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Determination of Attitudes and Knowledge Levels Toward Organ Donation: The Case of Amasya Province

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Ethical approval was obtained from the Amasya University Non-Interventional Clinical Research Ethics Committee on March 7, 2024 (Approval No. 2024/32). The study was conducted in accordance with the Declaration of Helsinki.

Informed Consent
Electronic informed consent was obtained from all participants before enrollment.

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The authors declared no conflict of interest.

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BT: Conceptualization, Methodology, Investigation, Formal analysis, Data curation, Writing – original draft, Writing – review & editing, MK: Conceptualization, Methodology, Investigation, Validation, Writing – review & editing, Supervision.

Use of Artificial Intelligence (AI) Statement
The authors declare that no AI tools or generative AI technologies were used in the creation, writing, or analysis of this manuscript.

Data Availability
The datasets generated and analyzed during the current study are available from the corresponding author upon reasonable request. The data are not publicly available owing to ethical restrictions related to participant confidentiality.

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Abstract

Background/Aim: Organ donation is a life-saving intervention, yet donor registration remains limited in many settings, partly because of persistent knowledge gaps and attitudinal barriers. This study aimed to determine the level of knowledge, attitudes toward organ donation, and factors influencing these attitudes among individuals aged 18 years and older residing in the city center of Amasya, Türkiye.
Methods: This cross-sectional study included 206 participants. The sample size was calculated using G*Power 3.1 for a one-sample t-test ($\alpha = 0.05$, power = 80%, Cohen's $d = 0.2$), yielding a minimum required sample size of 199. Data were collected between March 15, 2024, and April 15, 2024, via an online questionnaire using convenience sampling. The survey included a sociodemographic form, knowledge and general opinion items about organ donation, and the Organ Donation Attitude Scale (ODAS). Non-parametric statistical tests were used because continuous variables were not normally distributed.
Results: The median age was 21 (18–61) years; 73.3% of participants were female, and 62.6% held a bachelor's degree. The median number of correctly answered knowledge items was 5 (1–10). Median scores were 102.0 (20–120) for Humanitarian and Moral Convictions (HMC), 24.0 (10–52) for Fear of Medical Neglect (FMN), and 29.0 (10–52) for Fear of Bodily Mutilation (FBM). Only 5.8% of participants possessed an organ donor card. Participants who reported being positively influenced by media reports had significantly higher HMC scores ($P = 0.009$). Individuals who knew where to donate organs had significantly lower FBM scores ($P = 0.023$).
Conclusion: Although participants demonstrated strong humanitarian and moral attitudes toward organ donation, these attitudes did not translate into actual donor registration. Educational interventions targeting misinformation and leveraging positive media influence may help improve donor registration rates, including among younger adults.

Keywords: organ donation, attitude, knowledge level

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Introduction

Organ donation is defined as the voluntary transfer of one or more organs or tissues, either during life based on informed consent or after death with the authorization of a legal representative, for transplantation into another individual. In Türkiye, organ donation is primarily regulated under Law No. 2238 on the Removal, Preservation, Grafting, and Transplantation of Organs and Tissues [1]. According to this legislation, individuals aged 18 years or older who are mentally competent may donate organs. Living donor transplantation is permitted between spouses who have been married for at least two years and relatives up to the fourth degree, including affinity. Transplants from unrelated living donors require approval by a provincial ethics committee confirming compliance with ethical and legal standards. In deceased donation, there is no age restriction; however, a formal diagnosis of brain death is mandatory. Brain death must be confirmed unanimously by two physicians, one neurologist or neurosurgeon and one anesthesiologist or intensive care specialist, according to evidence-based medical criteria. Physicians involved in transplantation procedures may not participate in brain death determination. Only individuals diagnosed with brain death while maintained on life support under intensive care unit standards are considered eligible for organ transplantation. Brain death is defined as the permanent and irreversible cessation of all functions of the brain, including the brainstem and cerebellum, which constitute the intracranial components of the central nervous system [2].

