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Faith and palliative care: a partnership of care in low- and middle-income countries

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ABSTRACT
The provision of holistic palliative care has been identified by WHO as a human right, important for all people, at all ages, with all life-limiting illnesses. When faced with death and dying, issues of meaning and relationships with others, the world, and with the sacred are intensified even more in communities where faith and spiritual beliefs have a significant place. Being able to understand the significance of dying and interpreting the experience and period of living with life-limiting illness, presents an important challenge for palliative care. This article sets out the contribution that faith communities have made in understanding the significance of spiritual issues in health and in delivering palliative care in lower to middle-income contexts where palliative care has been prioritised.

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Introduction

The World Health Organization (WHO) defines palliative care as an “approach that improves the quality of life of patients and their families facing life-threatening illness, through the prevention and relief of suffering by means of early identification, assessment and treatment of pain and other problems, physical, psychosocial and spiritual” (WHO 2015a: 1). The need for palliative care services are great, and lack of services mean costly deaths, and significant suffering due to things as basic as the absence of analgesia. Universal health coverage cannot be achieved unless palliative care is available, accessible, and affordable for all people regardless of age, illness, or stage of illness. The quality signature of a nation’s health system is expressed in the way a nation deals with those who are being born, and those who are departing life.

Globally, numerous factors result in unmet palliative care needs. These include poverty, the continuing burden of HIV/AIDS and its co-morbidities, the rapid rise of non-communicable diseases (NCDs), the fragility and fragmentation of health systems, the disconnected pathways between urban and rural health services, workforce shortage, and scarce or unreliable opioid availability. The focal point of unmet needs is in sub-Saharan Africa (SSA) and the sub-continent of South Asia. In both SSA and South Asia, over 80% of all patients present with advanced disease (Connor and Sepulveda Bermedo 2014). Ninety-eight per cent of children needing palliative care live in low-and middle-income countries (LMICs), with almost half of them living in Africa (WHO 2015a).

The average life expectancy in Africa is 55.5 years, compared to 75 years of age in Europe (WHO 2015b). Estimates suggest that less than 5% of those in need of care can actually access such care (Grant et al. 2011). WHO has identified that the largest increase in death rates from cardiovascular disease, respiratory disease, and diabetes over the next 10 years will be seen in SSA. Figures from 2012 suggested there were 645,000 new cases of cancer in SSA, resulting in nearly half a million people dying (IARC 2012).

India also has rising levels of multi-morbidity, including a huge burden of NCDs, and, despite economic progress, inequalities in wealth distribution severely affect access to health care. Point estimates have suggested at least 34 million people are in need of palliative care in India, with less than 1% able to access the care that they need. The International Agency for Research on Cancer’s (IARC) Global Burden of Cancer Study (GLOBOCAN) calculated that there were 919,400 cancer deaths in South Asia in 2012 (IARC 2012), a number predicted to grow six-fold by 2050. This is attributable to aging populations, poor screening or early detection programmes, and HIV-related cancers (IARC 2012). The distribution of palliative care services is heavily biased towards the south and the state of Kerala in particular (Rajagopal and Palat 2002).

During the last few years, there has been a significant global shift in understanding of the value of, and the need for, palliative care. In 2014, the World Health Assembly (WHA) passed the first Resolution on Palliative Care (WHA 2014). This resolution recognises that the end-of-life care of millions living with NCDs, including cancers, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure, and chronic infectious diseases, such as Multi Drug Resistant Tuberculosis (MDR-TB) and HIV, are major concerns. The resolution points to a paradigm shift in global and regional understanding of the purpose of palliative care. It also calls for commitments to build services at national levels with the reach and capability to enable consistent holistic care to be delivered as a right of health (WHA 2014). The resolution was the result of significant advocacy, some of which had its beginnings in the work that faith-based initiatives carried out delivering the palliative care needs of millions who were dying with no recourse to adequate care. Cases drawn from studies from several LMICs (Table 1) will show how faith communities and services shaped by those motivated by faith were instrumental in leading the provision of palliative care services.

