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Viewpoint

Ethics in Action: Iran's Controversial Kidney Transplant Policies in Transition

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Introduction and Background

In recent years, several commentators have proposed regulated kidney markets to address the persistent shortage of transplantable organs.[1] Advocates often cite the "Iranian model" of "Kidney Transplantation from Paid Unrelated Living Providers" (KiT-PULPs) as a system that eliminated waiting lists. This paper re-examines the KiT-PULPs by analysing two recent official documents. Tables 1 and 2 summarise the two official documents analysed, with English terms reflecting faithful translations. Table 1 condenses the Iranian Academy of Medical Sciences' (IAMS') recommendations from IAMS Policy Brief in 2018.[2] Table 2 summarises the executive regulations issued by the Ministry of Health and Medical Education (MoHME) in 2019.[3] These regulations address administrative and technical requirements, including eligibility criteria, provider and recipient applications, clinical and psychosocial assessments, informed consent, and registration procedures. While ethics is not stated as an explicit aim, several provisions have clear ethical implications, highlighted in Table 2.

In 1967, Iran's organ transplantation was initiated at a University Hospital in Shiraz with kidney transplantation from a living donor.[4] In 1976, the Ministry of Health—later renamed the MoHME after merging medical universities with the previously known Ministry of Health—established an office that managed publicly funded haemodialysis and transplant travel to abroad. Following Iran's 1979 revolution, domestic kidney transplantation was discontinued, though sending patients abroad for transplants continued until 1984.[5] As the available public resources became extremely limited because of the Iran–Iraq war, domestic transplantation from living-related donors resumed in 1985,[6] but met only 30% of national needs.[7] To expand capacity, the KiT-PULPs program, later referred to by some authors as the "Iranian Model," was launched in 1988,[8] which raised ethical concerns.

A sharp decline in kidney transplantation from living-related donors and continuing ethical concerns prompted subsequent regulatory interventions. In 1997, the "rewarded gift" policy was introduced to reduce direct financial exchanges between recipients and providers by providing some financial support to providers by the government. However, in the absence of an anonymous matching system, direct payments continued. Over time, the official "gift" also lost much of its real value, gradually declining to a negligible amount as inflation eroded the value of the national currency. In 2005, kidney recipients were also classified as "patients with special diseases," receiving public insurance coverage for transplant and medication costs.[10]

After the 2008 *Declaration of Istanbul* and evidence of inadequate informed consent[11], the IAMS issued a recommendation document emphasizing informed, voluntary consent, psychological evaluation, and separation of the consent process from transplant teams.[12] MoHME later endorsed parts of this guidance, limiting provider age (20–40 years) and adding family consent requirements. As another step to address ethical criticisms, MoHME banned internationality transplantation in 2010, mandating matching nationalities for paid kidney providers and recipients. This regulation aimed to reduce exploitation among vulnerable groups, including refugees[12] and Iranian people from low socioeconomic levels for the benefit of transplant tourists.

Currently, the KiT-PULPs system involves MoHME as regulator, Kidney Foundation of Iran (KFI) as financial intermediary for the official and transparent portion of exchanged money and also as the mediator for matching. Yet anonymity is absent, and private, unregulated financial arrangements remain common, sustaining ethical concerns and informal markets. It is important to note that, unlike underground organ trafficking systems, kidney transplantation in this Iranian context takes place within the official health system. Providers and recipients are therefore known, and the procedures are recorded in formal medical records. Globally, the Iranian experience continues to shape debates on financial incentives in organ donation, including consideration of compensated living donation in UK,[13] and USA.[14]

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Table 1. Ethical Reasoning and Recommendations From IAMS Policy Brief

