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“Fight Your Own Battle”: Hospitalisation and Livelihood of Cancer Patients in Kenya

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Introduction

The incidence of cancer in developing countries is increasing and the disease is no longer confined to affluent countries. More than eight million cancer cases are diagnosed yearly in the world, and contrary to what many know, over half of these are in developing countries. The International Atomic Energy Agency (IAEA) estimated that more than 10 million persons are diagnosed annually with cancer and over 50% of these cases occur in developing countries. The number of new cases in the developing countries is expected to double from just above five million at present to ten million by 2015 (IAEA 2003: 6). Despite the growing cancer crisis in developing countries, they are underserved with facilities to save lives and institutions to protect households against socioeconomic shocks due to the disease.

Researches have been conducted to explain the livelihood impacts of major communicable diseases such as malaria, HIV/AIDS and tuberculosis in developing countries (Rugelema 1999, Barnett and Blaikie 1992, Koestle, 2002, Nur 1993, Chima *et al.* 2003, Onwujekwe *e al* 2000, Russell 2004, Chuma *et al.* 2006). The economic burden of these diseases includes loss of labour of the patients and their caregivers and reduced investment in both cash and food crops. Most of the researches on the impacts of illness on livelihoods use surveys methods and focus on quantifiable things where only the formal economy counts (Wallman and Baker 1996). This approach may fall short of portraying the impacts of illness as experienced by the sufferers from in-depth qualitative inquiry. The survey data do not cover all the social and emotional aspects of ongoing treatment. These aspects have consequences for livelihoods of affected individuals and families. Ethnographic descriptions can facilitate further understanding of the responses to the economic and social burdens of illness at the individual and household levels (Russell 2005).

Most researches on illness and livelihoods do not investigate sufficiently the impacts of non-communicable diseases such as cancer in developing countries. This article adopts the basic denotation of livelihood as a means of support or subsistence which is both economic and social. I draw on the idea of livelihoods included in the framework of sustainable livelihoods postulated by Chambers and Conway (1992). Drawing on this conceptual framework, a livelihood is defined as comprising ‘...the capabilities, assets (including material and social resources) and activities required for a means of living’ (Carney 1998:4). This paper explores the wider social and economic realities of cancer treatment in hospital ward in Kenya. The question is how patients and their families cope with treatment and hospitalization costs. I highlight the implications of hospitalization on livelihood organization and describe patterns in the patients’ access to formal and informal supports. I examine the choices which patients and their families make to cope with hospitalization and treatment pointing out the implications of the choices for household livelihoods and patients’ well being.

Incidence of cancer and treatment situation in Kenya

Despite this increase in cancer cases in Kenya many patients do not have access to effective curative and palliative care (Nyong’o and Miheus 1994, Miller 1992, Gichangi *et al.*

2002). Most patients present for specialised therapies in advanced stages and the requisite radical treatment through surgery, radiotherapy, or chemotherapy often fail to yield desired results (Onyango and Macharia 2006). Extant documentation indicates a steady rise in cancer countrywide. The estimates quoted by Sanson and Mutuma (2002) indicate that the five common types of cancer in order of incidence among men in Kenya are oesophagus, prostate, non-Hodgkin lymphoma, liver, and stomach cancers. Among the women, cervical and breast cancers are the commonest with an incidence rate of about nineteen and ten percent respectively. Ovarian, non-Hodgkin and stomach cancers have an incidence rate of about 4.5% each. The adult and child deaths due to cancer in Kenya were reported to be on the increase at twenty and nine percent respectively about two decades ago (Kasili 1983). The epidemiology of cancer in Kenya is under reported due to insufficient diagnosis and documentation.

Available data at the cancer treatment centre in Kenya indicate an increase of new cases from 659 in 1995 to 1,135 in 2003 and 1,499 in 2004. The new cases have doubled and yet the treatment facility at the national hospital has not been expended. Poor socioeconomic circumstances such as low income, lack of education and insufficient awareness about the disease contribute to under reporting of the incidence. Up to 40% of the poor people do not seek medical care when they are sick because of their inability to meet the costs while about three percent of them have limited physical access to health facilities. New and re-emerging non-communicable diseases such as cholera, typhoid and dysentery worsen the health care experience in Kenya. There is also a rise in non-communicable diseases, particularly cancer, diabetes and cardiac diseases, which were once believed to be “diseases of the Western world” or “diseases of civilization” from which Kenyans seldom suffered (Iliffe 1998: 177). The spread of HIV/AIDS complicates further the disease burden and affects the treatment of other ailments in hospitals. More than 60% of the patients in the medical wards in the national hospital, for instance, are HIV positive (Kenyatta National Hospital 2005).

The public sector in the health care system caters to most of the population at several levels. At the community level, health care is characterized by ill equipped health centres, clinics, dispensaries and maternity homes. The next level is at the primary or district hospitals followed by secondary or provincial hospitals which cover wider areas. The national referral hospital has been at the top of the health care system and it is relatively affordable but not universally accessible to the poor. Admission in the national hospital for most cancer patients in Kenya is often a culmination of delayed diagnosis and multiple referrals. The degree of cancer patients’ suffering is shaped by of their poor socioeconomic backgrounds. Similarly hospitalisation and protracted treatment further threatens their livelihood as illustrated in this article.

Methodology

I conducted the fieldwork between August 2005 and July 2006 as an obtrusive ethnographer in a teaching and referral hospital in Nairobi, Kenya. I took the visible researcher and student role (Agar 1996) and did not disguise my presence in the hospital. My participation was limited to activities and conversations that a lay non-medical person can generally engage in.

The ethnographic data collection consisted of two main parts. The first part involved observation and informal conversations with patients, relatives and hospital staff on the cancer ward and clinic. I held short informal conversations with numerous patients and in-depth conversations on multiple occasions with 42 key informants whom I selected purposively. I asked the key informants to talk about the social and economic implications of hospitalisation for themselves and their families. I then asked them to describe how they were coping with the impacts of cancer management in the hospital and at home. I collected more data through

informal conversations with of the patients' relatives and other participants in their social support. I collected more data from medical record files and conversations with the ward personnel. I visited ten private pharmacies and dispensing chemists that were often mentioned by patients and clinic staff for information on the costs of cancer drugs outside the hospital.