In communities where faith and spiritual beliefs have a profound place in determining perspectives and values, being able to understand the significance of dying, and being able to support people during the increasingly lengthy period of living with end-stage illness, presents an important challenge to all health systems. Human beings are intimately and intricately connected to the world in which they
Table 1. Summary of studies synthesised in this article.

<table>
<thead>
<tr>
<th>Study title and country</th>
<th>Study year, country, and method</th>
<th>Ethics</th>
<th>Core results</th>
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<tr>
<td>1. Exploration of narratives as a form of spiritual support to patients with life-limiting illnesses within Mulago National Referral Hospital (Onapito 2016)</td>
<td>2015–16 Uganda An exploratory qualitative study using semi-structured interviews ($N = 14$), purposively sampled from adult patients with life-limiting illnesses referred to the specialist palliative care team.</td>
<td>Mulago Research and Ethics Committee and the Uganda National Council for Science and Technology.</td>
<td>Response to diagnosis: feelings of hopelessness, fear and isolation, and loss of meaning. Sources of support include family and faith/religious practices. Listening is valued (providing hope, meaning, and presence). Challenges faced in telling stories. Eliciting narratives is an important spiritual support system that enables at different stages of the illness. Patients can construct rich descriptions and meaning which may contribute to better health.</td>
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<td>2. Multidimensional experiences and needs of Ugandan heart failure patients over their illness course (Namukwaya 2016)</td>
<td>2013–16 Uganda Patients with heart failure recruited in MNR hospital and serial in-depth interviews ($N = 48$) conducted at three points over six months. Interviews with 21 patients and some family carers. Grounded theory approach used in analysis.</td>
<td>Mulago Research and Ethics Committee and the Uganda National Council for Science and Technology.</td>
<td>Patients’ experience of learning to live with the unknown in a life dominated by symptoms. The trajectory of functional and social decline mirrored the increasing symptom burden. Other themes included: high levels of health illiteracy; lack of information on illness; high reliance on local cultural beliefs to make health decisions; and health system challenges. Illness impacted social, psychological, and spiritual domains of patients’ lives, creating multidimensional needs which available services failed to meet.</td>
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<td>3. Experiences of patients living and dying with advanced heart failure in Kenya (Kimani, Murray, and Grant 2016)</td>
<td>2013–17 Kenya At rural district hospital in Kenya, serial in-depth interviews ($N = 20$) conducted with patients at 0, 3 and 6 months after recruitment and bereavement and with some carers. Translation between Kiswahili and English and thematic analysis.</td>
<td>Kenyatta National Hospital/University of Nairobi Ethics and Research Committee (P469/07/2014) and the Ethics Review Group at the University of Edinburgh.</td>
<td>Patients experience physical, psychosocial, and spiritual suffering throughout their illness. Many felt uncertain about the future but believed God was in control of their illness and had power over life and death. Accumulating costs from long-term care created a substantial financial burden for patients and at times strained relationships with family members. Many patients expressed a desire for more information about their illness.</td>
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<td>4. Understanding models of palliative care delivery in sub-Saharan Africa: learning from programmes in Kenya and Malawi (Downing et al. 2015)</td>
<td>2010–11 Malawi and Kenya Case study evaluation to define the models used, contextualise them, and identify challenges, best practices, and transferable lessons for scale-up. Included seven site visits and varied data collected from programme staff,</td>
<td>Ethical approval not required.</td>
<td>Three models of palliative care service delivery were identified: specialist, district hospital level, and community level. Sets of assumptions underpinned each model and influencing staff and patient decision-making and allocation of resources. The health system structure and the beliefs about palliative</td>
</tr>
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live, they have choice and control, a responsibility to each other and a responsibility to, and for, the use of the world’s resources. Just as there is an interconnection between the health of the natural systems and the health of populations, there is also a fundamental, though complex, relationship between the unity of physical and spiritual health in an individual. As one of the most significant ways we express spirituality, religious traditions and beliefs shape people, places, and cultures, determine health behaviour, and the ways in which individuals and their communities face illness and death. For religions—whether their core aim is one of individual negation and separation from this world, or of investment and improvement within the world, or somewhere in between—their sacred texts, symbols, stories, rites, and traditions have recognised the space between the living and the dead as a powerful space, and the journey from life through death as one imbued with meaning.

