The Gift that Pays?
Money, Morals, and Classed Bodies in Paid Plasma Donation

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I did it, mom.

Table of Contents

LIST OF FIGURES

Chapter 1

Buying Bodies, Selling Life

When I meet Shea at the train station to walk her to a library study room for our interview, she is eager to share her experiences. She is 55 years old, identifies as white despite her Native American father, and she has sold plasma on and off for 13 years whenever money was tight. Money is tight again when we talk on a snowy February morning, so we agree to meet just before she heads to the plasma donation center for her bi-weekly afternoon draw, the earnings of which she uses to supplement her Social Security Disability Insurance. As we walk together from the train station to the library, Shea confesses that she only responded to my Craigslist ad because she was curious why anybody would care about people who sell their plasma. "No one's really listening to us," she tells me, "Do people really listen to us lower to the ground people? Not really." Her comment comes well before I ever ask her a single question about selling plasma, yet the stigma is clear from the get-go; if she's someone who sells plasma, she's – as she puts it – "lower to the ground."

Shea is one of over one million people in the United States regularly selling their blood plasma to a pharmaceutical company. Selling plasma is stigmatized, associated both with financial desperation and with using one's body for economic self-interest. As part of that stigma, selling plasma regularly acts as a social marker or symbol for poverty, a symbolic stigma. Plasma is one of the very few body parts that can be 'donated' for money (i.e., sold), and it's the only bodily tissue I currently know of that can be manufactured into an unrecognizable, completely disembodied pharmaceutical product.

While it would be shocking to read about millions of Americans rerouting their work commute to stop off at a strip mall to sell other parts of their bodies like hair, skin, or urine, people seldom give pause to paid plasma donation. Like so many other things that predominantly impact the working poor and people of color, this hidden-in-plain-sight body market remains on the periphery of public concern.

As one of the few countries in the world that allows donor remuneration, the United States provides between 65 and 80 percent of the world's source plasma,[1] functioning as what medical journalist Douglas Starr calls "the OPEC[2] of plasma" (Starr 2001; Weinstein 2018). In 2016, the United States exported $19 billion worth of plasma, a value comparable to what we export in medium sized cars and clothing (Ferranti 2018). By another measure, plasma is worth more by unit than oil (George 2018). Though rates of plasma collection declined 20 percent during the earlier months of the COVID-19 pandemic, the market is still fully expected to bounce back, with a projected value of nearly $50 billion by 2027 (Marketing Research Bureau 2020).

Scholars have long been interested in the relationship between morality and markets, debating whether morality tempers markets or if markets have their own moral order. Contemporary approaches posit that "all economic transactions are fundamentally social interactions," (Zelizer 2012:149) and that markets and morals are inseparably intertwined, making markets "explicitly moral projects" (Fourcade and Healy 2007:299).[3] In this interplay between money and morals, people and institutions do a lot of

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[1] Source plasma refers specifically to plasma gathered and used for pharmaceutical manufacturing; this is different from convalescent plasma which refers to plasma used for direct, person-to-person transfusions.

[2] OPEC stands for the Organization of the Petroleum Exporting Countries. It is an intergovernmental organization overseeing much of the world's global oil market.

[3] Morality, in this contemporary context, is also a shift away from an older Durkheimian view "seeing morality as a property of entire societies and bindings its members together" to the Weberian view that "morality belongs more to cross-cutting groups and less to society as a whole" (Hitlin and Vaisey 2013:53).

complicated and creative boundary work to negotiate moral dilemmas and "articulate the relationship between moral and economic classification in their personal interactions and activities" (Fourcade 2007:1028). *Relational work* refers to the processes that people engage in to differentiate meaningful social relations within economic action (Zelizer 2012). Though there is a breadth of research examining relational work in markets, little is known about how social relations based on categories like class, gender, and race "are not only expressed in but *constituted by and reproduced*" through these markets (Fourcade 2007:1028; my emphasis). This question is unavoidable when examining a market known for strategically targeting low-income communities the way the plasma pharmaceutical industry does.

Markets dealing in the exchange of bodily tissues and parts (henceforth referred to as *body markets*) provide a rich context for sociologists to examine how class and morality shape the interplay between economic and social relations. Few sociological studies of body markets exist, but those that do provide excellent insight as to how organizations craft moral frameworks to avoid the 'yuck factor' of buying and selling body parts. Healy's (2006) analysis of blood and organ donation in Europe and the United States, for example, demonstrates how altruism is highly institutionalized. Subsequent research also considers how sex and gender shape body markets. Almeling's (2011) study of sex cell donors found that agencies applied a gendered discourse about maternal altruism to downplay the commodification of eggs, a moral framing absent in sperm banking. Several studies examining international surrogacy markets[4] additionally

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[4] Even though surrogacy doesn't fall neatly into the category of body markets, I include it because it involves essentially the paid rental (rather than buying and selling) of one's body and thus is relevant to my overall theoretical framework.

show how market actors draw on culturally specific beliefs about gender roles to craft their moral palatability (Hovav 2019; Rudrappa and Collins 2015).

Still unanswered, however, is the question of how class and morality interact to shape a body market. Here I use class not just as a category or relational identity but also as what sociologist Imogen Tyler (2015) calls "a word that describes a problem," the problem being inequality and a struggle against classification. This is part of a shift within the discipline of sociology to better understand class in a neoliberal context, and it provides a broader lens for analyzing relational work in the plasma market.

I use paid plasma donation to examine how classed morality is constituted by and reproduced within a body market. Drawing on in-depth interviews, participant observations, and content analysis, I trace the organizational logic of the plasma pharmaceutical market; examine how the 'donation' process shapes the experiences of plasma suppliers[5]; and identify how plasma suppliers navigate the stigma of selling plasma. I draw from literatures of body markets, morality of the body, and stigma to inform my theoretical framework. My analysis reveals that the plasma pharmaceutical industry, fraught with concerns about exploitation and bodily commodification, emphasizes altruism to craft a moral palatability. To craft a convincing moral narrative, the industry focuses on patient needs but gives little attention to plasma suppliers, rendering them and their labor invisible. Even when the industry refers to plasma supplying in altruistic terms like "donation," the market commodifies plasma suppliers through payment structures and incentives that in turn create disciplined, employee-like

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[5] I often struggled with what to call my participants. The industry refers to them as "donors," which masks the financial component of their participation. That masking feels dishonest. However, the participants themselves rarely referred to themselves as plasma "sellers," and I did not want to apply any further stigma to their participation via labelling. Ultimately, I settled on the morally neutral term "suppliers."

participants. For their part, plasma suppliers describe their time and compensation like work, but they are hesitant to claim it as such, aware that it does not carry the same social and moral worth as formal employment. This in turn reifies beliefs about the social worth of poor people, which plasma suppliers navigate or reject through moral boundary-making to distance themselves from the stereotypes of poverty as a marker of moral corruption and failure.

I argue that the industry's altruistic framing strategies and compensation structure, coupled with the work-like conditions and stigma of poverty, constitute and reproduce class. Both the industry and the actors involved draw on moral frameworks to reify class in the plasma pharmaceutical market. Within this context, it does not matter if a plasma supplier is actually poor or if market actors truly see the market as altruistic; the outcome is the same.

Body Markets and Inequality

The plasma pharmaceutical industry is part of the larger world of body markets, a term for the market exchange of bodies and body parts. In these markets, economic value is assigned to bodily services and goods, a process known as bodily commodification (Almeling 2011). Body markets are big business. Today sex cells, organs, blood, hair, breast milk, umbilical cords, and cadavers are all legally – though sometimes not[6] – exchanged in complex global body markets mediated by organizations like blood banks and organ procurement agencies. Some body markets like breast milk also exist more

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[6] Black markets for bodily tissues are beyond the scope of this dissertation. For more, see: Goodwin, Michele. 2006. *Black Markets: The Supply and Demand of Body Parts*, New York: Cambridge University Press; Scheper-Hughes, Nancy. 2001. "Commodity Fetishism in Organs Trafficking," *Body & Society* 7(2-3):31-62.

informally via Facebook groups and Craigslist community boards. Whether knowingly or not, "citizens in industrial nations are more and more likely to have some fragment of their body retained in a tissue bank" (Mitchell and Waldby 2006:36). And while body parts have historically been exchanged, gifted, stolen, worshipped, and repurposed for a range of religious and cultural reasons,[7] contemporary exchanges of body parts for money elicits repugnance in large part because of the myriad cultural meanings ascribed to the human body deeming it sacred and inalienable. This dilemma provides a rich intersection for sociologists to reconsider the meanings of money, bodies, and social exchanges, as well as the organizational logics of markets and how participation impacts participants.

Like all American histories, the history of body markets is one of inequality, racism, marginalization, and power. Examining body markets reveals the extent to which they are shaped by beliefs about whose bodies matter culturally and morally, and whose bodies are economically profitable yet socially disposable. Slavery, for example, is arguably the first American body market. Legally deemed property rather than people, enslaved peoples' ascribed economic value fluctuated at every stage of the life course, from conception to death. Age, sex, health, fertility, physique, market demands, and even "ghost values"[8] affected the legal monetary worth of an enslaved person (Berry 2017). Enslavers also marked up the price of childbearing slaves, making enslaved women's bodies "catalysts of nineteenth-century economic development, distinguishing U.S. slavery from bondage in other parts of the world" (Berry 2017:14).

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[7] Anything from "trophies of war, religious relics, therapeutic materials, medicinals and anatomical specimens, among other uses" (Lock 2001:65-66).

[8] Defined as: "the price tag affixed to deceased enslaved bodies in post-mortem legal contestations or as they circulated through the domestic cadaver trade" (Berry 2017:7).

Seventeenth century medicine created a new market for bodies in Europe and the United States. Unlike slavery, this market assigned value to bodies based not on labor productivity but on their usefulness to scientists. Aspiring surgeons in need of cadavers began aggressively seeking corpses for dissection and experimentation. For the first time, the deceased body became a commodity, one that "could be owned privately. It could be bought and sold" (Linebaugh 1975:72). Disenfranchised populations like the homeless and those marked as criminals were most vulnerable to having their bodies stolen and experimented on after death. In England, surgeons attended public hangings, gruesomely fighting with the deceased's kin over possession of the still warm dead body. Graverobbing was also a rampant practice at this time, as was the buying and selling of bodies of people whose families could not afford proper burial (Linebaugh 1975). Medical research deemed bodies of the poor as "socially dead, their commoditized bodies not due the respect given to those of the rest of society" (Lock 2001:67). Similar problems arose in North America where medical institutions disproportionately targeted bodies of Native Americans and enslaved Africans for experimentation and theft. In response to public revulsion, the U.K. Parliament signed the Anatomy Act of 1832 prohibiting the sale of dead bodies, setting the precedent for similar restrictions throughout Europe and the United States.

A long way from those crass experimental dissections of stolen corpses, modern medicine has transformed body markets from markets for whole bodies to markets for fragmented parts and pieces. The advent of effective bodily tissue storage methods in the early twentieth century created new opportunities for physicians to experiment with bodily extractions, transfusions, and treatments, leading to safe blood donation in the late

1930s followed by advancements in organ and tissue donation in the 1950s. This medical technology transformed the human body into “a source of harvestable property,” for the development of “therapeutic merchandise” (Swanson 2014:4-7). Like other body markets before it, this “harvestable property” was disproportionately sourced from marginalized people. Most of the blood, for example, came from “professional donors,” who were unemployed men that routinely sold their blood to for-profit blood centers until payment for whole blood donations ceased in the 1970s (Starr 1998). It was also during this time that doctors acquired countless cell lines from patients without their consent, the most famous being from Henrietta Lacks, a poor Black woman whose cancer cells were used without her knowledge to create the first immortalized human cell line for medical research (Skloot 2010). Legal historian Kara Swanson likens this period in medicine to the 19th century U.S. expansion into western territories, arguing that “on the medical frontier of the twentieth and twenty-first centuries, it is the human body that is the natural resource available for development part by part” (2014:2).

Today’s body markets encompass nearly every body part and tissue one could imagine down to the smallest bit of DNA. Many of us partake in body markets without even necessarily recognizing it. For example, if you have ever donated blood at your church or workplace’s blood drive, mailed a cheek swab to a genetic ancestry testing company,[9] or worn hair extensions made of real human hair, then you have participated in a body market. One of the reasons one may not think of these exchanges as occurring

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[9] As of 2019, 26 million people had contributed a sample of their DNA to four leading commercial ancestry and health databases via genetic ancestry tests like 23andMe, with little to no knowledge of how those companies could go on to use that DNA (Regalado 2019). The amount of information available via that swab of DNA is what Alondra Nelson calls “the ultimate big data,” with unique properties “that deem it suitable for making political claims” (2016:15).

within body markets is because organizations work very hard to create and maintain cultural frames to avoid that ‘yuck’ factor. Some markets, like sex cells and organs, promote altruistic framing by referring to these bodily goods as gifts. Other markets like hair fully depersonalize the product, alienating the supplier from the supplied.

Inequality remains a central component of contemporary global body markets. The transfer of body parts is a “trajectory of power and wealth, as the poor sell their body parts to those with more wealth” (Mitchell and Waldby 2006:8). African Americans are more likely to be organ donors than Whites yet wait the longest of any racial group in the U.S. to receive an organ transplant (Sehgal 2004); transnational surrogacy allows Americans and Europeans to outsource surrogacy to low-income women in developing nations for a discounted cost (Rudrappa and Collins 2015b); and an entire global black market exists for organ theft from poor, marginalized, and incarcerated people around the globe (Scheper-Hughes 2000). Paid plasma donation presents an interesting case to examine inequality within body markets because unlike most other body markets, it combines payment, long-term commitment incentives, routine, and pharmaceutical manufacturing strategically masked by altruistic frameworks.

Morality of the Body

The body is a key site for the inscription of moral codes and beliefs (Appelrouth 2005). Like other aspects of culture, morality is embodied and learned “with and through our bodies” (Wacquant 1998:346). However, morality is also inscribed *upon* the body through morality frames that label certain bodily practices, states, and appearances as morally sound and valuable while dismissing others as amoral, immoral, or impure. Some of these morality frames stem from religious contexts, for example the traditional Christian framing of the body, particularly women's bodies, as "a container of sin" (Shilling 2007).

The body is closely tied to one's class, though the bodily markers of class can be subtler than other forms of social inequality based on, for example, race and sex (Mason 2013). Weathered hands worn from years of manual labor may signal working class, just as pearly white, straight teeth only achievable through orthodontistry signal upper middle or affluent class status. Beyond aesthetic appearance, class may also be inscribed on the body through action and use. Bourdieu (1984) identified the central role that the body plays in the construction of class:

> The body is the most indisputable materialization of class taste, which it manifests in several ways. It does this first in the seemingly most natural features of the body, the dimensions (volume, height, weight) and shapes (round or square, stiff or supple, straight or curved) of its visible forms, which express in countless ways a whole relation to the body, i.e., a way of treating it, carrying for it, feeding it, maintaining it, which reveals the deepest dispositions of the habitus (190).

Bourdieu argued that cultural norms inform the care and use of the body, creating preferences and behaviors that become part of one's class persona and classed body. These preferences and behaviors become legitimated such that "the legitimate use of the body is spontaneously perceived as an index of moral uprightness" (1984:192-3).

Historically, the upper class or bourgeoisie has cultivated their bodies to maintain social power, refining and disciplining their bodies as a way to distinguish themselves from lower or upwardly mobile classes (Elias 2000; Foucault 1990). These practices are historically and culturally specific, as bodily appearance and standards of beauty shift over time and context. Cultivation of the classed body often requires time, money, and resources, all of which poor people do not have. Additionally, exposure to environmental toxins, poor working conditions, low quality nutrition, and inadequate health care access may lead to emaciation, obesity, illness, disability, and poor hygiene, all of which become visible signs marking the bodies of the poor (Mason 2013). As a result, bodies of the poor are constructed as "sites of moral and intellectual lack and of chaos, pathology, promiscuity, illogic and sloth, juxtaposed always against the order, progress, control and decency of the bodies of allegedly 'deserving citizens'" (Adair 2008:1663).

The twentieth century shift from treating disease towards preventing it through preventative medicine and wellness reframed health as a personal responsibility and moral pursuit (Conrad 1994). As a result, structural inequalities that lead to unequal health outcomes are often overlooked, and instead individuals are blamed for their poor health. Bodies considered healthy or fit come to represent discipline, self-control, and evidence of moral virtue, whereas bodies read as unhealthy are seen as undisciplined, irresponsible, and morally failing (Mason 2013; Saguy 2013; Saguy et al. 2005; Saguy and Gruys 2010).

There are some important exceptions. Chronic, long-term illness and/or serious genetic conditions often escape critical moral judgment, in large part because suffering is what Kathy Charmaz calls a "profoundly *moral status*" (1999:367; her emphasis). She explains that "suffering can award an individual an elevated, even sacred, moral status… [it] may also present opportunities to play out the myth of the hero who emerges victorious against all odds" (Charmaz 1999:368). Because these more extreme medical conditions are considered involuntary and blameless, they occupy the top of a moral hierarchy of suffering. Whereas many of the conditions treated by plasma protein therapies like hemophilia would fall into this category, many of the chronic health conditions associated with poverty would not. This moral distinction is most clear when looking at the public rhetoric surrounding Social Security Disability Insurance benefits, which treats indigent people dependent on that cash assistance program as 'undeserving' and potential scammers (see: Hansen, Bourgois, and Drucker 2014).

The Stigma of Poverty

Stigma refers to an attribute that discredits an individual, reducing them "from a whole and usual person to a tainted discounted one" (Goffman 1963:3). Stigma exists "when elements of labeling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them" (Link and Phelan 2001:377). It is interpersonal, relational, and residing in a social context (Major and O'Brien 2005; Reutter et al. 2009). Stigma is also a moral experience, casting individuals who violate core values as moral "others" (Yang et al. 2007). The process of devaluing a social identity – known as stigmatization (Crocker, Major, and Steele 1998) – can be pragmatic and tactical, acting as a means of self-preservation or psychological defense, and can result in the stigmatized person or group feeling vulnerable and prone to exclusion (Reutter et al. 2009; Yang et al. 2007).

People respond to and manage stigma differently, and they do so within their larger social contexts. Cultural and structural contexts shape the "rhetorical and strategic tools deployed by individual members of stigmatized groups in reaction to perceived stigmatization" (Lamont and Mizrachi 2012:366). People can come to believe the cultural stereotypes about a stigmatized group even if they themselves belong to that group and do not personally endorse that stigma (Link 1987; Steele 1997). As a result, members of a stigmatized group may try to pass or conceal themselves or neutralize the stigma (Goffman 1963; Thompson, Harred, and Burks 2003). Even people who might technically be a part of a stigmatized group may resist being exclusively categorized with that group (Ellemers, Spears, and Doosje 2002). This strategy is particularly common among those with a concealable stigmatized identity, which refers to an identity that is socially devalued but can be hidden (Crocker et al. 1998).

Poverty is extremely stigmatized in the United States and seen as a moral failure (Spicker 2007). Nearly half of Americans attribute poverty to poor life choices and substance abuse rather than structural factors (Cato Institute 2019) and believe that poor people "have it easy" because they can access government benefits without working for them (Pew Research Center 2014). As a result, poor people are often held responsible for their poverty, stigmatized as lazy and unwilling to work hard (Cozzarelli, Wilkinson, and Tagler 2001). Poverty stigma is also closely tied to race, with Whites being more likely to ascribe individualistic reasons (i.e., ability and motivation) to one's class status, and they are more likely to dismiss structural factors like racism (Hunt, Croll, and Krysan 2021). This stigma permeates discussions of deservingness which categorizes certain groups of poor people (e.g. people with disabilities, veterans, widows, and children (Mohr 1994)) as deserving of government support while categorizing others (e.g. single mothers, able-bodied men, high school drop-outs, and people with substance abuse problems) as responsible for their poverty and thus undeserving of any assistance (Bullock 2006; Katz 1989; Piven and Cloward 1993; Weiner 1995). As a result, low-income people often fear that others view them “as a burden to society – as lazy, disregarding of opportunities, irresponsible, and opting for an easy life” (Reutter et al. 2009:297).