Reasoning	Ethical Argument/Challenge)	Main Recommendation
The phenomenon of exchanging organs for money is a result of the ailing social security system and the lack of necessary support for the vulnerable or impoverished segments of society. Their income is insufficient to meet their basic needs or address the challenges they face, including covering unforeseen losses and securing essentials for a minimum standard of living. Consequently, they resort to seeking ways to meet their needs through organ sales.	These individuals, often motivated by commendable goals (eg, improving their family's economic situation), do not resort to criminal or illegal methods to address poverty. They believe they are providing comfort to their families by spending on their health.	• It is necessary to provide more support to kidney sellers, protecting them from physical, mental, and social harms and risks through medical support and destigmatization. • Efforts should be made to prevent possible physical, psychological, and social harm in any way possible.
Changes in the country's conditions, including significant developments since the inception of this KiT-PULPs program, have led to advancements in the country's dialysis facilities, approval of relevant laws, and successful initiation, and development of the brain death transplant program. Additionally, the establishment of the Supreme Council of Medical Ethics, the National Committee of Clinical Ethics, and the presence of the Supreme Transplantation Council in the MoHME signify important progress.	• There are ethical challenges and disagreement in the current program such as those related to informed consent, equity, commercialization, potential exploitation, transplant tourism. • More regulation and oversight required for preventing and combating unethical practices.	• A comprehensive ethical revision of the current kidney transplant model is necessary, involving participation from diverse disciplines (relevant medical specialists, jurists, experts in medical ethics, sociologists, and representatives of the people including organ donors, recipients, their families, and other important stakeholders) and based on scientific and logical evidence. • The need for transparency of the process of kidney transplants from unrelated living donors, including financial transfers and considerations of the donor's physical, mental, economic, social, cultural, and motivational situations. • The need for conducting research on debated issues, such as the condition of donors and social attitudes toward this model, to be conducted by independent researchers in reputable research institutes.
Each transplant significantly impacts [decreases] the costs incurred to the health system, the patient, and their family. This impact includes the elimination of dialysis costs, the freeing up of time previously spent on dialysis, the reduction of travel expenses for the patient and their companions, and, of course, a substantial improvement in the patient's quality of life.	• From a utilitarian point of view, clarifying the financial impact of the KiT-PULPs program on health services provides suitable justification for increasing the financial support for other sources of transplantable organs, including the present method of donations after brain death, implementation of new models such as organ donation after cardiac death, and offering more public financial support for donors. In case this KiT-PULPs program is kept this financial support could be used to prepare the ground for cutting direct financial relations between donors and recipients. • The (financial) connection between donors and recipients can cause ethical problems.	A detailed scientific analysis should be conducted to evaluate the direct and indirect cost savings for each kidney transplantation and the financial impact of removing individuals from the dialysis list. The transplantation costs saved through KiT-PULPs could provide better support for kidney donors who are disconnected from recipients, preventing social and ethical issues.
In recent years, due to the expansion of the transplant program involving donation after brain death and possibly other factors, we have witnessed a decrease in the number of transplants from unrelated living donors.	The KiT-PULPs model may be better justified if, after a reasonable waiting period and the utilization of other organ procurement methods, it remains the primary source for organs due to persistent need. Even in this case, the KiT-PULPs model must be designed to minimize infringement upon the moral values and human dignity of various stakeholders, including donors, recipients, and medical professionals.	Expansion of the organ transplantation program involving brain death victims and donation after cardiac death.
Family connections and emotional relations in Iranian society represent one of the strengths of the current social situation. The fundamental role of families in Iranian society, as depicted in the moral and religious beliefs of the people, is exceedingly important. In many countries, this group of related donors constitutes the largest or only living organ donor group.	The availability of the kidney transplant program from living unrelated donors in exchange for receiving monetary compensation affects the rates of related [altruistic] living donors such as family members and emotionally dependent individuals in a negative way. This undermines the ethical justifiability of KiT-PULPs, if any.	Call for evaluation and expansion of donation programs by related donors by using strategies such as paired donation (while ethical aspects of such programs should be considered).

