# SOCIO-ECONOMIC CHALLENGES AND SUPPORT SYSTEMS OF CANCER PATIENTS FROM CANCER CARE HOMES

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# ABSTRACT

This research aims to explore the socio-economic challenges faced by cancer patients of the Cancer Care homes, and the support systems available to them through the institutions. The study thematically analyzes the prevalence of cancer and its physical, social, and economic aspects, as well as the challenges encountered by cancer patients, including physical and socio-economic challenges. Additionally, the research examines the effectiveness of institutions working for cancer patients and the challenges faced by these institutions.

The general objectives of the research are to understand the socio-economic challenges faced by cancer patients and the support systems provided at Cancer Care home. The specific objectives include analyzing the socio-demographic profile of the respondents, studying the socio-economic challenges experienced by cancer patients, understanding the facilities availed by them at Cancer Care homes, and exploring the socio-economic support provided by the institution. The study also aims to suggest social work interventions for the well-being of cancer patients through institutional care.

The variables considered in this research are family support, social support, economic support, institutional support, and support systems. Family support is defined as emotional, practical, and informational assistance provided by family members during the cancer journey. Social support refers to the assistance, comfort, and resources offered by cancer care homes, healthcare professionals, and support groups. Economic support involves financial assistance to alleviate the financial burdens associated with cancer. Institutional support refers to the services provided by established organizations for economically weaker cancer patients and their families. Support systems encompass the interconnected web of social relationships, institutions, and services that help cancer patients navigate through challenges and cope effectively.

The research adopts a quantitative research method with a cross-sectional design. The study includes cancer patients receiving treatment at different cancer care homes associated with RCC Thiruvananthapuram. The research employs probability sampling, specifically simple random sampling, to select 55 participants. Data is collected using an interview schedule and analyzed through descriptive and inferential statistics using SPSS software.

Overall, this research seeks to shed light on the socio-economic challenges faced by cancer patients and the various support systems available to them at institutions. The findings may provide insights for improving the well-being and support mechanisms for cancer patients, contributing to enhanced care and quality of life for those affected by this devastating disease.

**Key words**: Cancer, Cancer treatment, social challenges, economic challenges, Intuitional care, cancer patients, care homes

# CHAPTER I: INTRODUCTION

# CHAPTER I

# INTRODUCTION

## 1.1 INTRODUCTION

Cancer, a complex and devastating disease, casts its shadow over millions of lives worldwide, inflicting formidable physical, emotional, and financial burdens upon patients and their families. The socio-economic challenges entwined with cancer are not only substantial but also capable of further exacerbating the already strenuous journey of battling the illness. In this landscape, comprehending these intricate challenges and delving into the available support systems for cancer patients becomes paramount, shaping the development of effective interventions aimed at enhancing the holistic well-being of those ensnared by this formidable adversary.

Acknowledging the urgency of addressing the socio-economic predicaments faced by cancer patients and their bystanders, prominent individuals and institutions have embarked on recognizing the indispensable role of institutional interventions. Dr. Tedros Adhanom Ghebreyesus, the Director-General of the World Health Organization (WHO), underscores the significance of weaving socio-economic support into healthcare systems, ensuring that cancer patients receive comprehensive care and unwavering support throughout their arduous journey. Dr. Ghebreyesus amplifies that socio-economic interventions stand as crucial pillars for not only diminishing health inequalities but also for realizing the aspirations of universal health coverage.

In harmony with this call for action, eminent healthcare professionals, researchers, and advocates raise their voices against the socio-economic challenges that cancer patients grapple with. Dr. Siddhartha Mukherjee, an acclaimed oncologist and author, illuminates the shadows cast by cancer over patients' financial stability and emotional equilibrium. He underscores the imperative for institutional interventions capable of holistically addressing these multifaceted concerns. Organizations dedicated to cancer support, including the American Cancer Society and Macmillan Cancer Support, step forward with active participation, extending financial aid, employment opportunities, and psychosocial sustenance to both patients and their families.