If an individual did not declare consent during their lifetime to donate their body or specific organs through an official will or in the presence of two witnesses, organs or tissues may be retrieved from the deceased with the consent of the next of kin. Consent may be provided sequentially by the spouse present at the time of death, adult children, parents, or siblings. In the absence of these individuals, authorization may be granted by any relative present at the time of death. Unless a contrary testamentary declaration is presented, tissues that do not cause visible alteration of the body, such as the cornea, may be procured. However, if the deceased explicitly stated during their lifetime that they opposed posthumous organ or tissue retrieval, no organs or tissues may be removed [1].

Although nearly all organs and tissues can be transplanted from deceased donors, living donor transplantation is generally limited to kidneys, liver segments, and bone marrow. In kidney transplantation, ABO blood group compatibility constitutes the most critical criterion for donor-recipient matching. Rh factor compatibility is not required. Although histocompatibility is not an absolute prerequisite, higher degrees of human leukocyte antigen compatibility have been associated with improved graft survival and overall transplant outcomes [3]. Crossmatch testing is performed by comparing blood samples from donor and recipient candidates. This test aims to detect preformed antibodies in the recipient's serum that may react against donor antigens, particularly those expressed on the donor kidney. In both living and deceased donor transplantation, crossmatching is the first mandatory immunological assessment performed after ABO blood group and tissue compatibility testing.

The first successful organ transplantation in humans was performed in 1954 by Joseph Murray. In this landmark procedure, a kidney transplanted from an identical twin enabled the recipient to survive for an additional eight years [4]. In Türkiye, the first living donor kidney transplantation was performed in 1975 by Mehmet Haberal. Subsequently, the first living donor segmental liver transplantation was also performed by Haberal in 1990 [5]. In Türkiye, all transplant centers and related procedures are supervised by the Department of Tissue, Organ Transplantation and Dialysis Services, operating under the Directorate General of Health Services within the Ministry of Health. Nationwide, 92 organ transplantation centers are affiliated with nine regional coordination centers [6]. According to data from the Ministry of Health, a total of 74,704 organ transplantations have been performed in Türkiye since 2002. Of these procedures, 52,258 were kidney transplants, 20,671 were liver transplants, 1,210 were heart transplants, 320 were lung transplants, 198 were pancreas transplants, and 47 were small intestine transplants [7]. According to data from the World Health Organization Global Observatory on Donation and Transplantation, approximately 80% of organ donations worldwide, particularly in developed countries, originate from deceased donors, whereas approximately 20% are obtained from living donors. In contrast, Türkiye demonstrates the opposite pattern. In 2022, Türkiye ranked first globally in living donor transplantation, with a total of 4,802 living donor transplantations [8]. This situation, particularly the low rate of deceased donor transplantation, suggests insufficient societal awareness regarding organ donation. Identifying factors contributing to this pattern and implementing policies aimed at promoting organ donation are critically important. Accordingly, the present study aimed to determine the level of knowledge and attitudes toward organ donation, as well as the factors influencing these attitudes, among individuals aged 18 years and older residing in the city center of Amasya.

Materials and methods

The sample size for this cross-sectional study was calculated using G*Power version 3.1 for a one-sample t-test. Assuming an alpha error level of 0.05, statistical power of 80%, and a small effect size (Cohen's d = 0.2), the minimum required sample size was determined to be 199 participants. The primary outcome was attitude toward organ donation, as measured by the ODAS subdimension scores. Because no previous data were available for the study population, a small effect size was assumed to obtain a conservative (larger) sample size estimate. Ethical approval for this study was granted by the Amasya University Non-Interventional Clinical Research Ethics Committee on March 7, 2024 (Approval No: 2024/32). The study was conducted in accordance with the ethical principles of the Declaration of Helsinki. Because the survey was administered online, electronic informed consent was obtained from all participants before enrollment. Before accessing the questionnaire, participants were presented with an introductory page describing the study objective, ensuring anonymity, and emphasizing that participation was entirely voluntary. Participants were explicitly informed that completing and submitting the online questionnaire constituted formal consent to participate in the study, and they retained the right to withdraw at any stage by closing the browser window.