Table 1. Continued

Reasoning	Ethical Argument/Challenge)	Main Recommendation
The issue of organ donation after confirming cardiac death (Donation after Cardiac Death) has previously been investigated by the Medical Ethics Group of the Academy of Medical Sciences, and a related policy brief has also been published. This approach does not have any serious contradictions with the country's laws and religious doctrine [of Islamic Republic public policy], which Iran's laws must conform to.	Providing a substitute source for transplantable kidneys, and donation after cardiac death, in this case, could help decrease ethically questionable [or unjustified] KiT-PULPs.	Considering the possibility of Donation after Cardiac Death to increase the number of kidneys procured for organ transplantation.
[Social] sensitivity of the issue and the possibility of numerous [ethical] problems in the field of transplantation necessitates the effective intervention and sovereignty of the government and the health regulators [by instruments such as establishing national allocation systems].	The establishment of a national allocation system within a National Organ Transplantation System paves the way for the implementation of a fair and transparent kidney allocation system which anonymously pairs potential donors and recipients, omits the role of brokers, and increases compliance with ethical standards by locating the fair priority for recipients in the waiting list based on justified criteria.	MoHME should take immediate action to set up a nationwide system to register, track, monitor, and supervise all kidney transplants from unrelated donors. Allocation in such a system should be anonymous.
[One of] the most important players of any organ transplant system is the medical professionals who perform the transplant operation. In the current KiT-PULPs program in Iran, medical professionals, particularly transplant surgeons, often see themselves as operators rather than as active moral agents who should be aware of their moral commitments and ethical responsibilities in the transplantation process.	Those medical professionals, specifically transplant surgeons, who are involved in the process of KiT-PULPs need to consider their ethical obligations seriously. The involvement of MoHME or other stakeholders in the process does not justify the passive role of medical professionals and their ignorance of the social consequences and ethical grounds of the medical practice that they perform.	Medical professionals should not be passive witnesses and executors of this process, seeking their responsibility only in the transplant operating room.
The absence of mechanisms such as independent committees or guidance that specify precise technical, medical, social, economic, and psychological indicators for people who apply for kidney donation in the KiT-PULPs system has led to discrepancies and problems in this case.	The availability of some mechanisms such as independent committees for careful examination of the mental and psychological competence of donors helps ensure that their decisions are informed and voluntary.	Independent committees should be formed for the comprehensive evaluation of donors and their informed consent. The criteria for eligibility for donation in the KiT-PULPs program should be compiled in such a way that groups that may be susceptible to abuse, coercion, or exploitation are systematically removed from the list of possible donors.
In the current KiT-PULPs system, there is no mechanism to ensure that the financial motivation and the amount of money received by kidney donors adequately meet their needs and enhance their well-being.	The amount and type of financial support to unrelated donors should be sufficient to meet their basic needs and enough to enhance their well-being to a meaningful level to make the KiT-PULPs system justified.	[to alleviate the current situation] Independent committees should ensure the adequacy of the financial support received. It is recommended that the support should be directed towards non-monetary and continuous social assistance, including suitable employment.
The financial transactions and payments in the current KiT-PULPs system are not transparent.	Direct donor-recipient recognition and financial relations before the transplantation operation provide ground for serious ethical concerns. Financial transparency and cutting direct recognition and financial relations solve the problem of brokers and financial intermediaries to a great extent and minimize such ethical concerns.	Any financial transfer and other support mentioned in this system should be conducted through the official institutions involved in the matter and should be recorded transparently. Any contribution of recipients in the compensation to the donors should be anonymous and indirect to ensure that the recipient and the donor do not know each other and do not meet before the transplantation. The continuation of the mentioned support for the organ donor must also depend on financial disconnection between the donor and the recipient.

Abbreviations: IAMS, Iranian Academy of Medical Sciences; KiT-PULPs, Kidney Transplantation from Paid Unrelated Living Providers; MoHME, Ministry of Health and Medical Education.