Deeply aware of this stigma, indigent people must navigate micro and macro perceptions of their identity, often by concealing their poverty, withdrawing or self-isolating, and/or cognitively distancing from it (Reutter et al. 2009). The stigma of poverty is so significant that even people living in poverty may come to believe popular stereotypes about indigent people and will try to distance themselves from those stereotypes through a process called defensive othering. In these cases, people living in poverty often use the same moral boundaries drawn by elites to deny their own class standing. For example, they may deny their poverty by defending their moral standing to dissociate from the “lazy” or “undeserving” people associated with poverty (Shildrick and MacDonald 2013). This process ultimately reproduces inequality by reinforcing the dominant group’s claim to superiority (Schwalbe et al. 2000).

Paid Plasma Donation in the United States

Today there are over 900 commercial donation centers in the United States, most of which are owned and operated by major plasma pharmaceutical companies. Global pharmaceutical companies like CSL Behring and Takeda combine plasma from thousands of people to manufacture plasma protein therapies for the treatment of several diseases and conditions, including primary immune deficiencies and hemophilia. Many of these conditions are rare and chronic genetic conditions that require regular lifelong infusions or injections. Approximately 90,000 people rely on these treatments each year (PPTA 2020). Patients using these treatments are often featured on paid plasma donation center websites, and their stories are highlighted in lobbying efforts to expand paid plasma donation beyond the United States.

Pharmaceutical companies state that they compensate people for their time rather than their plasma. This is debatable, since compensation rates vary from $20 to $50 depending on the amount of plasma extracted. Companies also offer incentives and bonuses based on frequency of supplying plasma. Additionally, the United States allows people to sell their plasma twice a week for as long as they want, three times the rate recommended by the World Health Organization and significantly higher than donation rates allowed elsewhere in the world (World Health Organization 2017).

Yet despite the clear monetary components, the plasma pharmaceutical industry uses altruistic language common in blood and organ donation, referring to plasma suppliers as “donors,” and the centers themselves as “donation sites.” Press releases, websites, and even promotional material inside center spaces often make no mention of payment. Instead, signage urges suppliers to “Donate the Gift of Life!” while discreetly paying them via their personal reloadable debit card directly linked to their “donor” number. Lobbying efforts by plasma pharmaceutical trade organizations looking to expand the industry beyond the United States emphasize the moral responsibility to alleviate the suffering of people in need of plasma-based therapeutics while seldom referencing the people who supply that plasma.

Donors must be at least 18 years old, weigh at least 110 pounds, and must pass a preliminary examination that includes a medical history screening and testing for transmissible viruses like hepatitis and HIV. They must provide their social security number, photo identification, and proof of address. Donors must be legal residents[10] who can prove their identity and residency within a defined donor recruitment area near the plasma collection center. Those living in halfway houses, hotels, homeless shelters, and missions are not permitted to donate. Companies do not track all demographic information, so who sells their plasma is unclear. However, we do know that commercial donation centers are disproportionately located in low-income neighborhoods, suggesting that donation centers disproportionately attract poor and working-class people (James and Mustard 2004; Olsen et al. 2019a; Volkow et al. 2009).

Once approved, plasma suppliers undergo plasmapheresis – the process that withdraws blood from one's body via a long needle placed into an arm vein, then externally separates the plasma from the whole blood, and finally returns the plasma-less blood to the body via the same large needle. The process can take anywhere from 35 to 70 minutes not including wait times, and though the process is quite safe, some people do complain of tiredness, dizziness, an uncomfortable drop in body temperature, and painful injection sites. This plasma is then stored, shipped, and manufactured, a process described by one plasma donation center CEO as, "like, a brewery where you've seen, like, one of those giant metal – it's, like – it's the same kind of container, maybe larger than that" (National Public Radio 2021). The result are pharmaceutical therapies and treatments, many of which treat rare autoimmune and blood clotting disorders.

Though today's donation system is relatively safe and well-regulated, selling plasma is stigmatized. Much like the 'skid-row' centers Titmuss described in *The Gift Relationship,* selling plasma is associated with financial desperation and other 'unsightly'

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[10] Prior to June 2021 COVID-19 related travel restrictions, a loophole did allow Mexican nationals with a B-1/B-2 tourist visa to cross into the United States.

bodily practices like drug use (Kretzmann 1992). One mid-1960s exposé in *New York* magazine reported that commercial plasma centers in Manhattan were filled with “winos, addicts, [the] malnourished, and destitute,” even claiming that a recently deceased body of a plasma supplier was once observed in a center waiting room (Starr 1998:209).

Plasma industry scandals further exacerbate the stigma. The Arkansas Prison Plasma Scandal, for example, saw the international spread of HIV and hepatitis C through pharmaceutical products manufactured using plasma acquired from inmates at the Cummins Prison in Grady, Arkansas between 1982 and 1994 (Chase 2012). More recently, in 2019 the Shanghai Food and Drug Administration ordered the recall of a batch of intravenous immunoglobulin after the Jiangxi Provincial Center for Disease Control and Prevention detected the presence of H.I.V. antibodies (Qin 2019). Poor people’s bodies are already deemed risky, unsafe, and moral failures (Adair 2002); these scandals exacerbate the stigma of selling plasma by associating it with criminality, poverty, and disease.

The Gift that Pays?

In this dissertation, I use the plasma pharmaceutical market to examine how beliefs about morality and class are constituted and reproduced through markets. Class is not just about one’s income or assets; cultural beliefs about social and moral worth also inform class. Building from the premise that markets and morals are interwoven, I argue that cultural beliefs about the morality of classed bodies shape the plasma pharmaceutical market. Specifically, the market crafts its moral palatability using arguments about the suffering of people needing plasma-based therapeutics while simultaneously leaving plasma suppliers (symbolically coded as poor) out of the narrative. In rendering plasma suppliers invisible, this process reifies beliefs about the poor as having little moral or social worth. Treated as low-wage workers engaged in a stigmatized practice, plasma suppliers navigate their participation in the market by creating moral boundaries between themselves and other poor people, thus reifying cultural beliefs about poverty. It is through this iterative process that the plasma market constitutes and reifies class.

I spent two-and-a-half years conducting in-depth interviews, participant observations, and content analysis. I interviewed 38 plasma suppliers in the Minneapolis-St. Paul metro area about their experiences regularly selling plasma. To identify broader institutional patterns in the plasma industry, I also conducted a textual analysis of materials including advertisements, laws, regulations, congressional testimony, medical textbooks, tax codes, donor center websites and newspaper articles. Additionally, I visited two donation centers: one in a busy, low-income urban neighborhood and another in a quiet, working-class suburb. At both centers I underwent the intake process, gathering information about procedures, paperwork, and social interactions. Together, these methods allowed me to best examine the relational work done by both the market and its participants.

In Chapter 2, I lay out my methodological approach and decisions, followed by Chapters 3-5 which address my substantive arguments. Chapter 3 draws primarily from textual analysis and some participant observation to trace the organizational logic of the plasma pharmaceutical market. My analysis reveals that in crafting its moral palatability for public, government, and industry audiences, the plasma pharmaceutical market focuses on the suffering of people needing plasma therapeutics but pays little to no attention to the plasma suppliers themselves. This limited focus is a departure from many other body markets which emphasize the morality of suppliers through celebratory displays like donor banquets and awards. This approach renders plasma suppliers relatively invisible. Inclusion of payment alone does not explain this difference, because even body markets like egg donation which pay women thousands of dollars still emphasize altruism (Almeling 2011). I argue that class – or at the very least the perceived class identity of plasma suppliers – informs this approach, with two outcomes. The first outcome is that the market successfully distances itself from long-standing concerns that targeting low-income plasma suppliers is coercive or unethical. The second outcome is that it renders plasma suppliers invisible, thus further reproducing and reifying classed experiences of invisibility, shame, and minimal social worth.

In Chapter 4 I examine the actual process of routine plasma supplying and how it shapes supplier experiences. Despite legal definitions and industry claims that paid plasma donation is not a form of employment, I find that the industry creates disciplined, employee-like suppliers. I demonstrate that the market does in fact organize its plasma suppliers like employees with schedules, duties, and fees. Suppliers prepare and maintain their bodies and adhere to a twice-weekly donation schedule to maximize earnings. In turn, many suppliers adopt language that frames their participation in terms of work, referring to earnings as “wages” and their bodies as “products,” yet resist categorizing plasma supplying as work because of the shame associated with selling one’s body. These findings signal that precarious income sources like selling plasma commodify already disciplined, classed bodies that only exacerbates poverty stigma.

Finally, in Chapter 5 I use interviews with plasma suppliers to examine their experiences selling plasma and how it informs their beliefs and sense of identity. I argue that selling plasma acts as a form of symbolic stigma coded as poverty and all the negative implications associated with it. I find that plasma suppliers engage in moral boundary-making processes to mitigate their stigmatized experiences. Because selling plasma is so closely associated with poverty, even suppliers who are not low-income must navigate the stigma. I identify three strategies that plasma suppliers use to draw moral boundaries between themselves and other poor people. The first two strategies relate to the cultural meanings that people attach to earning and spending money. The third strategy relies on beliefs about health, cleanliness, and the body. Together, these boundary-making strategies plasma suppliers to elevate their actions and worth compared to other poor people, while ultimately reinforcing many of the stereotypes of poverty.

This dissertation makes valuable contributions to the study of markets, morals, class, and precarity. Beyond these scholarly contributions, this dissertation provides some semblance of visibility for plasma suppliers whose narratives are otherwise lost among academic jargon-laded debates about bodily commodification, poverty, and exploitation. Nor are suppliers’ experiences included in industry discussions. Like Shea pointed out at the start of this chapter, people do not really listen to “us lower to the ground people.” In letting people’s stories and experiences speak for themselves, I hope I have afforded them the dignity and respect they deserve.

Chapter 2

Research Overview, Design, and Methodology

In this chapter I detail the methodological choices I made while conducting this project. I collected data through semi-structured in-depth interviews with paid plasma suppliers, participant observation of plasma donation spaces as well as plasma industry conferences, and a textual analysis of marketing, news, and policy materials related to the plasma pharmaceutical industry. I began initial pilot data collection in fall 2015, but the bulk of data collection occurred over a 2-and-a-half-year period, starting in spring 2018 and concluding in fall 2020. During this period, I conducted 38 interviews with paid plasma suppliers and approximately 20 hours of participant observation in plasma industry spaces. Additionally, I examined approximately 300 print and electronic materials. I also interviewed seven people who donated plasma at not-for-profit blood banks, as well as attended several not-for-profit blood banking drives, fundraisers, and networking events, all of which provided supplemental insight as to how people involved in altruistic bodily donation systems dismiss or look down upon paid plasma donation. Together, these data inform my analysis and arguments in Chapters 3-5.

Case Selection

I began the doctoral program in 2014 with a general interest in medicine, inequalities, and sociology of the body. Having just completed a master's thesis examining how transgender men navigate medical institutions, I had an underlying but unformulated question about the intersections of medical institutions, commodification, and the bodily autonomy of people whose bodies had been socially marked and stigmatized. I also knew that qualitative research aligned well with my curiosity about the human condition and that I wanted to take full advantage of the methodological mentorship available in the University of Minnesota Department of Sociology.

With all of that in mind, I enrolled in Teresa Gowan's ethnography seminar in fall 2015 hopeful that, like her, I too would blossom into an expert ethnographer. Her hands-on approach meant that I could not sit back and take notes about ethnography. Instead, she insisted that everyone in the seminar also be actively engaged in ethnographic data collection so that we could learn by doing. It was through her encouragement, as well as her ongoing motto to "Be bold! Be wrong!" that in September 2015 I began noticing a CSL plasma donation center on my daily commute route. I had never seen a plasma donation center before. Had I only driven past it once or twice, maybe I would not have even noticed it among the strip mall shops and fast-food restaurants lining the road. But at least three days a week, I sat in my car at a stop light watching as people filtered in and out of the building with little external information beyond the large "CSL PLASMA" lettering. A quick Google search of the center led me down a rabbit hole of journalistic exposés on the predatory nature of the plasma industry, but the topic was relatively absent from social science literature.

Using the ethnography seminar as an intellectual playground for brainstorming and feedback, I began a pilot study observing commercial plasma donation centers throughout the Minneapolis-St. Paul region (henceforth Twin Cities). At the time of this pilot study, the Twin Cities had six for-profit plasma donation centers. Every few weeks, I would pick a different center to observe, visiting a total of three centers in a three-month period. I took extensive fieldnotes on my phone in the waiting areas, underwent the donation intake process at each center, chatted casually with staff and suppliers, and recorded voice memos in my car upon leaving. I initially intended to sell my plasma but learned during my first visit to a donation center that I was ineligible because I have small veins that cannot safely sustain the large needle required for plasmapheresis. I did not disclose this at subsequent visits to new centers, nor did I ever identify myself as a researcher. Rather, I continued to undergo the hour-long intake process, up until the point that I was deemed ineligible.

I did not initially intend to take on an entire dissertation project about paid plasma donation. However, once I started really questioning what kind of case I had on my hands (i.e., puzzling (Tavory and Timmermans 2009)), it became clear that examining paid plasma donation provided an excellent opportunity to explore so many of the interests and questions that initially brought me to graduate school, as well as an opportunity to build upon the valuable – albeit limited – sociological research on body markets and bodily commodification. As an understudied market known for its predation on the poor, examining paid plasma donation in the Twin Cities – a region with stark racial and economic inequalities – provided a case for illuminating how marginalized people navigate and make sense of their social, economic, and moral worth. Additionally, because paid plasma donation is overseen by pharmaceutical companies rather than a bodily tissue banking system (e.g., sperm banks, Red Cross, and other not-for-profit blood banks, etc.), this case provides an interesting opportunity to study how money as well as oversight by a distrusted industry[11] shape moral relations within a market.

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[11] A 2021 Gallup poll found that of U.S. business sectors, the pharmaceutical industry is viewed the second most negatively, tying with Oil and Gas and runner-up to the Federal government (Gallup, Inc. 2021)

Overall, I was able to investigate meaning-making processes, boundary-work, and stigma management, and given this focus I adjusted my methodological approach appropriately.

Research Design and Methodology

This project uses qualitative methods and logics. Unlike quantitative methods, which are best suited to questions about populations and generalizability, qualitative methods are best for getting at "the inner experience of participants, to determine how meanings are formed through and in culture, and to discover rather than test variables" (Corbin and Strauss 2008:16). Specifically, my dissertation is a case study, which emphasizes saturation rather than generalizability, and works particularly well for studies of cultural phenomena (Pugh 2013; Small 2009). When done effectively, case study logic is an all-encompassing research strategy that shapes project design, data collection, and analysis (Yin 2002). The case study method works well for research exploring 'how' and 'why' questions, particularly those investigating "the boundaries between phenomenon and context" (Yin 2002:13). Further, it helps researchers understand broader social forces and societal significance (Burrawoy 1998). These methodological strengths align well with my dissertation's focus on examining embodied practices, meaning-making processes, and cultural frames.

Although I once thought of myself as an aspiring ethnographer, I ultimately opted for other research methodologies that better suited my research questions (Lamont and Swidler 2014). In-depth interviewing, with its strength in getting at the "broader, social dimension to individual motivation" (Pugh 2013:43) aligned well with my primary interest in understanding how plasma suppliers make sense of their experiences navigating paid donation. In-depth interviewing allows the researcher to learn about "behavior, [and] also about representations, classification systems, boundary work, identity, imagined realities and cultural ideals, as well as emotional states" (Lamont and Swidler 2014:157). According to Pugh (2013), there are at least four distinct types of information the researcher can glean from interviewing: the "honorable," self-presentation focused on how the interviewee wants to be viewed; the "schematic" which invites the researcher to examine how people use their language to communicate; the "meta-feelings" examining how people feel about how they feel; and finally the "visceral" data focused on the "emotional landscape of desire, morality and expectations that shapes their actions and reactions" (51). All four of these components are critical to understanding the complexity of how people experience and feel about using their bodies to navigate financial precarity.

Of course, one of the major challenges of in-depth interviewing is that to effectively capture these data components, the researcher must juggle the conversation simultaneously along with observations of body language, word choice, pacing, emoting, tone, and shifts in conversation. In sum, they must monitor the situation "logistically and emotionally" (Arendell 1997:342). By observing all of these verbal and nonverbal cues, I "ethnographized" these interviews to piece together how my interviewees made sense of their experiences and how selling plasma fits into their overall sense of self (Ortner 2003).

Interviews alone do not reveal much about institutional patterns (Lamont and Swidler 2014). To better understand the institutional side of the plasma industry, I conducted supplemental observation and content analysis. I looked to other sociological studies of body markets for insight and inspiration and found that many successfully combined in-depth interviewing and supplementary content analysis. This adaptive, mixed methods approach is particularly useful when studying industries that can otherwise be difficult to access as a researcher. For example, to study changes to biomedical policy, Steven Epstein (2007) combined interviewing with an analysis of print and electronic materials ranging from government reports and trade organization materials to newspaper editorials, advertisements, and medical journal articles. Similarly, Rene Almeling (2011) combined dozens of interviews with workplace observation and analysis of written materials and websites to explore the market for sex cells. Both studies demonstrate the usefulness of this mixed methodology, particularly when examining how people make sense of medical marketplaces. In this spirit, I observed spaces like plasma industry conferences, combined with analysis of recruitment materials, websites, advertisements, industry regulations, and policy, all of which provided critical context for my study.

Access and Positionality

Researchers need to be aware of their social, historical, and cultural baggage that shape each component of the research process, including during data collection as well as in the later stages of analysis (Arendell 1997; Best 2003). For me, that meant first considering what it meant to study a stigmatized practice I knew nothing about and that culturally symbolized a social class I did not belong to. In the early stages of conceptualizing this project, I ambitiously sought to take up the call for more carnal sociology (Contreras 2015; Wacquant 2015) by selling my plasma. This proved to be more difficult than expected because I was denied based on weak veins and banned from attempting again at any associated sites for at least three months. I did attempt to sign up for plasmapheresis later at a different center, but the center's stipulation that my blood could be shared with a third party for criminal background checks ultimately felt like an icky moral dilemma, and I declined to go through with plasmapheresis at this site.

Being unable to sell plasma added to a growing list of checkmarks in the "outsider status" column. Sociologists are frequently faced with the challenges of entering research fields of study. Standpoint epistemology urges us to reflect on our production of knowledge within various location and contexts, as well as to resist either treating identity as an obstacle to be omitted from discussion of research design and methodology, or reducing identity to crude measures (like gender, class, and race) without examining how that also shapes their data, analyses, and conclusions (McCorkel and Myers 2003). With that in mind, I was attentive to the many obvious and not-so-obvious ways that I am an outsider both to plasma suppliers as well as the pharmaceutical industry. First, I cannot sell plasma. Second, as a well-educated and arguably middle-class person, I am not the typical plasma supplier. Third, as a university researcher, I was both "studying down" when it came to interviewing low-income plasma suppliers as well as "studying up" by examining the pharmaceutical industry (Schwartzman 1993).

I am also an outsider in less obvious ways. Being racially ambiguous and an East Coaster in Minnesota meant that I never quite felt at ease. During my six years living in Minneapolis, I often felt that the combination of my racial ambiguity with my east coast brashness meant that even if people could not place me, they knew I was not "one of them." I struggled early on in graduate school to pick up on many of the "Minnesota

Nice" social cues and general midwestern communication style. I rather unintentionally learned how to navigate some of these social contexts through a research assistantship at a regional healthcare organization from 2015 to 2016. In this role, I accompanied my supervisor on many in-home interviews, my favorite being when one woman warmly offered us beverages but would not let me have a cup of the freshly brewed coffee because she worried that at 25 years old, I was too young for caffeine. Overall that 16-month period of qualitative research accustomed me to the cultural nuances that would later help me to understand the verbal and nonverbal cues I observed during interviews.