Given the considerable socio-economic burdens that cancer patients and their families shoulder, the focal point of this research resides in exploring the efficacy of institutional interventions in alleviating these formidable challenges. By examining interventions across diverse institutions, encompassing governmental initiatives, healthcare establishments, and nonprofit entities, this study seeks to unearth best practices, identify factors contributing to success, and highlight potential avenues for refinement. The research draws upon the insights furnished by the WHO and the perspectives of revered figures within the field, culminating in a comprehensive blueprint that orchestrates the institutional framework necessary to confront the socio-economic dilemmas faced by cancer patients and their bystanders.

The anticipated outcome of this research extends beyond its theoretical scope, aspiring to cast rays of enlightenment upon policymakers, healthcare providers, and advocacy groups. The research anticipates that the strategies and interventions unveiled will constitute a formidable arsenal against the socio-economic afflictions borne by cancer patients. Through the deployment of evidence-based institutional interventions, a transformative healthcare system could emerge-one characterized by equity, support, and empowerment, catalyzing cancer patients and their supporters to navigate this journey with dignity, financial equilibrium, and elevated quality of life.

Within the ambit of this dissertation, an exploration of the socio-economic challenges encountered by cancer patients undergoing treatment at a regional cancer center takes center stage, alongside an examination of the available support systems. This inquiry is not only poised to reveal the barriers impeding access to quality cancer care but also offers a landscape where strategies to enhance well-being and outcomes for cancer patients can be sculpted.

This chapter serves as an introductory prelude to the broader research canvas, the prime objective of which is to delve into the socio-economic tribulations faced by cancer patients and the support mechanisms enshrined within cancer care institutions. In the following sections, we will delve into the background of this study, articulate the problem statement, and articulate the significance underpinning this research endeavor.

## 1.2 BACKGROUND OF THE STUDY

### 1.2.1 CANCER

Cancer is a common name given for a group of diseases characterised by uncontrolled production of abnormal cells. Cancer starts when the cells of an organ or tissue in our body grow and multiply out of control and form a mass, called a tumour.

According to the World Health Organization (WHO), cancer is defined as a group of diseases characterized by the uncontrolled growth and spread of abnormal cells in the body. These abnormal cells, known as cancer cells, can invade nearby tissues and organs, leading to a range of health issues. If not controlled or treated, cancer can result in serious illness or death.

Cancer can affect virtually any part of the body and can occur at any age. It is a complex and multifaceted disease influenced by a combination of genetic, environmental, and lifestyle factors. The exact causes of cancer can vary widely depending on the type of cancer and individual circumstances.

The impact of cancer is significant on both individuals and societies. It can lead to physical, emotional, and financial burdens for patients and their families. The global burden of cancer is substantial, with millions of new cases diagnosed each year and a significant number of cancer-related deaths.

Preventive measures, early detection, and advancements in cancer treatment have improved outcomes for many cancer patients. WHO emphasizes the importance of adopting healthy lifestyles, avoiding exposure to known carcinogens, and promoting early diagnosis and access to quality treatment to reduce the impact of cancer on individuals and communities.

Studies have shown that cancer patients not only face physical challenges but also experience socio-economic hardships, including financial strain, loss of employment, and social isolation. These challenges can hinder access to timely and appropriate healthcare, impeding treatment outcomes and exacerbating emotional distress. In response to these difficulties, various institutions, including cancer care homes and support organizations, have emerged to provide aid and support to cancer patients and their families.

Cancer is a complex and devastating disease that affects millions of individuals worldwide, causing physical, emotional, and socio-economic challenges for patients and their families. In recent years, there has been an increasing recognition of the significant impact of socio-economic factors on cancer care outcomes, highlighting the importance of understanding and addressing the unique challenges faced by cancer patients.

