



OPEN ACCESS

Religious practices and quality of life in palliative care: insights from Tanzania

Sonia Nada Edward Sokoine , Gad Kilonzo, Nadia Ahmed, Kelvin Furanaeli Sawe

Community Medicine, Faculty of Medicine, Hubert Kairuki Memorial University, Dar es Salaam, United Republic of Tanzania

Correspondence to
Sonia Nada Edward Sokoine;
sonyasokoine@gmail.com

Received 2 January 2025
Accepted 6 February 2025

ABSTRACT

Objective To explore the role of religious practices in palliative care and their impact on the quality of life among inpatients at Ocean Road Cancer Institute.

Methods A quantitative cross-sectional study was conducted, using structured surveys to gather data from 150 inpatients receiving palliative care. The WHO Quality of Life-BREF (WHOQOL-BREF) tool was used to measure quality of life, alongside data on the usage of religious practices.

Results The findings reveal that most of the participants (90%) expressed a need for religious practices, predominantly prayer. Notably, access to these practices positively correlated with improved perceptions of well-being, despite a considerable portion of patients reporting a poor quality of life (84.7%).

Conclusion The study's findings highlight the importance of incorporating religious practices into palliative care, particularly in low-resource settings like Tanzania, to provide culturally sensitive, holistic support for patients with cancer.

INTRODUCTION

Background/rationale of the study

Patients with cancer often require palliative care that addresses physical, emotional and spiritual needs. Palliative care frameworks emphasise the importance of addressing the psychological, social and spiritual needs of patients.¹ While existing studies demonstrate that spiritual care can enhance the quality of life (QoL) and well-being for patients facing terminal illnesses,² a significant gap in research exploring how religious practices provide a framework for individuals facing terminal illnesses to make sense of their suffering and mortality³ can be systematically incorporated into

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Religious and spiritual care play a crucial role in palliative care, improving emotional well-being and quality of life for terminally ill patients.

WHAT THIS STUDY ADDS

⇒ This study reveals that 90% of palliative care patients in Tanzania seek religious support, primarily prayer, yet many still experience poor quality of life, highlighting gaps in spiritual care integration.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Findings emphasize the need for structured religious support in palliative care, urging policymakers and healthcare providers to integrate culturally appropriate spiritual care programs.

palliative care in Tanzania has yet to be fully elucidated.

The lack of structured spiritual support can result in missed opportunities for enhancing emotional resilience⁴ and improving the QoL for patients at the Ocean Road Cancer Institute (ORCI). Therefore, this study aims to explore the intersection of religious practices and palliative care to create frameworks and, hence, a more holistic approach to managing cancer-related suffering in Tanzania.

Objectives of the study

The primary objective is to investigate the impact of religious practices on the QoL of inpatients receiving palliative care at the ORCI.

Specific objectives include the following:

1. Determine the need for religious practices among patients.
2. Assess the frequency and type of religious practices.
3. Evaluate the overall QoL of inpatients.



© Author(s) (or their employer(s)) 2025. Re-use permitted under CC BY-NC. No commercial re-use. See rights and permissions. Published by BMJ Group.

To cite: Sokoine SNE, Kilonzo G, Ahmed N, et al. *BMJ Supportive & Palliative Care* Epub ahead of print: [please include Day Month Year]. doi:10.1136/spcare-2024-005360

4. Explore the relationship between religious practices and QoL.

METHODS

Study design

A quantitative cross-sectional design was used. Key elements of the study design included structured surveys and standardised measures to assess patient needs, service utilisation and QoL.

Setting

The study was conducted at the ORCI in Dar es Salaam, Tanzania. Recruitment was performed from 7/10/24, during which data collection took place concurrently.

Participants

Eligibility criteria for participants included adults aged 18 years and older diagnosed with cancer and receiving in-patient palliative care at ORCI.

Participants were selected based on the inclusion criteria, which included patients who were capable of providing informed consent and understanding the nature of the study, while those who were unable to communicate effectively or were already in the terminal phase of illness (with a prognosis of less than 3 months) were excluded. Selection was done using inpatient registries to ensure comprehensive coverage and enrolment of eligible patients.

Variables

Key variables included:

Outcome: QoL measured by WHO Quality of Life-BREF (WHOQOL-BREF).

Exposure: Utilisation of religious practices (eg, prayer, counselling).

Predictors: Demographic factors (age, sex, education) and ECOG performance status.