Beyond just being an outsider, I recognized early on that I ran the risk of misrepresenting my research site as one of the problematic "slum ethnographies" creating strife in the discipline (see: Fischer 2014) . Part of what makes studies of the urban poor so problematic is that the researcher can easily center themselves while exploiting poverty for gain (Small 2015). These critiques mainly target ethnographers who earn the trust of their informants over long periods of time. Because I would be interviewing total strangers, there was no pretext or expectations for such relationships. I also had relatively open criteria for interview participants (explained below) and did not screen for class or other identity markers. Although it is impossible to remove all preconceived notions or expectations, designing my study with such open criteria meant that I had few expectations regarding who talked to me. In addition, I have tried throughout this dissertation to heed Mario Small's (2015) advice to write in a way that elicits empathy rather sympathy.[12]

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[12] "If the reader cannot see himself in the teenager out of school, or the undocumented worker, or the single mother of three, then an ethnographic text has failed as an empathetic project, even if it elicits easy sympathy" (354).

Finally, though I was an outsider in several ways, I could very much identify with many of my interviewees' experiences navigating financial precarity while trying to care for a family member. During this project I kept a log of my own subjective and embodied reactions, experiences, thoughts, and feelings. These logs are not part of the formal data analysis used in Chapters 3-5. Instead, they provided a means to care for myself personally and professionally as I witnessed people's pain, shame, self-doubt, and stigma (González-López 2010). Writing down my emotional reactions separate from my field notes and post-interview summary memos allowed me to record my experiences as a researcher distinct from my embodied experiences, which aided reflexivity during the data analysis process.

Data Collection and Analysis

Interviews

I began interviewing plasma suppliers in September 2018 and finished my last interview in May 2020, for a total of 38 interviews. These participants occupy a range of demographic backgrounds and identities. My sample had more women than men, with 24 and 14, respectively. Additionally, 27 interviewees are white, six are Black, three are Native American, and three identified as multiracial. At the time of our interview, nearly half of the interviewees were unemployed or underemployed, with some receiving Social Security Disability Insurance benefits. Age of participants ranges from 25 to 67. Most have no or some college education. All interviewees were assigned pseudonyms.

There was no single straightforward way to recruit interviewees; I could not exactly sit in one of the small donation center's waiting rooms soliciting potential interviewees. Instead, I created a flyer providing a brief overview of the study, qualifications for participation, university affiliation, contact information, and participant compensation. It also included an assurance of confidentiality. I posted this flyer every 2-3 months to Craigslist, as well as on several Facebook discussion boards including groups for generic neighborhood information, gig work, and paid plasma donation discussions. I also posted printed copies of the flyer in public spaces near centers, including nearby fast-food restaurants and public libraries. I kept extra copies of these recruitment flyers with me during interviews, offering them to interviewees who may know additional people interested in participating.

My inclusion criteria were intentionally broad. I wanted to speak with people who had routinely (i.e., more than once or twice) sold their plasma sometime over the past ten years. This time frame allowed me to focus on the current historical moment of the plasma market, as it has grown exponentially since 2005. This time frame also encompassed the 2008 recession, which correlated with a large spike in donor turnout (Wellington 2014). When people reached out to see if they qualified for the study, I asked how recently they had sold plasma and how often they do it. I excluded people who had not been to a plasma center in over ten years and/or had only gone a few times. Because I wanted to conduct in-person interviews, I also limited my study to people living in the Twin Cities region.[13] I was also interested in speaking to people who had previously worked at a plasma donation center, but this was less fruitful. I did interview three people in total who had worked at a plasma center, but all three had also been routine plasma

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[13] Any interviews conducted between March and May 2020 were remote (either Zoom or by phone) due to COVID-19

suppliers as well. In other words, I was unsuccessful in recruiting anyone who worked at a center without also participating in plasmapheresis.

Unlike ethnographers who spend months in a place building relationships and establishing trust, I was an unknown researcher seeking information from total strangers. To aid in recruitment, I opted to offer participants monetary compensation for their time and energy. Payment is tricky, and I was initially hesitant to offer compensation just like the plasma companies central in my study. On one hand, compensation can offset some of the "power imbalance between the researcher and the researcher so that the former isn't the only one in the relationship to benefit directly" (Head 2009:337). On the other hand, payment risks being coercive, particularly for low-income participants who may not feel they can afford to pass up the opportunity for payment. This type of coercion permeates medical and pharmaceutical research (Cook and Nunkoosing 2008). Ultimately, I opted to offer payment as a gesture of recognizing participants' valuable time, energy, and knowledge. Payment was in the form of $25 Visa gift cards, funded through a departmental research grant. The irony of this payment form was not lost on me nor my participants. All of them knew exactly how to use the Visa gift card – including registering it with a pin number as well as how to avoid potential fees placed on the card when used at an ATM – because plasma donation centers pay them via the exact same type of card.

It is a strange experience to be a young woman soliciting calls, information, and in-person meetings from complete strangers. I set up a Google Voice phone number with a Minneapolis-based area code to list on any study recruitment materials. Having this separate number provided a layer of privacy and allowed me to filter all text messages, calls, and voicemails through the Google Voice app. I would return inquiry text messages and calls usually within 24 hours, and I would provide an overview of the study as well as eligibility criteria. Once I determined eligibility, I would then present a series of potential meeting dates and times, as well as potential interview meeting spots for the interviewee to choose from. While no space is neutral, presenting this option allowed them to choose locations that were hopefully convenient or somewhat comfortable.

Over the course of the study, I interviewed people primarily in university classrooms and public library study spaces, occasionally meeting someone at a McDonald's or Starbucks. On a few occasions, interviewees would bring family members or friends along with them unannounced, saying that they had also sold plasma and wanted to participate in the study. In these circumstances, I did an initial eligibility screening, and if eligible I invited them to participate. I did stipulate that all interviews be individual, so any additional participants had to wait for their turn.

I developed and used an interview guide that focused on six areas of interest: the plasmapheresis process; how people started selling their plasma; disclosure among social networks; payment; embodied experience; and finally, basic demographics. I asked participants to walk me through their experiences at the plasma donation center, how they first learned about paid plasma donation, and if they ever invite others to join them. We also discussed more generally how supplying plasma on a biweekly basis impacts their daily routines, diet, energy, and/or social lives. I also asked them about compensation rates and methods, and how they use their earnings. I avoided asking any "why?" questions, instead inviting interviewees to provide examples and stories. Inviting the interviewee to go into story-telling mode allows the researcher "to get past the belief statements, interpret the cultural meanings from the particular discursive choices of language and metaphor participants use to access the schematic, read for the emotional meanings behind the narrative to attempt to glean fragments of the visceral and meta-feelings" (Pugh 2013:54). I ended the interviews with demographic questions about age, race/ethnicity, gender, education, religion, and occupation.

I was aware that my presentation and position as a young female researcher informed power dynamics in the interview. As I explain in Chapter 5, many plasma suppliers are constantly navigating the stigma of selling plasma as well as class-based stigmas of poverty. I wanted to present as professional and legitimate while also minimizing any major imbalances in power that come from differences in class, education, and (presumed) experiences. Instead of pretending I could renounce privilege, which comes across as disingenuous and insulting (McCorkel and Myers 2003), I leaned into my perceived identity as a naïve young woman and someone whose privilege might limit their understanding of precarity. I started each interview by telling the interviewee that I didn't know much about paid plasma donation, and I'd invite them to walk me through it. I quickly learned from the first few interviews that routine plasma suppliers find the process mundane and provided few details. To get past this initial lull in conversation, I would interject with follow-up questions and ask for specific examples. Sometimes I would also disclose that I had tried to sell plasma but had been denied. I shared this information to signal that I was comfortable with paid plasma donation, though interestingly sometimes people would respond by enthusiastically telling me strategies for getting around donation restrictions or barriers.

With consent, I recorded all 38 interviews. Recording interviews allowed me to focus on the conversation at hand, though I did take written notes during interviews about body language, tone shifts, and other nuances I worried would not be captured on an audio recording. Even though the University of Minnesota Institutional Review Board provided an exception for the study, I still provided interviewees with consent forms and details about how the study would be used. After each interview but before returning home, I would sit in my car and use a phone app to record any stream-of-conscious thoughts, ideas, themes, or impressions I initially had during or after the interview. I would also refer to my written notes and elaborate when necessary.

I coded interview transcriptions for emergent themes, with attention to the mental maps people used to explain themselves and their worldviews (Luker 2008). Early themes included shame, precarity, and dignity. I used an abductive process of analysis, balancing deductive and inductive approaches by returning to extant literature to make sense of my initial findings (Timmermans and Tavory 2012). Through this iterative process, I went back and forth between my interviewees' words and the emerging themes, checking my codes and linking them to analytic memos (Pugh 2013). This process helped me to identify the boundary-making, stigma management, and moral framing processes highlighted throughout Chapters 3 through 5.

Participant Observation

Though interviews make up the primary component of my data collection, I did also seek opportunities for participant observation. Because I could not just sit in the donation space taking notes, I would sometimes go to the center during peak hours when lines of potential suppliers were long and extended out to the sidewalks. I would stand in line, presumably just another plasma donor, for anywhere from 15 to 40 minutes depending on that day’s wait time. While standing in line, I might make small talk with others nearby or ask if they knew what that day’s compensation rates were. Other times I listened in on nearby conversations to get a sense of who came with a friend or family member versus who came alone. I would sometimes take notes of my observations on my phone, pretending to text or play a game. When I did not have the privacy for notetaking, I would wait until I left the line and returned to my car to record audio memos like those I recorded after interviews. Overall, these lines were relatively quiet and uneventful; I gained little data from them and ended this form of data collection.

I also observed some plasma pharmaceutical industry spaces during my data collection. It was not easy to gain access to industry spaces. Each year the Plasma Protein Therapeutics Association (PPTA) and the International Plasma and Fractionation Association (IPFA) host conferences for industry leaders, policy makers, doctors, scientists, and patients. Smaller conferences included the International Plasma Protein Congress and the Plasma Product Biotechnology annual meetings. The goal of these conferences is to build trust among constituents, disseminate new research findings and resources, and promote product value. While I intended to attend at least two of these major industry conferences throughout my study, my access was initially limited by the very high cost of attendance. In 2018 and 2019, industry conferences were held in major cities in the North America, Asia, and Europe. These in person meetings charged upwards of $1600 per person just to register, let alone stay at the private conference hotels where all conference activities occurred.

In October 2020, PPTA held their annual Global Plasma Summit meeting virtually due to the COVID-19 pandemic, and lowered registration costs significantly. I attended all three days of this summit held via Gatherly and Zoom platforms. The meeting featured presentations and panel discussions with industry leaders including PPTA's president and CEO, several PPTA board members, industry regulatory leaders in the U.S. and Europe, and directors and managers of major plasma pharmaceutical companies as well as the FDA. Chairs and presidents of several interest groups like the Immune Deficiency Foundation also spoke and participated in panels. In total, I collected 15 hours of observations and hundreds of notes and screenshots of presentation materials and chat window discussion. I coded and analyzed this data in the same way I did my interviews, with additional attention to institutional narrative frameworks.

Textual Analysis

Finally, for the textual analysis I gathered a wide range of materials related to the plasma industry. These materials include advertisements, policies, press releases, website pages, online forums, Facebook groups, publicly accessible interviews with industry leaders, conference presentations, newspaper articles, and senate testimony. For over two years I also subscribed to and received *The Source,* an internationally distributed magazine put out by the Plasma Protein Therapeutics Association semi-annually to share news, information, and advertisements. These documents amounted to over 300 individual pieces of information that I uploaded into NVivo for coding, following a process similar to but more pedantic than coding with my interview and observation data.

For this level of coding, I tracked individual word choice – like ‘donation’ and ‘life-saving’ – in addition to themes.

Supplemental Data

Throughout the course of my research, I was occasionally approached by people involved in unpaid plasma donation. Sometimes these people would come to me via my recruitment materials, but other times through networks and conference presentations. This included seven people who donated their plasma at not-for-profit centers that used plasma for direct transfusion at a hospital. Although these people did not fit my study criteria, I did end up interviewing them and recording their interviews. I did not analyze or code this data, and it did not directly inform my arguments in Chapters 3-5. However, I do include it here because these interviews provided supplemental confirmation about the stigma that surrounds paid plasma donation. These interviewees were eager to tell me about the great altruistic benefits of donating plasma, and they also spoke critically of the paid system in place. Seven is too small a pool of interviewees to make any conclusive statements, but it did confirm I was on the right track early on in my work when I began questioning whether the stigma of selling plasma still exists today.

Additionally, after a conference presentation in April 2019 I was approached by a senior level employee for a not-for-profit blood donation center in the Midwest. He was an audience member while I presented very preliminary findings about plasma supplier experiences, and he was adamant that I learn more about his center and the benefits of altruistic systems. He invited me and a guest to attend a large fundraising gala with comped tickets. I attended and was clear with anyone I engaged with that I was a researcher. I used my phone to take fieldnotes and video and wrote up a summary memo later that evening. Again, this one event does not provide enough data to make large-scale arguments about the moral judgments people place on different plasma collection systems, but like my interviews with unpaid donors it did provide useful added context.

Chapter 3

Organizing Morals, Organizing Class

In September 2015, a circuit judge in rural Alabama garnered national attention when he offered to reduce or dismiss fines and fees for hundreds of offenders in exchange for a pint of their blood. "There's a blood drive outside," Judge Wiggins announced, "if you don't have any money and you don't want to go to jail, as an option to pay it, you can give blood today." A subsequent ethics complaint filed by the Southern Poverty Law Center referred to the ultimatum as "a violation of bodily integrity" (Robertson 2015). National media headlines charged the judge with coercing poor people to sell their blood. Beyond the obvious shock value of a judge trading fines for fluids, the reaction speaks more broadly to how incentivizing blood donation violates the altruistic system culturally upheld as a morally pure act of civic engagement and social solidarity. In sum, the judge's error was suggesting that blood could be exchanged for monetary value.

In this chapter, I examine how the plasma pharmaceutical industry crafts its moral palatability despite violating the strong cultural belief that blood is inalienable. I begin with a brief overview of the false altruism/commodity dichotomy that is frequently used to frame body market debates. Next, I provide historical context on blood banking in the United States, showing how the plasma pharmaceutical market's split from other forms of blood banking created a moral hierarchy around blood donation. This historical background provides an important context for how and why paid plasma donation has been stigmatized, as well as how it came to symbolize poverty and moral bankruptcy. I then show how today's plasma pharmaceutical industry crafts a moral palatability through centralized and cohesive narrative framing that emphasizes patient suffering while rejecting the gift/commodity dichotomy common in other body markets. Finally, I demonstrate how the market's predatory practices and management of their bodies in space reinforces their class positioning while diminishing their moral standing.

The Gift/Commodity Dichotomy

The gift/commodity dichotomy – sometimes called the social versus economic dichotomy – refers to the debate over whether body parts should be treats as inalienable gifts or market commodities. Proponents of structuring body markets as any other commodity system believe that markets should oversee bodily tissue exchange. In a commodity system, suppliers would receive compensation for their bodily tissues, even for nonrenewable body parts like kidneys, as a way to increase the supply of bodily tissues to meet the growing need (Goodwin 2004). For people in favor of the commodity system, markets are the moral answer to what they see as an unethical reliance on altruism that is unable to meet the needs of so many sick and dying patients.

Opponents of the commodity system argue that social relations are threatened, and bodies degraded when markets incorporate bodily goods (Almeling 2011). Nancy Scheper-Hughes, for example, likens commodification of bodily goods to "a new form of late modern cannibalism" (2002:4). They see profit-making from body parts as the ultimate example of how markets can corrupt a society and coerce marginalized populations into participating. This framing adds to the stigmatization of plasma suppliers by implying that they are morally corrupted by financial desperation. Instead, they advocate a gift system that removes money from the equation.

As tempting as it may be to categorize body products in this gift/commodity dichotomy, it is “neither accurate nor useful… [the categories] have been neither distinct nor opposite” (Swanson 2014:9). Additionally, the fear that market logic will infiltrate and corrupt bodily donation implies that bodily donation has always been a selfless, altruistic gift exchange sans market interests or monetary exchanges. Rather, altruistic framing of bodily donation is relatively new. Blood and organ procurement organizations have been so effectively framed body markets as altruistic that it is easy to take for granted that this framing was an intentional, modern effort, decades in the making. For nearly as long as blood donation has existed, so has *paid* blood donation.

Historical Context of Blood Donation in the U.S.

Early forms of blood transfusion at the turn of the twentieth century required a donor body be directly linked to the recipient in a process colloquially called “blood on the hoof” (Slonim, Wang, and Garbarino 2014). The development of effective blood storage methods during the Spanish Civil War (1936-1939) ushered in a new era of blood donation that allowed for less invasive, more diffuse exchanges of blood like what we use today. With the onset of World War II, this safer and easier blood transfusion technology became a key means to care for injured troops. European government propaganda began urging citizens to donate blood at small blood collection centers throughout Europe and northern Africa as a way to support the Allied troops. In this context blood donation came to symbolize a new social contract, one of civic responsibility and nationalism that is still present today, seen in surging donation rates after national crises like the September 11 attacks (Mitchell and Waldby 2006; Starr 1998).

In the post-World War II years, a stark decline in blood donation prompted the sprouting up of unregulated for-profit blood centers across the United States that paid "professional donors" to sell their whole blood. These for-profit centers would then sell that blood to local hospitals, creating higher medical costs that prevented poor patients from receiving necessary transfusions (Starr 1998). While many physicians believed in maintaining blood supplies in hospitals from unpaid donors, the practice of paying donors was so common that at one point professional blood donors in New York City effectively unionized, joining the American Federation of Labor in 1938 (Lederer 2008).

All of this unregulated blood exchange was going on during the so-called golden age of medicine where medical professionals gained nearly monopolistic jurisdiction over the body. The privatization of blood donation did not sit well with the medical profession, and many physicians began operating their own small blood storage systems for patients. Hoping to remove money from the equation entirely to inspire a completely altruistic system, in 1937 Dr. Bernard Fantus from the Cook County Hospital in Chicago adopted the term bank and urged other doctors to as well:

> Fantus had a particular vision of what he was trying to accomplish with his adoption of the term *bank*. By treating blood as money, he was trying to circumvent the need to pay money for blood. His goal was to replace reliance on "professional donors," the common term for paid blood sellers, with a communal system of blood as a shared resource among patients, in which all who used blood also provided blood, continually replenishing the supply. Like his medical colleagues who had worked to make disembodied blood into a life-saving therapeutic in the decades before he set up his blood bank, he was interested in this body product as a fungible commodity – that is, a standardized item that could be bought and sold – but also as a commodity that was under complete medical control. (Swanson 2014:7)

Fantus's goal was to create a banking system for blood, completely under medical –rather than government or commercial control – that would act as a communal resource for all. By using the term 'bank,' he hoped that people would come to see their donations as a deposit, and any future blood transfusions as a withdrawal. Though the term banking stuck, today's body banking is far from the socialized system Fantus and other physicians had in mind.

This mixed methods hodge-podge of blood collection continued well into the mid-twentieth century, when a combination of lax regulation and Blood Shield laws[14] created room for untrained entrepreneurs to open for-profit blood banks. In one of the more notable and legally controversial cases, in 1955 a Houston couple with no prior blood banking experience opened a small storefront in Kansas City, Missouri with a sign reading "Cash for Blood." Local doctors disagreeing with unregulated, paid donation took the couple to court. The court ultimately ruled in their favor, with hearing examiner William J. Bennett proclaiming that the addition of chemicals to the blood "makes the blood something other than virgin human tissue; it becomes a product – more specifically, a drug. As such, it is subject to all laws that govern commerce in the United States, including those that prohibit monopolies" (Starr 1998:195).

Richard Titmuss's 1971 *The Gift Relationship* ushered in a major shift in the organization and framing of blood donation. In this seminal text, Titmuss compared the blood donation system in the United States to that in the United Kingdom. Whereas the

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[14] Blood Shield laws categorize blood and blood products as services rather than products. These laws were intended to protect not-for-profit blood banks from liability and warranty because pathogens in blood create an inherent risk different from most products. In other words, these laws meant that someone could not sue for faulty product if they contracted something from a blood transfusion (Goodwin 2006; Siplon and Hoag 2001).

United States used a mix of voluntary and paid donors to meet its blood demands, the United Kingdom relied on a centralized, completely altruism-based system. Titmuss believed that financial incentives used in the U.S. attracted “skid row” donors, primarily black and working-class, further implying that these groups were less healthy than altruistic donors and thus risked polluting the national blood supply.