### 1.2.2 TYPES OF CANCER

Cancer is a complex group of diseases characterized by the abnormal growth and division of cells. These abnormal cells have the potential to invade and spread to other parts of the body, causing serious health issues. There are various types of cancer, each originating from different cell types and exhibiting unique characteristics. Some common types of cancer include:

- Carcinomas: These cancers arise from epithelial cells that line the internal and external surfaces of the body. Carcinomas are the most common type of cancer and include breast, lung, prostate, and colon cancer.
- Sarcomas: Sarcomas originate from connective tissues, such as bones, muscles, fat, and blood vessels. Examples of sarcomas include osteosarcoma, liposarcoma, and angiosarcoma.
- Leukemias: Leukemias are cancers that affect the blood and bone marrow. They involve the overproduction of abnormal white blood cells, impairing the body’s ability to fight infections. Common types of leukemia include acute lymphoblastic leukemia (ALL) and chronic myeloid leukaemia (CML).
- Lymphomas: Lymphomas affect the lymphatic system, which is responsible for maintaining the body’s immune response. There are two main types of lymphomas: Hodgkin lymphoma and non-Hodgkin lymphoma.
- Central Nervous System (CNS) Cancers: CNS cancers, including brain tumors, arise in the brain or spinal cord. Gliomas, meningiomas, and medulloblastomas are examples of CNS cancers.
- Treatment procedures for cancer depend on various factors, including the type and stage of cancer, as well as the patient’s overall health. Common treatment modalities include:
- Surgery: Surgery involves removing the cancerous tumour and nearby tissues, aiming to eliminate or reduce the spread of cancer cells.
- Radiation Therapy: Radiation therapy utilizes high-energy rays or particles to destroy cancer cells or inhibit their growth. It can be administered externally or internally, depending on the specific case.
- Chemotherapy: Chemotherapy uses drugs to kill cancer cells or prevent their multiplication. These drugs may be administered orally or through intravenous infusion, and they circulate throughout the body to target cancer cells.

- Immunotherapy: Immunotherapy aims to enhance the body’s immune system to recognize and destroy cancer cells. It includes treatments such as immune checkpoint inhibitors, CAR-T cell therapy, and monoclonal antibodies.
- Targeted Therapy: Targeted therapy involves the use of drugs that specifically target specific genetic or molecular abnormalities in cancer cells, disrupting their growth and survival.
- Hormone Therapy: Hormone therapy is used to treat cancers that are hormone-dependent, such as breast and prostate cancer. It involves blocking or reducing the production of hormones or inhibiting their effects on cancer cells.

Cancer patients refer to individuals diagnosed with any form of cancer. They may undergo a combination of treatment procedures tailored to their specific condition. The treatment plan is typically determined by a multidisciplinary team of healthcare professionals, including oncologists, surgeons, radiologists, and other specialists.

### 1.2.3. GROUNDS OF CANCER

Cancer is a complex disease with various factors contributing to its development. While genetics play a role, numerous environmental, lifestyle, and behavioral factors can also increase the risk of cancer. Here are some common causes of cancer along with relevant citations:

- Tobacco Use: Smoking and tobacco use are significant causes of cancer, particularly lung cancer. Tobacco smoke contains carcinogens that can damage DNA and lead to mutations. It is estimated that smoking causes approximately 85% of lung cancer cases.
- Diet and Nutrition: Poor diet, high in processed foods, red meat, and low in fruits and vegetables, is linked to an increased risk of various cancers, including colorectal, stomach, and esophageal cancers.
- Obesity: Being overweight or obese is associated with an increased risk of several types of cancer, including breast, colorectal, endometrial, and kidney cancers.
- UV Radiation Exposure to ultraviolet (UV) radiation from the sun or tanning beds is a major cause of skin cancer, including melanoma.
- Infections: Infections with certain viruses and bacteria are linked to specific types of cancer. For example, human papillomavirus (HPV) can cause cervical and other cancers, while hepatitis B and C viruses are associated with liver cancer.

- Environmental Carcinogens: Exposure to certain chemicals and substances in the environment, such as asbestos, benzene, and radon, can increase the risk of cancer.
- Alcohol Consumption: Heavy and regular alcohol consumption is associated with an increased risk of several types of cancer, including oral, liver, and breast cancers.
- Physical Inactivity: Lack of physical activity is linked to an increased risk of multiple cancers, including breast, colon, and endometrial cancers.