Spirituality is a complex paradigm that encompasses meaning, purpose, value, connectedness, and an awareness or relationship with the transcendent. For many people, this is expressed in and through their internalised faith construct and through communities. Definitions include a “search
for what is sacred or holy in life, coupled with a transcendent (greater than self) relationship with God or a higher power or universal energy” (Wasner et al. 2005, 616), and a system which focuses on those elements that impart vitality and meaning to life’s events (Tanyi 2002). Literature, especially from high-income countries, has identified the significance of spirituality in supporting, navigating and delivering palliative care (Grant et al. 2004; Grant, Murray, and Sheikh 2010; Loike et al. 2010; Lorenz et al. 2005; Miller et al. 2005).

At various points, faith communities have contributed to delivering palliative care in LMICs where palliative care has neither been prioritised nor adequately resourced. Responding to the AIDS pandemic, faith communities developed multiple palliative care responses such as those described by Van Wyngaard (2013) which sought to understand and address the spiritual needs of HIV-infected patients. Faith-based charities and NGOs such as Tearfund, Christian Aid, and Mildmay, established services and developed resources for end-of-life care (Clark et al. 2007; Featherstone 2015; Mildmay 2017; Tearfund 2011). In a review of hospice and palliative care services in 15 countries, Clark et al. (2007) identified that the majority were delivered by non-governmental, charitable groups and faith communities. In a further review of services and experiences of dying in India, McDermott identified similar findings, with negligible public resources invested in end-of-life care (McDermott et al. 2007).

This article explores the intersection of faith and health issues from the perspectives of patients living with terminal illnesses. Our aim is to identify how faith motivated health care users and providers – and influences care – in particular the spiritual and physical needs of people with end-stage NCDs. The article also outlines ways in which faith communities shape the narrative of death and dying and determine demand for, and use of, services.

Method

The findings of several related studies to which the authors have contributed over the past six years are synthesised. These studies are based on primary research in LMIC communities relying on a variety of data sources and methodologies. Core themes from each study were identified, summarised, and interpreted to gain deeper insight into the relationship between faith and palliative care in different contexts (see Table 1).

Faith services in action: patients’ spiritual issues and needs

The palliative care team at Mulago National Referral Hospital in Uganda

Uganda, like many countries in SSA, is highly religious, with 84% of people identifying themselves as Christians (Uganda Bureau of Statistics 2014). While many people are religious, traditional religious beliefs and practices have survived, and been incorporated into the expressions of Christianity and Islam. Church funerals are frequently held alongside mourning rituals, libations, and traditional grieving practices and rites (Leggett 2001).

The palliative care multi-disciplinary team at Makerere University and Mulago National Referral Hospital (MNRH) Uganda, comprises doctors, nurses, trainers, and a theologically trained Pastoral and Social Care Coordinator who manages a strong team of volunteers, many of whom are motivated by their faith to work alongside those who are sick and vulnerable. The following two case studies illustrate different components of spiritual needs, and spiritual care offered to end-of-life patients (Table 1, studies 1 and 2).