The second part of data collection entailed follow up home visits of ten patients I selected purposively from the forty two key informants. I observed the patients' socioeconomic conditions at home and talked to them and their relatives about the challenges of their hospitalisation. Four of the patients lived in the rural areas outside Nairobi while three of them were temporarily living in the city during the treatment period. A 28 year old male patient had relocated temporarily to a rented room in the city leaving behind his wife and four children at their rural home about 400 km away. Two patients lived in Nairobi city and one in an urban area approximately two hundred kilometres from the hospital. I had three to four home visits of each of these patients. The patients were assisted by spouses or adult members of the family to fill expenditure diaries for at least two months of current hospitalisation. We discussed the entries during the home visits, on telephone and subsequent hospitalisations to clarify issues. The estimated incomes against expenditure during the hospitalisation period for the selected cases are the averages of two months of self reported expenses.

Characteristics of the patients

The majority of the patients who are treated on the cancer ward live in rural areas. Although some had relatives in Nairobi, they commuted back and forth the rural homes when readmission appointments were due. The patients travel from all parts of the country as far as six hundred kilometres to access treatment at the national hospital. The forty two key informants' ages ranged from eighteen to seventy three with a mean of forty two years. Sixty five and thirty five percent of the key informants were male and female respectively. Thirty two of the key informants were either married or previously married while ten of them were single. The patients who had formal employment were mainly primary school teachers; clerical officers and technicians. They were uncertain about the possibility of retaining their jobs due their frequent hospitalization. *Long term patients* stayed on the ward for one month or more and the average monthly length of stay was seven days.

There were at least three categories of patients with different livelihood bases on the cancer ward. The socially *dependent* patients were unemployed primary or secondary school leavers. These patients had been diagnosed with cancers while they were still in school or shortly after their final school examinations. This category of patients was dependent on their parents and other able kin for support and hospitalisation implied total dependence. The dependent patients from families without salaried members required more concerted kinship support. Some of the school leavers were already pursuing casual labour or self employment in petty entrepreneurship before their affliction was discovered. The second group of patients consisted of the main *household bread winners* in formal or informal employment combined with subsistence farming or petty business. This category included widowed, divorced and unmarried single mothers. Married female bread winners had some benefit of the supportive livelihood activities of their husbands. The third category comprised the *patients with stable joint supports*. These included patients with formal employment or stable sources of income and potential support from their spouses and family members with reliable sources of income. Apart from kin support, all the patients depended on unreliable subsistence farming while a few of them had small scale cash crop farms. Over seventy percent of the patients admitted to the cancer ward were not covered by the National Hospital Insurance Fund (NHIF) or any other health insurance. The majority of the inpatients and their families experienced cancer management as an extra burden the burden and adversity due to their already weak livelihood bases.

Bearing cancer management cost burden

The experiences of the social and economic burden of illness management among the patients and their relatives varied with the type of cancer. Delayed presentation for specialised treatment also shaped the financial and social burden of hospitalisation. Some patients had already spent a lot of resources on initial attempts to diagnose and treat the disease in regional and/or peripheral health facilities. The general cost of treatment, hospitalisation and care of patients exceeded the estimated monthly family incomes (see table1). The direct costs included regular diagnostic charges, therapy regimen costs, hospital admission fees and transport costs for both the patients and their carers. Patients and their families also struggled to meet the special dietary needs on the ward and at home and other concurrent costs of family needs.

The inevitable coping choices led to livelihood insecurity and high vulnerability. The cost of hospitalisation and treatment in public hospitals in Kenya is subsidised in conformity with the cost sharing policy. The policy makers assume that the subsidised health care at the national hospital is affordable. The prevailing poverty situation however makes specialised cancer treatment financially inaccessible to many patients. Cancer management is particularly expensive and unsustainable due to the high costs of drugs and related therapies. Protracted diagnostic tests and treatment of the disease and persistent shortages of the subsidised drugs in public hospitals aggravate the inability to pay for subsequent health care. Adverse side effects of treatment and recurrence of the disease implies more financial and emotional strain in efforts to relieve pain and rehabilitation of the patients. The commonly used anticancer drugs are sold at varied prices outside the hospital. The prices in private pharmacies are higher and at times double that offered in the hospital.

When the hospital runs out of drugs, the patients were advised to do “window shopping” for cheaper drugs. The shortages of subsidised medicines in the hospital imply further delays as the patients and their families attempt to raise money to purchase them private pharmacies. Some pharmacies only ordered drugs for the patients who committed themselves to pay and wait to collect the drugs when delivered. A number of private pharmacists confirmed that some of the cancer drugs were too expensive for patients and stocking them would result in loss in dead stock. When the drugs were available hospital, the patients could benefit from the lapse in time for payment since most of the services are charged at the end of treatment sessions.

Although the subsidised medicines are relatively cheap, they are unaffordable to most of the patients given the prolonged nature to treatment and their poor backgrounds. The doctors and the pharmacists tried hard to prescribe treatment options that they perceived to be relatively affordable to the patients. There were three options for second line breast cancer regimens and these cost over five times the price of the options per course in the first line treatment. Three of the informants did not proceed with the recommended second line chemotherapy for breast cancer because of the cost and the perceived futility of further treatment. In general, a maximum of six chemotherapy courses with an interval of three weeks were administered before further evaluations.

Patients who were undergoing radiotherapy paid 300 shillings per daily sessions which ranged between eight and twenty five. Interruptions in radiotherapy were caused by side effects, weekend and public holiday pauses, long queues, machine breakdown and unavailability of assistance from the ward to the treatment centre. The patients and their families therefore were faced with the challenge of accumulating bed charges of 450 shillings per day. The burden of hospitalisation becomes heavier as patients and families struggle with therapy costs and payments for other related services. The other costs included payments for occasional physiotherapy for some patients, medications for other ailments such as diabetes

and malaria. Similarly, the costs of special foods transport to the hospital and required diagnostics affected the patients and their families differently.

The cancer management burden was an additional challenge to the ongoing livelihood struggles in families during intermittent hospitalisation and discharges which lasted for at least six months. The total expenditures related to cancer management in the hospital and at home exceed the available income in typical hospital treatment months as indicated in table 3. In most cases, the portion of expenditure on cancer treatment and care alone exceeded the income available to families from formal and informal sources.

The livelihood contexts of cancer treatment.

