

# Beyond prayer: Expanding the understanding of quality of life in Tanzanian palliative care

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## Abstract

The recently published study "*Religious practices and quality of life in palliative care: insights from Tanzania*" has brought to the forefront the indispensable role of spiritual practices in supporting patients with advanced cancer. The overwhelming demand for prayer and faith-based engagement demonstrates how religion provides meaning, resilience, and comfort in the face of terminal illness. However, quality of life (QoL) is multifaceted, and evidence from ongoing research in Tanzania suggests that functional status, social support, and psychosocial well-being are equally critical determinants. For instance, preliminary data from the Ocean Road Cancer Institute indicate that performance status, measured by the Eastern Cooperative Oncology Group (ECOG) scale, is strongly associated with physical and psychological domains of QoL, while social support offers protective benefits. This commentary extends the conversation by situating religious practices within a broader, integrative framework of palliative care that encompasses spirituality, functional ability, psychosocial support, and socioeconomic realities. We argue that only through such holistic approaches can Tanzania and other low- and middle-income countries (LMICs) meaningfully improve QoL for patients at the end of life.

**Keywords:** Palliative care, Quality of life, Spirituality, ECOG, Functional status, Tanzania

## Introduction

The publication of "*Religious practices and quality of life in palliative care: insights from Tanzania*" marked an important contribution to the literature on culturally sensitive palliative care in low-resource settings [1]. The study demonstrated that religious practices, especially prayer, are central to how Tanzanian patients cope with the realities of advanced cancer. Ninety percent of participants expressed a need for spiritual engagement, and frequent religious practice was positively associated with better quality of life (QoL) despite widespread suffering [1].

While these findings are significant, they also raise critical questions: Are spiritual practices sufficient to sustain quality of life in the face of progressive disease? What other domains of experience should be prioritized if palliative care is to become truly holistic? This commentary argues that, in Tanzania and other low- and middle-income countries (LMICs), spirituality must be integrated with attention to functional ability, social support, and psychosocial well-being.

## The Centrality of Religious Practices

The BMJ Supportive & Palliative Care short report rightly situates spirituality as a cornerstone of palliative care in Tanzania. Such findings resonate with global literature, where spiritual support has been shown to reduce distress, enhance coping, and influence end-of-life care preferences [4–6]. In societies where religion permeates daily life, spiritual care is not an optional luxury but a fundamental dimension of health.

Yet, the paradox observed in Sokoine *et al.* remains striking: despite near-universal demand for religious practices, 84.7% of patients reported poor QoL [1]. This disconnect suggests that spirituality, while essential, cannot fully counterbalance the effects of physical decline, uncontrolled pain, and socioeconomic deprivation.

## Emerging Evidence: Functional Status as a Determinant of QoL

New local research at the Ocean Road Cancer Institute is beginning to highlight additional determinants of QoL in Tanzanian palliative care. Preliminary findings from a cross-sectional study of 150 cancer patients reveal a significant association between functional status, measured by the ECOG scale, and quality of life. Patients with higher ECOG scores—indicating greater physical disability—reported markedly poorer QoL, particularly in the physical and psychological domains.

Conversely, those with stronger social support networks scored better in emotional well-being and life meaningfulness, even when functional decline was advanced. These findings mirror studies from Nigeria and Kenya, where mobility limitations and pain have been linked to diminished QoL, while family and community ties act as buffers against emotional distress [7,8].

Although preliminary and unpublished, these Tanzanian data suggest and reinforce the notion that religious practices must be embedded within a multidimensional framework of palliative care—one that addresses the whole person, not just the spiritual domain.

## Interplay of Spirituality and Functionality

Taken together, the religious practices study [1] and emerging ECOG data suggest a complex interplay:

- Spirituality provides existential comfort and meaning.
- Functional capacity shapes physical and psychological well-being.
- Social support strengthens resilience in both domains.

QoL in palliative care therefore cannot be understood as the product of one determinant but as the interaction of many. Ignoring functional limitations risks leaving patients physically debilitated despite their spiritual strength. Similarly, focusing solely on pain control or mobility without addressing spiritual needs neglects existential suffering.

## Implications for Policy and Practice in LMICs

For LMICs like Tanzania, the integration of spiritual and functional care is not merely idealistic—it is practical and necessary. Resource constraints mean that high-tech interventions are often unavailable, but low-cost strategies such as:

- routine ECOG assessment,
- structured pain management,
- community-based psychosocial support, and
- incorporation of spiritual counselors

could be feasibly implemented. ORCI and other regional centers could pioneer QoL monitoring protocols using WHOQOL-BREF and ECOG alongside spiritual assessments, ensuring that care remains patient-centered.

## Research Gaps and Future Directions

Both studies share limitations. Cross-sectional designs prevent causal inference, and single-institution recruitment limits generalizability. Future research should:

- Employ longitudinal designs to map changes in spiritual engagement and functional decline over time.
- Test integrative interventions—such as combining physiotherapy with pastoral care—to evaluate synergistic effects on QoL.
- Explore environmental and socioeconomic determinants, such as financial burden and housing conditions, which remain under examined in Tanzanian oncology.

## Conclusion

The study on religious practices in Tanzanian palliative care made a vital contribution by documenting the spiritual needs of patients with advanced cancer [1]. Yet, preliminary data from ORCI highlight that functional status, social support, and psychosocial well-being are equally critical determinants of QoL.

We therefore call for a reframing of palliative care in Tanzania: one that retains spirituality at its core but integrates it with interventions that sustain physical functionality, manage pain effectively, and strengthen social and economic support systems. Only through such holistic strategies can the paradox of strong spirituality alongside poor QoL be resolved.

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