Though not a faith-based hospital, volunteers in this national public hospital have been trained to provide a combination of practical and spiritual support to patients using the technique of storytelling. Storytelling has been at the heart of human interrelatedness and caring, with communities defining and describing themselves by receiving, holding, and telling stories about themselves and their forebears (Frank 1995, Posey 1999). Patients described storytelling as being valuable in providing spiritual care to patients with palliative care needs, as patients reported being able to share their
fears and concerns about death and dying. It provided a system to construct meaning about what they were going through (Onapito 2016). One of the patients explained:

“When I got HIV, I somehow got used to it and I was living well while taking my medication. However, I was then diagnosed with cervical cancer. I got so confused, angry, with many questions in my head. The truth is I have not been living a right life, so I thought that maybe God is punishing me for what I was doing, because I had got used to the HIV, and I had accepted it. Then this cancer also came. The Priest visits me and I talk to him always. That helps me a lot otherwise I would have gone insane.” (45-year-old female, Kampala, 2016)

Another patient described the value of having religious leaders visiting in hospital:

“Sometimes we just need the Reverend to just come and sit with me. You may not say anything, but just the fact that you are around and I can feel your presence means a lot to me. It is a sign that God cares about me.” (57-year-old male, Kampala, 2016)

Where the clinical team recognised the importance of religious activity and provided the opportunity for practical religious observances, patients described a sense of well-being and coping in the face of their impending death.

A complementary study conducted in 2014 by Namukwaya et al. (Table 1, study 2) interviewed 20 patients with end-stage heart failure registered at Mulago hospital. Patients expressed spiritual interpretations of physical needs as they searched for meaning and significance in the face of death. Patients described seeing their illness as caused by God and as a test of their faith, a punishment for their past behaviour, or as having its origin in Satan or witchcraft brought about by jealous or angry neighbours or family:

“It is a test and you have to go through it … In my religion it is said that every test must have a reason for its occurrence and must have an answer to it. So this is what scares me most because, whenever there is a test and you have no answer you must be scared that you have failed so if an illness comes and you don’t know the cause you just know that it will continue to get worse because you do not know what the cause is.” (Patient 8, Interview 1, Kampala, 2014)

Beliefs that the source of illness lay in being bewitched determined health-seeking behaviour for participants who described how they simultaneously used medical services and traditional healers to manage their illness. “As you know in the village, people thought I had been bewitched, I even tried and went to a witch doctor” (Patient 13, Interview 1, Kampala, 2014).

The impact of living with terminal illness was expressed by many as spiritual pain or loss. The experience led to a sense of being valueless and being abandoned by God. “For me I think God got tired of us” (Patient 4, Interview 1, Kampala, 2014). Religious decision-making impacted on medical care, especially where patients interpreted medical treatment as incompatible with faith. This was most pronounced in situations of palliation where health providers, anxious not to be seen to be carrying a message of death, struggled to inform individuals of the inevitable course of their illness.

“The pastors have been praying for me but most problems have changed now. Do you know that I do not take my medicines these days but my blood pressure is normal it surprises me too … yes, but well it mostly depends on your faith, if they pray for you and you believe that you are cured.” (Patient 20, Interview 1, Kampala, 2014)

Having faith in God and surrendering to Him, as well as meditating on descriptions of suffering in sacred texts, were frequently identified as core strategies for coping.

“I am strong but it is just that God has not allowed my cure yet but I am hopeful that I will get better. I am not worried God knows my future my faith supports me. I left it in God’s hands.” (Patient 1, Interview 2, Kampala, 2015)

The experiences of individuals with advanced heart failure in Kenya

This case provides further insights into the ways in which religious beliefs shape the experience of patients living with terminal illness. Kimani, Murray, and Grant (2016, 2017) explored the experiences
of 20 patients with advanced heart failure living in central Kenya. They identified ways in which individuals with palliative care needs expressed their spiritual needs and issues (Table 1, study 3). Serial interviews conducted in Kiswahili revealed that patients suffered significant distress on all levels – physical, psychosocial, and spiritual, throughout their illness. At all stages, patients expressed an overarching belief that God was in control of their illness and life in general. Although most patients were aware that they had a “heart problem”, they resigned their fate to God. “I leave everything to God. What he decides shall be” (57-year-old female, Nairobi, 2015).

Illness was frequently interpreted through a lens of cosmological beliefs. Some saw their illness as the result of a curse or witchcraft, especially when their symptoms were unresponsive to treatment. “I think this is a curse … I don’t understand what type of curse this is. I’m not dead but I’m not getting better either” (31-year-old male, Nairobi, 2015).