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Data were collected between March 15, 2024, and April 15, 2024, using convenience sampling, which is a non-probability sampling technique. Participants were recruited via an online questionnaire distributed within the researchers' social networks, and only individuals who voluntarily agreed to participate were included. Being aged 18 years or older and residing in the Amasya city center were stated on the introductory page of the questionnaire as preconditions for participation. Because the questionnaire link was distributed through social networks and could be shared further, the exact number of individuals invited could not be determined. A total of 211 individuals completed the questionnaire, of whom 5 were excluded because of missing data, leaving 206 participants for the analysis. Item-level missing responses were not imputed, and the corresponding denominators are reported in the table footnotes. Data collection instruments included a sociodemographic data form developed by the researchers and the Organ Donation Attitude Scale (ODAS). To ensure confidentiality, personal information was not shared with any individuals or institutions other than the research team.

The questionnaire used for data collection consisted of three sections. The first section included a three-item sociodemographic data form developed by the researchers to assess age, gender, and educational status. The second section comprised 10 items evaluating participants' knowledge of organ donation and 6 items assessing their general opinions on the subject, all prepared by the researchers. For the knowledge-based items, participants were provided with three response options: "True," "False," and "I do not know." The third section used the ODAS to measure attitudes toward organ donation. The scale was originally developed by Parisi and Katz in 1986 and was subsequently modified by Kent and Owens in 1995 [9, 10]. The Turkish adaptation and validity and reliability analyses of the scale were conducted by Yazıcı Sayın [11]. The scale consists of two main dimensions and 40 items. The first dimension comprises 20 positively worded items reflecting individuals' Humanitarian and Moral Convictions (HMC) regarding organ donation (items 1, 3, 6, 7, 9, 10, 12, 15, 18, 20, 22, 23, 25, 27, 28, 31, 34, 36, 38, and 40). The second dimension includes negatively worded items and consists of two subdimensions: Fear of Medical Neglect (FMN) and Fear of Bodily Mutilation (FBM). The FMN subscale includes items 4, 11, 14, 16, 17, 19, 24, 30, 32, and 37, whereas the FBM subscale comprises items 2, 5, 8, 13, 21, 26, 29, 33, 35, and 39.

Scale scores are calculated by summing item responses. Scores for the HMC dimension, reflecting positive attitudes, range from 20 to 120. Scores for FMN and FBM range from 10 to 60. The total negative attitude score ranges from 20 to 120. Higher positive scores and lower negative scores indicate stronger voluntary attitudes toward organ donation. Each ODAS item is structured as a six-point Likert-type statement. Participants are asked to indicate the extent to which they agree with each statement. Response options range from "strongly agree" to "strongly disagree", without a neutral category reflecting indecision. In the Turkish validity and reliability study, Cronbach's alpha coefficients were reported as 0.857 for the overall scale, 0.925 for the positive attitude subscale, and 0.914 for the negative attitude subscale [11].

Statistical Analysis

After coding, data were analyzed using SPSS version 22.0 (SPSS Inc., Chicago, IL, USA). The normality of continuous variables was assessed using the Kolmogorov-Smirnov test. Because continuous variables were not normally distributed, they were expressed as median (minimum-maximum), whereas categorical variables were presented as number (percentage). The Mann-Whitney U test was used for comparisons of continuous variables between groups, and Spearman's rank correlation test was applied to assess associations between two variables. A *P*-value of less than 0.05 was considered statistically significant for all analyses.

Results

A total of 206 individuals participated in the study. The study cohort was predominantly young, female, and highly educated, with most participants in the 18-30-year age group and holding a bachelor's degree (Table 1).