> The commercialization of blood and donor relations repressed the expression of altruism, erodes the sense of community, lowers scientific standards, limits both personal and professional freedoms, sanctions the making of profits in hospital and clinical laboratories, legalizes hostility between doctor and patient, subjects critical areas of medicine to the laws of the marketplace, places immense social costs on those least able to bear them – the poor, the sick, and the inept – increases the danger of unethical behavior in various sectors of medical science and practice, and results in situations in which proportionately more and more blood is supplied by the poor, the unskilled, the unemployed (1971:245-246).

Titmuss concluded that the UK’s system produced safer and morally preferable blood, appealing to both a public safety argument as well as a moral one, with racist undertones that appealed to segregationist legislators. His arguments also came at a time when there was increasing concern about how to address hepatitis in the blood supply. He strongly advocated for the United States to adopt a centralized altruistic blood collection system, arguing that it was a critical feature for a democratic, morally sound welfare state: “blood as a living tissue may now constitute in Western societies one of the ultimate tests of where the ‘social’ begins and the ‘economic’ ends” (Titmuss 1971:158). In 1973, the Department of Health, Education, and Welfare announced the National Blood Supply Policy to implement an all-volunteer whole blood collection system (Healy 2006). Fragmented blood – i.e., plasma collection – remained outside the purview of the policy.

Despite its considerable biases and outdated arguments, *The Gift Relationship* successfully created “a framework for thinking about tissue donation and banking that is *still highly influential* in bioethical and health policy arenas throughout the world” (Mitchell and Waldby 2006:13; my emphasis). Because contemporary bodily donation is now so closely associated with altruism, it is easy to take for granted that this altruistic framing was an intentional effort, decades in the making. As a result, body markets that shifted away from unpaid, gifted bodily donations needed to find alternative ways to craft their moral palatability or fly under the moral radar completely.

Crafting the Narrative

Emerging from the historical backdrop of early twentieth-century stigmatized blood collection, as well as their own industry scandals, the contemporary plasma pharmaceutical industry has done extensive image management via organizational framing to craft a moral palatability acceptable to government agencies, market investors, and political partners. I argue that much of the industry’s success is its rejection of the gift/commodity dichotomy. Instead, the industry uses a combination of both frames to craft its moral palatability. In doing so, this framing rejects the ‘hostile worlds’ argument that markets are at odds with morals, instead showing how markets are moral projects.

The most obvious way that the industry crafts a moral palatability is by applying altruistic language that masks commercial components. Plasma suppliers are always referred to as “donors,” and their plasma is always referred to as a “donation.” Advertisements consistently use this altruistic language, while also promoting a framing focused on saving lives for patients in need. This framing is nearly identical to what blood banks use to attract blood donors. In other words, despite breaking off from the blood banking industry at large, the plasma pharmaceutical industry borrows the same altruistic frameworks that so effectively promote blood donation as a moral imperative and civic duty.

Take, for example, the Grifols ad in Figure 1. It uses the imagery of a white military family to evoke patriotism and duty with large print words emphasizing donation and saving lives:

Image A: Grifols advertisement

Blood donation in the United States has always been tied to the military, specifically as a way to support the troops and inspire civic engagement. By using this imagery, the Grifols ad borrows from the social and moral frameworks that blood banks like the Red Cross have strategically crafted for years. This imagery allows paid plasma donation centers to morally align themselves with blood banking and patriotism, while distancing themselves from the connotations of exploitation and the pharmaceutical industry. In addition, featuring a white family in an advertisement for a center located in a majority-minority city[15] creates racial distance between who is perceived to sell their plasma (low-income people of color) versus the image of upstanding, morally upright citizens.

Elsewhere, advertisements for plasma donation centers mimic other themes present in blood banking advertisements. The superhero theme, for example, is a common frame that equates blood donors to real-life superheroes:

Image B: Grifols advertisement

Image C: American Red Cross advertisement

Although the Grifols ad shown in Figure 2 does not have the celebrity status or production value of the American Red Cross's advertisement partnering with the latest Wonder Woman film (Figure 3), it invokes the overall superhero theme to counterbalance the financial incentives for selling plasma. Again, there is no mention of pharmaceutical

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[15] 46.5% of Columbus, Georgia residents are Black of African American compared with 42.5% White residents (U.S. Census Bureau 2021)

intervention or manufacturing therapeutics, just the assertation that “donating” saves lives.

Whereas advertisements and center websites mention payment, imagery within the centers I observed did not mention money. Instead, promotional materials like posters proclaim: “You’re Saving a Life!” and “Give the Gift of Life Today!” Money is overall absent from the physical center space – a topic I address in further detail in Chapter 4 – however the absence of monetary visibility in the space does suggest that once someone is in the center, they must already know about the compensation. In other words, money likely attracted someone to the center, and now once in the space promotional materials urge them to also consider the supplementary moral benefits of selling plasma. A plasma pharmaceutical industry leader confirmed as much when telling Canadian law makers concerned about predatory and coercive payment incentives that: “one should never overlook the fact that a well-educated donor coming into a center comes into contact with information quite soon that shows they’re helping people.”[16]

With hundreds of plasma donation centers in the United States and plasma product manufacturing sites around the world, creating a centralized and consistent narrative is key to the industry’s successful framing efforts. Unlike body markets for sex cells and surrogacy which leave framing up to individual organizations, the plasma industry is governed by an international trade association: the Plasma Protein Therapeutics Association (PPTA). According to its website, the PPTA “represents more than 1,000 human plasma collection centers in North America and Europe, as well as the manufacturers of lifesaving plasma protein therapies.” Among its primary tasks it lists:

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[16] Proceedings of the Standing Senate Committee on Social Affairs, Science, and Technology Issue No 52, December 5, 2018.

(1) advocating for access to and affordability of therapies for patients; (2) engage in constructive dialogue with regulatory agencies; and (3) collaborate with more than 20 patient advocacy organizations." Notably, there is no mention of plasma suppliers. As I demonstrate throughout this chapter, the industry seldom mentions plasma suppliers unless responding specifically to accusations of supplier predation and coercion. Otherwise, their absence from the centralized narrative focused on patient suffering invisibilizes suppliers, reinforcing their moral and classed standing within the market.

PPTA functions as a centralized source for narrative framing and market organization, allowing the industry to craft consistent messaging in law, policy, medicine, and public spaces. One way that they implement this consistent messaging is through up-to-date responses to media coverage. Messaging is formulaic. Between 2015 and 2020 I tracked PPTA responses to news coverage mentioning paid plasma donation (all of which are available through their website). These responses are typically released within 48 hours of the initial news coverage and include narrative components: acknowledgment of news source, acknowledgment of plasma suppliers with a moral framing, and finally a majority emphasis on patient suffering. To demonstrate the formula, I include the following response to a 2018 *Time Magazine* article about teachers supplementing their income by selling plasma:

> In an article published September 14 by Time magazine describing the national conversation surrounding teachers' salaries across the United States, a teacher in Versailles, Kentucky, is profiled for earning supplemental income by donating blood plasma twice a week. The Plasma Protein Therapeutics Association (PPTA) commends the teacher, Hope Brown, for her commitment to empowering the next generation of Americans with a quality education and for her dedication to supporting individuals who rely on access to lifesaving therapies derived from blood

> plasma donations. We are grateful for each of the donations provided by Hope Brown and every healthy, committed plasma donor.
>
> Each of Ms. Brown's donations – along with the 42 million other plasma donations made in the United States last year – will ultimately become medicines for people living with rare, genetic, and chronic diseases. People's reasons for donating plasma are as varied as the diseases treated by plasma protein therapies themselves. Plasma cannot be made in a laboratory, so most rare disease patients who need these therapies rely on plasma donors for their treatments. Plasma protein therapies are truly unique, lifesaving biologic medicines.
>
> While many donors contribute their plasma out of a sense of community support, some do so as a means to ease financial stress or to earn extra income. A 2018 letter from 31 ethicists and economists, including two Nobel Prize winners, explains the compensation plasma donors receive is for their time and inconvenience.
>
> As Jim, who lives with Guillain-Barre Syndrome and Chronic Inflammatory Demyelinating Neuropathy says, "Rare diseases are only 'rare' until they happen to you. Having access to plasma protein therapies saved my life and allowed me to start a career and have a family."
>
> Solyanna is a young woman who donates blood plasma regularly and said, "If my plasma donations can help other people who rely on plasma to treat their diseases, why wouldn't I donate? I want to be a part of improving other people's lives."
>
> To learn more about the diseases treated by plasma protein therapies, and to read the stories of patients and plasma donors, please visit www.HowIsYourDay.org.

Despite the sensationalist headline - "'I Work 3 Jobs and Donate Blood Plasma to Pay the Bills.' This Is What It's Like to Be a Teacher in America" - the *Time Magazine* article has little to do with paid plasma donation (Reilly 2018). Rather, it was part of a cover story called "Teaching in America," highlighting the many ways that teachers are undervalued and underpaid in the United States.

In any case, PPTA's response demonstrates their formulaic narrative construction to crafting a moral palatability in three distinct ways. First, responses begin with an expression of gratitude for plasma suppliers. Second, responses couple altruistic and financial motivations – "while many donors contribute their plasma out of a sense of community support, some do so as a means to easy financial stress or earn extra income" – and then defend compensation. Coupling these motivations together offsets the gift/commodity dichotomy, instead implying that all motivations are morally equal or at the very least morally neutral. This narrative framework also frames plasma suppliers as agentic – "people's reasons for donating plasma are as varied as the diseases treated by plasma protein therapies themselves" – which lessens industry responsibility for predation and coercion. This framing is paired with a sample quote from a plasma supplier promoting the benefits of plasma for patients. Finally, the response pivots to patient suffering, even featuring personal narratives and a separate website created for the sole purpose of promoting source plasma donation.

Pivoting to patient suffering is a key component in crafting the industry's moral palatability. Illness is socially constructed, meaning that culture influences the meanings of illness and how people experience illness within their social worlds (Cockerham 2013). Whereas some illnesses are stigmatized as a marker of poor social or moral standing (e.g., HIV/AIDS), chronic long-term illnesses and conditions considered involuntary or blameless come to occupy a high moral status. Kathy Charmaz (1999) identifies this moral status within what she calls a moral hierarchy of suffering. People with conditions considered "blameless," like genetic conditions occupy the highest moral status within this hierarchy.

Plasma protein therapeutics are used in the treatment of a wide range of conditions, including everyday medicines. However, the industry emphasis has remained on the need for source plasma in the treatment of rare genetic, chronic conditions. This strategy is particularly effective because it aligns with Charmaz's moral hierarchy of suffering. By featuring stories from patients living with severe, rare disorders like the one highlighted in the *Time* magazine response shift the emphasis away from the market's organization and practices, instead emphasizing the moral imperative of the end result.

While press releases and responses are just one way that PPTA can push its narrative framework, global market expansion efforts provide a larger-scale opportunity for the industry craft its moral palatability on the world stage. Most recently the industry has made efforts to expand into Canada, a country that currently uses on an unpaid source plasma collection system largely supplemented by purchasing plasma products sourced from U.S.-based collections. Concerned that for-profit centers will encroach on the altruistic system, in 2017 Canadian Senator Pamela Wallin proposed the Voluntary Blood Donation Act, that if passed would place a federal ban on compensation. A 2019 Canadian Senate Committee on Social Affairs, Science and Technology hearing on the proposal invited testimony from representatives of the plasma pharmaceutical industry. Looking at this testimony provides a contemporary example of how the industry applies both gift and commodity frames to craft its moral palatability.

In his February 27th testimony, Barzin Bahardoust, Chief Executive Officer of Canadian Plasma Resources provided an overview of his for-profit company's operations:

> We… collect plasma from donors for the sole purpose of manufacturing life-saving medications. These are for patients who suffer from immune

> deficiencies, cancer, HIV/AIDS, burns and bleeding disorders. Starting in 2019, we also collect rare specialty plasma which is used to prevent the most common infection from expectant mothers to their babies, known as Cytomegalovirus, or CMV infection. This is a severe infection that can lead to neurological abnormalities, deafness, and even death.

After centering the severe suffering that can be alleviated with plasma protein therapies, Bahardoust argues that Canada's failure to secure a self-reliant system "is the real reason Canada and so many other countries rely on paid donors. It is why no country in the world meets the needs of their patients with a wholly volunteer model." This line of argument rejects beliefs that money and markets are inherently immoral or even amoral. Rather, meeting market demand is the primary moral imperative.

Much of the committee's concerns focused on potential exploitation, providing an excellent opportunity to examine how the industry crafts a centralized narrative about compensation by rejecting the gift/commodity dichotomy in favor of a "both-and" approach. For example, in his testimony to the Canadian Senate Committee, Joshua Penrod, Senior Vice-President of Source and International Affairs for PPTA, specifically addresses accusations of market predation:

> You will hear from the proponents of this bill that private plasma collectors take advantage of donors or are somehow unethical. These concerns are misplaced. *One can still be motivated to donate one's plasma in order to help patients while at the same time receiving a fair and modest compensation* for their time commitment. [my emphasis]

Penrod's testimony challenges the gift/commodity dichotomy, arguing that money and morals are not at odds when it comes to the plasma market. On one hand, he appeals to concerns about plasma supplier motivation, saying that payment does not negate altruism. On the other hand, he frames compensation as a secondary component rather than the primary or sole motivation for someone to supply their plasma.

These narratives are starkly different from what I observed while attending PPTA's 2020 Global Plasma Summit annual meeting. This virtual conference brought together key industry players including regulators, directors, managers, physicians, and interest groups. At any given time, somewhere between 150-200 attendees were logged in for live viewing of panel discussions and presentations. This smaller, focused audience allowed the industry to tailor messaging specifically to industry insiders rather than external critiques like the Canadian Senate Committee.

During one panel discussion about the challenges of plasma collection during a pandemic, a panel of industry directors and pharmaceutical presidents spoke about safety and international trade regulations. Audience members were advised to "tell policymakers about the immediate need for plasma collection and urge them to support regulatory changes that foster plasma collection." During this panel I submitted a question to the live Q&A chat focused on recruitment tactics for meeting this growing need for plasma: "I would love to know more about how the industry reaches out to potential donors. How can they recruit more donors and identify committed donors?" The question went unanswered, notably the only unaddressed question from the panel chat. Instead, this and other panels went on to emphasize lobbying efforts over recruitment methods, and only talked about plasma suppliers in broad strokes as "life-saving heroes" with little attention to who they are and why they participate.

Reifying ("Low") Class

Returning briefly to the Canadian Senate Committee hearing, Penrod fields a question about whether he thinks paid donation will deter people from other forms of unpaid bodily donation. He replies:

> It’s not just the compensation; they go there for an experience… A lot of centers have a social connection inside the center among donors.

Selling plasma is likely not the experience Penrod thinks it is. As I show in Chapter 5, most plasma suppliers intentionally avoid any social connection in the space as a form of moral boundary making. Instead, predatory recruitment combined with the organization of the physical space of centers reify class, which in turn perpetuates the shame and stigma felt by many plasma suppliers.

Both the predatory targeting of low-income communities as well as the design of the spaces themselves reify class. I argue that the plasma pharmaceutical industry engages in predatory practices to recruit and retain plasma suppliers, and those predatory practices reify and reinforce the symbolic classed status of suppliers. As a concept, predation “specifies relations and practices that (i) are based on a subordinated group’s oppression and marginalization and (ii) leverage the group’s vulnerabilities and needs to pursue projects of expropriation, extreme exploitation, and/or dispossession” (Page and Soss 2021). In this case, indigent people are the subordinated group, and the ongoing extraction of bodily tissue for minimal compensation is the project of exploitation.

Once inside the urban plasma donation center, the restrictions, minimal afforded comforts, and monitoring of the space all further reiterate class as well as morality. Like other spaces that limit the personal freedoms and privacy of poor people (e.g., cramped housing, crowded public transit, restrictive public seating), many plasma donation centers are small, uncomfortable, and unaccommodating to crowds. Minimal décor and aesthetic investment mimic other unaccommodating businesses in low-income income neighborhoods. In addition, the presence of security guards, cameras, easily monitored room setups, and messaging about high-risk behaviors and criminal activity all create a moral framing that attaches immoral or criminal behavior with people in the space. These monitoring practices are not standard across all plasma donation centers, but instead they target specific centers, especially those in lower-income neighborhoods. The implication of this surveillance is that poor people cannot be trusted and are instead marked as morally inferior and potentially criminal.

In many parts of the country, plasma donation centers are ubiquitous with the urban landscape. Many are scattered along bus lines or tucked away in strip malls. In El Paso, for example, there are over a dozen centers within the city limits, uncoincidentally all within a 10-minute drive from the Mexico-U.S. border. The Twin Cities has fewer centers, just six, spread out across the metropolitan region. There are two centers immediately within the city limits, both on busy roads easily accessible by public transit, and both in lower-income neighborhoods in Minneapolis and Saint Paul.

For as long as paid plasma centers have existed in the United States, they have been primarily focused on lower income urban spaces. There is little research on the placement of centers, as if their concentration in these lower income neighborhoods is a taken-for-granted fact. One study looking at census tract locations of plasma centers between 1980-1995 found that centers were five to eight times more likely to be in lower-income areas.[17] More recent studies confirm that plasma donation centers are disproportionately and intentionally located in low-income urban spaces (Olsen et al. 2019b). Though the industry has begun extensive expansion efforts over the last decade, putting new centers all over the country in more suburban and rural areas too, plasma centers remain synonymous with the urban landscape.

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[17] The study broke these areas down into three categories: extreme poverty, underclass, and economic deprivation/residential instability. I group them together for ease.

Plasma donation center spaces vary, with some looking like brand new, state-of-the-art clinical settings, and others looking and feeling more like a free clinic. At least in the Twin Cities, these variations correlate with neighborhood location. In other words, nicer facilities exist in the more suburban locations whereas run-down, crowded centers occupy city spaces. Below is a fieldnotes excerpt from my first visit to a suburban center, located approximately 15 miles north of Saint Paul and 12 miles north of Minneapolis:

> Upon entering through the wide doorway, I am taken aback. Directly ahead is a large front reception desk, not unlike a hotel front desk in both size and demeanor. It is loud, but not distractingly so, it's more like a buzzing of conversations, light laughter, and children playing. The lighting is bright but not sterile, and the walls are a calming light blue. Everything looks new, clean, and sterile. The walls are mostly empty, except for a few large images of smiling faces that advertise the company's name. Nowhere does anything even say the word "donation" – and it sure as hell doesn't mention the monetary exchange that happens. [Field notes]

Newly opened center spaces beyond the city limits like the one I describe above provide ample physical space, as well as unexpected comforts like reclining leather seats and large flat screen televisions.[18] Some offer the option to schedule an appointment rather than wait in the first come, first served lines; one center I visited even offered child-care. Unfortunately, none of the plasma suppliers I interview have had such comfortable experiences, as nearly all of them frequent centers within the city limits in busier urban areas. Instead, they are more accustomed to what I find when I visit a center at a busy intersection in Saint Paul:

> The parking lot, located to the side of the clinic, is uneven and filled with potholes. Bars block the entry to a basement door and an unlocked bicycle leans against the building, its seat wrapped in a plastic grocery bag

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[18] I started referring to these centers in my fieldnotes as the mani-pedi-plasma centers, as the seating looked like to that found in nail salon pedicure stations.

> shielding it from the pouring rain. I maneuver the shoddy pavement and make my way inside.
>
> Upon entering the clinic, I spot security guards. The walls are a sallow yellow made dingier by the harsh florescent lights. Red tape with the words “CSL Plasma” creates a waiting line that winds past three glass rooms and a narrow but tall black desk. If movie theatres could procreate with DMVs, this room would be the offspring. Despite this front room’s small size, I cannot tell exactly where this line intends to lead. My noticeable confusion draws attention, as one of two security guards at the door leans towards me and asks, “is this your first time donating?” “Yep,” I reply, and he directs me to bypass the line and go right towards the front desk. [Fieldnotes]

In the center I describe above, six closely spaced plastic chairs are aligned along the front window. Above the chairs, a small piece of scotch tape clings to the dirty window securing a haphazardly hand-written “Waiting Area” sign. I am directed to this waiting area after checking in, a process that requires identification and a social security card, plus a validated address cross-checked with a binder labeled “Unacceptable Addresses.” As I wait in this area, I read the packet of laminated literature that each new supplier receives, featuring information about the plasmapheresis process, as well as a warning that ‘high-risk’ activities like drug use, anal sex, and criminal behavior may disqualify me from supplying plasma. At one point a receptionist leaves his desk posting, walking the 10 feet towards the waiting area to hand me a laminated drawing of a human body with a dry-erase marker. He asks me to use that picture to mark anywhere on my body that I have piercings or tattoos.

