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The Role of Psychosocial Support in Mitigating Emotional and Economic Stress Among Caregivers of Cancer Patients: Evidence from Kenyatta University Teaching, Referral and Research Hospital, Kenya

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Abstract: *The study assessed how psychosocial support influences the emotional and economic well-being of caregivers of cancer patients at KUTRRH in Nairobi, Kenya. Grounded in the Biopsychosocial Model and Family Systems Theory, it explored four key areas: emotional support, financial assistance, social support networks, and informational support. A cross-sectional design was used, involving 200 caregivers and 35 healthcare workers. Data collection methods included questionnaires, interviews, and focus group discussions. Findings revealed that most caregivers received moderate levels of emotional and financial support. Emotional support, particularly from family and friends, was rated highly (mean = 4.0), while counseling services and support groups were moderately available. Financial support was perceived as accessible and helpful (mean = 3.9). Statistical analysis showed a significant positive correlation among all four psychosocial support variables and family quality of life ($r = 0.51$ to 0.64, $p < .01$). Regression analysis indicated that psychosocial support accounted for 5.7% of the variability in family quality of life ($R^2 = .057$, $p = .015$). The study concludes that psychosocial support, especially emotional and financial assistance, plays a crucial role in reducing caregiver stress and improving family well-being. It recommends strengthening mental health services, increasing awareness, improving financial support systems, and establishing structured peer support networks for caregivers.*

Keywords: *Psychosocial Support, Mitigating, Emotional and Economic Stress, Caregivers, Cancer Patients, Kenyatta University Teaching, Referral and Research Hospital, and Kenya*

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1. Introduction

Cancer-related stressors and subjective appraisal of stressors may have an impact on caregiver quality of life during the dynamic transition of active cancer treatment, which is marked by distress and uncertainty (Jones et al., 2022). Quality of life has been defined as the impression of well-being that results from an individual's contentment or discontent with those areas of life that are significant to them. The World Health Organization defines quality of life (QoL) as an individual's grasp of value systems and culture, including their aspirations, norms, expectations, and worries. Quality of life is influenced by the patient's health, beliefs, social ties, surroundings, and psychological state. It has been discovered to provide prognostic data on the prediction of cancer patients' survival length for various types of cancer (Kim, Sim, Yun, Bae, Nam, Park & Park, 2016).

Cancer caregiving places significant emotional and financial strain on families, particularly in low- and middle-income countries like Kenya. At Kenyatta University Teaching, Referral and Research Hospital (KUTRRH), caregivers of cancer patients experience heightened psychological stress, including anxiety, emotional burnout, and depression, due to the overwhelming demands of balancing caregiving with daily responsibilities and work (Carlson et al., 2020; Stefan et al., 2020). These challenges are intensified by limited access to mental health services, leaving caregivers without the professional support necessary to manage their emotional burdens effectively (Kimani et al., 2021).

Concurrently, families bear a heavy economic burden stemming from the high cost of cancer treatment, limited health insurance coverage, and significant out-of-pocket expenses (Globocan, 2021; Kenya Ministry of Health, 2021). Many caregivers are forced to reduce working hours or leave employment entirely, further exacerbating household financial instability (Ng et al., 2020). These financial pressures, coupled with emotional exhaustion, compromise caregivers' ability to provide sustained, effective care. Cancer treatment's high cost might also lead to reduced investment on essential requirements like education and nutrition. Patients may delay or discontinue therapy due to financial constraints, resulting in poorer health outcomes and higher mortality rates. Alternative or traditional medicine choices, such as herbalists and herbal remedies, may also postpone necessary medical care (Mugisha, 2025).

The lack of coordinated psychosocial support services means caregivers are left to shoulder both the emotional and financial responsibilities alone, significantly undermining their quality of life (Stefan et al., 2020). Despite the known link between family well-being and effective patient care, psychosocial support systems in Kenya remain underdeveloped and under-researched, especially in public facilities like KUTRRH (Faller et al., 2021). The major providers of social work services, particularly psychosocial support to people who need cancer care, and consequently to their families and carers, are social workers who specialize in oncology (Muhingi & Machani, 2022). There is a good effort at KUTRRH, which has employed Medical Social Workers to play this key role. This study is two-fold: to assess the effectiveness of emotional support services at Kenyatta University Teaching, Referral, and Research Hospital, and to examine the extent of financial support available to families of cancer patients at Kenyatta University Teaching, Referral, and Research Hospital, Nairobi County, Kenya. Addressing these gaps is essential for improving caregiver resilience and delivering holistic, family-centered cancer care.

1.1 Statement of the Problem

Family caregivers of cancer patients face intense emotional and financial burdens, often with minimal support. In addition to providing direct care—such as medication management, transport, and physical assistance—caregivers frequently experience psychological distress, fatigue, and burnout that compromise their well-being and quality of life (Penson et al., 2000). Research shows that 70% of caregivers report high levels of emotional distress, with many reducing work hours or leaving employment entirely to meet caregiving demands (Muralidharan, Gore & Katkuri., 2023).

In Kenya, where around 80% of cancer treatment costs are paid out-of-pocket, caregivers shoulder a disproportionate economic burden, with 40% experiencing severe financial hardship (Essue et al., 2021). These challenges are further worsened by social stigma, with nearly a third of caregivers reporting feelings of abandonment and isolation Muralidharan, Gore & Katkuri., 2023). Despite growing global recognition of caregiver challenges, research continues to underrepresent their experiences—particularly in low- and middle-income countries—where only a small fraction of cancer research focuses on caregiver outcomes (Lingens et al., 2023).

This study investigates the availability and effectiveness of psychosocial support, particularly emotional and economic aspects, at Kenyatta University Teaching, Referral and Research Hospital (KUTRRH), with a focus on how such support can mitigate the emotional and financial stresses experienced by caregivers and improve their overall quality of life.