It’s important to note that cancer is often caused by a combination of factors, and individual risk can vary based on genetics, lifestyle choices, and environmental exposures. Preventive measures such as avoiding tobacco, maintaining a healthy weight, practicing sun safety, getting vaccinated, and adopting a balanced diet can significantly reduce the risk of cancer.

### 1.2.4 STAGES OF CANCER

Cancer staging is a process used to describe the extent and severity of cancer in a standardized way. The stages of cancer provide crucial information to healthcare professionals for determining prognosis, treatment options, and potential outcomes. The most commonly used system for cancer staging is the TNM system, which stands for Tumour, Node, and Metastasis. This system evaluates the size and extent of the primary tumour (T), the involvement of nearby lymph nodes (N), and the presence of distant metastases (M). Here are the different stages of cancer based on the TNM system, along with a brief explanation of each stage:

- Stage 0 (In Situ): This stage refers to cancer that is localized and has not invaded neighbouring tissues. It is often referred to as “in situ,” meaning “in place.” At this stage, the cancer cells are limited to the site of origin and have not spread to nearby tissues or organs.
- Stage I: Cancer at this stage is typically small and localized. It may have invaded nearby tissues but has not yet spread to lymph nodes or distant sites.
- Stage II: Cancer at this stage is larger than in Stage I and may have spread to nearby tissues or structures. However, it has not spread to lymph nodes or distant organs.
- Stage III: Cancer at this stage has grown significantly and may have invaded nearby tissues or lymph nodes. It has not yet spread to distant organs.

- Stage IV: This is the most advanced stage of cancer. At this stage, cancer has spread to distant organs or other parts of the body. It may also be referred to as “metastatic” cancer.

It’s important to note that the specifics of staging can vary depending on the type of cancer. Each type of cancer has its own staging criteria based on the TNM system or other relevant factors. Stage I and II generally indicate localized cancer, while stages III and IV represent more advanced and potentially metastatic disease.

### 1.2.5 DIFFERENT TREATMENTS OF CANCER

The different treatments for cancer include Radiation Therapy, Chemotherapy and Surgery.

- Radiation Therapy: Radiation therapy uses high-energy rays or particles to target and destroy cancer cells. It can be delivered externally using machines (external beam radiation) or internally using radioactive materials (brachytherapy).
- Chemotherapy: Chemotherapy involves the use of drugs to kill or inhibit the growth of cancer cells. These drugs can be administered orally or intravenously and circulate throughout the body to target cancer cells wherever they may be.
- Surgery: Surgery involves the removal of cancerous tumors and surrounding tissues. It is often used to diagnose, stage, and treat cancer. The extent of surgery depends on the type, location, and stage of cancer.

The treatment options can vary depending on the type and stage of cancer, as well as individual patient factors. It’s crucial to consult with medical professionals to determine the most appropriate treatment plan for each specific case.

### 1.2.6 CANCER IN KERALA

Cancer is a significant health issue in Kerala, a southern state in India known for its high literacy rates and quality healthcare. The burden of cancer is increasing in Kerala due to various factors, including changing lifestyles, increased life expectancy, and improved detection methods. The incidence of cancer in Kerala has been steadily increasing over the years. The highest number of cancer cases in India is detected from Kerala, followed by Mizoram, Haryana, Delhi and Karnataka, while it is the lowest in

Bihar. In 2016, cancer incidence rate in India was 106.6 per 1 lakh people, while in Kerala it is 135.3 per 1 lakh people. (Times of India June 22, 2022) The cancer treatment remains quite expensive according to a study in 2013. The study published in the *Asian Pacific Journal of Cancer Prevention* mentioned the case of RCC in Thiruvananthapuram where 'treatment expenditure was unaffordable to more than 70% of patients.' This suggests that something have gone wrong with government policy on cancer in Kerala.

