

## A Philosophical Defense of Deceased Donor Kidney Donation Over Living Donation in Tanzania

<sup>1</sup>Charles Maribwa Muyenjwa, <sup>2</sup>Dr. Sabas Kimani & <sup>3</sup>Dr. Carlyne Buya

*The Catholic University of Eastern Africa*

**ABSTRACT:** Chronic Kidney Disease (CKD) is an increasing concern in Tanzania, as well as a significant concern worldwide, due to the fact that transplantations rely on living donors. While living kidney donation may be ethically acceptable, there are many concerns with regard to the harm caused to living kidney donors, the potential for coercion of these donors, and the lack of equitable access to this form of donation. The purpose of this paper is to demonstrate that deceased kidney donations are the morally superior alternative to live kidney donations. The rationale behind this argument is based on a moral principle known as Utilitarianism. That is to say, the primary goal of all decisions made with regard to transplantation should be to maximize benefits to the largest number of people. In addition to the moral principle of utilitarianism, this paper will also draw upon three additional moral principles of Non-Maleficence, Justice, and Respect for Autonomy to demonstrate how deceased donor kidney transplantation can avoid the harm associated with live kidney donation, increase the number of available kidneys for transplantation, and create a system whereby kidneys are allocated fairly.

**Key Terms :** Deceased Donation, Kidney Donation, Living Donation, Utilitarianism, Non-maleficence, Justice, Autonomy, Ethics, CKD.

### I. INTRODUCTION

In Tanzania, CKD has been identified as an emerging public health threat with significant contributions to both morbidity and premature death.<sup>1</sup> The development of CKD creates a need for treatment options beyond dialysis; however, in Tanzania, there is little availability of renal replacement therapy. The distribution of what renal replacement therapy is available is often inequitable. As such, kidney transplantations provide the best long-term treatment option for patients diagnosed with ESRD.<sup>2</sup> However, due to the reliance on living donors in Tanzania, many are faced with ethical dilemmas, including imposing risks to healthy individuals, obtaining valid informed consent from family members, and social and economic barriers preventing access. Deceased organ donation can offer an alternative to living donation. This method of organ donation has become widespread throughout much of the globe. However, in Tanzania, this form of organ donation has developed slowly due to institutional, cultural, and policy-based barriers rather than due to a specific moral objection.<sup>3</sup> The purpose of this paper is to present a philosophical argument in favor of deceased donor kidney donation as opposed to living donor kidney donation in Tanzania. The philosophical basis of this position will be grounded in John Stuart Mill's Utilitarianism. Living kidney donation may be viewed as acceptable under some circumstances. However, when examined through the lens of medical ethics (non-maleficence), fairness (justice), and long-term patient care and quality of life, living kidney donation is viewed as unethical. In contrast, deceased kidney donation presents an opportunity to utilize a more equitable and safer model of organ procurement. This model allows for the prevention of harm to living individuals who would serve as donors and maximizes the potential for saving lives. Using both a philosophical analysis and contextual considerations, this paper will argue that, based upon a utilitarian perspective that is committed to eliminating avoidable suffering and enhancing overall well-being, the prioritization of deceased donor kidneys is not only practical, but also morally imperative.<sup>4</sup>

<sup>1</sup> Francis Furia, "Progress in CKD Care and Integration of Adult and Childhood Nephrology Services in Tanzania," *Kidney360* (New York), ahead of print, 2024, <https://doi.org/10.34067/KID.0000000000000477>.

<sup>2</sup> Thaminda Liyanage et al., "Worldwide Access to Treatment for End-Stage Kidney Disease: A Systematic Review," *The Lancet* 385, no. 9981 (2015): 1975–82, [https://doi.org/10.1016/S0140-6736\(14\)61601-9](https://doi.org/10.1016/S0140-6736(14)61601-9).

<sup>3</sup> Furia Francis et al., "Establishing Kidney Transplantation in a Low-Income Country: A Case in Tanzania," accessed May 26, 2025, <https://rrtjournal.biomedcentral.com/articles/10.1186/s41100-024-00545-z>.