1.2 Theoretical Framework

The Biopsychosocial Model and Family Systems Theory offer complementary perspectives for understanding health and illness within the context of cancer care. The Biopsychosocial Model, introduced by George Engel in 1977, emphasizes a holistic, patient-centered approach that considers biological, psychological, and social factors as interrelated determinants of health. In cancer care, this model highlights the influence of disease stage, treatment options, and genetic predisposition, while also recognizing the psychological burden—such as anxiety, depression, and diminished self-image—that patients and caregivers often endure. It also addresses social determinants like healthcare access, financial strain, and community support, which significantly impact patient outcomes and caregiver well-being, especially in resource-limited settings.

On the other hand, Family Systems Theory, developed by Murray Bowen, views the family as an emotional unit where changes in one member, such as a cancer diagnosis, reverberate across the entire system. This theory underscores the emotional interdependence within families, showing how illness can disrupt established roles, heighten anxiety, and alter communication patterns. It also introduces the concept of differentiation of self, which helps explain how families vary in their responses to stress. Families with poor emotional boundaries may experience more distress, while those with strong differentiation are better equipped to support both the patient and one another. Understanding these family dynamics is crucial for healthcare professionals when delivering support and planning interventions that extend beyond the individual patient. Together, these two theoretical frameworks offer a robust foundation for holistic cancer care.

While the Biopsychosocial Model addresses the multi-dimensional nature of health at the individual level, Family Systems Theory highlights the systemic and relational impacts of illness within the family unit. By integrating insights from both, healthcare providers can develop more inclusive, responsive interventions that support not just the physical treatment of cancer but also the emotional and social well-being of patients and their families. This dual approach fosters improved quality of life and ensures that care remains both person- and family-centered.

2. Literature Review

2.1 Quality of Life

Multiple cross-sectional studies consistently highlight the profound impact of emotional stress and financial hardship on the quality of life (QoL) of caregivers for cancer patients. Kim et al. (2022) demonstrated that caregiver psychological and physical stress, particularly stemming from financial concerns and lifestyle disruptions, negatively affects immune function and overall well-being. Similarly, Üzar-Özçetin and Dursun (2020) identified low resilience as a key factor associated with higher caregiver burden and reduced QoL, implying that economic strain likely exacerbates these outcomes. These studies collectively underline how unaddressed emotional and financial stressors can compromise both the health of caregivers and the quality of care they provide.

Further insights from Pereira et al. (2020) and Chan and Ng (2022) reinforce the multidimensional challenges caregivers face. Pereira's validation of the CarGOQoL scale affirmed the complex emotional, social, and functional stress experienced by caregivers, while Chan and Ng reported high rates of anxiety and depression among caregivers of palliative patients, attributing this to emotional distress, lack of support, and existential fears. Even outside oncology, as seen in Amodeo et al. (2022), the need for psychological support and family-centered interventions is evident, supporting the argument for integrated, holistic care models that address both the psychological and socio-economic realities of caregiving.

2.2 Emotional Stress and Services

Recent studies emphasize the emotional and physical burdens faced by family caregivers of cancer patients, especially in low-resource settings. Muliira et al. (2024) found that caregivers in Oman experienced poor quality of life (QoL) due to low self-rated health, limited confidence in managing symptoms, and physical exhaustion. Psychological distress—often triggered by the patient's pain and declining health—emerged as a key predictor of reduced caregiver well-being. While the study highlighted important links between caregiver emotional health and clinical factors, its cross-sectional nature and lack of tested interventions limit practical application. In contrast, Applebaum (2022) showed that virtual emotional support communities in the UK can alleviate isolation and promote emotional support, though access barriers—like poor digital literacy and connectivity—pose challenges, especially for older or rural caregivers.

Other studies explored more structured support systems. In Brazil, Oliveira et al. (2022) demonstrated that hospital-based counseling and peer support significantly improved resilience and QoL among caregivers of children with cancer, underscoring the value of integrated emotional support in care settings. In the U.S., Longacre et al. (2018) reviewed successful caregiver interventions like the FOCUS Program and CancerSupportSource®-Caregiver, which use psychoeducation and digital tools to reduce distress, though their applicability in lower-income contexts remains uncertain. Zhang et al. (2023) further supported the effectiveness of targeted psychological interventions among breast cancer caregiver-patient pairs in China, showing improvements in hope, resilience, and QoL. However, short intervention periods and limited follow-up suggest a need for long-term research to assess sustained impact. Collectively, these findings affirm the importance of context-sensitive, accessible emotional support strategies in improving caregiver outcomes.

2.3 Economic Stress and Support

Recent research consistently shows that financial toxicity—the economic strain resulting from cancer diagnosis and treatment—has profound effects on both patients and their caregivers, exacerbating emotional distress and reducing quality of life. Programs like Cancer Care's Financial Assistance Program (Zaleta et al., 2024) demonstrate that even modest grants can alleviate financial and emotional stress, particularly when directed toward essential needs. However, broader applicability is limited by small grant sizes and short-term impacts. Complementary findings from Rashidi et al. (2024) suggest that while some financial interventions, like financial navigation, offer benefits for high-risk groups, most general interventions show limited success in reducing material hardship or improving adherence. These findings emphasize the importance of designing targeted, need-based financial interventions to maximize impact.

In parallel, studies examining caregiver experiences reveal how financial toxicity disrupts family life, employment, and emotional stability. Shi et al. (2024) found that caregivers bear a dual burden—managing both the economic costs and the psychological toll of cancer care—highlighting the need for early identification of financial distress and personalized support systems. Ritter et al. (2023) further exposed global disparities in cancer-related financial hardship across six key domains, particularly in low-income countries, and called for standardized assessment tools and localized interventions. Collectively, these studies stress the interconnection between financial and emotional well-being, reinforcing the need for integrated, holistic care models that address both economic and psychological vulnerabilities in cancer-affected households.