Security guards are a common fixture in the more urban locations but absent from the more suburban locations I observed. From what I can tell these are privately hired security guards employed by the center. They monitor the small intake area and make small talk amongst one another, providing little more than their symbolic violence to civilize the space. Above the reception desk is an old security camera pointed towards the small waiting room. I noted security cameras in each of the plasma donation centers I visited, though the newer centers installed dome ceiling cameras, giving the impression that the entire space was watched like a panopticon rather than just the confined waiting room of potential suppliers.

Center staff all wear long white lab coats that provide a cohesive, clinical look. Looking around the space, you would not be able to tell which employees are nurses, phlebotomists, technicians, or receptionists. This cohesion grants a sense of legitimacy as well as codes the space as a medical or clinical. They create the impression of a clinical gaze, though when combined with the presence of security it takes on a different feeling entirely. These white lab coat uniforms, coupled with those of the security guards, create an overall impact of unity among center staff and authority for the monitoring and enforcement of bodies in the space.

Together, the urban donation center creates a highly monitored space where bodies have little space, privacy, or freedom to move about. The tight quarters and dingy setting reinforce what many may come to expect in urban spaces. Neither the private space nor time of the poor is valued. Pamphlets remind donors that this is not a free clinic, and the heavy police presence suggests that this space attracts criminal bodies that must be closely monitored. Much like a DMV or free health clinic, this space reminds everyone present that this is a marked space for stigmatized bodies.

Repugnant practices are often hidden from those that benefit from them (Pachirat 2011). The juxtaposition between the industry’s centralized narrative framework and the reality of some plasma donation center spaces creates an interesting distinction about visibility. Whereas industry narratives focusing on product need and patient suffering ultimately invisibilizes plasma suppliers, the actual center space is an atmosphere of monitoring and policing. On one hand, plasma suppliers are mostly left out of the narrative, and on the other hand once present they are constantly under surveillance.

The industry's narrative focus on patient suffering elevates their moral claims, raising their products to the status of not just necessary but good. This focus also successfully distances the industry from long-standing accusations about the coercive nature of payment and neighborhood targeting. When the industry does acknowledge plasma suppliers, it promotes an altruistic framing but does not center supplier actions in the overall narrative the way that blood and organ procurement agencies often do with their hero-status donors. By rendering plasma suppliers invisible from the larger narrative while simultaneously creating hyper-surveilled spaces that reiterate concerns about criminality and poor behavior, these centers ultimately reproduce and reify classed experiences of invisibility, shame, and minimal social worth. As I explore in the next chapter, the industry's payment incentive structure further disciplines plasma suppliers, encouraging them to adhere to work-like schedules that feel anything but altruistic.

One final but important note in considering the industry's projection of class. The global movement of the plasma itself contributes to the masking of class inequality. In many markets, the transfer of bodily goods and services (e.g., surrogacy, sex work, human hair), typically moves from poorer nations to wealthier nations. However, sourcing most of the world's plasma from the United States masks the classed trajectory of power, wealth, and resources. Buying and selling body parts under the guise of one of the wealthiest nations provides some cover for the classed exploitation that occurs in this global body market.

<u>Chapter 4</u>

Like *Work: Precarity and Bodily Labor*

Tommy (58, white) is a self-described job hopper. He does not like working full-time, he tells me, and prefers to "work two, three part-time jobs" instead. With only a high school education, he has made a living by piecing together part-time jobs for over 40 years. He supplemented his taxi driving income with occasional side gigs like errand running and temp agency work. One of those side gigs, he tells me, was selling plasma on and off for nearly a decade. I ask him what led him to stop, and he relays with simmering anger a story about a phlebotomist who ruptured his vein, turning his arm black and blue.

> They put me in the room with the nurse and a couple other people and they got really belligerent with me and I said, "No, this was your fault totally. It's never happened before." …They were mad, I was mad too… she said I wiggled it in there…and then after that, they banned me for life.

Tommy comes back to this story throughout our interview, each time in a bout of frustration akin to how a disgruntled employee might describe an unjust firing. I ask about that frustration and he later explains that he came to think of selling plasma like a job:

> I would treat it like a part-time job, go there a couple times a week. And I'm self-employed, so I do a lot of side gigs, taxi driving, and errand running and stuff. It's kind of like Uber.

The unanticipated ban prevented Tommy from bringing in that additional income he can come to expect. While every plasma supplier is aware that they can be denied based on a variety of health measures like weight or protein levels, most of them come to expect that they will be able to sell their plasma on any given day, and they often factor that money into their monthly income. And like many other frequent plasma suppliers I spoke with, Tommy had developed a biweekly routine for selling plasma and referred to his compensation as earnings and wages.

Upwards of forty million people in the United States live below the poverty threshold of $12,228 per year (U.S. Census Bureau 2022). While routinely selling plasma twice a week would amount to less than $4,000 a year - hardly a living wage - it does provide an opportunity for supplementary income for many Americans struggling to make ends meet. In a time of growing precarity and inconsistent work, paid plasma donation offers a relatively consistent means for supplementary income akin to a side gig. In this chapter, I explore the hidden work-like conditions of paid plasma donation. I argue that the plasma industry's institutionalized payment and incentive structure – both of which are managed through third-party corporate banking and phone apps – organizes plasma suppliers like gig laborers in the platform economy. Additionally, the industry uses the altruistic framing explored in Chapter 3 to mask the work-like components of paid plasma donation. This concerted masking is akin to the exploitative and "invisibilized labor contract" scholars have identified elsewhere in clinical trial testing and surrogacy (Cooper and Waldby 2014).

For their part, plasma suppliers like Tommy create regular routines and schedules like those observed among gig workers navigating platform labor. To be clear, none of the plasma suppliers I interviewed categorized routine plasma selling as work or employment. However, in the neoliberal era of increasing employment precarity, many plasma suppliers come to treat routine paid plasma donation as like work or at the very least a semi-reliable income. Additionally, many plasma suppliers adopt employment-like language that frames their participation in terms of work, referring to earnings as "wages" and their bodies as "products." One interviewee even joked of unionizing and going on strike to increase compensation rates. Finally, plasma suppliers regularly invest in preparing and maintaining their bodies to maximize potential earnings.

Yet despite the payment structure, routines, and language, plasma suppliers still do not categorize selling plasma as a job, instead framing it a hustle or side gig. This framing is a departure from other body markets like sperm donation and clinical trial testing[19] where participants frequently frame their participation as a job (Abagie 2010; Almeling 2011; Monahan and Fisher 2015). Given all the work that routine plasma suppliers do to care for their bodies and maximize earnings, why are they so hesitant to consider it work? I conclude this chapter by examining how the social and moral meanings ascribed to work – as well as the altruistic organizational framing explored in Chapter 3 – deter plasma suppliers from embracing paid plasma donation as a type of work. Instead, many plasma suppliers come to see selling plasma as either supplemental income or, as one interviewee put it, a "temporary gig until they got a real job." These finding lays the groundwork for Chapter 5 in which I show how plasma suppliers engage in moral boundary-making to distance themselves from the stigma of selling plasma and poverty more generally.

Some of the shame and stigma surrounding paid plasma donation relates to the negative connotations of using one's body to make ends meet. In my analysis, I apply the underutilized category of *bodily labor* to capture the extent to which selling plasma is a form of work tied to the body. Put forth by feminist scholars theorizing about embodiment, bodily labor refers to "work undertaken on one's own body," though some

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[19] Many clinical trial participants self-identify as "professional guinea pigs" or "professional volunteers"

scholars also use it when referring to work on other people's bodies like massage therapy and caretaking (Shaw 2015:961; Twigg et al. 2011). Just as emotional labor refers to the work of managing one's emotions required by certain jobs (Hochschild 1983), bodily labor encapsulates the work done to one's body to maintain it for work. Unlike bodily capital which focuses on investing time, energy, and resources into one's body to increase status and earnings (Bourdieu 1984; Wacquant 1995), bodily labor offers a lens to examine the labor itself and how the intersection of work and the body shape the cultural, moral, and economic value of that labor. A handful of scholars have already begun using bodily labor as a lens for examining body markets, showing how both paid and unpaid donations require extensive labor to one's body that should inform future policy and regulations (See: Shaw 2015; Stoeckle 2018).

I identify two ways that plasma suppliers engage in bodily labor. The first way is by preparing their body through diet, taking care to organize meals and consume an influx in water to maximize protein levels and hydration for successful plasmapheresis. The second way that they engage in bodily labor is by maintaining the body through weight management, blood level monitoring, and a general heightened bodily awareness. Some plasma suppliers link this bodily investment to why they believe plasmapheresis should be compensated, thus demonstrating that the work on and to the body plays a role in how they come to think about the monetary value of it.

At first glance, plasma suppliers' investment in their bodies may make bodily labor seem synonymous with bodily capital. However, there are key differences for plasma suppliers. First, bodily capital leads to economic *and* social status, but there is no social status to be gained in selling plasma. If anything, selling plasma could diminish one's social status. Whereas models and athletes' bodily investments lead to gains in social status, plasma suppliers face stigmatization and often hide that they sell plasma from family and friends, which I explore further in Chapter 5. Second, bodily capital creates the opportunity that when "properly managed, this body is capable of producing more value than was 'sunk into it'" (Wacquant 1995:67). A plasma supplier will never see huge gains from their bodily investments nor reap any other rewards the way one would if exchanging their bodily capital. Instead, these investments allow them to maintain their bodies just well enough to continue selling plasma with fewer side effects or negative consequences. Finally, the successful functioning of bodily capital is reliant on the existence of a 'field' (Bourdieu 1984) or pre-determined space where that capital is valued (Hutson 2013). Even if one were to conceptualize plasma selling as a distinct field – which I think is a stretch – the investment that these plasma suppliers do to insure they can continue selling plasma is hardly a highly valued capital. For these reasons, bodily labor is a more useful and accurate conceptual tool for examining how and why plasma suppliers care for their bodies within a context of work.

Payment and Incentive Structure

The first time I entered a plasma donation center, I was perplexed by the absence of money. Surrounding display signs promoted the altruistic language of donation with no mention of compensation. As I sat quietly in the waiting area filling out intake paperwork, I watched as supplier after supplier left the center without stopping at a desk for payment or at the very least an ATM or kiosk. Finally, I turned to a woman three seats down, asking "hey, this is my first time, how do we get paid?"

“You’ll get a debit card,” she explained.
“No cash?”
“No, it’s all on the card now.”

Unlike the direct cash or check payouts common in plasma donation centers of the 1970s, money is notably absent from today’s plasma center. There are no kiosks, ATMs, cash registers, or check-out counters. Instead, payment transactions bypass the physical center space and are instead managed through a network of banks, phone apps, and software technologies.

Upon a first-time plasma suppliers initial intake approval, they receive a pre-paid Mastercard or Visa card prominently featuring the center’s logo. Some of these cards are directly linked to large banks like Bank of America and Chase. Like a debit card connected to a checking account, this card is their payment account, allowing for direct deposits of their plasma earnings after each successful plasmapheresis session. To use the card and begin receiving payments, suppliers register their card online or via a toll-free number, as well as set up a pin number should they want to use the card at an ATM. Upon activation, plasma suppliers can then download a phone app that allows them to easily monitor their account balance as well as transactions. Given that an estimated 2 million Americans do not have a checking or savings account at a bank or credit union because they cannot afford the minimum balances required (FDIC 2021), it is feasible that for some plasma suppliers, this card serves as their only account with a financial institution.

Prepaid cards are notoriously predatory, with hidden fees and charges that burden the user while benefitting the financial institution. Fees vary; some cards charge a flat rate per usage, whereas other cards charge a percentage for usage and/or monthly service fees. Fees can also vary based on where a card is used, for example a grocery store versus an ATM for cash withdrawal. Most suppliers I interviewed complained about fees, explaining how they learned through trial-and-error how to strategically use their cards to minimize or altogether avoid these charges. These strategies sometimes meant making decisions about how and when to use their money rather than using it freely however they would prefer. Overall, fees range from $0.35 to $3 per transaction. Given how little plasma suppliers receive, a $3 transaction can equate to nearly ten percent of a supplier's earnings per plasmapheresis session, functioning like other predatory fees found everywhere from banking and loans to bail bonds, all of which disproportionately burden the poor with a "poverty tax."

The payment structure also provides a false sense of scheduling autonomy for the plasma supplier. While plasma suppliers are not required to adhere to a strict schedule the way a service worker may need to adhere to a scheduled shift, their earnings do depend on their regularity. The FDA allows people to supply plasma at a twice-per-week maximum, and plasma donation centers aim to have every plasma supplier providing plasma at that rate to maximize manufacturing potential. To meet this demand, plasma centers vary payment amount based on whether it is a plasma suppliers' first or second plasmapheresis that week. For example, a plasma supplier might receive $15 for their plasma on a Monday but will then receive $25 when they go back on Friday. In other words, it pays to be routine and disciplined.

Payment matters for practical as well as symbolic reasons. From a company standpoint, direct payment via prepaid cards or other outsourcing avenues eliminates the costs of check printing, saving a company time and expenses. This payment structure also allows companies to shift fee burdens to the laborer, in this case the plasma supplier. Similar shifts are observed in the platform economy where increasingly workers forgo workplace protections and assume risk in exchange for autonomy and flexibility (Vallas and Schor 2020). Symbolically, payment form also has social intention, shaping social relations (Bandelj 2020). Payment via a prepaid card allows plasma pharmaceutical companies to continue framing payments as gift cards, which are seen as more socially and morally acceptable than cash or check. Finally, this payment process removes the literal exchange of money for body parts in the physical space itself, effectively rendering it invisible.

Finally, just as centers have outsourced payment, they also have increasingly little to do with targeting and recruitment. Instead, they partner with marketing and software companies skilled at recruiting and retaining plasma suppliers. In one advertisement that frequently appears in the industry's magazine *The Source*, biotech company InVita Healthcare promotes chain of custody software technologies that "optimize supply chains and streamline workflows to ensure product availability and quality." Supply chains, in this case, being plasma suppliers. The advertisement promises that their technology can "reach donors on any device and incentivize them to donate again and again." These tools are highly effective, as many people I spoke with mentioned that they may forget or stop going to sell their plasma for a few weeks, only to be notified via their phone apps or email that a new incentive bonus program was available should they return to the center.

The incentive structure also cleverly outsources recruitment to the plasma suppliers themselves, offering bonuses for bringing a first-time plasma supplier with them to the center. Figure 1 shows a coupon-like advertisement on BioLife Plasma

Services' Twitter account promoting bonuses for both the referring plasma supplier as well as the new supplier.

BioLife
PLASMA SERVICES

We have a special offer for you and a friend to say

Thank You!

Please print your name below, give this entire ad to a friend and ask them to bring it to their first donation.

SCHEDULE AN APPOINTMENT TODAY AND LEARN MORE AT BIOLIFEPLASMA.COM

$20
BONUS FOR YOU

Referring Donor (print full name):

New Donor (print full name):

Referring donor will receive a $20 BONUS after new donor completes their second successful donation. Second successful donation must be made within 30 days of initial donation.

STAFF: ENTER THE PAYCODE ABOVE FOR THE REFERRING DONOR ONLY. USE PAYCODE ON RIGHT FOR NEW DONOR.

$120

NEW DONORS PRESENT THIS COUPON AND RECEIVE $120 IN JUST THREE DONATIONS.

Must present this coupon prior to the initial donation to receive a total of $30 on your first, $40 on your second and $50 on your third successful donation. Initial donation must be completed by 12.31.15 and third donation within 30 days. Coupon redeemable only upon completing successful donations. May not be combined with any other offer.

A BONUS FOR YOU!

A BONUS TO SHARE!

Figure D: BioLife Incentive posted to Twitter

Much like employee referral hiring and signing bonuses, using an already existing plasma supplier to recruit new suppliers reduces company marketing costs. In some cases, these incentives are so effective that plasma suppliers take it upon themselves to promote the bonus. Mikey (44, white) for example, found his way to a plasma donation center not from a company advertisement but through a Craigslist ad posted by a plasma supplier.

> Mikey: I seen ads on Craigslist where the places would hire people to recruit people. So they'd put an ad on Craigslist and this person was promising a bonus if you donated so many times, but then again, it was a third party and he was like, I will give you a $50 bonus if you go in and-
>
> Caty: So it wasn't like the company itself, it was like someone else was offering an additional bonus?
>
> Mikey: Yeah. Yeah. Somebody else was trying to recruit people, and then they would give a bonus.

Mikey clarifies that the Craigslist posting was in fact from a plasma supplier looking to bring someone new to the center so that they could acquire the referral bonus. By incentivizing supplier referral, the plasma industry offloads some of the burden to recruit and retain plasma suppliers, instead benefiting from suppliers' desperation or at least enthusiasm for earning an extra ten or twenty dollars. Suppliers interested in this bonus referral will then take on the additional labor of creating ads and coordinating plasma center visits with complete strangers.

Language and Time Management

As seen in Chapter 3, the plasma pharmaceutical industry consistently uses altruistic language, referring to suppliers as "donors," plasma as "donations," and compensation as "rewards." Many plasma suppliers also adopt some of this language – for example by calling themselves "donors" rather than "sellers" or "suppliers" – but when it comes to money, they frame their compensation as "earnings" and "wages." Many share a common sentiment that even though the plasma supplier pool might be diverse, the motivation is always financial. When I ask Kevin (42, white) to explain the general vibe or atmosphere of the plasma center, he tells me:

> We were all pretty, pretty myopic about why we were there, you know, which is why we just want to get out and get paid and get on with the rest of life, you know, it wasn't a recreational or social time, it was, you know, this is my time to do this and make this money and go.

The atmosphere that Kevin describes is task-oriented and payment driven. Nobody's socializing, he emphasizes, and it isn't recreational. Shea shared a similar sentiment, saying "we all know we're there for the money, not because it saves people. We don't really care we just want the money." Shea may have said it the most cynically, but I heard a similar sentiment throughout my interviews, this sense that money drives participation.

When discussing compensation – and I was careful to always use either the term "compensation" or "payment" in my interviews so as not to provide leading language – some interviewees talked about payment in terms of wages.

> Caty: How do you feel about the payment amount and the way that they pay you?
>
> Kathryn: I mean it'd be nice if they didn't take out all the fees. That would be nice. But that's about my only complaint. They make it. I think they make it pretty attractive for what you have to do for it. You know in your first month, I think on your fourth donation, or sixth donation, you get $100. Everyone gets that. So they make it attractive. *And for an hour and a half, that's still pretty good wages*. [my emphasis]

In the above exchange, Kathryn (38, Latina) refers to payments as wages, situated in a context of hourly wages one might expect to hear in conversations about retail or service work. Other interviewees similarly equated their time to their compensation, telling me how they would try to speed up the plasmapheresis process by squeezing a stress ball so that they could maximize their output and minimize their time commitment. Logan boasted about how he got his plasmapheresis time down to exactly 31 minutes, telling me that most people take upwards of 45 minutes, so he was essentially making $40 in just one half-hour.