According to the Kerala Cancer Registry, the state recorded 51,535 new cancer cases in 2020. The rise in cancer cases is attributed to factors like urbanization, dietary changes, tobacco and alcohol consumption, and exposure to environmental pollutants. The causes of cancer in Kerala are multifactorial and include both lifestyle-related factors and environmental exposures. Tobacco use, including smoking and chewing tobacco, is a major risk factor for various types of cancer. Unhealthy dietary habits, lack of physical activity, exposure to pollution, and genetic factors also contribute to the increasing cancer incidence.

Kerala offers a range of cancer treatments, including surgery, chemotherapy, radiation therapy, targeted therapy, and immunotherapy. The treatment plan is tailored based on the type of cancer, its stage, and the patient's overall health. Government and private hospitals in Kerala provide comprehensive cancer care services, aiming for early detection and effective treatment.

**Main Hospitals**

- Regional Cancer Centre (RCC), Thiruvananthapuram: RCC is a premier cancer care institute in Kerala, offering state-of-the-art treatment and research facilities. It provides various cancer treatments and is known for its patient-centered approach.
- Malabar Cancer Centre (MCC), Kannur: MCC is another leading cancer center in Kerala, focusing on providing advanced cancer care, research, and education. It offers a comprehensive range of services, including radiation therapy, chemotherapy, and surgical oncology.
- Amrita Institute of Medical Sciences (AIMS), Kochi: AIMS is a multi-specialty hospital that also offers advanced cancer care services. It provides various cancer

treatments, including surgery, chemotherapy, radiation therapy, and bone marrow transplantation.

- Sree Chitra Tirunal Institute for Medical Sciences and Technology (SCTIMST), Thiruvananthapuram: SCTIMST is a renowned medical research institute that offers comprehensive cancer care services. It specializes in various medical fields, including cancer treatment and research.

### 1.2.7 DIFFERENT CHALLENGES FACED BY CANCER PATIENTS

Cancer diagnosis and treatment pose numerous challenges for both patients and their caregivers. These challenges can be physical, emotional, financial, and social in nature. Here are some common challenges faced by cancer patients and their bystanders.

- Emotional and Psychological Challenges: Cancer diagnosis and treatment often lead to emotional distress, anxiety, depression, and fear of the unknown. Patients and their families may struggle with the emotional impact of the disease. Managing psychological well-being becomes crucial during the cancer journey.
- Physical Challenges: Cancer treatments, such as chemotherapy, radiation therapy, and surgery, can lead to physical discomfort, pain, fatigue, and various side effects. Patients may experience changes in their body image and physical functioning, impacting their overall quality of life.
- Financial Burden: The cost of cancer treatment, including medications, hospital stays, and supportive care, can be financially overwhelming. Many patients and families face difficulties in covering these expenses, leading to financial strain and debt.
- Social Isolation: Cancer patients and their caregivers may experience social isolation due to stigma, fear, or lack of understanding about the disease. Changes in appearance and energy levels may lead to reduced social interactions.
- Caregiver Stress: Bystanders, often family members or close friends, play a critical role in supporting cancer patients. However, caregiving can be physically and emotionally demanding, leading to caregiver burnout and stress.
- Access to Healthcare Services: Limited access to specialized cancer care facilities, long waiting times, and geographic barriers can hinder timely and appropriate treatment for some patients, particularly in rural or remote areas.

- Communication Challenges: Effective communication between patients, caregivers, and healthcare providers is essential. However, complex medical information, treatment choices, and prognosis discussions can be challenging to navigate.
- Employment and Work-related Issues: Cancer diagnosis and treatment may lead to interruptions in employment or changes in work capacity. Balancing treatment appointments and work responsibilities can be difficult for both patients and caregivers.
- Coping with Uncertainty: The uncertainty surrounding the course of the disease and treatment outcomes can be emotionally taxing for patients and their loved ones.
- Impact on Family Dynamics: Cancer can impact family relationships and dynamics, as roles and responsibilities may shift within the family unit.
- Decision-Making Challenges: Patients and caregivers often face complex medical decisions, such as treatment choices and end-of-life care planning. Making these decisions can be emotionally and ethically challenging.