3. Methodology

3.1 Study Area

The study was conducted at Kenyatta University Teaching, Referral, and Research Hospital (KUTRRH), a leading Level 6 public referral hospital in Nairobi, Kenya, known for its advanced medical infrastructure and diverse patient population. This urban setting provided an ideal environment to examine how families from varied socio-economic backgrounds experience and manage the emotional, psychological, and social demands of cancer caregiving. The hospital's access to mental health and psychosocial support services further supported the study's focus on family quality of life. Findings from the study are particularly relevant to urban healthcare settings in Kenya and can inform strategies to enhance caregiver support and overall family well-being in similar contexts across the region.

3.2 Study Design

The study employed a mixed-methods approach using a cross-sectional research design to assess psychosocial support services for families of cancer patients at Kenyatta University Teaching, Referral, and Research Hospital (KUTRRH). This design enabled the collection of both quantitative and qualitative data at a single point in time, providing a snapshot of the status of emotional, informational, financial, and social support services. The cross-sectional nature allowed for the inclusion of diverse respondents, facilitating an in-depth understanding of the quality, effectiveness, and accessibility of available psychosocial services. Quantitative tools such as structured questionnaires ensured consistency and objectivity in capturing measurable data related to family quality of life (FQOL) and psychosocial support.

Furthermore, the study design enabled the identification of correlations between different types of support and overall family well-being. Statistical analysis was used to uncover significant relationships, offering insights into areas where psychosocial interventions could be improved. The combination of descriptive cross-sectional analysis and quantitative measurement provided a reliable foundation for evaluating the current support systems at KUTRRH and informing future enhancements aimed at improving the quality of life for caregivers and their families in cancer care settings.

3.3 Sampling and Sample Size

To determine the sample size, the study utilized Fisher's formula for estimating sample sizes in a population. Given an estimated population size of approximately 400 caregivers of cancer patients treated annually at KUTRRH, and assuming a confidence level of 95% with a margin of error of 5%, the sample size was calculated using the following formula

$$n = \frac{N}{N+N(e^2)}$$

Where:

- n = sample size
- N = population size (400 in this case)
- e = margin of error (expressed as a decimal)

$$n = \frac{400}{1+400(0.05^2)}$$

$$n = \frac{400}{1+400(0.0025)}$$

n= 200

3.4 Data Collection

The study employed multiple data collection methods to gather both quantitative and qualitative data on psychosocial support and family quality of life among caregivers of cancer patients and healthcare providers at Kenyatta University Teaching, Referral and Research Hospital (KUTRRH). Structured questionnaires were administered to 180 caregivers and 35 healthcare providers to collect quantifiable data on various support dimensions. Key Informant Interviews (KIIs) with five healthcare professionals provided in-depth insights into institutional practices and stakeholder challenges, while Focus Group Discussions (FGDs) with 20 caregivers allowed for collective exploration of caregiving experiences and identification of shared themes. These mixed methods enriched the understanding of support systems available to caregivers and healthcare workers.

To ensure the quality and reliability of the data collection tools, pilot testing was conducted at Kenyatta National Hospital with 30 participants. This process helped refine the questionnaires by assessing clarity, relevance, and response accuracy, with reliability confirmed through strong Cronbach's Alpha coefficients ($\alpha = 0.86$ for psychosocial support, $\alpha = 0.82$ for quality of life). Validity was established through expert consultations and literature reviews to ensure the instruments adequately captured the constructs of interest. Test-retest reliability was also confirmed through consistent results over time using Pearson's r. Data collection at KUTRRH followed structured protocols to maintain integrity and consistency throughout the research process.

3.5 Data Analysis

For qualitative data, four procedures, as defined by Guba and Lincoln, were used to ensure the credibility of the qualitative data. Researchers increased confirmability, transferability, and dependability while also using reflexivity to boost the interviewer's trustworthiness and dependability. To ensure reflexivity, field notes were recorded during and immediately following each interview. The analysis was conducted in a controlled and traceable manner to ensure dependability and authenticity. A collaborative interdisciplinary team conducted in-case and cross-case assessments to ensure the themes' relevance.

3.6 Ethical Considerations

This study adhered to strict ethical standards. Ethical approval was obtained from the National Commission for Science, Technology and Innovation (NACOSTI), the Catholic University of Eastern Africa, Kenyatta University, and the Kenyatta University Teaching, Referral, and Research Hospital (KUTRRH) before the commencement of the study. The researcher complied with all ethical guidelines and protocols established by these institutions and provided regular updates to the respective ethics boards to ensure continuous compliance.

All participants, including healthcare providers and family members of cancer patients, were fully informed about the study's purpose, procedures, risks, and benefits. Written informed consent was obtained using clear and detailed consent forms. Participation was entirely voluntary, and participants were assured of their right to withdraw at any stage without any consequences.

Confidentiality was strictly maintained. Personal identifying information was not disclosed, and responses were anonymized through coding to protect participants' identities. All data was securely stored. To maintain research integrity, the researcher ensured that all findings were accurately recorded and reported. No fabrication, falsification, or misrepresentation of data occurred. Data analysis was conducted rigorously to uphold the reliability and validity of the results.

4. Results and Discussion

This section presents the findings of the study on psychosocial support services for families of cancer patients at Kenyatta University Teaching, Referral, and Research Hospital (KUTRRH). The results are based on data collected through structured questionnaires and interviews from caregivers and healthcare providers, focusing on key domains of psychosocial support—emotional and financial—and their relationship to family quality of life (FQOL). Quantitative data are summarized using descriptive statistics and inferential analyses to highlight the availability, accessibility, and perceived effectiveness of support services. Qualitative insights from focus group discussions and key informant interviews complement these findings, offering a deeper understanding of caregiver experiences and contextual barriers. Together, the results provide a comprehensive overview of the current status of psychosocial support at KUTRRH and its impact on families caring for cancer patients.