Many plasma suppliers develop a routine schedule for their twice-weekly visits. For suppliers with full-time employment, their plasmapheresis schedule understandably varied based on their full-time work schedule. For those under- or unemployed, the center's bonus incentive calendar typically dictated their routine. These are calendars that plasma donation centers distribute via flyers and phone app notifications offering plasma suppliers bonus earnings if they come in on specific days. Much like Uber drivers adjust their schedules to drive during surge pricing hours (Chen and Sheldon 2016), a plasma supplier opts to visit the center with the promise of an additional $10 or $20 bonus. These schedules often change from month to month, encouraging plasma suppliers to keep a close eye on their center's calendar. In more than one of my interviews, plasma suppliers had the calendars on hand, either folded up in their wallet or saved to their phone. "You can keep this one if you want," one person told me, handing me the crinkled paper. "It ends in a couple of days and I'll get a new one." For people structuring their time around these bonus incentives, selling plasma takes on a work-like schedule much like a weekly shift schedule at a retail store or restaurant. The constantly changing incentive schedule also demands the supplier's attention, helping to create disciplined, employee-like suppliers responsive to wage schedules. Adhering to the incentive scheduling also allows plasma suppliers to feel like they are engaging with the system, much like platform workers are known to interact with algorithms (Vallas and Schor 2020).

One plasma supplier told me that center employees have their own incentive system:

> Jerry: Matter of fact, they [center staff] donate too when they get done, but they get $50 each time because they work there.
>
> Caty: How do you know that?
>
> Jerry: Because I've seen them, they told me. Sometimes they finish their shift and just take a seat and donate. And the one lady told me they get $50 because they work there.

Having only spoken to a small handful of center staff during this study, I cannot confirm Jerry's assertion. If accurate, however, a bonus incentive program for center staff suggests little difference between staff and routine suppliers in the eyes of the industry, eroding the distinction between formal and informal labor.

Bodily Labor

Preparing the Body

Many of routine plasma suppliers I interviewed spoke about how they would prepare and maintain their bodies to maximize plasma output and thus earnings. Plasma suppliers often begin “prepping their bodies” a day or two in advance of plasmapheresis. “You have to make sure you’re really hydrated,” Jasmine explains to me, “and you have to make sure you eat lots of protein.”

Hydration, as several plasma suppliers explained to me, eases the overall blood withdrawal process. As one person told me, “I really try to stay hydrated so that the puncture’s good.” Hydration can make veins easier to find which reduces the likelihood of a painful injection site, and it can also quicken the overall flow during blood withdrawal thus reducing time spent attached to the machine. Diet, on the other hand, has more to do with maintaining adequate protein and iron levels to reduce the likelihood of deferral. Mark (62, white) built his days around this preparation:

> I’d start in the afternoon of the day before just really hydrating and drinking lots of water because it made everything go much quicker and it was easier. I had to make sure I was buying the right things and eating lots of chicken and cottage cheese and beans and whatever it may be depending on the protein. And sometimes it got to be a little irritating, drinking what felt like gallons and gallons of water.

Like most routine suppliers, Mark visited the center twice a week. With preparation starting days earlier at the grocery store to “buy the right things,” and then dietary and hydration preparation a day prior to every center visit day, one could see how a week quickly fills up. Suddenly a twice weekly hour-long visit to the center can spill over, taking up hours of mental energy and physical preparation throughout the week.

Logan (47, Native American) also planned ahead. When we speak on a Tuesday afternoon, I ask if he has plans to visit a donation center sometime that week:

> Well let’s see, tomorrow, I'll drink probably eight glasses of water. And I'll eat some good food. So then mostly likely I'll go Thursday afternoon. And I'll drink about three, four cups of water, then eat a good little lunch and go in there.

Having sold his plasma regularly for about five years, Logan is what I would consider a seasoned supplier. He has comfortably adopted a routine for preparing his body. Another seasoned supplier, Mary (62, white), has sold her plasma on and off for over a decade. During “on” periods, she would adjust her grocery shopping and consumption patterns to maximize her success at the center:

> You eat a lot of protein. Chicken, fish, eggs, dairy, cottage cheese. Drink a lot of water, which I normally don’t do unless I know I’m gonna donate. I’ll drink 3 bottles of water today, I’m almost done with my second one.

While much of this bodily preparation can be learned through trial and error, the center also encourages this level of bodily preparation. During the initial intake process, suppliers are offered small snacks and water, as well as a printed list of high-protein foods they are encouraged to consume prior to coming in for their next visit. Several interviewees also told me about casual conversations they had with center staff, mainly the phlebotomists, who also encouraged this bodily preparation. This encouragement was especially common when someone faced the risk of deferment for low protein or iron levels. After deferring Jennifer (26, Black) once for low iron levels, center staff walked her through changing her diet to avoid further deferment:

> They just explained some of the foods that have a lot of iron in them. Because I'm anemic, so it can be hard for me to keep my levels up. So now I take my greens and make sure I'm drinking orange juice.

Anemia alone is not reason enough for a permanent deferral or disqualification. Instead, Jennifer and other plasma suppliers navigating iron and/or protein imbalances are encouraged to manage their conditions through nutritional preparation.

Bodily preparation is a commonly recognized component of professional work like modeling (Mears 2011), athletics (Wacquant 1995), and fitness coaching (Hutson 2013). However, these professions all garner social capital from their bodily investments (i.e., bodily capital), whereas plasma suppliers have comparably little to gain from their bodily preparation beyond the increased likelihood of being approved for plasmapheresis on a given day. Rather, plasma suppliers' preparation is more similar to the bodily preparations observed among clinical trial participants who prepare to qualify for potential trials via diet, exercise, and taking supplements (Monahan and Fisher 2015).

Maintaining the Body

Whereas preparing the body through hydration and nutritional consumption focuses on the impending days for plasmapheresis, some routine suppliers also focus on the long-term maintenance of their bodies to maximize longer-term earning potential. A few suppliers I spoke with, for example, talked about managing their weight, because higher weight can yield higher earnings. I was surprised to learn that weight could impact payment, as this is not something clearly listed or advertised on paid plasma donation websites. It also directly contradicts the industry's claim that payment is not linked to the body product, as paying per milliliter is an awful lot like paying for a body product rather than someone's time.

Shea (55, white and Native American) is the first person to tell me that weight can equate to payment amount. Surprised, I ask her to walk me through it.

> Shea: When you get done with the computer test and you stand in line, and then when they do the medical when they test your blood and you do your weight. Because the money you get is based on your weight.
>
> Caty: Interesting. So it's not the same for everyone?
>
> Shea: No it's not the same for everyone cause my roommate he's a slight little guy and he never gets $50 bonuses. He's like, 'man you got $50?' I'm like, 'yeah…"
>
> Caty: Is that your current roommate?
>
> Shea: No, the old meth roommate. He was just a little bit of a thing. I think I'm on the highest tier because I weigh over 175. So I get the most money. So you get paid by volume. So not everyone gets the same amount. And I've gained weight since I've been here, I've gained 20 pounds. Must be the Wendy's [laughter]. When I, I'd like to get down to 177, I'd really like to get down to 150. But then I would get less money for donating.

In our exchange, Shea explains that suppliers are categorized into tiers based on their weight because the more someone weighs, presumably the more plasma they can supply. Weight is highly moralized in the United States, with fatness – like poverty – culturally linked to sloth and gluttony (Saguy and Gruys 2010). Combine that with the gendered expectations for women to maintain a lower weight, and Shea is weighing (no pun intended) her physical comfort and self-esteem with her earning potential at the plasma center. It's a challenging predicament, she explains, because she would like to lose the weight she has gained since moving to Minneapolis three years prior but does not want to risk losing that extra plasma money.

Corey (36, white) on the other hand, tells me that he struggles to keep his weight up. He tells me, “I have a problem with the weight, weighing 150.” I ask him why that’s a problem and he explains:

> If you don't weigh exactly 150 pounds, say if you went in there and weighed 149.5 or 148.5, you'll get $20. Yeah, yeah. You get $20. But then if you weigh over 150 you get $25.

That extra five dollars is enough of a difference for him that he came up with a creative work-around:

> I went, got me a napkin, and I put about three rocks in one pocket, three rocks in the other pocket, and then I went and weighed 154.

Seeing the look of surprise on my face, he elaborates:

> Corey: Then after I just went into the bathroom and put the rocks in the garbage can. See cause if you don’t weigh over 150 pounds, you get $20. Then your second donation, instead of $45 you get $25. So it’s a big difference. And I weigh 154, between 148 and 154, all the time. So I put the rocks in my pockets numerous times.
>
> Caty: And nobody noticed?
>
> Corey: Nope, I couldn’t believe it. One time I weighed, God, I weighed 144. I went to Target and I got this weight thing I put along my waist. I didn’t realize it was like, 20 pounds. I went in there weighing, gosh, another 18 pounds. There’s no way I could gain 18 pounds in two days [since my last plasmapheresis]. And I thought they were going to say something to me, but they didn’t say nothing.

Shifting from rocks to purchasing a weighted belt marks a shift to financially investing in bodily equipment to maximize earning potential. Manipulating his weight to move up in tiers and thus increasing his plasma output also puts his body at extra risk for exhaustion, something he notes later when telling me he tries to spread out his plasmapheresis to every three days instead of two because “it really takes a lot out of you.”

Other long-term routine plasma suppliers spoke similarly about gaining a heightened bodily awareness. Coco (26, biracial), for example, started mentally tracking her iron and hemoglobin levels each time she visited the plasma center, noting which times of day were best for her body:

> I'd do everything I needed to do the keep myself up to par… and I'd try going in the morning. I found that my levels were better in the morning. By the afternoon everything was dropping.

Every single one of my interviewees spoke similarly about their "levels," sometimes also calling them "marks" (e.g., "I kept a rigid schedule to keep my marks up"). By levels and marks, they mean data measured at each visit, things like weight, protein levels, hemoglobin, and sometimes blood pressure. I knew little about these measures, so whenever the topic arose, I invited interviewees to elaborate and take on the expert role in our conversation.

Whereas some plasma suppliers I interviewed did not experience any long-term side effects, others explained that regardless of whatever bodily preparation or maintenance they put in, they would still have to take breaks from plasmapheresis. Tammy (61, white) for example, seemed annoyed when I asked her why she took long-term breaks from the center, as if the reason should be obvious: "well you get tired. I have to give my body a rest. It wears you down, you're tired, after a while you need to stop."

It is all this added body work that some people argue justifies the compensation. James (53, white), put it best:

> Caty: Would you continue doing it if you weren't compensated?
>
> James: No, I don't think so. It's nice helping people but I do it for the money. Because it takes a lot out of you, and I have a whole process just

> understanding what I ate, and how much I drank. And it can take a lot out of you.

For James and several other plasma suppliers, caring for their body as well as taking on the physical strain of plasmapheresis justified financial compensation. After detailing the physical drain that routinely supplying plasma took on her body, Jennifer came to the same conclusion: “I just don’t feel like it’s enough.”

Not Work / Work ‘Like’

In its simplest form, employment is defined as “work that produces earnings” (Kalleberg 2009:2). From the payment structure to the ways that plasma suppliers adjust their time, language, and schedules, routine paid donation shares much in common with platform labor and other forms of precarious work. The work-like conditions of paid plasma donation are significant enough that several legal cases have successfully argued that refusal of some potential plasma suppliers is a form of discrimination and denied income.[20] For its part, the industry uses technology as well as incentive programs to recruit and retain plasma suppliers, transforming them into disciplined worker-like suppliers. Yet despite its many parallels to work, plasma suppliers remain hesitant to categorize it as work, instead telling me it’s “like work,” or a “temporary gig until they get a real job.” Why do plasma suppliers – even after describing their schedules, routines, budgeting, and the energy that they invest in their bodies – cringe at the implication that selling plasma is work?

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[20] In one recent case, for example, the Minnesota Department of Human Rights sued and successfully won a case against CSL plasma for unlawfully denying a transgender woman and non-binary person from selling their plasma on the grounds of denied income (Johnson 2021).

Despite arguments that interviews only provide surface level information about individual motivations (See: Haidt 2005; Vaisey 2009), contradictions between what people say versus what they do provide some of the richest data for understanding how people make sense of themselves within their social worlds. These contradictions provide "powerful tools for highlighting the emotionally charged – what is emotionally difficult to claim, where anxiety lies, and what sort of cultural problems people face for which they need to reach for such contradictory explanations" (Pugh 2013:48).

Many plasma suppliers I spoke with point out that earnings are substantial but not enough to depend on. Ironically, in this era of neoliberal precarity, many jobs do not provide sustainable income, leading many to take on additional sources of income through gig labor like ride-hail apps and AirBnB. Over 55 million U.S. workers – that's over one third of the American workforce – participate in the gig economy, many of whom take on that work to supplement another income.[21] There is a level of intimacy to this form of supplementary earning. People share their cars and their homes with total strangers, just as with plasma they share a part of their bodies.

> Caty: So do you treat it like a job or like something else?
> Tammy: No, no, it's definitely not a job.

I prompt Tammy again, asking, "if it doesn't feel like a job, then what does it feel like?" She shifts in her seat, eyes looking around the room momentarily before settling back to me with a sigh as she explains:

> I feel like a loser when I go. I don't feel financially, socially successful when I go to plasma, because I'm selling a body part for money because I can't, I don't have my shit together enough to be financially successful without it.

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[21] https://www.reuters.com/world/us/exclusive-us-labor-secretary-says-most-gig-workers-should-be-classified-2021-04-29/

Selling plasma weighs heavy on her self-esteem. In airing her frustrations to me, whom she has (correctly) pinned as someone who cannot fully empathize with her experiences of poverty and shame, Tammy ties together so many components of the classed experience in the United States. First, she links financial and social success, treating them as synonymous. And she's not wrong; the U.S. class system's meritocratic framework loves to push the idea that everyone is personally and morally responsible for their class position (Cech et al. 2010). Second, she emphasizes that she's selling a body part, fully aware that to use the body to make money is considered a desperate and immoral – or at the least amoral – act. Selling is different from earning; earning has a moral implication, tying an honest day's work to one's dignity and self-respect. Selling, on the other hand, feels cheaper, passive, and desperate. Each time Tammy goes to the plasma donation center, she is reminded of these perceived shortcomings and the social expectations to be "financially successful without it." Her bi-weekly visits to the center remind her of those perceived shortcomings, leaving her feeling like a "loser."

The plasma pharmaceutical industry benefits from attracting people like Tammy who feel a shameful lack of economic success and stability. Predation allows powerful institutions to leverage a marginalized group's vulnerabilities to achieve exploitation (Page and Soss 2021). In addition to the predatory targeting of low-income communities I addressed in Chapter 3, the industry also employs several predatory strategies and techniques like those used in the platform economy to recruit and retain plasma suppliers. However, instead of wholly treating plasma suppliers as a workforce, they instead pair this work-like structure with altruistic framing observed in other body markets like surrogacy as a way to discourage complaints and discipline participants into a "docile and compliant labor force" (Hovav 2019:281). Strategically applying this altruistic framing has the added effect of minimizing claims of exploitation by ultimately arguing that plasma suppliers are engaged in voluntary exchanges based on autonomous decisions.

For plasma suppliers, routinely selling plasma to make ends meet creates a moral crossroads that merge cultural beliefs about work, morality, and social worth. Many suppliers create work-like routines and adopt employment-like language, as well as engage in bodily labor to maximize earning potential, yet ultimately, they reject the implication that selling plasma could be called work. Rather than claim a sense of pride or agency like clinical trial participants who come to see their participation as employment (Monahan and Fisher 2015), some plasma suppliers even experience guilt for participating in bodily donation for what they call "the wrong reasons" (i.e., money instead of altruism). This moral dilemma creates an opportunity for moral boundary-making as a stigma management strategy, which I examine next in Chapter 5.

CHAPTER 5

Stigma Management Via Moral Boundary-Making

On Tuesdays and Thursdays just before dawn, Mark (62-years-old, white) leaves for work an hour and a half earlier than usual, hoping he has carved out enough time to beat the line that typically gathers outside the neighborhood plasma donation center as it prepares to open its doors for the day. His coffee in hand, he and a dozen or so others file in at 6:00 am and make their way to one of the waiting room kiosks to check in. Mark answers a series of standardized questions – all of which he has memorized by this point – and shortly afterwards a center phlebotomist escorts him to the donation area beyond the waiting room. Once done with the plasmapheresis process, he rolls down his sleeve, effectively hiding the small indentation forming just inside the crux of his elbow from months spent routinely selling plasma. From there he heads to his executive level office at a regional nonprofit, never mentioning to anyone that despite his middle-class income, impressive job title, graduate degree, and 401k, he's been selling plasma biweekly for years to stash away an emergency fund to cover expenses for his disabled wife. He doesn't mind doing it, he tells me, but "I never told anybody or shared that I did it," explaining that people have all sorts of negative beliefs about people who sell their plasma. Perhaps that is why he requests to speak with me in his office at 8 a.m., well before other his coworkers arrive.

Mark is one of the few plasma suppliers I interview who has a college education and a middle-class job. Because of that, he is not whom one thinks of as a typical plasma supplier, yet he tells me that when he's at the center early in the morning, many of the other suppliers look like him – seemingly employed, working professionals, and maybe middle class too. However, regardless of who actually visits the plasma center, the stereotype of a plasma supplier is so culturally engrained in the American imagination that Mark feels he must hide his participation from coworkers and friends. He explains:

> There is kind of this undercurrent of why people donate or who donates. And I think that maybe I was concerned that people would feel that, you know, I was hanging out in a place filled with homeless people who were, you know, trying to get enough money to do whatever. And the interesting thing was I never felt that when I was in there. The people were all lots of professionals and working people and I think that a lot of people who just were doing the same thing I was you know, this is a way to make 400 bucks this month. But I never told anybody or shared it, I just never felt comfortable doing that.

Selling plasma is stigmatized, associated both with financial desperation and with using one's body for economic self-interest. Every one of the 38 plasma suppliers I interviewed identified payment as their primary motivation for going to the plasma center, but there remains an underlying anxiety about what that need for extra cash means about them. Mark, for example, does not want people thinking he's there "trying to get enough money to do whatever," presumably implying to buy drugs or alcohol, as that is the cultural and moral perception of poverty, especially homelessness.[22] Selling plasma becomes a marker of financial desperation, carrying with it the moral weight of shame and stigma.

Stigma is about more than one action or practice; it is about social identity. Though "plasma supplier" is not exactly a salient identity or category, it does signal membership to the broader category of poverty. To capture this signaling, I conceptualize the stigma associated with selling plasma as *symbolic stigma*, meaning that selling

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[22] People without confirmed addresses – aka unhoused people or those living in shelters – do not qualify to sell their plasma. Most people don't know that though, demonstrating how powerful that false stereotype is.

plasma comes to symbolize poverty and financial desperation. As a concept, symbolic stigma emerged from the study of AIDS to better capture the stigma tied to the social meanings attached to the disease. Just as AIDS came to represent "a vehicle for expressing a variety of attitudes… toward the groups perceived to be at risk for AIDS" (Herek 1999:1110), so too does selling plasma come to represent poverty and all of the social meanings – including moral – attached to it. Poverty may be a challenging category to define, but it is a salient and highly stigmatized category in the United States. Whereas one could easily hide that they sell plasma, poverty is much less discrete, visible everywhere from housing and education to food and clothing. The symbolic stigma of selling plasma is so closely tied to poverty that it exists regardless of the actual class demographics of plasma suppliers.[23]

In their efforts to minimize or avoid the impacts of stigma, members of stigmatized groups often engage in boundary work, a process that allows them to manage how and when they claim group membership (Lamont and Mizrachi 2012). These boundaries can be symbolic, referring to "conceptual distinctions made by social actors to categorize objects, people, practices, and even time and space" (Lamont and Molnar 2002:168). Moral boundaries are a type of symbolic boundary focused on the moral distinctions between groups to foster in-group identity formation and solidarity (Adler 2012; Bailey 2008; Ecklund 2005; Edgell 2012; Edgell et al. 2019; Ghaziani 2011; Guenther 2014; Kato 2011) as well as exclude others as outsiders or outgroups (Bail 2008; Edgell et al. 2016; Jaworksy 2013; Silva 2017). In these contexts, morality can be

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[23] Data which, to this day, does not exist. For all we know, the plasma supplier pool is made up of wealthy elites. It's not, but comprehensive data does not exist to prove otherwise.

used as an “alternative measuring stick” for people from low social and economic status to judge themselves against others (Lamont 2000:147).