Table 2. 2019 Ministry of Health and Medical Education Regulation

Ethical Issues Influenced by the Guidance	Specific Ethical Issue	The Clause and Article Number of the Guidance and the Content	Ethical Implication
Informed consent	Disclosure of information: Putting the responsibility for disclosure of information for obtaining informed consent from donors on KFI personnel and social workers in transplant centers.	- KFI is responsible for providing necessary explanations to kidney donation volunteers and disseminating educational pamphlets on kidney transplantation, potential donor complications, post-donation care, and the donation process (Article 2-2-1). - Hospital social workers are responsible for discussing the potential impact of donation on donors' careers and family relationships and for ensuring comprehension of explanations on risks, benefits, and drawbacks of donation to candidate donors. (Article 2-3-3-5).	Exclusion of the surgical team from the informed consent process. Put some safeguards to ensure autonomous decision-making by involving social workers, psychologists and hospital committees.
	Capacity and competence: Putting the responsibility for the assessment of the decision-making capacity of donors on one psychologist.	A psychologist should conduct a comprehensive assessment of the kidney donor regarding psychological, personality, and social factors (Article 2-3-2).	
	Voluntariness of consent: Putting the responsibility for the assessment of the decision-making capacity of donors on one committee in the hospital.	- One specific committee should assess the donor's motivation to donate a kidney and confirm that the decision to donate is voluntary (Article 2-3-2-5). - One specific committee should determine that the individual's autonomy in deciding to donate is without coercion or external influence (Article 2-3-3-4).	
Donor's well-being	Ensuring the availability of post-operation support systems for donors.	Assisting the individual in the decision to reintegrate into daily life by the social worker (Article 2-3-3-5).	Noticing the importance of providers' well-being which was less noticed earlier.
Equity	Preferring other source for transplantable kidneys such as altruistic or cadaveric organs to the KiT-PULPs model.	Preference for using other sources of organs including: - Unrelated donation with altruistic motivation (Article 2-1). - Paired donation or paired exchange (Article 2-1). - Indirect encouragement of kidney transplantation from brain-dead donors: According to this directive, public hospitals that receive at least 30% of their kidney transplants from brain-dead donors are permitted to conduct kidney transplants from living unrelated donors (Article 2-4).	Deprioritizing KiT-PULPs model to other ways which could be indirect recognition of ethical problems of KiT-PULPs system by the main regulator (MoHME) which could be a critical step for starting corrective measures.
	Establishment of a central Registry and allocation system.	- Registering the information of recipients and donors in MoHME's system by KFI (Article 2-2-1). -There are no registered instructions and guidelines for organ allocation (Article 2-5).	Such a central system could help to cut the direct relations between providers and recipients and reduce the role of brokers, ensuring an unbiased allocation mechanism.

Abbreviations: KiT-PULPs, Kidney Transplantation from Paid Unrelated Living Providers; MoHME, Ministry of Health and Medical Education; KFI, Kidney Foundation of Iran.

To clarify key terminology in this study, we use the term "provider" instead of donor or seller to capture both the economic and ethical complexities of the act. Donor implies altruism that does not accurately reflect most cases, while seller overlooks structural vulnerabilities and may convey a reductive or negative image, suggesting a purely transactional motive.

Ethical Analysis

Despite of some supports to Iran's KiT-PULPs program,[15,16] or describe it as a regulated market, the system has faced extensive ethical criticism. Many argue that organ providers are effectively selling rather than donating their kidneys.[17] A major concern is the socioeconomic vulnerability of providers; 84% are impoverished,[5] raises serious risks of exploitation. Studies also suggest that allowing paid kidney providing has reduced the number of related-donor transplants.[18] Moreover, the rise of broker-mediated black markets and the dominance of financially capable recipients have deepened inequities in transplant access.[19,20] Furthermore, challenges related to informed consent and long-term follow-up further intensify ethical concerns.[19-21] Nevertheless, some liberal and libertarian perspectives defend the model, opposing governmental restrictions on voluntary organ transactions between consenting adults.[22] Both documents reviewed here recognize ethical shortcomings in the KiT-PULPs system. While Iran's health system once defended it as a well-regulated model, the new analyses reveal a shift toward acknowledging ethical flaws. For instance, the IAMS document explicitly calls for prioritizing alternative organ sources over living unrelated providers. Overall, these developments indicate a move from unconditional defence toward a more self-critical and reform-oriented stance within the Iranian health system.

The Central National Registry and Allocation System

The KiT-PULPs program lacks transparency, national registry, and long-term follow-up of paid providers.[23] Currently, the program operates as a segmented system, with provider-recipient relationships, financial transactions, and allocations largely opaque, although medical details are recorded at each transplant centre. While recipients are nationally registered, paid providers frequently remain untracked. New MoHME[3] and IAMS regulations[2] aim to address this by establishing a national registration and allocation system for all living paid providers. However, one important question remains unanswered: why has the MoHME, as the legal regulator of Iran's health system, failed to establish a national registry despite acknowledging its necessity? Part of the answer may lie in the human and financial resources, technical expertise, and institutional capacity required to develop and maintain such a national system. More importantly, however, the explanation may be found in the political dynamics surrounding the current system. Those with vested interests in maintaining the status quo may recognise that a national registry would introduce a level of transparency that could fundamentally alter and even shut the programme down. By exposing the system to greater scrutiny, such a registry could affect the interests and motivations of providers, brokers, and other actors who benefit from the existing arrangements.