<sup>4</sup> Beauchamp Tom and Childress James, *Principles of Biomedical Ethics*, (London), 2019.

## II. LIVING KIDNEY DONATION: MORALLY PERMISSIBLE BUT ETHICALLY PROBLEMATIC

Living kidney donation has generally been accepted as ethically acceptable. This acceptance stems from the fact that the practice is based on the moral obligation to save human life through altruistic actions. A person can choose to provide a kidney to someone who is either improving their quality of life or preserving their life. These types of donations have been recognized as being morally good. While living kidney donation has been viewed as ethically acceptable, there exist significant ethical challenges. One of the largest challenges facing living kidney donation involves the risk of physical harm associated with the surgery involved in the donation.<sup>5</sup> Because a “healthy” individual will undergo the surgery, the act of donating an organ could be seen as violating the principles of non-maleficence (do no harm) of medical ethics. Although there are mechanisms available to manage the risks associated with the surgery, many see the intentional infliction of harm on a person who is not a patient as creating a continuing moral dilemma within medical ethics.<sup>6</sup>

The other major area of concern surrounding living kidney donation includes issues related to autonomy, fairness/justice, and vulnerability. In many cases, consent for living kidney donation is influenced by family responsibilities and societal expectations, especially among individuals who live in close-knit communities. As a result, the voluntary nature of the decision made by the potential donor may be limited.<sup>7</sup> Access to a transplant becomes dependent on whether or not an appropriate living donor is available. Therefore, structurally unequal opportunities exist in terms of those who do not have access to relatives who possess similar blood type characteristics.<sup>8</sup> In resource-constrained environments, the reliance on living donors may lead to subtle forms of exploitation and/or organ commercialization. Therefore, this creates serious challenges to the ethical legitimacy of transplant programs.<sup>9</sup> Based on these considerations, although living kidney donation continues to remain ethically acceptable, it represents a heavy ethical burden and should not represent a model for establishing a fair and equitable transplant program.

## III. THE PHILOSOPHICAL AND COMPARATIVE DEFENSE OF DECEASED DONATION

A stronger philosophical case for donating kidneys from deceased donors is required. This would require that the ethics of the practice are justified internally as well as that they are addressed on a larger scale through the use of theory and comparative experience of other transplant programs. In this regard, an evaluation based upon Mill’s utilitarianism (i.e., how much well-being does it produce and respect liberty) provides additional clarity to the issue of whether or not to allow deceased organ donation when compared to jurisdictional areas in which deceased organ donation has been successful. The increased strength in this argument comes about due to applying a comparative perspective to the practice and providing a theoretical understanding of it, along with the application of policy that have evolved over time.

### 3.1 Non-Maleficence on Harm vs Non-Harm

The most important ethical difference between living kidney donors and those who donate after death is how each option applies to the principle of non-maleficence. While both are life-saving options, live donation exposes a healthy individual to surgery and its associated risk factors. A direct conflict arises here as medicine seeks to avoid causing harm while at the same time imposing harm upon an otherwise unharmed individual for the benefit of someone else. Although the risks can be minimized and the individual’s consent obtained, there is still an ethical burden placed upon them in order to provide their organs.<sup>10</sup> Deceased donation, however, completely eliminates this problem. Death has occurred, and therefore no experientially harmful actions have been taken against the individual from whom the organs were retrieved. Therefore, provided that there was ethically appropriate documentation of death and informed consent given by the decedent before death, then the principle of non-maleficence will be upheld where it could not be under live donation.

<sup>5</sup> Dorry L. Segev et al., “Perioperative Mortality and Long-Term Survival Following Live Kidney Donation,” *JAMA* 303, no. 10 (2010): 959–66, <https://doi.org/10.1001/jama.2010.237>.

<sup>6</sup> Tom and James, *Principles of Biomedical Ethics*.

<sup>7</sup> Abimereki D. Muzaale et al., “Risk of End-Stage Renal Disease Following Live Kidney Donation,” *JAMA* 311, no. 6 (2014): 579–86, <https://doi.org/10.1001/jama.2013.285141>.