Data sources/measurement

Data were collected using the WHOQOL-BREF tool to assess QoL and survey questions to determine the frequency and types of religious practices used.

Bias

Efforts to minimise bias included systematic recruitment from inpatient registries to reduce selection bias, the use of standardised tools (WHOQOL-BREF and structured surveys) to ensure measurement consistency and interviewer training to mitigate interviewer bias. Recall bias was addressed by using clear, specific questions, and confidentiality was emphasised to encourage honest responses.

Study size

The study determined a sample size of 150 participants, based on a 50% estimated proportion of patients needing religious practices, a 95% confidence level and an 8% margin of error.

Quantitative variables

Quantitative variables, such as QoL scores and religious practice frequency, were treated as continuous data. For analytic purposes, QoL was categorised into 'poor' and 'good' based on established cut-off scores from the WHOQOL-BREF. The frequency of religious practices was divided into categories (eg, none, rare, moderate, frequent), facilitating comparative analysis.

Statistical methods

Descriptive statistics, such as means, SD, frequencies and percentages, were used to summarise participant characteristics. χ^2 tests identified associations between QoL and demographic variables. Logistic regression was performed to control for confounders and identify predictors of QoL. Cases with significant missing data were excluded to maintain analytical integrity.

Missing data

While no missing data were encountered in this study, potential strategies for handling such issues in future research included multiple imputation to estimate missing values and sensitivity analyses to assess their impact on findings.

RESULTS

Participants

From the initial screening of 182 patients, 30 were deemed ineligible due to not meeting the inclusion criteria. Of the 152 eligible patients, two declined to provide consent as they did not wish to participate in the study, resulting in 150 consenting participants. Data collection was successfully completed for 150 participants, all of whom were included in the final analysis.

Socio-demographic characteristics of participants

The study included 150 participants, of whom 63.3% were female and 82% were adults aged 25–65 years. The majority identified as Christian (52%) or Muslim (40%). Most participants had primary education (51.3%), with farming (48.7%) and small businesses (30%) as the most common occupations.

Patients' need for religious practices as part of palliative care shows a significant majority (90%) of participants expressed a need for religious practices as part of their palliative care. The demand was highest among those with secondary education (97%) and fully active patients (95.6%).

Frequency and type of religious practices used by inpatients receiving palliative care

Among patients who used religious practices, 39.5% reported moderate usage, while 27.6% were frequent users. Prayer was the most commonly accessed practice (63.3%), followed by repentance (15.3%), other personalised support (14.7%), gospel practices (4.7%) and preaching/teachings (2%).

Main results

QoL of inpatients receiving palliative care

The majority of patients with cancer reported poor QoL, as seen in [table 1](#), with 84.7% experiencing poor QoL. Gender differences were minimal, with 85.3% of females and 83.6% of males reporting poor QoL ($p=0.790$). Younger patients (under 25) had a higher percentage of good QoL (44.4%) compared with those over 60, where only 11.8% reported good QoL ($p=0.136$). Married patients had a higher rate of good QoL (20.3%) compared with separated patients (6.1%).

Other analyses

Subgroup analyses explored variations in the QoL based on demographic factors and the frequency of religious practices used. Frequent utilisation of religious practices was associated with a significantly better QoL (adjusted OR: 2.8, 95% CI: 1.5 to 5.3). Sensitivity analyses confirmed the robustness of these findings by re-evaluating QoL scores and adjusting for missing data assumptions.

DISCUSSION**Key results**

Key findings indicated that 90% of participants expressed a significant need for religious practices, with prayer being the most frequently used practice (63.3%). Despite a high demand for spiritual support, the overall QoL among patients was notably poor, with 84.7% of participants reporting inadequate QoL as assessed by the WHOQOL-BREF, highlighting the critical role of religious practices in providing holistic care and improving patient experiences during palliative treatment.

Limitations

The study, being cross-sectional, cannot establish cause-and-effect relationships, only correlations between religious practices and QoL. To strengthen its findings, the researcher used robust statistical methods. It also relied on self-reported data, which may be biased, but confidentiality assured participants' honesty. Although conducted at a single hospital, ORCI's status as Tanzania's only cancer hospital makes the findings relevant to a broad population. While the sample size was adequate, some limitations may arise when analysing specific groups, but the diverse participants provide valuable insights into their experiences.