When their physical functioning deteriorated further despite treatment, patients expressed their disappointment in God. They felt abandoned and wondered why this illness had befallen them. “Have I wronged you God? Why should I be the only one with these problems?” (57-year-old female, Nairobi, 2015).

Feelings of disappointment increased with subsequent hospital admissions and were more pronounced in younger patients. For other patients, illness was interpreted as a trial they had to overcome before they received a blessing. “What I am going through is a trial. Before you receive a blessing you must go through difficulties. I know there are blessings ahead” (33-year-old female, Nairobi, 2015). This belief was grounded in a particular expression of religion, often cited within a prosperity gospel domain, popular across Kenya (Hunt 2000).

Many patients saw their faith communities as sources of support, and guidance as to live with their illness. Sharing experiences with fellow church members helped individuals feel less alone, and reduced social isolation and fear. However, while the majority of patients interviewed spoke positively, a small number described how they experienced judgement from religious leaders. One patient spoke about being turned away as the church was not for those who were ill:

“I used to be a pastor in a church but once they found out I was sick they abandoned me. I was asked not to go back to the church. No one wants to be close to you when you have problems.” (33-year-old female, Nairobi, 2015)

During their last days of life, most participants found it difficult to speak about death as they felt that life and death were in the hands of God, and therefore to speak about death was to question God’s authority. However, while holding this belief, many held a parallel view that it was good to do what they could to secure their health. “It’s good to go to the hospital to see if you’ll get better … you never know God’s plans” (60-year-old male, Nairobi, 2015).

This study, though small, is to our knowledge the first to examine in detail the perspectives of individuals with heart failure about their illness and how it is interpreted through a highly religious world view in which God is viewed as the overall orchestrator of health, illness, life, and death. Biomedical approaches to healthcare can fail to appreciate the central role of religion and faith in the lives of communities in Kenya and many other LMICs (Kimani, Murray, and Grant 2016). Recognising that palliative care is a holistic approach that acknowledges the role of spirituality in patients’ experience of illness provides space for patients to express their own understanding of the intersection of faith and health.

These studies present patients’ voices describing the significance of faith, and the intertwining of spiritual beliefs, interpretations of illness, and decisions about health care. These have been influenced by religious agencies and personnel that have spearheaded palliative services.

**Faith services in action: faith communities delivering palliative care**

**Provision of palliative care through a Roman Catholic order in Malawi**

The following case study describes the provision of palliative care within a faith-led health initiative (Table 1, study 4) at the Chipini Health Centre (CHC), situated in a rural region of southern Malawi. The
Medical Missionaries of Mary provides services to patients with HIV, TB, cancers, and vulnerable patient groups such as elderly patients, and those who are physically disabled. These include counselling and spiritual support, pain relief and symptom control, nutritional support and herbal remedies; for example, extracts from the plant aloe vera for pain management. The adaptation of services to provide holistic care established a strong continuum of care to meet end-of-life care needs. Participants explained that Chipini’s approach was to provide care shared between clinic and homestead. This basic and yet often misunderstood or unrecognised emphasis on shared care is a core feature of faith communities’ approaches. It has significant impact on the health system, which frequently works in silos and functions as the centre of care. It breaks down traditional and often rigid views, choices, and decisions that are made as to the place and nature of care. The success of faith initiatives in promoting shared care is a result of the physical proximity of clinics to the community. Faith communities’ additional innovation in palliative care has been to actively draw together the different components of care, recognising that holistic care is not just about managing physical symptoms.

The Chipini team developed a regional network providing care for 76 villages within the Chipini region. Using a parish-based system, common within faith-based organisational structures, they have demonstrated how to best manage health workloads. Volunteers are appointed for each village (population 300–500 people). The 76 villages are arranged into seven clusters or centres and volunteers from each centre meet regularly. Each group has its own executive. The volunteers also care for the orphans in their villages, meeting regularly with their guardians to report special needs. Volunteers feel involved, carry responsibility and autonomy in their decision-making and have clear remits, contributing to a system of extensive and equitable geographical coverage.