<sup>8</sup> Sue Pondrom, “The AJT Report,” *American Journal of Transplantation* 13, no. 9 (2013): 2233–34, <https://doi.org/10.1111/ajt.12454>.

<sup>9</sup> María Isabel Rebollo Mateos, “Ethical Dilemmas of Living Donor Kidney Transplantation: A Systematic Review,” *Revista de La Sociedad Española de Nefrología* 46 (2026).

<sup>10</sup> Krista L. Lentine and Anita Patel, “Risks and Outcomes of Living Donation,” *Advances in Chronic Kidney Disease* 19, no. 4 (2012): 220–28, <https://doi.org/10.1053/j.ackd.2011.09.005>.

### 3.2 Utilitarian Superiority on Maximizing Benefit without Competing Harm

Deceased organ donations have a strong moral justification based on the principles of utility since it provides maximum benefits to society at minimal risk to individuals. John Stuart Mill has argued that “actions are right in proportion as they tend to promote happiness; wrong as they tend to produce the reverse of happiness.”<sup>11</sup> Based on these principles, deceased organ donors can save numerous lives. These lives would be saved through organs provided by a single donor. It is also important to note that the use of deceased organ donors does not require that a living person’s health be sacrificed. On the other hand, living organ donors do provide considerable benefit to recipients; however, their donation comes with some risk.<sup>12</sup> Therefore, when we have two options available that achieve similar or better outcomes with no additional costs (in terms of avoiding risk), then the option that does not introduce risk will be favored over the risky alternative. Thus, when comparing deceased and living donors, based solely on the ability to maximize total well-being among all parties involved, deceased organ donation is both logically and ethically superior.

### 3.3 Justice in Inequality vs Fair Allocation

Living kidney donation is inherently constrained by both the biological and social aspects of matching potential donors with recipients. The nature of these constraints leads to unequal structural opportunities for those who are seeking transplantations. For individuals who do not have either a donor who has been deemed medically compatible or one who is willing to donate, they are essentially left out of the transplant opportunity pool. Therefore, the access to potentially life-saving treatment is based upon chance, i.e., “moral” and “social” luck, creating an ethical dilemma regarding access to treatment.<sup>13</sup>

In contrast, deceased donation allows transplantations to occur through a larger, more neutral system. While there is still an issue regarding organ availability and therefore scarcity, organs can be allocated based upon medical need and probability of successful outcome rather than social or personal relationships. Deceased donation organ systems provide a greater opportunity for distributive justice and are more fair frameworks for allocation. In addition, developing countries like Tanzania rely heavily on living donors for organ procurement, limiting opportunities for accessing transplants.

### 3.4 Autonomy in Constrained Choice vs Reflective Consent

Although there are many arguments in favor of supporting Living Donations based upon Autonomy, the voluntariness of decisions for Living Donation is very commonly shaped by the expectations of family members and emotional pressures. As a result of being part of close-knit communities, individuals who might wish to donate organs may feel as if they have a moral obligation to give their consent to donate organs even when they do not want to, which undermines the authenticity of their decision-making process. These situations raise questions about the nature of subtle coercion and limited autonomy.<sup>14</sup>

Deceased Donation preserves individual autonomy better because it does so under an opt-in consent model. The decision to donate can be made independently, without any immediate emotional pressure, and demonstrates a moral commitment after having had time to consider it.<sup>15</sup> Additionally, when a person has given his or her consent before death, the wishes of the individual will still direct future action with regard to posthumous donations, therefore continuing an extension of personal autonomy, rather than limiting it. Therefore, deceased donation enables organ giving to be transformed into a voluntary, self-directed moral act.

### 3.5 Moral Status of the Deceased Body

A main issue with deceased donation is the ethical consideration of what is considered the “moral status” of the human body after death. While many religions and cultures place great emphasis on the preservation of bodily integrity, they create an ethical dilemma when considering whether organ removal from the deceased results in harm to or degradation of their dignity. Since the deceased does not have the capacity to feel pain or suffer loss, no immediate, personal, or experiential type of harm results from removing organs.