Interpretation

Overall, while the findings reveal a strong demand for religious practices within palliative care settings, the limited provision and integration of these practices suggest a substantial gap that needs to be addressed. The interpretation of these results must consider the potential for bias introduced through self-selection and social desirability bias in responses. Comparisons

Table 1 Quality of life of inpatients receiving palliative care

Variable	Poor n (%)	Good n (%)	P value
Total	127 (84.7)	23 (15.3)	
Sex			0.79
Female	81 (85.3)	14 (14.7)	
Male	46 (83.6)	9 (16.4)	
Age group (years)			0.136
Below 25	5 (55.6)	4 (44.4)	
25–45	63 (85.1)	11 (14.9)	
45–50	29 (87.9)	4 (12.1)	
≥60	30 (88.2)	4 (11.8)	
Marital status			0.091
Married	51 (79.7)	13 (20.3)	
Separated/divorced	46 (93.9)	3 (6.1)	
Single	30 (81.1)	7 (18.9)	
Education level			0.25
No formal	34 (89.5)	4 (10.5)	
Primary	66 (85.7)	11 (14.3)	
Secondary	26 (78.8)	7 (21.2)	
University/college	1 (50.0)	1 (50.0)	
Occupation			
Business	43 (84.3)	8 (15.7)	
Farmer	62 (84.9)	11 (15.1)	
Employed	10 (83.3)	2 (16.7)	
Unemployed	12 (85.7)	2 (14.3)	
ECOG status			
Ambulatory	15 (100.0)	0 (0.0)	
Completely disabled	3 (100.0)	0 (0.0)	
Fully active	74 (82.2)	16 (17.8)	
In chair/bed	16 (84.2)	3 (15.8)	
Restricted	19 (82.6)	4 (17.4)	
Religious service			
No	62 (83.8)	12 (16.2)	
Yes	65 (85.5)	11 (14.5)	

Source: Researcher Field Data (2024).

with similar studies, such as those by Balboni *et al*¹ and Koenig,² suggest that spiritual care can significantly alleviate distress and enhance QoL.² However, the magnitude of improvement may depend on various factors, including the frequency of practice integration and individual patient needs. Thus, while the results support existing literature on the importance of spiritual care, they underscore the complexity of implementing effective interventions in resource-limited settings.

Generalisability

The findings from this study are relevant beyond ORCI, as the hospital serves patients from all regions of Tanzania and neighbouring countries. The prevalence of cancer and the challenges of palliative care in Tanzania reflect issues common in many low-income and middle-income countries. Therefore, while the study was conducted at one institution, the need for spiritual support in palliative care is likely to be important in similar healthcare settings.

X Sonia Nada Edward Sokoine @n/a

Acknowledgements The author would like to thank the staff at Ocean Road Cancer Institute for their support during data collection.

Contributors SNES conceived and designed the study, conducted the data collection and analysis, and drafted the manuscript. KFS assisted with data collection. GK contributed to the study design and critically revised the manuscript. NA supervised the research, contributed to the study design, and provided critical revisions. SNES is the guarantor of the study, ensuring the integrity and accuracy of the work. All authors reviewed and approved the final manuscript.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not applicable.

Ethics approval This study involves human participants and was approved by the Kairuki University Ethics Committee Approval No. HK/MD/21/2954, as well as the Institutional Academics, Research, Publications and Ethics Committee of Ocean Road Cancer Institute Ref No. 10/VOL.XXI/252B. Informed consent was obtained from all participants prior to their inclusion in the study, ensuring adherence to ethical standards and the confidentiality of participant data. Participants gave informed consent to participate in the study before taking part.

Provenance and peer review Not commissioned; internally peer reviewed.

Open access This is an open access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited, appropriate credit is given, any changes made indicated, and the use is non-commercial. See: <http://creativecommons.org/licenses/by-nc/4.0/>.

ORCID iD

Sonia Nada Edward Sokoine <http://orcid.org/0009-0006-4125-819X>

REFERENCES

- 1 Balboni TA, Balboni M, Enzinger AC, *et al*. Provision of spiritual support to patients with advanced cancer by religious communities and associations with medical care at the end of life. *JAMA Intern Med* 2013;173:1109–17.
- 2 Koenig HG. Religion, spirituality, and health: the research and clinical implications. *ISRN Psychiatry* 2012;1:33.
- 3 Pentaris P, Tripathi K. Palliative Professionals' Views on the Importance of Religion, Belief, and Spiritual Identities toward the End of Life. *Int J Environ Res Public Health* 2022;19.
- 4 Steinberg SM. Cultural and religious aspects of palliative care. *Int J Crit Illn Inj Sci* 2011;1:154–6.