Most of the patients admitted to the cancer ward come from the rural areas where many people have unreliable sources of income. These patients are part of the over 57% of the Kenyans who live below poverty line. The level of unemployment has increased with most of the younger people lacking skills and reliable sources of livelihood. Many cancer patients in Kenya afford neither analgesia nor basic essentials of care both at home and in the hospital (Murray 2003). The economic circumstances contribute to the inaccessibility of essential diagnostic equipment and inability of many patients to find suitable food and care assistance. Management of cancer among dependent patients shuttered their livelihood from petty business and participation in family subsistence and small scale cash crop farming. The case below illustrates the livelihood the context and treatment experience of the socially *dependent patients*.

Mukuru² (see table 1) was a 22 year old male, unemployed, and the last born in a family of five. He was diagnosed of nasopharyngeal carcinoma in a district hospital. A minor surgery had been done below the right ear to remove the tumour and after the operation scar healed was admitted on the cancer ward. He was discharged on credit after twenty five sessions of radiotherapy because he had no money to clear the hospital bill of about 7, 500 shillings. He remained hospitalised for one month and a half due to unexpected interruptions in the therapy process. The patient lived in a rural setting, about 120 km from the hospital his aged mother since his father had died five years earlier. His mother grew beans, bananas, vegetables and maize for their own subsistence use. As in other villages in the district and other regions in Kenya his family was gradually replacing coffee trees or intercropping them with food crops. They had small sections on their land on which they grew French beans and less than five macadamia trees for some cash. Macadamia nuts are harvested and sold to manufacturers of salad oil.

Since the near collapse of the coffee industry and poor returns from tea in the 1990s, many small scale farmers started uprooting coffee trees and neglecting their tea plants. As compared to the payment of a shilling per kilogram of coffee, Macadamia nuts were fetching up to 80 shillings per kilogram. However macadamia trees seedlings may take 8 to 12 years to bear crop and the quality of the nuts may be unpredictable due to climatic vagaries. Reasonably good trees produce 30-50 pounds of nuts at 10 years of age and gradually increase.³ The drought that occurred during my fieldwork led to the regret of many farmers who had dropped coffee and tea for macadamia trees. The nuts were dislodging from the trees soon after production due to inadequate water in the soil.

Mukuru's self employed elder brother was just recovering from the death of his 15 year old daughter. She had been admitted for leukaemia treatment at the same time as Mukuru in the same hospital. He owed the hospital 90, 000 shillings for his daughter's hospitalisation and had agreed to pay 1, 000 shillings per month to clear the debt. Their 27 year old sister

² I use pseudonyms and professional designations to refer to other informants through out this work

³ See Waikwa Maina; "How Macadamia farmers can avert crisis" Daily Nation, Thursday February 9 2006; Pp 23-25.

also lived with her mother. During my first visit, she had just completed treatment for pulmonary tuberculosis in a district hospital. Mukuru was anxious about the recommended diet which he barely managed through the help of his relatives and neighbours. He had barely raised the initial diagnostic fees of 5,200 shillings and transport charges of about 2,000 shillings. Since he owed the hospital for the previous treatment his re-admission for chemotherapy was delayed for over a month. He could not be readmitted on credit because the hospital did not have the stock for the required regimen.

The dependent patients relied on their parents and other kin to meet the daily care expenses. Mukuru's case illustrates the context of competing family needs and unaffordable cancer treatment. Table 3 shows a summary of estimated cancer management costs in estimated the context of other needs from the daily expenditure diaries of the three categories of patients described in the previous section. The estimates are derived from the average of two months expenditure coinciding with intermittent hospitalisations. These patients estimated their household income from all the possible sources, including assistance from well wishers. Hospitalisation and treatment costs alone often exceeded the estimated monthly earning of the dependent patients' households. These costs, coupled with other health care and family needs added to the burden of already existing suffering and livelihood struggles.

Table 1: Average two month's cancer care and other costs during ongoing Hospital treatment (in Kenya shillings)⁴

Cases	Medical costs	Other costs	Hospital costs	Total costs	Household income
Samia	4,100	14, 920	12,250	31, 770	7,000
Kaswali	3,800	4, 900	16, 350	25, 050	6, 500
Mukuru	6, 000	3,000	7, 440	16, 440	3, 000
Souda	7,793	16,746	7,500	32, 039	12, 000
Pakot	8,000	17, 240	18, 150	43, 390	6,000
Jabari	3,100	41, 388	8,000	51, 988	50, 888

Source: Patients' self reported expenditure and income diaries 2006

Samia and Kaswali were also dependent and lived with their parents about 47 km and 86 km away from the hospital respectively. Samia was a twenty six year old patient who had just completed his high school when he was diagnosed of osteocarcoma. His right leg was amputated three years before the treatment for recurrence with metastasis to the lungs during my field work. His kin and family friends contributed 160, 000 shillings in a fund raising event to mediate the burden of the disease on his poor parents. Over half of the money was spent on complications that accompanied recurrence of the disease.

Kaswali was the second born in a family of three and was diagnosed of cancer just before his final high school examination. The teachers contributed money for the medication costs during and after amputation of his leg in a local hospital. He had a brother who had been allowed to stay in school 'on credit' since the limited bursaries were given only to orphans, especially victims of HIV/AIDS. His father was a casual labourer working as a mason 30 km away from his home. He earned about 4,500 shillings monthly. They supplemented their income through small scale tea and subsistence farming. The poor economic circumstances of the cases cited above was apparent in their pitiable family timber houses and limited land for cash crop and subsistence production.

⁴ During the research period, between August 2005 and July 2006, One Euro bought 86 Kenya shillings on average. The entries were completed for different hospitalisation months between December 2005 and July 2006.

Medical costs in table 1 include the expenditure on medicines that are prescribed to be used by the patients at home for three weeks before next hospitalization. Patients also spend money on the required diagnostic tests before re-admission. The patients often spent more money on the diagnostics either because they were asked to repeat the tests due to unsatisfactory results or perceived errors in the tests. Many patients travelled to the city anticipating treatment after the doctor's examination of the laboratory results. However a couple of patients did not qualify for subsequent therapy due poor diagnostic test results. Those who did not qualify for therapies due to low blood count were often were asked to go back home and 'eat well' despite the inability of most households to meet the patients' recommended diets. Nearly all the patients whose blood count was low did not afford Neupogen which could boost their blood count more rapidly. Poor laboratory results were also attributed to infections in the hospital and at home. Similarly, many patients did not afford amokalvin, a drug that would treat infections and consequently boost the blood count. When available in the hospital, this drug cost 600 shillings but the cost varied between 1, 500 to 2, 250 shillings in the private pharmacies in the nearest town to Kaswali's home.