4.1 Response Rate

Table 1 provides information on the participating groups, target sample size, actual respondents, and response rate in percentages.

Table 1: Participant's response rate

Participant Group	Target Sample Size	Actual Respondents	Response Rate (%)
Caregivers	180	180	100.0%
Healthcare Professionals	35	34	97.1%
Total Response Rate	200	200	**> 70%**

The study aimed to involve 180 caregivers and 35 health care professionals. Ultimately, there were responses from 180 caregivers and 34 healthcare professionals, generating effective response rates of 100% and 97.1%, respectively. Additionally, to surveys, we included three focus group discussions with caregivers, and five individual interviews with health professionals and hospital administrators to ensure we captured richer responses. The study response rate of 70 %. not only of the topic of cancer care but also the data collected. They have reported personal and professional experiences of the respondents (Kusi *et al.,* 2020).

4.2 Demographic Characteristics

Table 2: Caregiver Demographics

Demographic character	Attribute	Frequency	Percent
Age range	20-29	45	25.4
	30-39	72	40.7
	40-49	35	19.8
	50-60	23	13.0
	61 and above	2	1.1
	Total	177	100.0
Gender	Male	58	33.3
	Female	111	63.8
	Other	5	2.9
	Total	174	100.0
Relationship to patient	Spouse	55	31.4
	Parent	40	22.9
	Sibling	40	22.9
	Child	23	13.1
	Other	17	9.7
	Total	175	100.0
Duration of caregiving	<6 months	69	40.4
	6-24 months	77	45.0
	>2 years	25	14.6
	Total	171	100.0
Patient's cancer type	Breast cancer	37	21.1
	Digestive	34	19.4
	Prostate cancer	26	14.9
	Cervical cancer	21	12.0
	Blood	45	25.7
	Brain cancer	8	4.6
	Lung cancer	2	1.1
	Kidney	1	0.6
	Sarcoma	1	0.6
	Total	175	100.0

The demographic profile of caregivers in this study indicates that the majority were aged between 30–39 years (40.7%), followed by those aged 20–29 years (25.4%), with fewer respondents in older age groups. A significant gender disparity was observed, with 63.8% of caregivers identifying as female, aligning with existing literature that caregiving responsibilities in low-resource settings predominantly fall on women in their productive years

(Breitbart et al., 2018; Ngugi et al., 2022). Most caregivers were close family members, particularly spouses (31.4%), parents, and siblings (22.9%), reflecting a pattern of informal, emotionally motivated caregiving common in African contexts (Kusi et al., 2020). These findings underscore the critical role of female family members in providing unpaid care, often without formal training, reinforcing caregiving as both a gendered and relationally driven responsibility.

Regarding caregiving duration, nearly half of the respondents (45.0%) had provided care for 6 to 24 months, while 14.6% had done so for more than two years, suggesting a potential for cumulative burden over time. This prolonged caregiving aligns with prior evidence from Kenya and Ghana indicating increased psychological, physical, and financial strain with longer caregiving periods (Breitbart et al., 2018; Kusi et al., 2020). The distribution of cancer types among patients showed blood cancer (25.7%) and breast cancer (21.1%) as the most common, followed by prostate and cervical cancers. This pattern is consistent with national trends reported in Kenya, where these cancers are increasingly prevalent across both urban and rural settings (Globocan, 2020; Deo et al., 2022; Macharia et al., 2018). These findings provide crucial context for understanding the scope and nature of caregiver experiences in oncology care.

4.3 Health Care Provider Characteristics

The following is the information on health workers' socio-demographics, particularly on their profession and years of experience.

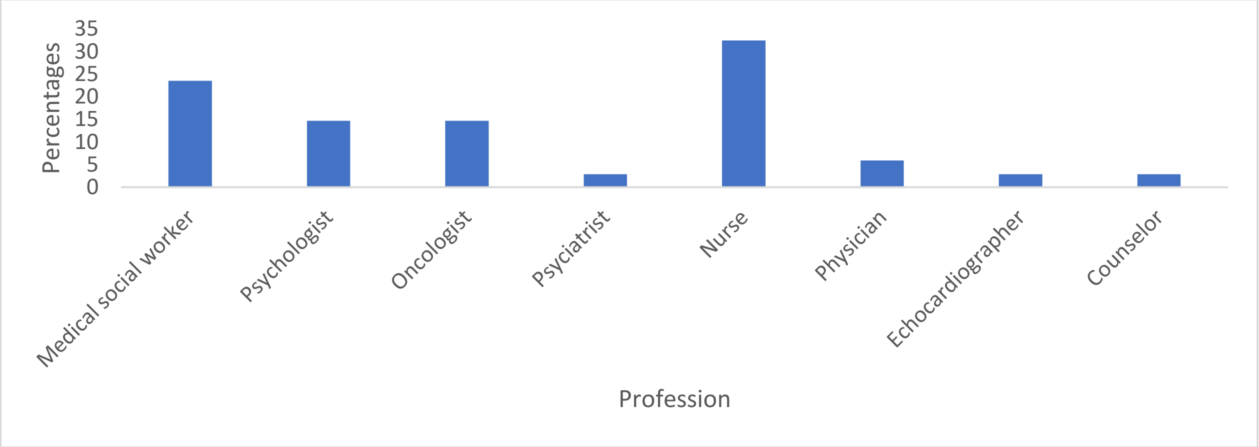

Figure 1: Health Worker Profession

The largest group of health care providers was nurses, with 11 (32.4%) participants. Eight (23.5%) were medical social workers. Psychologists and oncologists were represented equally, with each having 5 (14.7%). The remaining participants were physicians, at 2 (5.9%), and psychiatrists, echocardiographers, as well as counselors, each at 1 (2.9%). The representation of different professions is representative of the multi-disciplinary team aspect of cancer care. In referral hospitals, care is often multi-dimensional and related to the medical care or treatment an individual may receive (Reiss & Sandborn, 2015).