I found that plasma suppliers create moral boundaries to mitigate their experience of symbolic stigma and distinguish themselves from poor people both outside of *and* within the plasma donation center. They draw these moral boundaries using cultural frames already embedded in the U.S. class system deeming individuals as personally and morally responsible for their class positioning (Cech et al. 2010). In doing so, they engage in defensive othering, meaning that they “accept the legitimacy of a devalued identity imposed by the dominant group, but then say, in effect, ‘There are indeed Others to whom this applies, but it does not apply to me” (Schwalbe et al. 2000:425). The emphasis on morality allows plasma sellers to maintain self-worth while locating themselves above others of similar social and economic status.

I identify three strategies that plasma suppliers use to draw moral boundaries between themselves and other low-income people and poverty more generally. The first two strategies relate to the cultural meanings that people attach to earning and spending money, and the final strategy relates to moral meanings attached to health and the body. In the first strategy, plasma suppliers compare selling plasma to other activities poor people engage in to *earn* money. These comparisons relied on stereotypically negative, socially immoral, and/or illegal activities like sex work, panhandling, and drug dealing. By deeming their earning methods as morally superior, plasma suppliers distinguish themselves from how other low-income people earn extra money through amoral or immoral means.

Whereas in the first strategy plasma suppliers compare themselves to non-plasma suppliers, people also felt a need to distance themselves from other plasma suppliers too. In the second strategy, plasma suppliers distinguish themselves from other plasma suppliers they encounter in the donation space based on how they *spend* their earnings. Relying on stereotypes of plasma suppliers as drug users and alcoholics, the plasma suppliers I spoke with emphasized that unlike plasma suppliers with substance abuse issues, they use their earnings as supplemental income for gas, groceries, and childcare products, all of which they frame as a moral use of that money. This process of monetary differentiation is called earmarking, and allows people to "create, maintain, negotiate, or sometimes dissolve their social-economic relations by searching for appropriate matches among distinctive categories of social ties, economic transactions, and media of exchange" (Bandelj, Wherry, and Zelizer 2017:6). Mark's use of his earnings to fund his wife's medical care is a great example of earmarking. By earmarking their earnings, plasma suppliers acknowledged the stereotypes associated with selling plasma while distinguishing themselves as morally superior to it based on how they spend their earnings. For some plasma suppliers, earmarking had the additional effect of justifying or at least neutralizing any guilt or apprehension they had about selling their plasma regularly for financial rather than altruistic reasons.

The third strategy relies on beliefs about health, cleanliness, and the body. Plasma suppliers suggest that selling plasma means that they are healthy, and they use this qualification to distance themselves from other poor people who are unable to sell their plasma. There are numerous reasons why someone could be refused from selling plasma, many of which could be completely out of someone's control.[24] However, by using their qualification to regularly sell plasma as a measure of their health status, plasma suppliers accept and reaffirm the cultural beliefs that health is a personal, individual, and moral responsibility well within one's control (Crawford 1980). It is within that context that bodies considered healthy or fit come to represent discipline, self-control, and evidence of moral virtue, whereas bodies read as unhealthy are seen as undisciplined, irresponsible, and morally failing (Mason 2013; Saguy 2013; Saguy et al. 2005; Saguy and Gruys 2010). Within this context, some plasma suppliers also emphasize that they are drug and disease free, invoking a sense of 'cleanliness' that carries with it its own sense of moral purity (see: Ignatow 2009). By using distinctions about health and cleanliness, the plasma suppliers I spoke with reinforced cultural beliefs that bodies of the poor are unhealthy, irresponsible, and unhygienic. This form of boundary work was especially important for the plasma suppliers receiving Social Security Disability Insurance benefits, as they must navigate the additional stigmas of government assistance and disability status by showing how their bodies are "healthy enough" for plasmapheresis.

Not every plasma supplier experiences stigma the same way. Experiences and reactions vary based on one's multiple stigmatized identities as well as the visibility of those identities. Whereas middle-class Mark uses moral boundary work to distance himself solely from the symbolic stigma of selling plasma, many others described below must work much harder to distance themselves from the intersecting stigmas of poverty, disability, unemployment, and the moral failures culturally tied to those statuses.

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[24] My own rejected attempts on the grounds I have tiny veins, for example.

Moral Earnings

In each interview, I ask plasma suppliers to walk me through their compensation: how does the center pay you and how much? Is it enough and are you happy with the payment methods? How do you use this money? Do you have to pay taxes on it?[25] As Shea describes how selling plasma fits into her weekly routine and finances, she begins comparing selling plasma to other activities that low-income people engage in to make extra money, namely panhandling.

> *Caty*: How do they pay you?
>
> *Shea*: Well 30 years ago you'd get a little paper check. Now it's on a debit card, and as soon as you're done, money's on there.
>
> *Caty*: Does that method of payment work well for you?
>
> *Shea:* It's handy because then you can tell the beggars, 'no, I don't have any money.'

Shea is referring to the handful of homeless people who routinely linger around the outskirts of the plasma center, hopeful that recently paid plasma suppliers might spare them a dollar or two. The placement of many plasma centers within urban landscapes means that plasma suppliers are likely to encounter other people marked by poverty at nearby bus stops, fast food chains, and bodegas. Shea talks about them with contempt, a tinge of frustration if not disgust in her voice: "They're everywhere…I tell them 'get a job, quit doing drugs.'" Shea herself doesn't have a job, as a series of chronic medical conditions have left her unable to work and dependent on Social Security Disability

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[25] People were quite surprised and amused when I asked about taxes. Some tax codes suggest that plasma suppliers should be declaring their earnings on their taxes, but there is no information at centers about claiming these earnings and I got the impression that nobody I talked to had done so nor would consider it.

Insurance, yet throughout our hour-long interview she continues creating a distinction between selling plasma and asking for money.

Panhandling is a very public, corporeal display of poverty. It is a “deviant activity, engaged in by the stigmatized poor, that carries significant costs and is disapproved of by the majority of citizens” (Lee and Farrell 2003:300). Though panhandling and selling plasma are both within the domain of shadow work that falls outside the formal economy (see: Snow and Anderson 1993), for Shea there are important distinctions between these two practices. “At least I’m doing *something*,” she says about selling plasma, “and I’m not doing anything illegal.” Rather than align herself with other poor people struggling to make ends meet, she distances herself from the stigma of poverty, creating a clear boundary between how she uses her body to make money versus how others use theirs.

The boundaries that Shea draws between herself and the panhandlers she encounters are emblematic of the stigma felt by those navigating poverty and the defensive othering strategies used to navigate it. Unlike Mark whose only proximity to poverty is the symbolic stigma of selling plasma twice a week, Shea has been navigating poverty and poverty stigma for most of her life. Her shame is palpable throughout our conversation as she explains how she first started selling plasma on and off in the early 1990s as a single mom caring for a special needs teenage son. Shea’s identity is more closely intwined with poverty than Mark’s, and it is that close proximity to extreme poverty that spurs Shea’s defensive othering. In other words, Shea fits many of the stereotypes of poverty that Mark distances himself from. The closer one is to a stigmatized, exploitable identity, the harder one works to distinguish themselves from it, and in doing so they actually reinforce the negative stereotypes imposed from a dominant group. Just as homeless men may refer to other homeless men as “lazy bums” (Snow and Anderson 1987), Shea takes any chance she gets to remind both me – “at least I’m doing something” – and the poor people she encounters outside the center – “I tell them ‘get a job’” – that she is different and not like other poor people earning money through amoral or immoral means.

Like Shea, many other plasma suppliers compare themselves to the poor people they encounter outside the donation center. Some reference the center’s location and express discomfort with its surroundings. One woman tells me that she used to hate visiting a particular center in the evenings after work: “I was afraid someone would mug me for my money, because back in the day you’d get cash.” Other interviewees similarly mention neighborhoods and people on the periphery of the donation center. These descriptions serve as important reminders about the visibility that these centers have within the urban landscape. For people who do not sell their plasma or live nearby, paid plasma donation is out of sight and out of mind. However, for those who do sell their plasma, the center space can act as a physical boundary between themselves and the poverty immediately surrounding it. Even though none of my interviewees had personally experienced any altercations or knew of any other plasma suppliers who had, they still had this general sense that people immediately surrounding the center space might pose a violent and criminal threat.

Comparisons and moral boundary-making extended beyond the people within the periphery of the center. Some interviewees hypothetically compare selling plasma to illegal or illicit practices. Shea introduced yet another comparison as we discussed the stigma of selling plasma.

> *Caty:* Tell me a little more about the stigma you said you feel like is attached to [selling plasma].
>
> *Shea:* There definitely is one. I mean I wouldn't spread the word about it… I do feel like, it's a last resort. Well no, cause I could be a prostitute. That would be the absolute last resort [*laughter*]. It is one step better than being a prostitute, [but] you probably don't make as much money.

Like many other people I spoke with, Shea's hesitation to tell other people in her life that she regularly sells plasma is a way of avoiding the stigma associated with it. As if to make herself feel slightly better as she discusses her shame, Shea uses sex work as a moral yard stick with which to measure selling her plasma. She implies that both bodily practices are desperate forms of selling one's body, falling in the category of last resorts. However, in distinguishing selling plasma as "one step better" than sex work, Shea uses these bodily practices to creates a boundary that gives her a moral leg up (however minor).

Hernán, a 31-year-old Afro-Latino man who sold his plasma twice weekly over a three-year period, compared selling plasma to selling drugs:

> I'm not out there, you know, selling, dealing. I used to, back in the day, but not anymore. Now, I have kids, I got my life together. I don't do that anymore.

He's forthcoming as he paints a detailed picture of how he sold drugs for several years and engaged in other illegal street activities in his early twenties, but "put that behind him" after suffering a gunshot wound to his leg. Though Hernán doesn't particularly like selling plasma given his fear of needles, he frames it as significantly better to previous ways he made money. This distinction is clearest when he talks about fatherhood, frequently reiterating that he “got his life together and earns an honest living” to make his kids proud. Selling plasma fits into that honest living and for him, other ways of making extra money like selling drugs do not.

Panhandling, sex work, and selling drugs are all highly stigmatized practices associated with criminality, poverty, and moral bankruptcy. Poor plasma suppliers use these practices as markers to create moral boundaries between selling plasma and what they consider more extreme, shameful, or immoral means to earn money. This boundary allows plasma suppliers to distance themselves from the ways that poor people make ends meet, as well as the moral and ethical implications of those practices.

Earmarked Earnings

In the second moral boundary-drawing strategy interviewees distinguish themselves specifically from other plasma suppliers they encounter in the center. They make this distinction by earmarking their earnings. Through the process of earmarking, they would differentiate their plasma earnings, like Mark from the opening vignette who earmarked his earnings to create an emergency fund for his wife. Plasma suppliers also used this earmarking to differentiate their reasons for needing the money and how they spend it from other people in the center whom they assume use it for drugs or alcohol. “You hear stories about people who donate plasma and why,” one interviewee tells me, “so you can get these preconceptions in your head.” These differentiations allow plasma suppliers to ascribe a moral value to their spending compared to how they perceive other people in the center might use their earnings, further reinforcing their moral boundary.

This distinction was subtle, usually hidden beneath surface level stories shared in hopes of amusing me with tales from the plasma center. Interviewees often shared stories about plasma suppliers who seem intoxicated, high, or otherwise inebriated. Some of my interviewees, like Jamal (33, Black) told me:

> I laugh at everybody in there because there's some crazy people in there. Crazy people. Drunk people coming in there. High people coming in there. And they just be crazy like, they ready. They don't care. I've seen people taking the needle out they own arm because they tired of waiting.

Jamal is a bit surprised by the behaviors of others in the space, but not overly concerned or upset by them. Several other interviewees similarly joke about encountering people at the plasma center who seem noticeably intoxicated or inebriated. Michelle (56, white) tells me that plasma suppliers are tested for drug use, but adds, "I used to have a roommate who did meth and he used to donate, so I don't know how that works." Gabe (53, white) a long-time plasma supplier, says the centers aren't nearly as bad as they used to be in the 1980s, but there's still a noticeable presence of drug users.

> *Gabe:* You go in there and you kinda see people and think, ok yeah, [laughter] he's a little messed up. You know.
>
> *Caty:* How do you know? Do you ever interact with them?
>
> *Gabe:* No, [laughter] but you can just tell. I used to go in with some friends and we'd always kinda joke about it. Afterwards like, 'oh did you see that guy?!'

Of the people I interviewed who joked about seeing drug users in the plasma center, most were older plasma suppliers who had experienced the plasma center in the 1980s and 1990s when they were less regulated. Still, even in their humor, these jokes create a boundary between the plasma suppliers I interviewed versus other suppliers who are presumably there to earn money for drugs and alcohol. These jokes express a sense of individuality and distinction, as if to say, ‘yeah I’m there, but I’m not like those other plasma suppliers.’

Jasmine (28, Black) continues telling me about all the different people who come into the plasma center. Having both worked at the center and sold her plasma, she offers interesting insight from both perspectives. I ask her why she thought people come into the plasma center, and she says,

> I think it’s a lot of different reasons. I knew a lot of people coming in and I knew it’s more likely cause of bills, kids, and things they need. You get the people who come in and you can tell their reason for coming in is probably cause of drugs. I hate to be judgmental, but you know when you know. And you could tell it’s like a drug thing or an alcohol thing. I think people go for different reasons.

This narrative reveals several components of the boundary-making process. First, though Jasmine lists several reasons that people sell their plasma, they all boil down to money. For her and my other interviewees, money is the only real reason that anyone sells their plasma; nobody is there for what Jasmine called “the real reason” people should be there, which is to help people in need of plasma therapeutic treatments. Second, assuming that everyone at the plasma center is there to make money, Jasmine then distinguishes between the various reasons people need that money. There is a difference, she suggests, between needing the money to pay bills or support children and needing the money for drugs or alcohol.

Interviewees working to distance themselves from other plasma suppliers must draw on stigmatized stereotypes of poor bodies as undisciplined. This strategy assigns a moral worth to the actions (e.g., type of lie) and motivations (e.g., need for money) of those sharing the space. In so doing, interviewees invoke the same stereotypes that stigmatize plasma selling, and rather than wholeheartedly rejecting those stereotypes, they affirm them while creating a boundary to distance themselves from it.

Healthy Enough

Part medical, part commercial, the plasma center straddles the line between a medical office and a factory production line or chain restaurant. As one person told me, "It's weird, it's kind of like a store-front business." Everyone knows that the plasma donation center is not a doctor's office; some people even jokingly questioned the credentials of the staff who perform the intake screening. However, many of the plasma suppliers I spoke with use selling plasma as a baseline measure of their health. Coco, a 26-year-old biracial plasma supplier, equates the screening as a stamp of good health, telling me she likes that her husband also sells his plasma because it tracks his health:

> I worry about him, he's had all kind of stuff. He smokes, he's got a cousin with diabetes. So I worry about his blood pressure. But he won't really go to the doctor. At least at the center they're checking his blood pressure and stuff, so I know he's okay.

For Coco and her husband, the center provides at least some medical oversight. They recognize that it does not offer a full physical examination like he would receive at a doctor's office, but at the very least, the plasma center provides them with a sense of some basic health measures like blood pressure and weight.

First time plasma suppliers must pass a physical examination and a medical history screening. If approved, they qualify to sell their plasma twice weekly. At each subsequent visit, plasma suppliers must answer several questions on a waiting room kiosk about any changes in their health status or engagement with 'risky' behaviors like unprotected anal sex. Routine plasma suppliers typically memorize these questions, treating it like a routine hoop to jump through to get paid. One person tells me, for example, "if you want to get paid you just keep clicking through so you can donate." Center staff will also check their blood pressure, weight, and protein levels at each visit. Overall, this screening process provides a consistent, standardized measure of some very basic health measurements. Given that 28 million Americans do not have health insurance (Keisler-Starkey and Bunch 2021), it is realistic to assume that for some plasma suppliers, the plasma center may provide their only access to any medical oversight or information.

Of course, not everyone is overly impressed with the screening process. During her time working as a receptionist at a plasma donation center, Jasmine became a bit skeptical of the medical screening:

> I'm not judgmental at all, but what was weird to me is they ask you if you're a gay male or things like that. And then I've seen plenty of gay males come in and donate. So I don't know what the stipulations are. But even like, I guess with different diseases and stuff, they don't test you right away for that stuff. But they do ask you about it. And I don't know if people are straightforward or not.

Shea is similarly critical:

> *Caty*: What's the screening like? Is it like a physical?
>
> *Shea:* It's so stupid. They look through the glands, you know, they make sure you're not a druggie. It's basic. Blood pressure. It's real basic. It would be really easy to out-scam it and be sick, and still donate. It would be really easy to do that. It's even less than the physical you get when you go to the doctor. It's really kind of a look-over. And if you're not really sick you can donate.
>
> *Caty:* When you say sick, do you mean like you have the flu? Or are we talking about more serious illnesses?

Shea: Either way.

Although the people I spoke with had a range of opinions about the quality of the medical screening, they still reiterated that selling their plasma meant that they were in generally good health. In other words, the thoroughness of the exam did not matter as much as the small, routine measurements like blood pressure and protein levels that provided them with a frequent marker about their health status. This measure has two important functions. First, it allows plasma suppliers with health problems to have some autonomy in how they define their health and their body. Second, it allows them to distinguish themselves from other poor people who are not healthy enough to sell plasma.

Tim (53-years-old, Native American) uses plasma selling to distinguish himself as healthier than other poor people. He sells plasma in between participating in paid clinical drug trials across the United States. For years he has earned his living by 'guinea-pigging,' the term used by people who frequently enroll in short and long-term paid clinical trials. Plasma selling is easy pocket change compared to those studies, he says, but he groups these practices all together as evidence that he is healthy and taking care of himself. When I ask him if he thinks there is a stigma attached to selling plasma, he's dismissive, telling me that most people just do not understand it: "you have to be healthy to do all this stuff, to qualify for it all." He adds, laughing, "and with the trials, I'm around doctors all the time," suggesting that if he did have a major medical issue, trial clinicians would address it.

Health is widely constructed as a social responsibility and moral pursuit (Conrad 1994; Crawford 1980). For Tim and others, being healthy enough to sell plasma is an achievement or measure they can use to distinguish themselves from other poor people.

In this form of defensive othering, plasma suppliers create moral boundaries using cultural constructions of unhealthy bodies and bodies of the poor as irresponsible, lazy, and lacking moral worth (Adair 2008; Saguy and Gruys 2010). To distance themselves from these stigmatizing constructions of the poor body, plasma suppliers frame their health as an achievement or active project, and sometimes an investment or type of work as I addressed in Chapter 4. There was a notable pride for some interviewees as they shared their knowledge, teaching me all their tricks to building and maintaining my health measurements should I ever want to sell my plasma myself.

As part of this strategy, some plasma suppliers draw boundaries between themselves and other indigent people through a 'cleanliness' frame. This boundary draws from cultural rhetoric about bodily cleanliness, associated with intravenous drug use and sexually transmitted infections. Months of routine plasmapheresis can leave plasma suppliers with needle marks and scar tissue on the inside of their elbow, like scarring caused by intravenous drug use. "I do sort of worry in the summer when you're not wearing coats and stuff, people look at me and I'm thinking, 'do they think I'm a junkie?'" Tammy tells me, "So I massage the area with a vitamin E oil that's supposed to break up the scar tissue." Hernán mentions his scars too, but says, "at least I know where they come from."

Tammy, Hernán, and other plasma suppliers recognize that the scar tissue inside their elbows might signal drug use to onlookers. Rather than clarify the source of her marks, Tammy prefers to treat to scars, which helps her avoid the stigma of drug use and selling plasma, both of which are associated with poverty. Hernán has a different approach, suggesting that he can at least take some pride in his scars knowing where they came from unlike intravenous drug users who may not. By making this distinction, he draws a boundary between himself and other people who do not qualify to sell plasma because of their drug use.

A few interviewees also used this type of cleanliness/hygiene rhetoric in reference to sexually transmitted infections and diseases. For example, Kathy (48, white) jokes that she likes the frequent testing conducted at the center:

> I know they check you for STDs every time you go in. Which I'm like 'cool! So when I get sexually active I know I'm gonna be safe. I'm good. I'm clean. And you better be clean cause I'm gonna find out if you're not.' I got this covered.