Other costs in table 1 include the estimated financial expenditures at home on the patient's special food purchases and family meals, transport of the patient and an accompanying carer to local diagnostic facilities or the referral hospital. For all categories of patients, their treatment costs were experienced in the context of their own or other family members' training and education needs. The hospital therapy costs included the chemotherapy, radiotherapy and other services rendered to the patient during each hospitalisation. The admission fee deposit of 4000 shillings was meant to carter for these costs yet in some cases, the hospitalisation charges which included daily bed fees of 450 shillings exceeded the admission deposit.

Patients as main bread winners in their households experienced hospitalisation and other competing costs differently. The coping of patient bread winners vary with their socioeconomic backgrounds. There were patients for instance who were forced into early retirement due to cancer, separated or widowed single mothers, and the self and formally employed. In table 1, Souda was a 39 year old single mother of four children and the bread winner for her household. She was separated from her husband before she was diagnosed of cervical cancer. Due to her illness she lost her job as an accounts clerk in a corporation in Nairobi. The father to her first born child gave irregular support from abroad. She lived with her children in a two bedroom flat and relied on her elder brother, family members and friends for support. She was often in house rent arrears and food crises. She barely afforded the special food recommended in the hospital. Her medical costs at home included laboratory examinations and analgesics purchased from the hospice. Hospitalisation and cancer management costs further resulted in the drop out of two of her children from school. Souda's case was characteristic of households that were struggling for their daily livelihood. In these contexts, household income is unpredictable and monthly estimates are the sum from all possible sources that can be recalled. Patients and households without predictable sources of livelihood aptly express surprise on how they manage to survive.

Pakot was 49 years of age, mother of four and the main bread winner for her household and was in formal employment. She worked as a primary school teacher with gross salary of about 15, 000 shillings. She was undergoing second line chemotherapy for breast cancer. She had completed first line treatment after mastectomy five years earlier. During my fieldwork she was experiencing a recurrence of the disease and a new presentation that was diagnosed as first stage cancer of the uterus. After the first course of treatment of the second line therapy, she was readmitted with complications affecting her intestines and this required surgery. Due to this she stayed for more than one month on the ward. She exhausted her loan facility available through the teachers' Savings and Credit Cooperative society (SACCO). The

National Hospital Insurance Fund (NHIF) supplemented payment for the hospitalisation but this was hardly sufficient to cover the treatment costs. She received very little net salary because of salary advances and loans that were being deducted from her gross earnings. Her family earnings from tea and coffee were inadequate, and especially after the long spell of drought that had affected many parts of the country. Her husband, who had lost his job in the local farmers' cooperative union, could only support her through coordination of subsistence production for the family and hand outs from relatives and friends.

Due to protracted illness, many patients in salaried employment contemplate early retirement to safeguard their employment benefits. Those who had already retired early were on the verge of depleting their savings and retirement benefits due to cancer treatment and related contingencies. As in the case of Souda and Pakot the livelihood security in many households in Kenya depends on successful investment in education and training of family members. Protracted treatment and care cancer patients expose families to the risk of losing future income due to school drop outs and postponement of training. Pakot's family, for instance was in arrears of 28,000 shillings school fees for her daughter while two of the children Souda's children had dropped out of high school due to lack of school fees.

The case of Jabari (table 1) indicates the potential of formally employed bread winner patients with reliable joint supports to cope differently. Jabari was a technician in a local factory in his town about 200 km from the hospital. The social and economic burden of cancer management in his case was mediated by the income of his wife who worked as a teacher. This socioeconomic background combined the wider social networks among colleagues and church members to facilitate Jabari's hospitalisation experience. Despite the fact that initial diagnosis of the patient's cancer of the colon was delayed in the public hospitals at the district and provincial levels, the treatment after referral went without significant interruptions. Jabari was covered by the National Hospital Insurance Fund and a private insurance cover. Although the household expenditures were higher than the income during treatment as income as in the other cases, this patient had relatively better sources of socioeconomic support. He qualified⁵ for all the subsequent hospitalisations and secured the admission despite the fact that he lived far from the hospital. This patient kept four dairy cows and had adequate supply of vegetables from his home garden. He also had a rental housing project which guaranteed him some extra income. In addition, he raised a good amount of money in a fundraising event that was well attended by members of his church community, workmates and friends. Despite the expenses incurred in school fees for his three children, farm inputs, commuting to work and other monthly household costs, he managed relatively well the six courses of chemotherapy consecutively in six months. By the end of my field work, he had started completed recommended chemotherapy courses and had already started attending review clinics promptly. For the relatively poor patients, decisions about cancer treatment entailed personal

⁵ Patients reporting at the clinic for subsequent treatment 'qualified' for hospitalization if they several conditions were fulfilled. First, their blood should have recovered enough from the previous chemotherapy or radiotherapy for them to endure further therapy. This entailed adequate diet at home and healthy environment to prevent infection which affects the total blood count. If the blood count was low, they would need to buy neupogen (see table 1) and/or amokalvin for quicker blood recovery. Alternatively they were sent back home to 'go and eat well' and given another appointment to try again. Some patients took very long to have the required blood count due to dietary constraints at home. Another qualification for readmission was satisfactory results from urine analysis which was not guaranteed for the poor patients. If the patient qualified, he or she would be unlucky if they did not have adequate money for admission deposits and the purchase of drugs if there was shortage in the hospital. Admission was awarded on first come first basis served due to bed scarcity on the ward which had only a capacity of 32. The patients queued at the clinic as early as 5:00am in order to secure a bed incase they qualified for admission.

or family coping choices to make. These choices have varied consequences for patient well being and livelihood security and sustainability.

Coping choices

Patients and their families respond in varied ways to the economic and the social burden of cancer and related hospitalisations. The choices made in dealing with the socioeconomic costs of the disease reflect the relative livelihood strength of the affected individuals and families. Rural families affected by the costs of protracted illness resort to asset disposals which worsen their poverty situation (Freeman et al 2004). However not all the patients and their families in the present study had adequate assets to facilitate hospital treatment. Most of the patients had used a lot of resources on earlier diagnostic and treatment attempts before arrival on the cancer ward. Hospitalisation on the cancer ward and patient care at home entailed different decisions about basic livelihood organisation. In this context livelihood organisation are the arrangements and activities for earning a living among patients and their households. Cancer management causes frequent and prolonged interruptions in the livelihood activities of the patients and their carers. Patients in the informal sector of employment stop working consistently while those in the formal sector take frequent sick leave. Some of the patients formally employed patients opted for early retirement or were contemplating it because of the fear of losing retirement benefits related to employment termination due absenteeism.