4.4 Emotional Support

Table 3 provides information on the availability of support services to both caregivers and healthcare workers.

Table 3: Availability of Emotional Support Services as per caregivers

Question		Frequency	Percent
Received emotional/psychological support during caregiving	Strongly disagree	25	13.9
	Disagree	22	12.2
	Neutral	51	28.3
	Agree	56	31.1
	Strongly agree	26	14.4
	Total	180	100.0
Know where to get emotional support at KUTRRH	Strongly disagree	22	12.2
	Disagree	26	14.4
	Neutral	38	21.1
	Agree	69	38.3
	Strongly agree	25	13.9
	Total	180	100.0
Emotional support reduced stress and anxiety	Strongly disagree	20	11.2
	Disagree	15	8.4
	Neutral	30	16.9
	Agree	74	41.6
	Strongly agree	41	21.9
	Total	180	100.0
Counseling services are available to caregivers	Strongly disagree	30	16.8
	Disagree	15	8.4
	Neutral	30	16.8
	Agree	58	32.4
	Strongly agree	47	25.1
	Total	180	100.0
Felt emotionally supported in caregiving journey	Strongly disagree	20	11.3
	Disagree	20	11.3
	Neutral	24	13.6
	Agree	62	35.0
	Strongly agree	51	28.8
	Total	177	100.0

The demographic profile of caregivers in this study indicates that the majority were aged between 30–39 years (40.7%), followed by those aged 20–29 years (25.4%), with fewer respondents in older age groups. A significant gender disparity was observed, with 63.8% of caregivers identifying as female, aligning with existing literature that caregiving responsibilities in low-resource settings predominantly fall on women in their productive years (Breitbart et al., 2018; Ngugi et al., 2022). Most caregivers were close family members, particularly spouses (31.4%), parents, and siblings (22.9%), reflecting a pattern of informal, emotionally motivated caregiving common in African contexts (Kusi et al., 2020). These findings underscore the critical role of female family members in providing unpaid care, often without formal training, reinforcing caregiving as both a gendered and relationally driven responsibility.

Regarding caregiving duration, nearly half of the respondents (45.0%) had provided care for 6 to 24 months, while 14.6% had done so for more than two years, suggesting a potential for cumulative burden over time. This prolonged caregiving aligns with prior evidence from Kenya and Ghana indicating increased psychological, physical, and financial strain with longer caregiving periods (Breitbart et al., 2018; Kusi et al., 2020). The distribution of cancer types among patients showed blood cancer (25.7%) and breast cancer (21.1%) as the most common, followed by prostate and cervical cancers. This pattern is consistent with national trends reported in Kenya, where these cancers are increasingly prevalent across both urban and rural settings (Globocan, 2020; Deo et al., 2022; Macharia et al., 2018). These findings provide crucial context for understanding the scope and nature of caregiver experiences in oncology care.

Table 4: Availability of Emotional Support Services as per caregivers

Question	Attribute	Frequency	Percent
Availability of emotional support services for caregivers at KUTRRH	Readily available	18	52.9
	Rare	5	14.7
	Not available	8	23.5
	Occasionally	3	8.8
	Total	34	100.0
Effectiveness of emotional support in reducing caregiver stress	Highly effective	14	41.2
	Effective	6	17.6
	Not effective	6	17.6
	Moderate	7	20.6
	Rarely effective	1	2.9
	Total	34	100.0

There were also differences in attitudes towards the availability of counseling services. Whereas 105 caregivers (57.5%) affirmed such an availability, 58 (32.4%) agreed, and 47 (25.1%) strongly agreed; there were still 45 (25.2%) who affirmed otherwise. Interestingly, when 113 caregivers (63.8%) were asked if they were emotionally supported in their caregiving experience, 62 (35.0%) said yes, and 51 (28.8%) said strongly yes. On the other hand, 40 (22.6%) didn't feel emotionally supported at all, while 24 (13.6%) felt somewhat neutral. This finding indicates a disparity between expectations and real-life experiences of the support they received for their loved one during the cancer-care journey. Some felt they had experienced emotional abandonment or received no emotional support from family, friends, or the healthcare system. Instances of crying while alone, or statements about being invisible to health care staff, were repeated in the focus groups. Participants described emotional narratives that matched the findings of Githaiga and Swartz (2017) on the emotional invisibility of family caregivers within an African context.

4.4 Extent of Financial Support

Table 5 provides information on financial Support as per caregivers and healthcare workers.