---

<sup>11</sup> J. S. Mill, *Utilitarianism* (Savill & Edwards, Printers, 1863), 9.

<sup>12</sup> Lentine and Patel, “Risks and Outcomes of Living Donation.”

<sup>13</sup> Peter P. Reese et al., “Living Kidney Donation: Outcomes, Ethics, and Uncertainty,” *Lancet* (London, England) 385, no. 9981 (2015): 2003–13, [https://doi.org/10.1016/S0140-6736\(14\)62484-3](https://doi.org/10.1016/S0140-6736(14)62484-3).

<sup>14</sup> Nizam Mamode et al., “Donor Autonomy and Self-Sacrifice in Living Organ Donation: An Ethical Legal and Psychological Aspects of Transplantation (ELPAT) View,” *Transplant International* 35 (March 2022): 10131, <https://doi.org/10.3389/ti.2022.10131>.

<sup>15</sup> “An International Comparison of Deceased and Living Organ Donation/Transplant Rates in Opt-in and Opt-out Systems: A Panel Study | BMC Medicine | Springer Nature Link,” accessed April 1, 2026, <https://link.springer.com/article/10.1186/s12916-014-0131-4>.

Therefore, it is the respect for previously expressed wishes (such as consent) and dignified treatment during the procedure that creates moral obligation. When consent has been provided, and all appropriate measures are taken to ensure compliance with ethical principles, deceased donation may not represent a violation of dignity or rights, but rather an expression of continued moral agency by providing a means of saving lives for others through the deceased's body while not causing suffering or harm to a living person.<sup>16</sup> In essence, deceased donation represents a unique form of posthumous solidarity that possesses both social value and ethical importance.

### 3.6 Sustainability: Structural Limitation vs System-Based Model

The capacity to live donate and transplant organs is limited in terms of both quantity and frequency. Therefore, living donation can never be relied upon as a steady or adequate source of available transplants. Thus, it cannot serve as a reliable base for long-term transplant programs, especially in developing countries like Tanzania, where the demand continues to grow.

On the other hand, deceased donor transplantation enables the creation of formalized systems (for example, identifying potential donors, procuring those organs, and allocating them) which allow for a much greater degree of organization and scalability.<sup>17</sup> These types of systems also place responsibility for organ procurement and distribution throughout society and do not rely solely on the individual. As such, from a moral perspective, health care systems have a duty to implement models of organ procurement that are both effective and just. Since deceased donor transplantation provides both efficacy and justice that can support the demands of increasing numbers of patients, this will provide a more viable and ethical framework for the future.

## IV. IMPLICATIONS FOR TANZANIA

The findings from our study have significant implications for guiding ethically responsible decision-making regarding the direction of transplantation policy in Tanzania. To begin with, we argue that there is an urgent need to transition the normative basis for organ transplantation away from reliance upon live organ donation towards the establishment of a deceased organ donation system. While live organ donation will likely continue to play a role during the early stages of establishing a deceased organ donation system in Tanzania, the ethical disadvantages associated with the harms caused to live donors and the inequalities associated with access to organs make it unethical to rely on live organ donation as the sole basis of transplantation practice in the long run. Once a deceased organ donation system has been established, the practices of clinicians will be better aligned with both the principle of nonmaleficence and the principle of distributive justice.

In addition to changing how we approach the ethics of transplantation policy in Tanzania, developing a deceased organ donation program also necessitates the creation of a coherent legal and institutional framework. As noted previously, international experience indicates that effective organ transplantation programs require: clear definitions of death; regulated processes for procuring donated organs; and transparent mechanisms for allocating those organs once they are recovered.<sup>18</sup> Given the current lack of a cohesive national framework for deceased organ donation in Tanzania, creating such a framework will require legislative changes, coordination among various institutions, and will provide a mechanism to ensure that deceased organ donation occurs in ways that promote both the ethical recovery of donated organs and public confidence in the system.<sup>19</sup>