Most informants complained of their stalled projects due to hospitalisation and related costs. A 34 year old male patient who was undergoing chemotherapy for nasopharyngeal carcinoma summed up this concern when he observed that:

“...you know in life, people plan what they have to achieve in life. But what human beings fail to do in planning is to anticipate that they can fall be sick. We just plan on a fixed schedule that by such a time we should have achieved this and that regardless of the fact that we might be sick. When this sickness came; I had a number of projects I had to attend to personally. I have not worked for so long and I was just settling to do a few projects that can help me in life. Then this sickness came and I discovered that it is a very expensive kind of disease to manage. So I diverted whatever resources I had put aside for maybe putting up a house and other things to treatment. Initially I thought that cancer would be treated like malaria or something like that, but unfortunately it is something that lingers for a long time...so decided to postpone my projects.”

Most of the informants felt that delegating the management of personal projects to spouses and other kin was either cumbersome or inadequate. To begin with, the projects required money to be sustained. Some informants felt that it was difficult to trust other people with personal income generation ventures while in hospital. A 68 year old *long-term patient* said:

“I have delegated, but it is difficult to run my business when I am not there in person. I grow sugarcane and for this you just have to be on the farm yourself everyday, no one can be as effective as you want.”

Another patient, a 38 year old widower undergoing treatment for cancer of the colon said:

“...for example if you have a shop you can inform your brother that you are sick and give him 40,000 shillings to stock the shop. He will stock it with 30, 000 instead and this project will becomes more expensive in the long run.”

Spouses were also constrained in keeping family projects going on in spite of frequent hospitalisation and related financial and time implications. Some of the patients' spouses who were in salaried or informal employment noted that the frequency of hospital admissions frustrated their efforts in running family income generating projects. Hospitalisation of spouses or close relatives led to some of the carers' intermittent temporary relocation to Nairobi city to ease the transport and time costs related frequent visits to the ward. Some

patients occasionally moved from their rural homes to the relatives' houses in the city during the treatment period. This presented further limitation to the coordination of family livelihood activities through 'messengers' and the telephone. Patients with little or no social support in the city faced more burden of fending for themselves and were most destitute in the hospital.

The choices for coping with the increasing burden of cancer treatment entailed considerations of the patients' and family well being. Depending on prevailing socioeconomic circumstances, socially dependent, breadwinners and other patients perceived the dilemma of choice between treatment for personal well being and avoidance of therapy for the sake of their family and social network comfort. Compliance or non compliance with hospital appointments and cancer management recommendations implied pragmatic trade offs. Ephemeral or total avoidance of treatment or hospitalisation can be understood as coping choices based on subtle or explicit considerations of socioeconomic costs and benefits of treatment compliance. Skipping treatment appointments and lose to follow up due poor socioeconomic backgrounds and competing family needs often caused of poor prognosis. The coping choices often implied inevitable compromise of either or well being of the patient or the sustainability of already fragile family livelihoods. A 47 year old widow with recurrent breast cancer decided not to go back for the final the sixth course of second line chemotherapy. She preferred to continue only with the Chinese medicine from a clinic than spend more on the ward. The last course of chemotherapy would have cost 28, 000 shillings and she thought that it was futile to continue spending on both hospital treatment and alternative medicine. At her requiem mass three months later there was an appeal for impromptu money contributions to set up an 'education fund' for three of her orphaned children still in school.

A significant and unavoidable choice that characterized choices in poorer and better off families alike was the postponement or termination of educational or career development of members. The experience of choices for a single mother below sums up the predicament of both relatively well off and poor patients admitted on the cancer ward.

Nadia 37 years of age was a divorcee and lived with her three children in a squatter slum shelter in the city. She was diagnosed of nasopharyngeal carcinoma after about two years of suffering with the disease for about two years. She sustained her family through petty second hand clothes business. She reflected on the way frequent hospitalisation and expenditure on the disease had affected her life and the future of her children. She raised them without the support of their father who had already married another wife.

Different categories of patients have varied social and economic resources that facilitate their struggle against chronic illness. The prolonged trail of diagnostic, treatment, and hospitalisation experience imply enormous amounts of money. The management of cancer and the associated hospitalisation entailed a struggle for survival characterised by social and financial indebtedness. The numerous household needs and low incomes exposed patients and their families to further vulnerability to the financial burden of lost income and out of pocket medical costs. The poor patients who are the majority on the cancer ward were particularly vulnerable due to their low levels of assets that could facilitate coping with the prolonged and expensive illness (Ranson 2002, Freeman et al. 2004). Depletion and low levels of assets among cancer patients implied a vicious cycle of poverty and inability to cope with other illnesses and needs in the family. The household of dependent patients and those who were the main household providers had the most meagre options out of poverty. They were more vulnerable to adversity engendered by future illnesses and shocks to subsistence production.

Cancer treatment singly took the biggest share in the burden on available individual and family assets. The assets that were commonly sold included land, livestock. Two informants sold material they intended to use to build new houses while a few paid for

hospitalisation from proceeds of the sale of other family property such as houses and trees. Due to the urgency of the treatment or other household needs that coincided with hospitalisation decisions to sell the assets at throw away prices be made at times. The prolonged diagnosis and treatment of cancer meant that admission to the cancer ward was mere continuation of the financial burden and social suffering. Transport, treatment, diagnostic and subsistence costs for the patients and their relatives increased with the treatment process. In view of the struggle with the cumulative costs of cancer care; a 69 year old patient on supportive management for cancer of the oesophagus told me:

“I sold half an acre of land and the money was finished before I reached treatment in this hospital. Currently my brother’s sons are now struggling to pay for me yet they do not have formal jobs. The money I had did not last because I was ‘wandering’ around. Sometimes I tried the Makini⁶ medicine without success.”

Formal supports for cancer inpatients.