Table 5: Extent of Financial Support as per caregivers

Question	Attributes	Frequency	Percent
Received some financial support	Strongly disagree	25	13.9
	Disagree	23	12.8
	Neutral	40	22.2
	Agree	60	33.3
	Strongly agree	32	17.8
	Total	180	100.0
Aware of financial assistance offered at KUTRRH Total	Strongly disagree	11	6.1
	Disagree	23	12.8
	Neutral	38	21.1
	Agree	75	41.7
	Strongly agree	33	18.3
		180	100.0
Financial support was sufficient to meet basic needs Total	Strongly disagree	25	13.9
	Disagree	27	15.0
	Neutral	37	20.6
	Agree	55	30.6
	Strongly agree	36	20.0
		180	100.0
Financial strain negatively affected caregiving ability Total	Strongly disagree	4	2.2
	Disagree	8	4.4
	Neutral	16	8.9
	Agree	77	42.8
	Strongly agree	74	41.1
		180	100.0
Lack of financial support caused stress to caregiver and their family	Strongly disagree	3	1.7
	Disagree	11	6.1
	Neutral	15	8.3
	Agree	41	22.8
	Strongly agree	110	60.6
	Total	180	100

Most caregivers reported having received some financial support during their caregiving experience, with 92 (51.1%) agreeing 60 (33.3%) or strongly agreeing 32 (17.8%). About one quarter of caregivers 48 (26.7%) disagreed 23 (12.8%) or strongly disagreed 25 (13.9%) with the item, and 40 (22.2%) were undecided. A considerable proportion of the caregivers either had no financial services as needed or did not know how to utilize it. These gaps in coverage and communication are part of larger regional concerns where chronic illness financial support programs either exist in a limited capacity or households do not understand how to access them (Brundisini *et al.,* 2013; Fradgley, Paul & Bryant, 2015). In countries with low public health financing, like Kenya, families frequently pay over two-thirds of healthcare costs. Awareness of financial assistance services at KUTRRH also followed the same trend with the majority of the caregivers 108 (60%) reporting awareness of these services, where 75 (41.7%) agreed and 33 (18.3%) strongly agreed. However, 34 caregivers (18.9%) disagreed while 38 (21.1%) were not sure as indicated in Table 4.6. Zaleta *et al.* (2024) the study found that financial assistance had a major positive impact on recipients, with experiencing a reduction in financial stress. Moreover, emotional distress significantly declined, fading from before assistance to following it. The findings also indicated that greater amounts of financial assistance and uses relating to transportation or medical expenses were particularly effective in improving the outcomes for the patients.

When asked if the financial assistance was sufficient, just over half of the caregivers 91 (50.6%) felt that it was sufficient to cater to their basic needs. Out of these, 55 (30.6%) agreed and 36 (20%) strongly agreed. However, 52 caregivers (28.9%) did not feel that the support was sufficient. Even among those who did secure some assistance, less than half felt that the care resources were sufficient to address everyday demands in caregiving. Thus, there is an uncomfortable reality - financial support was generally available, but seldom fully paid for the full range of activities, including transport to hospital, regular medical tests, or prescription drugs (Tsimicalis *et al.,* 2020; Zaloom 2021) Families were in a state of ongoing financial juggling across many resources and expenses, such as a conscious decision to buy food or fund treatment.

The financial burden clearly affected caregiving. An overwhelming majority of caregivers, 151 (83.9%) believed that financial strain hurt their caregiving for their loved one. This consisted of 77 (42.8%) who agreed and 74 (41.1%) who strongly agreed. Only a small minority of 12 caregivers (6.6%) disagreed or strongly disagreed, while the rest were not sure. An even larger proportion of caregivers, 151 (83.4%) were of the view that the lack of financial support caused stress for them as well as their families, with 110 (60.6%) strongly agreeing and 41 (22.8%) agreeing. Just 14 individuals (7.8%) disagreed or strongly disagreed, while (8.3%) were not sure. Many caregivers spoke of losing their assets of value or withdrawing from income-generating activity to simply gravel pace with care demands. One caregiver recalled that he sold his motorbike to pay for chemotherapy - an account that builds on a general trend across African caregiving households experiencing financial hardship (Aluh, 2021).

Health providers' perceptions of the accessibility of financial support varied. Less than half (15; 42.9%) found services to be very accessible (8; 22.9%) or accessible (7; 20%), while the rest found them to be rare (9; 25.7%), not accessible (4; 11.4%), or partially accessible (5; 14.3%). Yet, over half (19; 54.3%) found the current financial support as very effective in reducing economic burdens, while another 6 (17.1%) found it as effective (Table 4.6). This confirms previous research around economic hardship as a dimension of caregiving - and not only an outcome - contributing to emotional and physical unrest (Friedline *et al.,* 2021). In some instances, families faced stark decisions like selling their possessions, delaying treatment, or incurring debt; and these findings were corroborated by recent regional studies which evidenced the catastrophic impact of out-of-pocket cancer-related spending for low-income families (World Bank, 2022; Muralidharan *et al.,* 2023).

Healthcare practitioners in the study recognized that while financial resources can significantly alleviate caregiver burden, these resources can be inconsistent and unreliable. Both caregivers and key informants acknowledged that the stability and visibility of support systems could be improved (both within spheres of complementary care and medically focused care). Most recommendations discussed how might a caregiver support system be more effective included: protected medical insurance schemes; improving financial literacy with families; and the means for sharing information on assistance can be improved regarding visibility and access to aid. They found that these recommendations were also consistent with the best international practices, as they identified that key system-level changes could alleviate caregiver "financial toxicity" and improve long-term sustainability (Smith *et al.,* 2022).

Table 6: Extent of Financial Support as per health providers

Question	Attribute	Frequency	Percent
Accessibility of financial support services for cancer patient families at KUTRRH Total	Highly accessible	8	23.5
	Accessible	7	20.5
	Not accessible	4	11.8
	Rare	9	26.5
	Not available	2	5.9
	Partially accessible	4	11.8
		34	100.0
Impact of support services in reducing caregiver economic burden	Very impactful	18	53.0
	Impactful	6	17.6
	Not impactful	5	14.7
	Low impact	3	8.8
	Moderate	2	5.9
	Total	34	100.0

Insights from focus group discussions revealed deep and personal struggles tied to financial strain. Themes that emerged included severe financial hardship (25%), the burden of out-of-pocket expenses (25%), inadequate help (12.5%), and having to quit jobs to care for patients (12.5%). These lived experiences were echoed in statements such as:

"I sold my motorbike to pay for chemotherapy" (Participant 10, FGD 2).
"SHA helps, but it doesn't cover everything—transport, food, and scans are on us" (Participant 9, FGD 2)

"I haven't worked in six months. My husband is trying to send fare from the village" (Participant 7, FGD 2)

The emotional burden of financial hardship was also exhibited during the sessions, with researchers noticing frustration, restlessness, conflicting frustration about own financial losses, and a seeming lack of knowledge regarding financial support services available.
The key informant interviews showed a similarity in distress. Most 3 (60%) of the informants felt that financial support mechanisms were unavailable, and only 2 (40%) acknowledged that financial support mechanisms existed. Overall, there were 14 mentions (77.8%) about caregivers experiencing financial hardship, including costs related to treatment, drug expenses, traveling long distances for appointments, and pre-paid investigations.