Table 1. Sociodemographic characteristics of the participants

Characteristic	n	%
Age group (years)		
18-30	162	78.6
31-65	44	21.4
Gender		
Man	55	26.7
Woman	151	73.3
Educational level		
Primary school	0	0.0
Middle school	4	1.9
High school	34	16.5
Associate degree	22	10.7
Bachelor's degree	129	62.6
Master's degree or higher	17	8.3

Participants' knowledge levels regarding organ donation demonstrated substantial gaps in technical and legal aspects. Although most participants correctly identified the statutory requirement for family consent in deceased donation, a striking majority held the misconception that strict tissue compatibility is an absolute prerequisite for successful kidney transplantation. Overall, the cohort displayed a moderate level of baseline knowledge, with a median of 5 correct answers out of 10 (Table 2).

In terms of behavioral outcomes, formal donor registration was remarkably low, as only a small fraction of the sample possessed an organ donor card. However, receptive attitudes toward transplantation were common and were strongly influenced by positive media coverage. Responses to other items assessing general attitudes toward organ donation are presented in Table 3.

Upon examination of ODAS scores, the median score for the positive attitude dimension, HMC, was 102.0 (20-120). Median scores for the negative attitude subdimensions were 24.0 (10-52) for FMN and 29.0 (10-52) for FBM. The median HMC score was significantly higher in the 31-65-year age group than in the 18-30-year age group (P = 0.022). No significant age-group differences were observed for FMN or FBM (P = 0.121 and P = 0.808, respectively) (Table 4).

No statistically significant correlation was identified between the number of correctly answered knowledge statements and ODAS subdimension scores. The median HMC score was 104.5 (65-120) among participants who reported being positively influenced by media coverage related to organ transplantation, compared with 97.0 (20-120) among those who reported no

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Table 2. Distribution of participants' knowledge levels regarding organ donation

Knowledge statement	Correct responses		Incorrect responses		No opinion	
	n	%	n	%	n	%
An organ donor card alone is sufficient for organ donation. (False)	87	42.2	22	10.7	97	47.1
Organ donation from a living person can only be performed between blood relatives. (False)	167	81.1	20	9.7	19	9.2
An individual must be older than 18 years to make a decision regarding organ donation. (True)	177	85.9	12	5.8	17	8.3
Organ donation from deceased individuals is possible in all deaths. (False)	163	79.1	13	6.3	30	14.6
In brain death, the individual is medically deceased and vital functions cannot recover. (True)	120	58.3	47	22.8	39	18.9
Family consent is required for organ transplantation from a person diagnosed with brain death. (True)	185	89.8	8	3.9	12	5.8
Only kidney, liver, heart, lung, and cornea transplants can be performed from deceased donors. (False)	51	24.8	42	20.4	112	54.4
Tissue compatibility is an indispensable criterion for the success of kidney transplantation. (False)	12	5.8	142	68.9	51	24.8
In Türkiye, deceased donor transplants are more common than living donor transplants. (False)	31	15.0	58	28.2	116	56.3
Once organ donation is declared during life, it cannot be revoked. (False)	107	51.9	28	13.6	70	34.0

Note: One participant did not respond to the last five items (n = 205 for these items). Percentages were calculated based on the total sample (n = 206).

Table 3. Distribution of participants' attitudes toward organ donation

Question	Yes / may request		No / should not request		Undecided / not applicable	
	n	%	n	%	n	%
Do you have an organ donor card?	12	5.8	193	93.7	Not applicable	
Do you consider it ethical for your organs to be transplanted into a convicted criminal?	34	16.5	88	42.7	83	40.3
Do you think media reports on organ transplantation have positively influenced you?	136	66.0	69	33.5	Not applicable	
Do you know through which institutions or organizations you can donate your organs?	82	39.8	123	59.7	Not applicable	
Do you believe that equal opportunities are provided to wealthy and poor patients in organ transplantation?	21	10.2	129	62.6	55	26.7
How do you evaluate individuals who request payment or gifts in exchange for organ donation?	57	27.7	148	71.8	Not applicable	

Note: For the final item, "Yes" and "No" columns correspond to "May request" and "Should not request", respectively. One participant did not respond to any item in this table (n = 205 for each item). Percentages were calculated based on the total sample (n = 206).