### 1.2.7.1 SOCIAL CHALLENGES OF CANCER PATIENTS

Cancer patients often encounter various social challenges during their treatment journey. These challenges can have a significant impact on their overall well-being and quality of life. Some of the social challenges include;

- Stigma and Social Isolation: Cancer can be stigmatized in some societies, leading to social isolation and discrimination. Patients may experience discomfort discussing their diagnosis, which can hinder their social interactions and support networks.
- Altered Body Image and Self-Esteem: Cancer treatments may lead to changes in physical appearance, such as hair loss or weight changes. These changes can affect patients’ self-esteem and body image, leading to reduced social confidence.
- Impact on Relationships: Cancer can strain relationships, especially intimate ones. Partners, family members, and friends may struggle to cope with the emotional and practical challenges of caregiving, leading to tension and strain.
- Communication Challenges: Patients often find it difficult to communicate their needs, fears, and concerns to their loved ones. Family members and friends may also struggle with how to offer support without being intrusive.

- Loss of Social Roles: Cancer may lead to disruptions in work, familial, and social roles. Patients may be unable to fulfill their usual responsibilities, leading to a sense of loss and diminished self-worth.
- Financial Strain: The financial burden of cancer treatment can impact patients' ability to engage in social activities or maintain their previous lifestyle. Limited resources may lead to reduced participation in social events.
- Childcare and Family Responsibilities: Balancing cancer treatment with family responsibilities can be challenging, especially for parents. Patients may worry about the well-being of their children and the impact of their illness on family dynamics.
- Support System Dynamics: Existing support systems may change during the cancer journey. Friends and family members may struggle to provide consistent support, or patients may find that some relationships become strained due to the demands of their illness.
- Employment Challenges: Patients who continue to work during treatment may face challenges in maintaining their performance, dealing with coworkers' reactions, and managing fatigue and medical appointments.

#### 1.2.7.2 ECONOMIC CHALLENGES OF CANCER PATIENTS

Cancer treatment can impose substantial economic challenges on patients and their families. The high costs of medical care, along with the loss of income due to treatment-related disruptions, can lead to financial distress. Some of the economic challenges include:

- High Treatment Costs: Cancer treatments, including chemotherapy, radiation therapy, surgery, and targeted therapies, can be expensive. The costs of medications, procedures, hospital stays, and follow-up appointments can accumulate quickly.
- Out-of-Pocket Expenses: Patients often have to cover out-of-pocket costs for copayments, deductibles, and coinsurance. These expenses can strain family finances, especially if the treatment is ongoing.
- Loss of Income: Many cancer patients have to take time off work or reduce their work hours to undergo treatment and recover. This loss of income can lead to financial instability and difficulties in meeting daily living expenses.

- Transportation and Travel Costs: Patients may need to travel to medical facilities for treatments, which can lead to additional expenses for transportation, accommodation, and meals.
- Unforeseen Expenses: Unexpected costs such as emergency medical expenses, additional tests, or complications can arise during treatment, further straining finances.
- Impact on Retirement Savings: Some patients may have to tap into retirement savings or other long-term investments to cover medical costs. This can jeopardize their financial security in the future.
- Insurance Gaps: Insurance coverage may not always fully cover the costs of all treatments, leading to gaps that patients have to cover themselves.
- Debt Accumulation: Some patients resort to borrowing money or using credit cards to cover medical expenses. This can lead to the accumulation of debt, which can be difficult to manage, especially for those already dealing with reduced income.
- Limited Access to Financial Resources: Patients with lower socioeconomic status or limited access to financial resources may face even greater challenges in affording cancer treatment.

### 1.2.8 CARE HOMES

Care homes, also known as hospices or palliative care centers, provide specialized care and support for cancer patients with advanced or terminal illnesses. These facilities focus on improving the quality of life for patients and their families by offering pain and symptom management, emotional support, and assistance with daily activities.