The role of financial burden included a manifestation in some way. Over half 10 (55.6%) of the caregivers reported some kind of emotional or psychological plight, others were compelled to make challenging decisions, including delaying or stopping treatments, selling their home, abandoning their patients, or disrupting their other life choices for financial expenditure on medical. Key informants offered some opinions on how to ameliorate these financial challenges. The majority 2 (40%) recommended better financial support mechanisms, other suggestions identified involved caregiver support in terms of skills (20%), thread improved health insurance (20%), and awareness of existing supports (20%).

5. Conclusion and Recommendations

5.1 Conclusion

This study achieved a high response rate, reflecting strong engagement from both caregivers and healthcare professionals and emphasizing the critical relevance of emotional and financial support in cancer caregiving. Most caregivers were women aged 30–39 years, typically close family members who had been providing care for 6–24 months, demographics linked to increased psychological and financial strain. While emotional and financial support services were reported to exist, access was inconsistent, with many caregivers unaware of or unable to benefit from them. Over 80% reported that financial strain hindered their caregiving ability and caused significant family stress, revealing the multidimensional burden of cancer care. Healthcare providers acknowledged these challenges but noted fragmented service delivery and limited caregiver support, further exacerbated by low financial literacy and poor communication.

5.2 Recommendations

To mitigate the emotional and financial burden of cancer caregiving, and to improve the quality of care for patients and families, the following evidence-informed and context-relevant recommendations are proposed:

1. Strengthen Emotional Support Systems
    - Institutionalize psychosocial support services within oncology care pathways, making them routine and not optional.
    - Train and deploy mental health personnel (e.g., counselors, social workers, psychologists) within cancer units to provide regular, accessible, and destigmatized emotional support.
    - Create caregiver support groups and peer-led programs to foster shared experience, reduce isolation, and enhance resilience.
    - Develop clear communication pathways between health professionals and caregivers to guide caregivers on where and how to access emotional support.
2. Expand and Optimize Financial Assistance Programs
    - Establish comprehensive caregiver financial support schemes that go beyond ad hoc assistance, incorporating transport, nutritional support, and medical equipment.
    - Increase the visibility and awareness of existing financial aid through routine orientation sessions, posters in wards, and information leaflets.
    - Introduce dedicated financial navigation services, where trained personnel help caregivers understand and access aid, as seen in high-burden populations.
    - Conduct regular needs-based assessments to tailor support according to the financial vulnerability and caregiving intensity of each family.
3. Integrate Caregiver Services into Hospital and National Health Policy
    - Recognize caregivers as an integral part of the healthcare system and include caregiver support in hospital strategic plans and national cancer control policies.
    - Advocate for universal health coverage schemes that prioritize chronic illnesses like cancer and protect families from catastrophic out-of-pocket expenses.
    - Encourage partnerships between government, NGOs, and the private sector to pool resources for caregiver assistance and psychosocial service delivery.
4. Build Capacity Among Healthcare Professionals
    - Train multidisciplinary teams on family-centered care, emphasizing the psychosocial, economic, and emotional realities of caregivers.
    - Embed psychosocial care modules into training curricula for nurses, oncologists, and social workers.
    - Equip healthcare professionals to recognize signs of caregiver burnout and financial distress and respond with empathy and practical solutions.
5. Conduct Further Research and Monitoring
    - Implement routine monitoring and evaluation frameworks for caregiver support programs to assess their effectiveness and satisfaction.
    - Fund longitudinal studies to track the emotional and financial trajectories of caregivers and the long-term impact of interventions.
    - Develop standardized tools for assessing caregiver distress and support needs to ensure early identification and response.

References

Adejoh, S. O., Boele, F., Akeju, D., Dandadzi, A., Nabirye, E., Namisango, E., … Ebenso, B. (2021). The role, impact, and support of informal caregivers in the delivery of palliative care for patients with advanced cancer: A multi-country qualitative study. *Palliative Medicine*, 35(4), 1–14.

Akpan-Idiok, P. A., Ehiemere, I. O., Asuquo, E. F., Chabo, J. A. U., & Osuchukwu, E. C. (2020). Assessment of burden and coping strategies among caregivers of cancer patients in sub-Saharan Africa. *World Journal of Clinical Oncology*, *11*(12), 1045–1063. https://doi.org/10.5306/wjco.v11.i12.1045

Amoo, P. O., & Ncama, B. (2024). The impact of socioeconomic and cultural factors on family caregiver burden in cancer patients: A study in Ogbomoso, Nigeria. *Asian Pacific Journal of Cancer Care*, 9(2), 257–275. https://doi.org/10.31557/apjcc.2024.9.2.257-256

Breitbart, W., Alici, Y., & Nelson, C. (2018). *Psychosocial aspects of cancer*. In D. Kasper, A. Fauci, S. Hauser, D. Longo, J. Jameson, & J. Loscalzo (Eds.), *Harrison's principles of internal medicine* (20th ed., pp. 690–698). McGraw-Hill Education.