Table 4. Distribution of ODAS scores according to sociodemographic characteristics

Characteristic	Group	HMC		FMN		FBM	
		Median (min-max)	*P*	Median (min-max)	*P*	Median (min-max)	*P*
Age group (years)	18-30	102.0 (20-120)	0.022	25.0 (10-52)	0.121	29.0 (10-52)	0.808
	31-65	109.0 (58-120)		21.0 (10-43)		28.5 (10-46)	
Gender	Man	99.0 (21-120)	0.602	24.0 (10-50)	0.608	29.0 (10-52)	0.967
	Woman	102.5 (20-120)		24.0 (10-52)		29.0 (10-52)	
Educational level	Associate degree or below	103.0 (21-120)	0.705	21.5 (10-47)	0.237	27.0 (10-52)	0.755
	Bachelor's degree or higher	102.0 (20-120)		25.0 (10-52)		29.0 (10-52)	

ODAS: Organ Donation Attitude Scale, HMC: Humanitarian and Moral Convictions, FMN: Fear of Medical Neglect, FBM: Fear of Bodily Mutilation. *P*-values were obtained using the Mann–Whitney U test. Educational level was dichotomized as associate degree or below versus bachelor's degree or higher. $P < 0.05$ was considered statistically significant.

positive influence; this difference was statistically significant ($P = 0.009$). The median FBM score was 26.0 (10-48) among participants who knew through which institutions or organizations they could donate their organs, whereas it was 30.0 (10-52) among those who did not; this difference was also statistically significant ($P = 0.023$). No significant differences were observed in ODAS subdimension scores with respect to the other opinion-based questions.

Discussion

This study was conducted to determine the level of knowledge, attitudes toward organ donation, and factors influencing these attitudes among individuals residing in the city center of Amasya. The principal finding was that participants demonstrated notably high humanitarian and moral conviction scores, but this favorable attitudinal disposition did not translate into concrete behavior, as reflected by the very low rate of organ donor card possession. This finding is consistent with the widely reported intention-behavior gap in the literature, which suggests that individuals may cognitively endorse organ donation yet remain hesitant to take actionable steps toward formal donor registration [12, 13]. A similar pattern has been reported in countries such as Jordan and Australia [13, 14].

In our study, the highest rate of correct responses was observed for the statement regarding the requirement for family consent in cases of brain death. This level of awareness is comparable to the knowledge levels reported among religious officials in Bolu (91.7%) and residents of Isparta city center (88.1%) [15, 16]. A high proportion of participants provided incorrect responses to the statement asserting that tissue compatibility is an absolute prerequisite for successful kidney transplantation. This finding suggests that substantial gaps persist in the public's understanding of medical procedures. Similar gaps in the legal framework and operational aspects of organ donation have been reported among health sciences students [17]. This finding is also consistent with data from Jordan, where limited technical knowledge about organ donation processes has been reported even among educated individuals [13].

In our study, the critically low rate of organ donor card possession directly mirrors trends observed in other regions of Türkiye, such as Sivas, Bolu, and Isparta [12, 15, 16]. This low registration rate also parallels findings from Australia, where hesitation regarding formal donor registration persists despite high levels of support for organ donation among students [14]. Notably, more than half of the participants in our study reported being positively influenced by media coverage related to organ transplantation, underscoring the influential role of visual and social media in shaping public attitudes in the Amasya context. Similarly, in the Bolu study, radio and television were identified as the primary sources of information [15]. These findings are further supported by studies conducted in Malaysia and Serbia, in which healthcare professionals identified mass media and digital platforms as principal sources of information, highlighting the critical role of media in shaping societal perceptions of organ donation [18, 19].