Provision of palliative care through a faith-based NGO in India

A review of Emmanuel Hospital Association (EHA) in India carried out by Goswami et al. (2015) provides a description how an established faith agency delivers palliative care (Table 1, study 5). EHA was founded in 1969, as an indigenous Christian health and development agency working in north India with a particular remit to provide healthcare for the rural poor, with 20 hospitals, 42 community health and development projects, seven nursing schools, six HIV/AIDS projects, and now ten palliative care services. With an area population of nearly 7 million, EHA treats more than 600,000 patients each year in some of India’s most needy areas. EHA partners with government, voluntary agencies, and other organisations. The hospitals and services are not-for-profit and funded from patients’ fees as well as project funding. They have a clear focus on care for the marginalised and poor, and values-based health care that makes the integration of palliative care intuitive and meaningful.

The first palliative care service was started at the Harriet Benson Memorial Hospital, Lalitpur, Uttar Pradesh in March 2010 following a comprehensive needs assessment conducted in 265 surrounding villages. A seven-bed in-patient and out-patient ward was renovated, staff trained, and an outreach programme developed to increase awareness. This religious-led centre has also become involved with local preventative measures such as tobacco control and secured a narcotic license, one of the essential components of palliative care provision. Similar models have been established in ten hospitals in six states in north and eastern India. The strategy of co-delivery of care within community and hospital simultaneously and consecutively is one of the markers of the faith-based initiatives of palliative care. The hospital has pioneered an extensive community home-based care programme with volunteers, many from faith communities, trained by hospital teams in delivering basic care. These community volunteers are the eyes and ears of the health system, creating the linked networks and ensuring that patients and their families become part of a family of care.

A significant contribution of faith-inspired agencies working in this area has been been the emphasis on holistic care. The motivations for such care were multi-faceted, from a recognition of the complexity of patients’ needs as they live with life-limiting illnesses, to a strong belief in
justice and human rights, and a responsibility of care derived from a faith conviction, “We are here to serve the sick, the downtrodden, and the suffering, we are here to be his model as we love our neighbour and love one another” (hospital palliative care team pastor, Uttar Pradesh, 2016).

**Faith services in action: palliative care as a microcosm of integrated poverty alleviating health service provision**

Faith communities were among the first to identify that palliative care provision is not simply good practice but a mechanism to prevent people from being pushed into cycles of poverty. A pilot study conducted by EHA in partnership with the Edinburgh Medical Missionary Society (EMMS) International (Thyle 2016, see Table 1, study six) has documented how palliative care functions as a poverty alleviation strategy in the rural, poor population of Uttar Pradesh. Sixty-six per cent of palliative care patients had lost their livelihoods due to illness, 26% of their families had members who had lost livelihoods due to the illness, 71% of households incurred costs of palliative care medicines, other treatments and laboratory costs, and 18% incurred high costs of travel to healthcare facilities. Eighty per cent of households incurred these costs, and 98% of enrolled households have debts, 39% had loans with interest, and 59% had loans without interest, for which they had had to sell assets. Sixty-nine per cent of households incurred debt after their family member fell ill. After receiving palliative care services 85% of patients and their families spent less each month on medicines and travel after joining the palliative care service than they had before, due to the service’s symptom management, provision of cheaper or free medicines and home-based care. Palliative care teams were able to inform patients and families of government benefits and support their enrolment as those least able to negotiate the systems to receive benefits (Thyle 2016).

**Providing spiritual support in children’s palliative care**

Like adults, children also need to attribute meaning to their illness, whether it be related to “God” or a “spiritual being” or linked to beliefs that their behaviour has caused the illness – for example, “if I had not been angry with my father he would not have died”. The Beacon Centre project (Downing et al. 2013) set out to develop children’s palliative care facilities in three African countries – Uganda, Tanzania, and South Africa. Central to the training provided was the concept of spirituality in children, the interplay between health and faith and traditional beliefs, and the role of faith-based organisations within the provision of care.