One important beneficiary of the current system is the MoHME itself, as the body responsible for addressing population health needs. MoHME decision-makers may be concerned about how the excess demand for kidney transplantation could be met if the current KIT-PULP system were negatively affected and the number of transplantations declined. However, one could argue that this potential shortfall might be partly compensated for by restoring and strengthening living-related donation, given features of Iranian society, including extended family structures and strong familial ties. Experiences from countries with similar social and family dynamics suggest that living-related donation can provide a substantial proportion of transplantable kidneys, for example 63% of living donors in Turkey.[24]

From a justice perspective, a national registry could make previously "invisible" providers identifiable, allowing monitoring of their health, motivations, consent quality, and post-operative follow-up, while enabling patient rights advocates to act on their behalf.

Unclear Allocation Criteria and the Waiting List

The new MoHME regulation[3] refers to the need for a central kidney allocation system within a national registry; however, it still lacks clear guidelines on allocation criteria.[25] Establishing such a centralized mechanism would conflict with the core feature of the current KiT-PULPs system, which depends on direct negotiations between recipients and paid providers over financial transactions. If matching were to occur transparently through a national system, individual bargaining and additional payments beyond the fixed amount set annually by KFI[26] would no longer be possible, effectively ending the current market-based model. Because many providers seek higher payments than the official rate, a centrally regulated system could reduce participation. Thus, a transparent national allocation mechanism, relying on publicly defined allocation criteria rather than private negotiations, may help distribute opportunities for transplantation more fairly among recipients.

Non-transparent Financial Relationships

A major issue identified in the IAMS policy brief,[2] which MoHME seeks to address through new regulations,[3] is the lack of oversight in the financial transaction. Although the KFI annually sets a fixed price for kidneys, actual payments are often significantly higher. Currently, an official rate of €570[1] is provided. Since 1994, the Iranian armed forces' insurance has covered this fixed sum for its members.[26] In practice, there is no effective control over payments, fostering a black-market and the commercialization of organ exchange.[27] Some scholars suggest that if these transactions were monitored within a transparent, regulated framework, the current black-market could evolve into a more ethical "white market."[28] However, after more than three decades, the system has shifted from a government "rewarded gift" model to an opaque private market, making reform difficult.

Establishing a transparent market with direct payments also seems unrealistic given Iran's economic realities and context, including weak legal enforcement. A more viable approach could involve a centrally regulated system eliminating direct provider-recipient contact. Such an arrangement could also address some concerns about distributive justice by reducing dependence on private bargaining and limiting the ability of wealthier recipients to secure advantages through informal financial agreements.

Kidney paid providers as Invisible and Vulnerable Victims

The recent MoHME regulation[3] and IAMS[2] documents reflect a more empathetic stance toward paid kidney providers. In Iran, selling a kidney remains socially stigmatized, contributing to the invisibility of providers within the health system and limiting both follow-up and support. The absence of explicit religious prohibition—in a political system grounded in Islamic law (Sharia)—has been a key factor sustaining the KiT-PULPs program. However, cultural resistance and social stigma persist. The motivation for selling a kidney often stems from acute financial distress.[29] Thus, these providers should not be labeled as sellers who sell their kidneys for benefit.[30] The empathetic language used, signalling a potential step toward greater visibility and recognition of paid providers. Given that the main ethical critique of kidney markets centres on the exploitation and harm faced by paid providers,[31] adopting a compassionate approach could empower them to voice their experiences, thereby exposing the exploitative dynamics of the current black-market and prompting greater accountability within the health system. Improved registration and long-term follow-up mechanisms may also contribute to address this invisibility.