When similar studies assessing attitudes toward organ donation among individuals aged 18 years and older in the general population are considered, the findings demonstrate comparable patterns. In a study conducted in urban and rural areas of Burdur, the mean HMC score was reported as 96.8 (20.2), the mean FMN score as 27.2 (11.2), and the mean FBM score as 28.3 (11.9) [20]. In a similar population study conducted in Isparta, a significant

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proportion of participants expressed a strong desire to receive further information regarding organ donation. However, formal organ donor registration remained critically low, mirroring the structural trends observed in our cohort. Furthermore, despite some participants having familial experience with organ donation, family opposition emerged as a substantial potential barrier, even when individuals personally consented to become donors. In that study, the mean HMC, FMN, and FBM scores were 95.5 (20.3), 25.5 (11.4), and 25.5 (11.4), respectively [16]. In a study conducted among healthcare professionals working in a public hospital in Ankara, individuals who had received organ donation training exhibited generally higher total negative attitude, FMN, and FBM scores. Conversely, those who had donated organs demonstrated lower total negative attitude and FBM mean scores. Participants who were considering donation had lower total negative attitude, FMN, and FBM mean scores, along with higher HMC mean scores [21].

In the present study, ODAS subdimension scores were not normally distributed; therefore, results were reported as median (minimum-maximum) values. In contrast, many studies in the literature have presented scores as mean (SD), which limits direct comparison. Nevertheless, the median HMC score in the Amasya sample (102.0) was higher than those reported in general population studies conducted in Burdur (96.8) and Isparta (95.5), and was close to the score reported among nursing students (103.85) [16, 20, 22]. Furthermore, the FMN median score of 24.0 in our study was lower than the values reported in Burdur (27.2) and Isparta (25.5) [16, 20]. This may suggest a comparatively higher level of trust in the healthcare system and medical professionals among participants in Amasya. The FMN score identified in our study was also lower than negative attitude scores reported in studies conducted in Serbia and China, where distrust in physicians and fear of medical intervention were more prominent [19, 23]. Moreover, the median FBM score was significantly lower among participants who knew the appropriate institutions for organ donation. This finding further underscores the role of structured knowledge as a critical factor in reducing anxiety-related concerns. Consistent with this interpretation, studies conducted in China have demonstrated that increasing public knowledge about brain death and transplantation procedures directly enhances individuals' willingness to become organ donors [23].

With respect to demographic variables, our findings diverge from the literature in certain aspects. In studies conducted in Burdur and Sivas, women were generally reported to have higher humanitarian attitude scores [12, 20]. However, in the Amasya sample, gender did not produce a statistically significant difference in ODAS scores. Studies from Australia and China have indicated that women tend to report a stronger sense of moral obligation and compassion regarding potential organ donation [14, 23]. Regarding age, the 31-65-year age group demonstrated a significantly higher median HMC score than the younger group. This finding contrasts with results from studies conducted in Sivas and Burdur, where younger individuals were reported to exhibit more positive attitudes [12, 20]. It may be speculated that increasing life experience with age contributes to greater moral maturity and humanitarian sensitivity toward organ donation. Additionally, studies conducted in Jordan and Saudi Arabia have emphasized that younger populations tend to display more favorable attitudes toward organ donation [13, 24]. The absence of a significant effect of educational level on ODAS scores in the Amasya sample may be attributable to the relatively homogeneous distribution of education, as 62.6% of participants held a bachelor's degree.

The principal limitation of this study is the use of a non-probability sampling method and the inclusion of voluntary participants from the researchers' social networks, which limit the generalizability of the findings. Consequently, the results cannot be readily generalized to the entire population of Amasya city center or to broader segments of society. Additionally, the cross-sectional design precludes the establishment of definitive causal relationships between variables.

Conclusion

In conclusion, individuals residing in Amasya demonstrated notably high levels of humanitarian and moral attitudes toward organ donation; however, this potential was not adequately reflected in donor card registration rates. Correcting misinformation regarding medical procedures and reinforcing the positive influence of media through structured educational programs appear essential. The lower humanitarian and moral conviction scores observed among participants aged 18-30 years in this sample suggest that awareness initiatives tailored to younger adults may be beneficial. Future research should incorporate qualitative methodologies to more comprehensively explore the psychological and social barriers that hinder progression from intention to actual donor registration.

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