The introduction of cost sharing in public hospitals removed the most reliable source of formal support for poor patients (Mbugua et al. 1995). User fees for inpatient and curative out patient services were introduced in government hospitals and health centres at the end of 1989 (Republic of Kenya 1989). This followed the economic problems since mid 1970s which compelled the government to adopt the IMF and World Bank supported structural adjustment programmes. Hospitalisation and treatment fee waiver at the referral hospital was replaced by a credit scheme. In this arrangement the patients who need urgent attention are admitted and treated on credit. Before being discharged, the patients and their relatives enter an agreement on how to pay what they owe the hospital in instalments. However the hospital expects that by the time treatment is over the patients and their families would have found means to pay the bills. Arguably, the expensive nature of cancer management excluded most patients from this scheme. Moreover, the frequent shortages of cancer medicines in the hospital make the admission of indigent patients on credit unnecessary.

In seven months of the fieldwork period, only seventeen cancer patients had been treated on credit. There were often instances of patients being detained on the ward for several days due to the non clearance of hospital charges. These patients were subsequently referred to as ‘social’ rather than ‘medical’ cases and they made frantic efforts to be released on credit. Nadia, for example narrated her experience with seeking to be discharged from the hospital on credit:

“...my bill is now 33, 000 shillings, not including the charges for this week that I have added since I was discharged. It has been a problem because my mother has been going to the credit people since Monday and they just told her they could not help her. She has been coming every day until yesterday. She told me that today she does not have bus fare and I told her that she can just stay at home because I have nothing to do.”

Credit was awarded only after the officers in the credit office determined that the patient and their relatives were totally unable to pay at once. The credit officers also wanted to be sure about the plan of repayment before allowing the patients to be discharged on credit. This process often resulted in prolonged stay on the ward regardless of its extra financial and psychological implications for the patients. The responsibility for credit burden patients who could not completely afford payment was transferred to the ministry of health. As in the case

⁶ This is one of the registered dealers in traditional African and other alternative medicines. The experience of many patients involves initial visits to the providers of alternative remedies in the form of food supplements and herbal medicines. Some patients used these remedies concurrently with radiotherapy and/or chemotherapy while others resorted to them during the interlude between hospitalisations. This added to the cumulative costs as the alternative therapies were equally expensive considering the patients’ weak economic backgrounds.

of Mukuru described above, unless admission was considered an emergency for supportive care, the patients who lacked the money to buy drugs did not qualify for hospitalisation.

The National Hospital Insurance Fund (NHIF), private insurance covers and Savings and Credit Cooperatives (SACCOs) are the other potential formal sources of support for inpatients. However, very few patients attending public hospitals in Kenya have access to the support from these institutions. Dependent patients and those in informal employment do not have the NHIF or any other cover. Plans were underway to enable and motivate the self employed to contribute to the NHIF, although many of the patients in this category could not commit themselves to this arrangement due to the unreliability of their wages. Moreover, the NHIF payments were sufficient only for the daily bed charges and the balance was frequently inadequate to cover the treatment and other inpatient care charges. A few patients attempted making contributions to private insurance covers.

Formally employed patients often supplemented the support from NHIF with monthly share contributions to SACCOs. Both the SACCOs and some private insurers facilitated access to loans which some cancer patients had exhausted through frequent emergency loan applications. This had negative implications for the expected monthly salaries due to over deductions on the patients' and/or their close relatives' payslips. A serious disease such as cancer is therefore singly responsible for health expenditure that threatens the financial well being of affected households (Ranson 2002). Patient and their relatives spend more on diagnostic tests, surgery and medicines and often reach a point where they do not expect to qualify for loans from the lending institutions. At least three informants were pursuing their early retirement benefits to facilitate their hospitalisation. The majority of people in Kenya are poor, unemployed remain unprotected by formal means against the main livelihood risks which include serious diseases as in other developing countries (Tostensen 2004, Jütting 2000, D'Haeseleer and Bergahman 2003). Although informal arrangements evolve as a response to the lack of formal protection of the poor they have varying effects on how people cope with protracted treatment in different situations.

Informal Social Supports in cancer management

Cancer management on the ward and at home was characterised by varied experiences of social support for the patients and their families. The nature of social support depended on the range of accessible networks of social support. Poor rural based families have lesser support either because they have limited social networks or the people they know are equally poor to assist them. The values of trust, reciprocity, compassion for the suffering and mutual help are put to test by the prolonged nature of cancer management. Collective solidarity of the extended family, clan, and the ethnic group in many parts of Africa are rapidly weakening due to social economic changes and the consequences of serious diseases (Tostensen 2004). These changes coupled with the hard economic times shape the experience of patients, especially those with few or no social relations in the city where the referral hospital is located. Such patients were hardly visited on the ward and this contributes to perceived destitution among some of them. For instance, a forty three year old female fibrosacoma patient who had been amputated and later tested seropositive for Human immunodeficiency virus had in self pity said:

“...So I have been afraid that I have never got a child. There is no one who has visited me since I came to the hospital five months ago. Only my elder sister from Nakuru (about 200 km away) came once. But I'm lucky that I can eat, even the fruits other people eat. Maybe some people bring some fruits for their patient and God talks them and they says I have not seen this *mama's* people coming, let her eat this...”

Some patients perceived that they were isolated as their illnesses and treatment became protracted. Social isolation can be attributed to the livelihood challenges faced by the patients' families and their networks of support. Relatives and friends supported the patients

during the initial hospitalisations and they gradually got exhausted as the treatment proceeded. Souda (table 1) who was undergoing treatment for the second stage cervical cancer narrated part of her experience below:

“When I think about it, I just cry, but now I think I am mature, I don’t cry any more. .. My relatives thought I was (HIV) positive and were hesitant to help me. I have been getting support from my first son’s father from abroad but his wife has not been happy. He has been promising to send some money but he has not. A friend found me in pain and contacted my brother. He had promised to call and assist me but yesterday he sent only 500 Shillings which is not enough for the next admission and medicines. I was expected to go back to the hospital two weeks ago. I have been surviving on handouts from friends and some relatives. When I get some money I buy my food stock for two or three months. I have been strained for the last two weeks. I need medicines yet my family needs food. You know, my brother just told me bluntly: ‘Souda, this medicine of yours is so expensive; I do not think anybody is going to afford it and you know I’m tired’...one day he said; ‘you know if you were sick and employed, it would be easier. You have to fight your own battle’. So I do not know where I will get the money to go back to the hospital. I have to fight my own battle.”