The Role of Medical Professionals and Exclusion of Transplantation Surgeons From Informed Consent Process

Beyond the potential exploitative aspects of the KiT-PULPs program, the issue of informed consent remains a major ethical concern.[32] Many argue that financial distress and structural coercion undermine the voluntariness of consent among paid providers.[33] Moreover, the quality and adequacy of information shared with them about potential harms is questionable.[32] While the MoHME regulation[3] emphasizes information disclosure and voluntary participation, it provides no clear guidance on how to ensure valid consent in practice. Responsibility for verifying consent accuracy has shifted from transplant professionals—particularly surgeons—to psychologists, social workers, and even non-medical personnel in the KFI. This delegation assumes that such bodies can ensure informed consent, yet it fails to guarantee that providers and recipients are adequately informed at each stage. Critically, consent should be obtained by a competent surgical team member, ideally the attending physician or transplant surgeon, before the operation—an essential ethical safeguard. The IAMS[2] identifies this omission as a fundamental flaw, while the MoHME regulation remains silent. By excluding surgeons from the consent process, the policy removes moral agency from those most directly responsible for the operation, undermining the patient-physician relationship that forms the ethical foundation of medical care. Some transplant surgeons may view their moral responsibility as limited to the operating room,[2] but the IAMS policy-brief explicitly rejects this stance, emphasizing that surgeons bear an irreplaceable moral obligation to ensure consent is truly informed and voluntary. This exclusion stems from a misinterpretation of ethical guidelines applicable to deceased-donor transplantation, where independence between brain-death determination and transplant teams is required. Applying this logic to living unrelated providers is inappropriate and ethically problematic. The IAMS policy-brief advocates reintegrating medical professionals—especially transplant surgeons—into the informed consent process, recognizing their central role in upholding ethical standards. Ultimately, the survival of the KiT-PULPs system depends on whether medical professionals continue to deny or reclaim their moral responsibility. The IAMS's updated stance, emphasizing the professional and ethical commitments of clinicians, marks a significant corrective step compared to its 2008 version.

Substitute Sources Are Preferred

Since 2000, deceased-donor transplantation has become an increasingly important component of the national transplantation system, reducing reliance on living donation. The number of cadaveric kidney transplants rose from 70 cases (out of a total of 1620 kidney transplants) in 2001 to 1462 cases in 2024 (out of a total of 3098 kidney transplants), accounting for approximately 47.2% of all kidney transplants.[34] Both the MoHME regulation and the IAMS policy brief emphasize the importance of expanding other potential alternative sources—such as paired exchange and deceased-donor transplants. According to the MoHME policy document,[3] public hospitals may perform transplants from paid living providers only if at least 30% of their procedures involve deceased-donor kidneys. This policy could be interpreted as official acknowledgment of the ethical shortcomings within the current KiT-PULPs program.

Transplant Nationalism

Both documents acknowledge, directly or indirectly, some of the ethical and procedural problems associated with the current KIT-PULP system. However, the long-standing presentation of this programme in the transplantation and bioethics literature as "the Iranian Model"[5,23]—a model claimed to have eliminated kidney transplantation waiting lists, although such claims are contestable—has made explicit criticism more difficult. In addition, Iran's emergence as a destination for kidney transplantation tourism, particularly for patients from neighbouring countries, may have turned the programme into a matter of national prestige. These factors among all other potential biopolitical factors, has increased the political and institutional burden of openly criticising the programme, making it more difficult for health system officials to acknowledge its shortcomings directly.

Conclusion

The Iran KiT-PULPs program has operated for decades despite persistent ethical criticisms. Over time, authorities have tried to address these issues through measures such as introducing the "rewarded gift" concept, banning internationality transplants, and promoting organ donation from brain-dead donors. An examination of two recent documents from MoHME and IAMS shows a growing institutional recognition of the program's ethical shortcomings, despite the program has long been portrayed as a national achievement. Since the present study is based on policy documents rather than implementation data, it cannot determine whether the proposed reforms have been successfully operationalized in practice.

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Endnotes

[1] Converting the reported amount from USD to EUR is not straightforward, as exchange rates and inflation have changed substantially over time, and reliable purchasing power data for Iran across the whole period is limited.

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