matoka in press, Hamdy 2012), whereas patterns of living donation in the US reveal a sustained gender imbalance, with women providing over 60 percent of live donor kidneys (UNOS 2014). This phenomenon, however, has garnered little open discussion or cultural elaboration, so dominant is the celebratory American discourse around organ donation as a ‘gift of life’ (Sharp 2006). A cherished national self-image of egalitarianism perhaps also works to dampen more explicit discussion of such gendered patterns of living organ donation in the US.

We argue that it is crucial to explore gendered dynamics within familial organ donation as ‘the family’ is so often marshaled as the ‘more ethical’ source of organs (posed as ‘gifts’) in bioethics and global health arguments against organ theft and sales (Scheper-Hughes 2000, 2007; Spital and Jacobs 2007, Garwood 2007). Such claims require more nuanced attention to the complex social relations of love, solidarity, obligation, and desperation that produce the organs that transplants require. In our settings, the act of living organ donation was often heavily feminized, in distinctive ways and to somewhat different effects. In Mexico, discussions in transplant wards often drew deep affinities between women’s bodies, women’s work, and living donation in ways that not only produced organs, but also naturalized the act of transplantation and re-instantiated nationalist pride. In contrast, in Egypt, where it was commonly acknowledged, for example, that wives readily donate kidneys to husbands but not the other way around, particular gendered patterns of living donation reified a pervasive association of organ transplantation with the exploitation of society’s most marginalized members. The transplant enterprise -- in which the fragmented physical bodies of others are part and parcel of the biomedical technology -- offers

an unusual analytic site where the pull of the ailing individual body upon a larger social body for the means of survival is starkly visible.

Through this gender-focused comparative analysis of our two distinctive ethnographic settings, we put forth three distinct arguments. First, it is not simply the case that ideology or culture shapes how biomedical technologies are received, but also that the material conditions of medical practice engender cultural ideologies to make those technologies work. In situations in which kidney transplantation relies exclusively on living donors, for example, gendered ideologies such as that of the ‘self-sacrificing mother’ may be rendered a kind of cultural technology, evoked to make organs more available in the face of weak cadaveric organ programs. Secondly, powerful gender ideologies that are woven through and constitutive of familial relations trouble how organ donations can be categorized as *either* ‘altruistic’ *or* ‘exploitative’. Ultimately, how and to what extent familial pressures are mobilized, and to what ends, goes back to the question of what other safe and efficacious therapeutic alternatives are available. The degree to which gender hierarchies within families are mobilized and re-instantiated in decisions about familial organ donation has very different outcomes in settings where there are limited available (e.g. cadaveric) alternatives to live donor transplants. Third and finally, in making decisions regarding organ donation, the ability to secure cherished life projects of marriage and reproduction may be a more salient indicator for health and vitality for patients than individuated assessments of physical health. We thus demonstrate the inadequacy of always assuming the primary biomedical goal as the extension of the individual patient’s life, or even more narrowly, as the longevity of the grafted organ. Attending with care and specificity to people’s desired life projects and their embeddedness in social relations, as this article aims to

do, renders a more expansive vision of what the complex, situated possibilities for what both gendered vulnerability and ‘saving life’ might look like within families and across generations in the face of biotechnological possibility.

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NOTES

¹ This dependence on living donors remains true despite considerable public attention to the issue of organ donation in both countries. In Mexico, concerted recent public promotion campaigns have aimed to increase deceased donation, particularly under the aegis of Mexican billionaire Carlos Slim (Horvat 2009, Harrison 2010). Yet from 1999-2013 the proportion of living to deceased donor kidneys transplanted in the region where the Mexican research was conducted remained highly skewed and fairly stable (CETOT 2014). In Egypt, a law was formally passed in

April 2010 to legalize procurement from deceased donors for the purpose of organ transplantation, but this has yet to be systematically applied, as there is still no centralized national organ donation system in Egypt. Furthermore, the infrastructural impediments to developing such a system have been exacerbated by political unrest in the country since 2011 (Hamdy 2012).

² See Smith and Mbakwem (2007) on the notion of “life projects” in the context of antiretroviral therapy.

³ Indeed, in Mexico the image of *la Virgen* is shadowed always in complex, contested ways by darker doubles such as *La Malinche* and *La Llorona* that explore the potentials for betrayal and destruction inherent in the roles of lover, wife, mother (Romero and Harris 2005)

⁴ This on-the-ground observation is corroborated by data across many settings that consistently reports gender imbalances in living donation as most acute among spouses, with wives as much as six times more likely to donate than husbands in one study (Zimmerman et al. 2000).