Most patients expressed the concern that, family members, relatives and friends got “tired on the way.” This often reminded the patients of their vulnerability and lost independence which rendered the patients perceive themselves as “a bother” to their carers, or a burden to others (McPherson et al. 2007a&b). The struggle with cancer management in the context of limited resources implied that patients and their families expected instrumental and financial support was from the wider community. The patients occasionally expressed despair and guilt for their over dependence on other people in their families and networks of social support. Some patients were anxious about possible loss of respect because of their inability to fulfil their social roles (Grant et al. 2003) and provide for their families. The ability of households to contribute to the informal social security of their members is constrained by various factors which leave very little to spare. The main limitation to patient care in most families included diminishing productive resources to tragic spending on cancer management. The soaring household expenditures on cancer has to be visualised in the context of cost sharing in health and other services and high social dependence due to unemployment in Kenya as in other developing countries (Tostensen 2004, Bogale et al. 2005).

The awareness among patients that others are bound to get tired of providing support reduced expectations of assistance from non relatives. A twenty four year old female patient, for instance said:

“...In our place who can give you support? No body, maybe your closest relatives, your uncles. Maybe they can give you fare from home to Nairobi. Community help? Forget that one. Not in our place... That is why I think I be prayed for, I get healed, to set my family free”.

In the event of unbearable economic strain only close family members and some religious organizations strived to bail the patients out of their suffering to a limited extent. The contribution of the community and religious carers are limited to social, emotional and spiritual support. Comprehensive well being of cancer patients in Kenya is challenged by general low access to pain relief and affordable clinic services. Shared poverty and vulnerability between the patients and their rural social networks implied that most of the patients’ physical needs often went unmet (Grant et al. 2003, Murray et al 2003). The feelings of guilt of depletion of family resources to pay for cancer management affected the decisions about compliance to treatment. Protracted illness and pain evoked feeling worthlessness and helplessness as some patients perceived hospitalisation and treatment as meaningless. It took the intervention of a friend, for instance, to curtail the above cited patient’s suicide plan when she lost hope. She contemplated suicide due to her experience of persistent deep pain and loss of her job due nasopharyngeal cancer.

The indigenous value of communal solidarity in most Kenyan cultures still underpins expectations of support during social, physical and material strain. This value motivated relatives and friends to participate in fundraising events during the hospitalisation of some of the patients. Attempts by patients and their families to raise money for treatment through *harambee*⁷ self help mobilisation yielded different outcomes. The support expected from this community mutual help initiative varies with the composition and extent of the patients' and family social networks. The contributions and attendance of *harambee* fundraising events varied for patients who were dependent, main household providers and those with joint spousal supports. The size, range and strength of social networks had implications for the amount of contributions and continuity of support of patients through the *harambee* ideology. The strength of kinship ties, membership to religious organisations, and employment status and history are significant aspects of support based on communal solidarity. However, *harambee* fundraising events for hospitalisation costs were limited to about two events in a given time interval. Many financially constrained patients therefore shied away from asking for more communal fundraising and support. An informant noted that:

“It will depend on the progress of the problem. If it is likely to take longer, relatives and friends relax and tend to withdraw. You can't take this to them anymore...they will think you are joking with them.”

A few patients had some experience with support from informal social organisations. The informal mutual aid associations in Kenya are either religious based or secular with a wide range of memberships. These are similar to the traditional small-scale rotating savings and credit associations set up to provide credit to individuals who are otherwise excluded from formal financial services (D'Haeseleer and Berghman 2003:8). The informal rural-based insurance and credit associations referred to by informants in the present study were characterised by poor organisation and mistrust. Secondly lack of income among the members affected the sustainability of the associations. The debilitation of cancer affected the patients' and family members' statuses in the merry-go-round groups in terms of the financial contributions and participation in related social activities. Cancer management depleted the support individuals and families received from the informal associations of mutual assistance.

Mrs Kadri, 44 years of age was a breast cancer patient for instance, had an experience of the informal social security arrangement in her village. Before she fell ill, she worked as a house help and sold vegetables part time. Her husband was not in salaried employment and she was the household bread winner. She continued with petty business after the first line treatment. She was supported by her daughter who worked as a casual labourer together with her spouse. Mrs Kadri used to be a member of a merry-go-round association called *makumi* (literally, tens) with about 200 members. The association mediated illness and funeral expenses incurred by the members. From the monthly contribution of 550 shillings 50 was kept in a cooperative savings account and 500 rotationally given to the members. The association collapsed due to misappropriation of the funds by the officials. Twenty five members decided to continue with the association but they failed to raise the monthly contribution of 250 shillings due lack of income.

Samia's parents (table 1) belonged to two separate self help associations called *seti* (local translation of “set”). His mother belonged to a group of twenty to twenty five members who made monthly contributions of 100 shillings. His father belonged to a group with 60 members who contributed 300 shillings monthly. Members committed their assets such as

⁷ *Harambee* is a Swahili word that means “pulling together”. It is derived from the value of communal solidarity in self help events. Since independence, this idea has been used to fundraise for informal and formal events. In the communities and families, people draw on the *harambee* spirit to raise money for treatment and hospital bills, payments for education and other financial needs that individuals and smaller groups can not manage.

bicycles, radios, furniture or livestock as collaterals in case they defaulted on the monthly contributions. The waiting time for each contributor's rotational round was too long especially in case support in serious illness and family financial needs were pressing. Referring to his father's group of 60 members, Samia noted:

"You know it is per month! I think it was started when I was in the first year of high school...its now about five years... And they have not yet completed one round!"

The data above show that the cancer patients' experience of hospital treatment is shaped by the contexts of livelihood struggles. Hospitalisation is a catastrophic addition to these struggles. The insufficiency of both formal and informal supports for cancer patients characterise their untold suffering during ongoing treatment.

Discussion

This paper has explored the wider social and economic context of the patients' experience of ongoing cancer treatment and care on a cancer ward in a national referral hospital in Kenya. The poor socioeconomic backgrounds of the patients explain their overall delay in presentation for specialised treatment. Moreover, the difficulties in diagnosing cancer and timely intervention reflect the inadequacy of the health care system in Kenya. Public hospitals and health centres at all levels of the health care system lack equipment and personnel to facilitate early diagnosis and referral. Lack of pathologists in district and provincial hospitals complicate the situation of suffering patients in the rural areas (Sanson and Mutuma 2002). Most of the patients' arrival on the cancer ward in the national hospital is a climax of multiple referrals that entail enormous burden on available individual and family resources. The delayed referral and presentation imply that the intervention at the cancer treatment centre require radical treatment (Onyango and Macharia 2006) which is hardly affordable to majority of the patients. The overall experience of cancer patients and the affected families reflects their poor backgrounds and further impoverishment engendered by hospitalisation.