Another interviewee, Justin (x,y), similarly joked that the STI screening was an added 'bonus' of selling plasma. By drawing on cultural beliefs about 'clean' bodies being drug and disease-free, interviewees invoke moral stigmas commonly ascribed to alcohol and drug use as well as STIs (Morone 1997). They use these beliefs to create a boundary between themselves and other poor people who are unable to sell their plasma for those reasons. However, in drawing these boundaries, plasma suppliers reify the cultural framing of bodies of the poor as unhealthy, unclean, and undisciplined.

Finally, the significance of this moral boundary work around health is compounded for plasma suppliers receiving Social Security Disability Insurance (SSDI) benefits. For the last three decades, neoliberal welfare reform has significantly restricted cash assistance, leaving as "the last substantial government cash assistance available to many indigent US adults" and as such, disability benefit recipients have become the new 'undeserving poor' and potential 'fraudsters' (Whittle et al. 2017:182). By linking cash assistance to a long term, chronic medical diagnoses, these benefits signal a medicalization and pathologization of poverty (Hansen et al. 2014). One outcome of this pathologization and medicalization is that it exacerbates the connections between health, the body, and poverty from cultural to political. As a result of these policy shifts, SSDI recipients face the dual stigma of poverty and disability, which includes the perception of being "lazy or immoral for living on government payments, and [recipients] come to internalize this stigma by feeling inadequate, dishonest, and ashamed for not being able to support themselves financially" (Whittle et al. 2017:186).

Because one cannot continue receiving disability benefits if they are also working, they must refrain from the formal workforce. Unsurprisingly though, benefits often barely meet one's financial needs, leaving people stuck in poverty and seeking additional sources of income. Selling plasma is one of the few ways that someone receiving disability benefits could earn extra income, and many of my interviewees sold their plasma to supplement their benefits. Whenever interviewees would mention SSDI, I always asked if plasma selling impacted their condition or interacted with any medications. Tammy (61, white) told me:

> Oh, I don't think so. Well I mean, they don't ask so I don't really know if I'm supposed to be doing it. But I take medications for chronic back pain and this doesn't affect it I don't think.

Like many people with a disability diagnosis, Tammy is left straddling the line between sickness and health. On one hand, her condition is chronic enough that she is unable to work, and she takes daily medications for pain management. On the other hand, like many people with disabilities she does not consider herself unhealthy (Foubert et al. 2014). She is also unsure if she's "supposed to be doing it" from a medical standpoint but the lack of any specific oversight means that selling plasma is one of the few things she can do to make money without violating SSDI policy.

Shea is equally unsure if selling plasma conflicts with her health status with SSDI:

> Because I don't think I'm supposed to be donating, but they haven't caught me yet. So I'm still going at it. [laughter] I have, I have a mental health disorder. I have PTSD with anxiety and depression. That doesn't disqualify me. But I think, and this may not be true, but I'm having intestinal issues. I've got a fatty liver. But that's not… there's something wrong with me. And the doctor can't quite figure it out. I had food poisoning two Father's Days ago, and I'm still sick because of it. There's things I can't eat, I'm just sick. But they ask you if you have pancreas or liver problems and because the doctor said that, they call it Irritable Bowel Syndrome, which is a blanket statement of I don't really care, I don't really know, you're just gonna have it deal with it kinda thing. So because it's not technically a liver or a pancreas [issue] I can still donate. But I really shouldn't be because it's very tiring for me.

As I listen to Shea describe her multiple medical ailments and issues, I begin to realize the extent to which she has had to navigate bureaucracies, stigmatization, and the toll that poverty has taken on her mind and body. First, she is experiencing some significant undiagnosed and untreated intestinal issues that leave her tired and uncomfortable. However, that condition is not tied to her SSDI benefits; rather, her benefits are tied to her mental health diagnosis. When benefits are specifically linked to a mental health diagnosis requiring pharmaceutical treatment, this "mental pathology becomes a valuable survival strategy" while also adding an additional layer to the stigma one experiences (Hansen et al. 2014:76). Finally, I am struck by how, like Tammy, Shea says she's not supposed to be donating and refers to a vague, unidentified authority ("they haven't caught me yet"). There is an ease to how Shea frames it though that makes me think she is quite used to navigating vague and paternalistic oversight of her body. When she jokes that "they haven't caught me yet" she could be referring to center staff, but just as easily be referring to the SSDI benefits office. Yet even after telling me about all of her medical conditions and how exhausted she is after selling plasma, Shea is still one of the interviewees who considers herself "healthy enough," thus using selling plasma to gain whatever autonomy and decision-making she has left over her body, income, and dignity.

At 62, Mary has been selling plasma on and off for thirteen years. When she first started, she was looking to make a little extra cash to top off her medical assistant income. However, now out of work, she uses the money to supplement her Social Security Disability Insurance benefits and off-the-books housecleaning gigs. As we chat about perceptions of plasmapheresis, she vents her frustrations about two acquaintances who recently learned that she routinely sells plasma:

> *Mary:* They said, 'oh you don't want to do that! That's not good for you!' And they just go on and on. 'I don't want to see you do that, you're gonna get sick.' And I'm like, 'no I'm not!'
>
> *Caty:* Why would they think you're going to get sick?
>
> *Mary:* I don't know. That's other peoples' views on it. They're not educated enough I don't think to understand.

In the above exchange, Mary dismisses concerns about her health as uneducated and uninformed. For her, the medical screening and intake process is a sign that she and other plasma suppliers are in good health. Mary does not disclose her medical condition or diagnosis for receiving SSDI benefits to me, and I don't ask, afraid to be seen as yet one more person questioning someone's legitimate claim for government assistance. Instead, she continues telling me about all the health measures that go into plasmapheresis:

> You know I gotta pass certain tests when I go in there. I can't just go in there and say I'm gonna donate. You can't do that. Your blood pressure has to be within certain limits. You know, your protein and hemoglobin.

These measurements allow Mary to gauge her health status while also demonstrating that she is knowledgeable about both her body and the plasmapheresis process. Mike, another SSDI recipient, explained that his chronic pain also prevented him from working a typical full-time job, but he was still “healthy enough” to sell plasma. Such distinctions allow plasma suppliers to distance themselves both from people who do not qualify for plasmapheresis based on poor health while also distancing themselves from the stereotypes of disability and benefit recipients as unhealthy and unproductive.

Poor but Moral

As a case study, selling plasma serves as a gateway to understand how people navigate the stigma of poverty and the exhaustion of hustling to make ends meet. To preserve their dignity in a culture that perceives them as unsuccessful or even immoral, I find that plasma sellers employ three strategies that create distance from the stigma of selling plasma and the stigma of poverty more generally. In the first strategy, plasma suppliers compare selling plasma to other means to making ends meet like sex work, panhandling, and drug dealing, and use these comparisons to position themselves as morally superior. In the seconds strategy, plasma sellers differentiate themselves from other plasma suppliers they encounter at the plasma center who they perceive to be drug users and/or alcoholics by earmarking their earnings as morally superior. In the third strategy, they use selling plasma as a marker of their health status, locating themselves above other poor people who do not qualify because of illicit drug use, disease, or more severe health issues. Together, these three strategies allow plasma sellers to elevate their actions and worth compared to other poor people.

Despite this comparative moral elevation, few participants communicated a sense of pride in their actions. Rather, many felt a tinge of shame and embarrassment, rarely ever telling other people that they sell their plasma to make ends meet. That shame stems from how they are using their bodies, and what they believe that use says about their social and moral worth. For some, selling plasma signifies being otherwise unable to earn a living and productively contribute to society. For others, it means defying moral beliefs that body parts are sacred or priceless and should not be sold. Ultimately, the stigma of selling plasma aligns closely with the overall stigma of poverty that deems poor bodies undisciplined, chaotic, moral failures (Adair 2002, 2008).

However, rather than outright reject beliefs that poor bodies are undisciplined and immoral, low-income plasma suppliers rely on those beliefs to elevate their moral worth. My interviewees created a moral yardstick between selling plasma and other stigmatized bodily practices as a way to uphold the moral worth of their bodies. Additionally, in a culture that blames poor people for their health conditions and illnesses, interviewees used their own health status as a measure of their bodily worth. Finally, they distinguished themselves from other plasma sellers who they felt fulfilled the longstanding stereotypes of plasma selling as a means for drug and alcohol money. In sum, this moral boundary-making allowed low-income plasma suppliers to say, ‘at least I’m not like *them*,’ to distance themselves from other poor people.

Chapter 6

Conclusion

In this dissertation, I draw from interviews, participant observation, and content analysis to identify how classed morality is constituted by and reproduced within a body market. Using a relational work approach to examine the interplay between morals and markets, I argue that the industry's framing strategies and compensation structure, coupled with the work-like conditions render plasma suppliers invisible while simultaneously disciplining them into workers. When these conditions merge with the stigma and shame of poverty, plasma suppliers work hard to maximize earnings but distance themselves from their participation and its symbolic stigma. In creating moral boundaries to navigate their stigmatization, they ultimately reinforce the stereotypes they aim to avoid.

In Chapter 3 I examine how the plasma pharmaceutical industry navigates violating strong cultural beliefs surrounding the morality of blood donation. I provide a historical overview of blood banking in the United States to show the relative recentness of altruistic framing around blood donation and the broader gift/commodity dichotomy plaguing body market debates, and how ultimately the plasma industry rejects the gift/commodity dichotomy. I then show how the industry crafts a moral palatability by focusing the need for plasma therapeutics to eliminate undeserved suffering but pays little to no attention to the plasma suppliers themselves. This approach renders plasma suppliers relatively invisible, which reifies their low class positioning as well as the low moral standing. Inclusion of payment alone does not explain this difference, because even body markets like egg donation which pay women thousands of dollars still emphasize altruism (Almeling 2011). Instead, the industry relies on a centralized narrative via a governing trade organization to implement consistent messaging. As a result, the market successfully distances itself from long-standing concerns that targeting low-income plasma suppliers is coercive or unethical. This approach also renders plasma suppliers invisible, thus further reproducing and reifying classed experiences of invisibility, shame, and minimal social worth.

In Chapter 4 I turn to the actual process of routine plasma supplying and how it shapes supplier experiences. Despite legal definitions and industry claims that paid plasma donation is not a form of employment, I find that the industry creates disciplined, employee-like suppliers. I demonstrate that the market does in fact organize and incentive its plasma suppliers to function like employees with schedules, duties, and fees. Suppliers prepare and maintain their bodies and adhere to a twice-weekly donation schedule to maximize earnings. In turn, many suppliers adopt language that frames their participation in terms of work, referring to earnings as “wages” and their bodies as “products,” yet resist categorizing plasma supplying as work because of the shame associated with selling one’s body. These findings signal that precarious income sources like selling plasma commodify already disciplined, classed bodies.

Finally, in Chapter 5 I use interviews with plasma suppliers to examine their experiences selling plasma and how it may inform their beliefs and sense of identity. I argue that selling plasma acts as a form of symbolic stigma coded as poverty and all the negative implications associated with it. I find that plasma suppliers engage in moral boundary-making processes to mitigate their stigmatized experiences. Because selling plasma is so closely associated with poverty, even suppliers who are not low-income must navigate the stigma. I identify three strategies that plasma suppliers use to draw moral boundaries between themselves and other poor people. The first two strategies relate to the cultural meanings that people attach to earning and spending money. The third strategy relies on beliefs about health, cleanliness, and the body. Together, these boundary-making strategies plasma suppliers to elevate their actions and worth compared to other poor people, while ultimately reinforcing many of the stereotypes of poverty.

These findings have several important implications for the scholarly understanding of markets, work, and experiences of poverty. First, this dissertation contributes to scholarly questions about the interplay between markets and morality. Economics are not just embedded in social processes, they are inseparable (Zelizer 2012). A relational work approach illuminates the cultural work that all participants do, showing how markets act as fields for culture and meaning-making processes. This approach has been especially useful for the study of body markets which have been historically framed within an altruism/commodity dichotomy. As it stands, the sociological literature of body markets provides excellent insight as to how various body markets craft moral frameworks that essentially reject the commodity framework in favor of altruism. This cultural work is so effective that these findings hold even in some body markets that do pay donors, like sex cell and surrogacy markets (Almeling 2011; Hovav 2019). However, these studies examine high-stakes body markets. Organs, sex cells, babies, these are all incredibly culturally high-value bodily products. Blood plasma, on the other hand, has no cultural significance or moral value, reiterated by the low rates of compensation that plasma suppliers receive. Additionally, the altruism/commodity framework has been so culturally engrained in debates surrounding body markets that it has become taken-for-granted, a type of “either/or.” Left unexamined has been when and how the dichotomy can be strategically used as a “both/and.”

By shifting the lens towards an otherwise banal and overlooked body market with low wages and relatively low physical risk, my dissertation demonstrates how large pharmaceutical markets engaged in seemingly small body extractions can dictate the terms of morality and visibility. My case study reveals how a market can successfully use a both/and approach to the altruism/commodity dichotomy to navigate public scrutiny and craft its own distinct moral palatability. One of the reasons this approach is so effective is because the plasma pharmaceutical market strategically targets low-income communities that are already overlooked and implicitly marked as morally inferior. Much like Timothy Pachirat’s (2011) study of how the meat-packing industry hides its horrors, my findings have broader implications for understanding how otherwise repugnant markets can successfully combine frameworks that rely on the invisibility of marginalized participants.

My findings also contribute to ongoing research of work and bodily labor within the neoliberal era. Whereas scholars have begun examining the growing platform economy and gig labor, it has yet to be put within the broader context of the informal economy. Nor has it raised significant questions about how definitions of work shift. What are the legal, social, and moral differences between earning extra money selling plasma versus driving Lyft? I do not use my findings to argue whether paid plasma donation should be classified as work. Rather, by identifying key patterns in how the plasma pharmaceutical market organizes and incentivizes plasma suppliers like workers, I problematize how we come to view and value work. Work involving the body, particularly poor bodies, is especially devalued or altogether disregarded. Illuminating the mental and physical energy that plasma suppliers invest in preparing and maintaining their bodies – much like other professions must maintain their emotions via emotional labor – provides an important contribution to the sociological literature of bodies as well as work and labor.

Finally, this dissertation contributes to the literature on poverty stigma and moral boundary-making processes. Whereas there is a substantive body of literature demonstrating how people draw on cultural repertoires of ethnicity, race, class, religion, and/or nationality in creating and upholding boundaries (Bail 2008; Edgell, Gerteis, and Hartmann 2006; Jaworksy 2013; Kato 2011), much less is known about how cultural repertoires of the body shape the creation of moral boundaries. In highlighting how people use cultural beliefs about the body to inform their boundary-making processes, I demonstrate how the body becomes a critical site for differentiating moral worth and creating moral boundaries. The construction of these moral boundaries simultaneously goes hand-in-hand with the cultural construction of the classed body. Both these moral boundaries and the construction of the classed body become tools for navigating and managing stigmatization. The sociological significance of the body has long been undervalued; these findings elevate the field's understanding of how cultural beliefs about the body shape moral boundaries and the management of stigma.

Beyond social science scholarship, examining the plasma pharmaceutical market also has urgent implications for ongoing policy. At the time of writing this dissertation, the PPTA is actively challenging a June 2021 U.S. Customs and Border Protection order to refuse entry to non-immigrant visitors crossing the border to sell plasma at U.S.-based centers. With over 50 donation centers in the border economic zone between the United States and Mexico, the industry has targeted plasma suppliers from Mexico where selling plasma is outlawed. Prior to the COVID-19 pandemic, non-immigrants with B-1/B-2 visas - which allowed non-immigrant visitors to travel for business or tourism purposes - were welcome to cross the border weekly to visit plasma donation centers. In June 2021 when COVID-19 related border restrictions eased, the United States Customs and Border Protection (CBP) blocked entry of non-immigrant visitors with B-1/B-2 visas from entering the United States to visit a plasma donation center. In blocking entry of these visa holders from visiting U.S.-based plasma centers, the CBP asserted that selling plasma constitutes "labor for hire," and thus was in direct violation of the visa (Lind and Dodt 2021; Villagran 2021).

Though the PPTA adamantly rejects the categorization of selling plasma as "labor for hire," whether the PPTA and their lobbying counterparts can overturn this new restriction and on what grounds has larger impacts for the regulation of body markets, migration, and pharmaceutical industries. How might this case shape policy for newer biomedical body markets, like those for genetic material or cell lines? Could we imagine a modern economy wherein immigrants enter and exit the country to sell other body parts under the guise of altruism, or will categorizing selling plasma as work provide new legal conceptions for bodily labor in the global neoliberal era? What does categorizing participation in body markets as work mean for workers' rights and immigrant rights? The plasma pharmaceutical industry is primary example of how a body market was moved out of the jurisdiction of medicine into the jurisdiction of global trade, and as such this market has the potential to set the pace for further body market expansions.

As with any study, this dissertation has notable limitations that create opportunities for further research. One obvious limitation is geography. Examining paid plasma donation in the Twin Cities provided an opportunity to scratch the surface on inequalities within this specific metropolitan area, but it is unclear whether my findings would be applicable in other geographic regions. While there is extensive research showing that marginalized groups engage in moral boundary-making processes and defensive othering to navigate stigmatization, are there places where the stigma is less salient and thus less relevant? Do plasma suppliers along the Mexico-U.S. border, crossing twice weekly to sell plasma for more than they could make for a day's work in Juarez, feel the same stigma or is there a sense of pride or success? Likewise, in regions with more plasma donation centers and seemingly more plasma suppliers, do people feel the same shame or invisibility, or is there a neutrality to their activities? Additionally, with more centers opening in rural areas, researchers may consider how rural identity as well as the increased likelihood of recognizing other plasma suppliers would shape experiences and responses.

An additional limitation or challenge to studying paid plasma donation is the ongoing lack of comprehensive, generalizable data about who sells plasma, how often, and why. Census tracts can show us who lives near centers, and we can observe correlations between national trends in unemployment and poverty with increasing rates of source plasma collection, but the data is limited. I would imagine that some of this data exists within the plasma pharmaceutical industry, or at least among their marketing partners. However, without this data it is hard to put into context the scope of problems – as well as potential benefits – associated with paid plasma donation in the United States.

Although debatable, I see my inability to actively participate in plasma selling as an additional shortcoming of this project. While I do not think selling plasma prevented me from garnering enlightening data about boundary-making processes, stigmatization, or bodily labor, I do think it prevented me from weighing in on the carnal, autobiographical element of paid donation. Additionally, being eligible and willing to sell my plasma would have expanded my participant observations and given me more access to potential interviewees. I would not advocate for future researchers interested in studying body markets to actively participate themselves, but even securing employment or observation privileges in my case could have been fruitful.

Sometimes when presenting my preliminary findings at department seminars or conference panels, an audience member would raise the question of intersectionality. Quite literally they would say, “what about intersectionality?” I can only assume that in raising intersectionality they meant something along the lines of: what can my research also teach us about race, as well as maybe gender, sexuality, and age within paid plasma donation, or body markets more broadly? These are important questions, and I grappled with what my data could explain versus what future questions it raised. Ultimately, my data illuminated experiences of poverty but no more than anecdotal information about these other important identity markers. For example, I did observe some minor differences between how men and women talked about their bodies, and I believe that overall people of color were more comfortable telling someone in their social network that they sold blood than the white plasma suppliers I spoke with. Throughout this study, I was attentive to intersectional identities, but I was also careful to not use a few examples from my data to make larger, generalizable claims about identity groups.

Additionally, while there is ample research on the gendering and racialization of bodies, there remains little work on how class, especially poverty, mark the body (Mason 2013). By attending to the classed body, I was able to contribute to a small but necessary area of sociological inquiry.

Should I continue building upon this dissertation research, I would more closely examine the overlap between paid plasma donation and SSDI recipients. Many of the plasma suppliers I interviewed casually mentioned that they received SSDI benefits for a range of mental health diagnoses and physical ailments. I wondered how many people’s physical and mental health conditions were exacerbated and worsened by constantly selling plasma. Simultaneously, it raises the critical concern that government benefits do not adequately support the most vulnerable populations that it claims to serve. An examination of this overlap would need to be highly sensitive to ongoing accusations that SSDI recipients take advantage of the system or risk further stigmatizing these groups. Ultimately, I hope this research can act as an example, or at the very least a starting point, into more interdisciplinary work that considers the complicated crosshairs of economics, medicine, inequalities, culture, and the body.

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