**Discussion and conclusion**

Dame Cicely Saunders, the founder of the modern hospice and palliative care movement in the United Kingdom, said, “You matter because you are you. You matter to the last moment of your life and we will do all we can, not only to help you die peacefully, but also to live until you die” (Saunders 1976, 1003). Dr Robert Twycross, speaking at Dame Saunders Memorial Service, noted:

“Her faith was a major, possibly the major, force in her life which sustained her through thick and thin. To ignore this would be to ignore a major source of her resilience and dedication. Cicely's personal watchword must surely have been: ‘I am loved, therefore I am’.” (St Christopher’s Hospice 2006)

Palliative care is more than a medicine-focused response to symptoms that arise in irreversible illness that may point to why faith agencies have been leaders in developing services. Its holistic approach sets palliative care apart from other clinical care specialties by recognising that humans are much more than a physical body; mind, spirit, and emotions together constitute personhood and are part of the health and the illness trajectory (Krikorian and Limonero 2012; Sulmasy 2002). Thus,
psychosocial and spiritual problems faced by those who are ill are as important as physical symptoms, and often problems in one domain feed into and impact problems in the others.

We have set out, through a series of descriptive examples, to explore how the particular partnership between faith and health agencies provides a platform for holistic care. We have illustrated that it is frequently religious beliefs and faith that gives meaning to people’s experience of illness, how belief frameworks affect patients’ understanding of the nature of their illness, and their acceptance of their illness. This understanding establishes connectedness between the experience of illness and individual’s faith framework. Understanding the connection between biomedical worldviews, and belief cosmologies is essential in interpreting need, care options, health decision-making and service uptake, health values, and compliance. The systems have often sat in parallel, with misinterpretations and wasted resources, and in some cases have generated fear, anger, and caused health risks rather than generating holism. The Ebola pandemic and the resisted attempts of external health protection systems to initiate protective burial processes is an example of a failure to understand the inclusiveness and permeation of legitimate religious beliefs (Marshall and Smith 2015). It was not until a resolution, developed in partnership between West African religious and public health leaders, and translated into the WHO Safe and Dignified Burial Protocol, that communal engagement became apparent (WHO 2014).

In the snapshots we have presented religious agencies have been at the forefront of palliative services globally, and their modelling of how to incorporate care into health service packages is being adapted and integrated into mainstream services. Faith and religious belief have functioned as a stimulus to providing palliative care, often by showing care and compassion to those who are suffering, especially those in poor and marginalised communities. These models suggest that moving away from a dichotomous paradigm of disease and wellness, provider and recipient is important. The drivers of religious belief, such as sacredness of life, can encourage healthcare staff to understand the patient as a partner rather than a recipient of narrowly focused disease-centred health care delivered within a hierarchical system. However, we also recognise that there are religious groups or agencies that encourage a particular focus on living in the present, praying for healing regardless of the prognosis. Studies such as that conducted by Phelps and colleagues, identified that in intensive care units, patients expressing religious faith were more likely to make use of more intensive life-prolonging therapy at the end of life, than those who did not have an active faith (Phelps et al. 2009).

As part of the international imperative for universal health coverage, the role played by faith-based communities in delivering palliative care is crucial in providing models of holistic care and bringing spirituality and community to the centre of living and dying (Jackson 2015). It is essential that the palliative care and faith communities work hand-in-hand and that the early work of faith organisations in delivering palliative care is interpreted and extended. As an approach, a service and a system of care, palliative care aims to ensure that no one is left behind. This model of faith in action underpins a new recognition that it is in the investment in the values that underpin development goals where the real and hard work sits and where the biggest differences will be made. Values shape people and belong to people, and it is the people of faith, the estimated 80%+ of the total world population whose values can determine whether or not the sustainable development goals change the world we live in for good.

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