Studies on the impacts of illness on livelihoods in developing countries have often focussed on communicable and other diseases that have been given higher profile in social and political discourse. The emerging crisis of cancer calls attention to understanding the impacts of single chronic diseases on livelihood security of families. It is difficult to have precise figures on the total costs of a cancer treatment trajectory. Families are unable to recall the exact costs linked specifically to their hospitalisation and management of cancer during actual treatment periods. Given the economic hardships and competing household needs, many patients and their carers expressed surprise that they had managed up to the current hospitalisation period. The heavy indebtedness and depletion of family resources for cancer treatment implied lose of the future earning capacity and ease of recovery (Wallman 1996, Bogale et al 2005, Russel 2005, Patterson et al. 2004). As in the cases of HIV/AIDS, cancer treatment has long term impacts linked to gradual and protracted depletion of available family resources. The affected households' resilience is gradually undermined as cancer management worsens livelihood vulnerability and expose families to more future shocks.

The cumulative impact of cancer management begins in the early stages of the disease. Patients and their families incur initial resource spending on attempted diagnosis and treatment. At these early stages, many patients lack access to pathologists and medical facilities to facilitate early detection and treatment of the disease. Initial frantic efforts to restore well being notwithstanding, admission to the cancer ward ushers in a new phase of costs incurred in frequent hospital visits and medication. At this juncture the households face further loses in livelihood organisation due to the illness. As the expenditures and support needs for the patient increases more income and human capital is lost. The impacts on the human capital are gradual as the household members lose chances for education, career

training and participation in requisite social interactions. The contribution of the patients to the household resources diminishes yet the use and sale of available assets for their treatment and care impoverish families. In the Kenyan context, informal and formal support to poor patients is either too insufficient or absent and this gradually implies that only the patients and their closest relative bear the brunt of the cancer crisis.

The relevance of indigenous livelihood values of reciprocity, communal solidarity and compassion to facilitate informal supports for cancer patients is inhibited by various factors. In the first place, cancer management cause fatigue of the social networks of support. Prolonged treatment that debilitates individuals and families undermines their abilities to effectively be part of pragmatic networks of reciprocity. Cancer treatment limits participation and contributions of patients and their families and this isolates them further from the potential sources of support. This invalidates expectations of balanced reciprocity and leads to subtle isolation of affected families and feeling of guilt among patients. Most patients and their families have common experiences of limited resources and income with the rest of the community and their social networks. This implies that, support to cancer patients' within kin and kindred groups gets exhausted before the patients realise satisfactory quality of life. Kinship support is particularly weakened by modern economic and social changes (Kayongo and Onyango 1984, Kilbride and Kilbride 1993). Some patients strive to refrain from being "burdens to others" by concealing their care needs. The patients are often aware the facts that that their families and other carers strain to support as they struggle with their own livelihood needs. The prolonged suffering of cancer patients in this regard constitute a cross road for the indigenous values of communal solidarity and support. Arguably, there are limits to indigenous African values of mutual support. In extreme circumstance of adversity, not all people, including close relatives would go readily support the afflicted. The sustainability of informal social security institutions is threatened by generalised poverty of potential members.

These patients do not benefit from the hospital credit scheme because of the expensive nature of cancer care. Since most inpatients are unable to settle the bills incurred this adds to the reduced revenue collection in the cost sharing scheme to sustain the hospital services. Debt collection is one of the challenges the hospital faces when they treat patients on credit involving large amounts of money. This is complicated by the fact that the government provision to carter for the subsidy of the services provided at the referral hospital is inadequate. Frequent shortage of cancer medicines in the hospital this implies that the patients should have their own means of getting the medicines before they can be admitted. The situation of needy cancer inpatients in Kenya reflect the fact that although health care provided by governments should cover poor people, in practice it often does not (Ranson 200:614). The implementation of the policy establishing a National Social Insurance Fund in Kenya to facilitate accessible and affordable healthcare services to the poor is long overdue. However, this policy would be more beneficial in cancer management if resources for early detection are made available in regional hospitals in Kenya.

Conclusion

This paper has explored the wider social and economic context of cancer patients' experience of treatment on the hospital. Hospitalization for cancer treatment in Kenya and other developing countries is often tragic for household assets and livelihoods struggles. Apart from the impacts of previous diagnosis and treatment attempts admission to the cancer ward entail further expenditure on requisite radical therapies. Ongoing management of cancer in the hospital and at home depletes available family resources and threatens future production capacity and livelihood security. The impoverishing effect of cancer treatment results from the use of individual and family savings, the sale of family assets, especially land and

livestock. The livelihood impacts unfold gradually and these result in coping choices that compromise either the well being of the patients or the sustainability of family livelihood. The most significant choices include decisions which interrupt subsequent treatment or education of family members. The socioeconomic impacts of cancer management are long term and intricate to examine since. The economic shocks that result can not be easily quantified since caring for cancer patients in poor families entail additional struggle in daily livelihood.

The devastating effects of cancer management on livelihoods are related to the lack of formal and informal social security institutions. Due to the shared context of limited resources, families and wider networks of social support are unable to enhance the patients' quality of life. Patients are isolation due to the exhaustion of social support and their feelings of guilt about being burdens to others. The informal social security groups rural settings are weak due to poor organization, and lack of trust and income. These groups however have the potential for boosting community solidarity and mutual assistance during chronic illness. Such groups can be revived and strengthened through the support of the government and non-governmental organizations. The government and non-governmental organizations can help in the establishment of mutual emotional support groups for patients and affected families. This can mitigate the impacts of perceived social isolation and scarce resources in the rehabilitation of cancer patients.

There is an urgent need for clear government policy on the treatment of cancer and protection of those affected by the disease. Priority of health policy to the protection of cancer patients and their families imply that the government has to forgo generation of revenue from cancer management services. This should include deliberate efforts to facilitate access and affordability of treatment and pain relief drugs, and inpatient and clinic care. The government needs to include policies for sustaining the education of family members affected by the illness and death of the bread winner. This policy can aim to target the children of divorced or widowed single mothers and people forced into early retirement due to cancer. The government and non-governmental organisations can also support in improving the living conditions of the patients during ongoing treatment. Poor cancer patients, for instance, need help to access the recommended diet during cancer treatment. However, implementation of the awaited National Social Insurance Fund will facilitate poor Kenyans' access to basic health services.