Engaging the general population in discussions about deceased organ donation is crucial for ensuring that deceased organ donation can occur in ways that are ethically defensible. The cultural and religious views held by individuals in Tanzania concerning what happens to their bodies after they die must be respectfully considered through dialogue that educates them on how organ donations save lives. Research has demonstrated that community acceptance of deceased organ donation grows when communities are educated about deceased organ donation through culturally relevant education and when they perceive medical institutions as being trustworthy.<sup>20</sup> Therefore, ethical reform of the policies governing organ transplantation in Tanzania will necessarily need to be accompanied by social and educational initiatives designed to demonstrate how solidary actions involving organ donation support shared values of caring for others, protecting the lives of others, and preserving human life.

<sup>16</sup> D. Gardiner et al., "Two Fundamental Ethical and Legal Rules for Deceased Organ Donation," *BJA Education* 21, no. 8 (2021): 292–99, <https://doi.org/10.1016/j.bjae.2021.03.003>.

<sup>17</sup> Raffaele Girlanda, "Deceased Organ Donation for Transplantation: Challenges and Opportunities," *World Journal of Transplantation* 6, no. 3 (2016): 451–59, <https://doi.org/10.5500/wjt.v6.i3.451>.

<sup>18</sup> Gardiner et al., "Two Fundamental Ethical and Legal Rules for Deceased Organ Donation."

<sup>19</sup> Frederike Ambagtsheer and Willem Weimar, "41 - Ethical and Legal Aspects of Kidney Donation," in *Kidney Transplantation - Principles and Practice (Eighth Edition)*, ed. Stuart J. Knechtle et al. (Elsevier, 2019), <https://doi.org/10.1016/B978-0-323-53186-3.00041-3>.

<sup>20</sup> Petru Contrau et al., "Ethical, Socio-Cultural and Religious Issues in Organ Donation," *Maedica* 14, no. 1 (2019): 12–14, <https://doi.org/10.26574/maedica.2019.14.1.12>.

## V. CONCLUSION

The argument here has been that while living kidney donation may be morally acceptable, it still faces an ethical burden due to potential harm to the donor, limited autonomy for the donor, and inequalities in access. Deceased donor kidney transplant presents a much clearer, ethical approach. Deceased donor kidney transplants do not involve purposeful harm being inflicted upon a normal, healthy individual; they provide greater and fairer distribution of kidneys, which meet the requirements of justice and allow for the greatest overall benefit possible.<sup>21</sup> Given that both transplant systems continue to develop within Tanzania, these differences will have great significance when considering the development of the best ethical practices. As such, a health care system that seeks to preserve life would act responsibly if it were to establish deceased donor kidney transplant as the preferred method of transplant moving forward in Tanzania.