Carlson, L. E., Watt, G. P., & Groff, S. L. (2020). Emotional and psychological impacts of caregiving in cancer: An overview. *Psycho-Oncology*, *29*(6), 928–935.

Deo, S., Koyier, V., Gatune, J., & Ombaka, J. (2022). *Cancer situation analysis in Kenya: Evidence for policy and action*. Ministry of Health, Kenya & International Cancer Institute.

Faller, H., Weis, J., Koch, U., Brähler, E., Härter, M., Keller, M., & Schulz, H. (2021). Psychosocial care for caregivers in cancer: Gaps and future directions. *Supportive Care in Cancer*, *29*(10), 5971–5980.

Globocan. (2020). *Cancer today: Data visualization tools for exploring the global cancer burden in 2020*. International Agency for Research on Cancer. https://gco.iarc.fr/today

Globocan. (2021). *Cancer fact sheet: Africa*. International Agency for Research on Cancer. https://gco.iarc.fr/

Jones, A. M., Browne, E. K., Adams, K., Potter, B. S., McLaughlin Crabtree, V., Jurbergs, N., ... & Tillery Webster, R. (2022). The toll of transition: Caregiver perceptions of family adjustment during the transition off pediatric cancer therapy. *Psycho-Oncology*, *31*(6), 985-994.

Kenya Ministry of Health. (2021). *Kenya cancer policy 2019–2030*. Nairobi: Government of Kenya.

Kimani, K., Ngugi, P., & Gichuru, M. (2021). Stigma and mental health service gaps in cancer caregiving in Kenya. *African Journal of Health Sciences*, *34*(2), 148–156.

Kusi, G., Boamah Mensah, A. B., Boamah Mensah, K., & Apiribu, F. (2020). Caregiving motivations and experiences among family caregivers of patients living with advanced cancer in Ghana. *Health Psychology Research*, *8*(1), 8876. https://doi.org/10.4081/hpr.2020.8876

Lingens, S. P., Schilling, G., Schulz, H., & Bleich, C. (2023). Effectiveness of brief psychosocial support for patients with cancer and their relatives: a quasi-experimental evaluation of cancer counselling centres. BMJ open, 13(3), e068963.

Macharia, W. M., Ombui, K., & Njuguna, F. (2018). Patterns of cancer incidence and mortality in Kenya: 2007–2013. *Kenya Medical Research Institute (KEMRI)*. Nairobi: Ministry of Health.

Mugisha Emmanuel K. (2025). The Financial Strain of Cancer Care in Eastern Nigeria: Assessing Household Impacts and Coping Mechanisms. *Idosr Journal of Scientific Research* 10(1):7176. https://doi.org/10.59298/IDOSRJSR/2024/10.1.7176

Muhingi, W. N., Machani, S. O. (2022). Medical Social Work in Kenya: Scope, Relevance, and Utility. *The International Journal of Social and Development Concerns (IJSDC),* 616*(1):* 17-31.

Muralidharan, S., Gore, M., & Katkuri, S. (2023). Cancer care and economic burden—A narrative review. *Journal of Family Medicine and Primary Care*, *12*(12), 3042-3047.

Najjuka, A., et al. (2023). *The caring experiences of family caregivers for patients with advanced cancer in Uganda: A qualitative study*. *BMC Palliative Care*, 22, Article 16.

Ng, C. G., Boks, M. P., Zainal, N. Z., de Wit, N. J., & van Bergen, A. H. (2020). The impact of caregiving burden on quality of life: A focus on caregivers of cancer patients in developing countries. *Current Opinion in Supportive and Palliative Care*, *14*(3), 239–245.

Ngugi, P. M., Nduati, R., & Muthuri, R. (2022). Gender and caregiving in cancer: Experiences of women caregivers in Nairobi County, Kenya. *African Journal of Social Work*, *12*(2), 78–88.

Penson, R. T., Dignan, F. L., Canellos, G. P., Picard, C. L., & Lynch Jr, T. J. (2000). Burnout: caring for the caregivers. *The Oncologist*, *5*(5), 425-434.

Rashidi, A., Han, X., Yabroff, K. R., & Zheng, Z. (2024). *Financial interventions to mitigate financial hardship in cancer: A systematic review and meta-analysis*. Journal of Clinical Oncology, 42(5), 612–623. https://doi.org/10.1200/JCO.23.01456

Ritter, J., Amankwah, E., Bérubé, S., & Njuguna, F. (2023). *Financial hardship among families of children with cancer: A systematic review across 47 countries*. The Lancet Global Health, 11(8), e1185–e1199. https://doi.org/10.1016/S2214-109X(23)00203-4

Shi, Y., Wang, L., Gonzalez, B. D., & Zullig, L. L. (2024). *The caregiver experience of financial toxicity: A qualitative systematic review*. Psycho-Oncology, 33(2), 201–213. https://doi.org/10.1002/pon.6162

Stefan, D. C., Baadjes, B., & Kruger, M. (2020). Catastrophic health spending in cancer care in Africa: Financial and emotional effects on families. *ecancermedicalscience*, *14*, 1019. https://doi.org/10.3332/ecancer.2020.1019

Too, W., Lelei, F., Adam, M., & Halestrap, P. (2023). (2023). *Preparedness, resilience and unmet needs of informal caregivers of advanced cancer patients in a Regional Mission Hospital in Kenya: Qualitative Study*. *BMC Palliative Care*, 22, Article 16.

Zaleta, A. K., McManus, S., Fortune, A., & Kircher, S. (2023). *Addressing financial toxicity in cancer care: Intersections with emotional well-being and health equity*. Journal of Psychosocial Oncology, 41(4), 451–469. https://doi.org/10.1080/07347332.2023.2176970