## BIBLIOGRAPHY

- [1] Ambagtsheer, Frederike, and Willem Weimar. "41 - Ethical and Legal Aspects of Kidney Donation." In *Kidney Transplantation - Principles and Practice (Eighth Edition)*, edited by Stuart J. Knechtle, Lorna P. Marson, and Peter J. Morris. Elsevier, 2019. <https://doi.org/10.1016/B978-0-323-53186-3.00041-3>.
- [2] "An International Comparison of Deceased and Living Organ Donation/Transplant Rates in Opt-in and Opt-out Systems: A Panel Study | BMC Medicine | Springer Nature Link." Accessed April 1, 2026. <https://link.springer.com/article/10.1186/s12916-014-0131-4>.
- [3] Contrau, Petru, Viviana Hodosan, Adriana Vladu, Cristian Daina, Lucia Georgeta Daina, and Carmen Pantis. "Ethical, Socio-Cultural and Religious Issues in Organ Donation." *Maedica* 14, no. 1 (2019): 12–14. <https://doi.org/10.26574/maedica.2019.14.1.12>.
- [4] Francis, Furia, Shoo Jaqueline, Ruggajo Pachal, and Valentine Gudila. "Establishing Kidney Transplantation in a Low-Income Country: A Case in Tanzania." Accessed May 26, 2025. <https://rrtjournal.biomedcentral.com/articles/10.1186/s41100-024-00545-z>.
- [5] Furia, Francis. "Progress in CKD Care and Integration of Adult and Childhood Nephrology Services in Tanzania." *Kidney360* (New York), ahead of print, 2024. <https://doi.org/10.34067/KID.0000000000000477>.
- [6] Gardiner, D., A. McGee, and D. Shaw. "Two Fundamental Ethical and Legal Rules for Deceased Organ Donation." *BJA Education* 21, no. 8 (2021): 292–99. <https://doi.org/10.1016/j.bjae.2021.03.003>.
- [7] Girlanda, Raffaele. "Deceased Organ Donation for Transplantation: Challenges and Opportunities." *World Journal of Transplantation* 6, no. 3 (2016): 451–59. <https://doi.org/10.5500/wjt.v6.i3.451>.
- [8] Lentine, Krista L., and Anita Patel. "Risks and Outcomes of Living Donation." *Advances in Chronic Kidney Disease* 19, no. 4 (2012): 220–28. <https://doi.org/10.1053/j.ackd.2011.09.005>.
- [9] Liyanage, Thaminda, Toshiharu Ninomiya, Vivekanand Jha, et al. "Worldwide Access to Treatment for End-Stage Kidney Disease: A Systematic Review." *The Lancet* 385, no. 9981 (2015): 1975–82. [https://doi.org/10.1016/S0140-6736\(14\)61601-9](https://doi.org/10.1016/S0140-6736(14)61601-9).
- [10] Mamode, Nizam, Kristof Van Assche, Lisa Burnapp, et al. "Donor Autonomy and Self-Sacrifice in Living Organ Donation: An Ethical Legal and Psychological Aspects of Transplantation (ELPAT) View." *Transplant International* 35 (March 2022): 10131. <https://doi.org/10.3389/ti.2022.10131>.
- [11] Martinelli, Valentina, Estella L. L. Lumer, Matteo Chiappedi, et al. "Ethical Issues in Living Donor Kidney Transplantation: An Update from a Psychosocial Perspective." *Healthcare* 12, no. 18 (2024): 1832. <https://doi.org/10.3390/healthcare12181832>.
- [12] Mateos, Maria Isabel Rebollo. "Ethical Dilemmas of Living Donor Kidney Transplantation: A Systematic Review." *Revista de La Sociedad Española de Nefrología* 46 (2026). Mill, J. S. *Utilitarianism*. Savill & Edwards, Printers, 1863.
- [13] Muzaale, Abimereki D., Allan B. Massie, Mei-Cheng Wang, et al. "Risk of End-Stage Renal Disease Following Live Kidney Donation." *JAMA* 311, no. 6 (2014): 579–86. <https://doi.org/10.1001/jama.2013.285141>.
- [14] Pondrom, Sue. "The AJT Report." *American Journal of Transplantation* 13, no. 9 (2013): 2233–34. <https://doi.org/10.1111/ajt.12454>.
- [15] "Principles of Clinical Ethics and Their Application to Practice | Medical Principles and Practice | Karger Publishers." Accessed April 1, 2026. <https://karger.com/mpp/article/30/1/17/204816/Principles-of-Clinical-Ethics-and-Their>.
- [16] Reese, Peter P., Neil Boudville, and Amit X. Garg. "Living Kidney Donation: Outcomes, Ethics, and Uncertainty." *Lancet* (London, England) 385, no. 9981 (2015): 2003–13. [https://doi.org/10.1016/S0140-6736\(14\)62484-3](https://doi.org/10.1016/S0140-6736(14)62484-3).

<sup>21</sup> Tom and James, *Principles of Biomedical Ethics*.

- [17] Segev, Dorry L., Abimereki D. Muzaale, Brian S. Caffo, et al. "Perioperative Mortality and Long-Term Survival Following Live Kidney Donation." *JAMA* 303, no. 10 (2010): 959–66. <https://doi.org/10.1001/jama.2010.237>.
- [18] Tom, Beauchamp, and Childress James. *Principles of Biomedical Ethics*. (London), 2019.