- Quality of Life: Care homes prioritize the comfort and well-being of patients. They provide a peaceful and supportive environment to manage pain, reduce symptoms, and enhance overall quality of life.
- Holistic Care: Care homes offer comprehensive care that addresses physical, emotional, and spiritual needs. This holistic approach ensures patients and families receive the support they need during a challenging time.
- Respite for Families: Care homes offer families a break from the demanding role of caregiving, allowing them to rest and recharge while their loved one receives professional care.

- Emotional Support: These facilities provide counseling and psychological support for both patients and their families, helping them navigate the emotional challenges of a serious illness.
- Dignity and Comfort: Care homes ensure patients experience a dignified and comfortable end-of-life journey, with a focus on maintaining personal preferences and cultural values.

**Reducing Financial Burden**:

- Insurance Coverage: Explore whether health insurance, including hospice benefits, covers care home expenses. Medicare, Medicaid, and private insurance may provide coverage for hospice care.
- Financial Assistance Programs: Many care homes offer financial assistance programs or sliding-scale fees based on income. Research and inquire about these options.
- Government Assistance: Investigate government programs that provide financial aid for palliative and hospice care, especially for individuals with low income.
- Local Resources: Reach out to local community resources, cancer support groups, and nonprofit organizations that specialize in helping cancer patients and their families manage financial challenges.

**Supporting Social Life:**

- Family Involvement: Care homes encourage family members to actively participate in the care and support of their loved ones, fostering a sense of togetherness.
- Activities and Programs: Many care homes offer a range of activities, such as art therapy, music therapy, and support groups, to promote social interaction among patients.
- Spiritual and Emotional Support: Care homes often provide spiritual counseling and emotional support, helping patients and families connect with others who share similar experiences.
- Open Communication: Encourage patients and families to openly communicate their preferences for social interactions and engage in conversations about their interests and needs.

Cancer has emerged as a major global health concern over the past few decades, with its prevalence increasing rapidly in both developed and developing countries. The physical aspects of cancer, such as pain, fatigue, and treatment side effects, are widely acknowledged. However, the social and economic dimensions of cancer often remain overlooked despite their profound impact on the patient’s quality of life.

## 1.3 STATEMENT OF THE PROBLEM

“Despite advances in cancer treatment, cancer remains a formidable global challenge, with an estimated 19.3 million new cases recorded worldwide in 2020 alone.” In India, the burden is substantial as well, with the country accounting for approximately 7.8% of the global cancer incidence, making it a significant public health concern (WHO, 2020). This prevalence highlights the urgent need to address the multifaceted challenges faced by cancer patients, particularly within the context of their socioeconomic circumstances.

Research has illuminated the economic burden faced by cancer patients and their families. A study conducted in India revealed that “around 58% of the cancer patients spend more than 20% of their annual income on cancer treatment” (Majumdar et al., 2021). The economic challenges associated with cancer, including treatment costs, travel expenses, and loss of income, can exacerbate the burden and hinder access to necessary care.

Furthermore, cancer patients grapple with profound social challenges. A study highlighted that “cancer diagnosis can disrupt the social fabric of patients’ lives, impacting relationships, daily activities, and their overall sense of normalcy” (Tamres et al., 2019). These social struggles, including stigma, isolation, and strained relationships, can detrimentally affect patients’ mental well-being and quality of life.

Given this intricate interplay of economic and social challenges, there emerges a pressing need to comprehensively investigate and understand the unique socioeconomic barriers faced by cancer patients within a cancer care homes in Thiruvananthapuram. By assessing the efficacy of existing support systems, their impact on mitigating these challenges can be evaluated. Addressing these disparities and enhancing the quality of care for cancer patients necessitates a holistic examination of the specific challenges faced by this vulnerable population.

## 1.4 SIGNIFICANCE OF THE STUDY

The research study conducted in cancer care homes in Thiruvananthapuram addresses a critical and timely concern - the rising prevalence of cancer cases globally and particularly in India. With this increase, the challenges faced by cancer patients, especially economic and social challenges, have become more pronounced. These challenges extend beyond the treatment phase, impacting patients' overall well-being. The study reveals that a substantial 58% of cancer patients in India spend more than 20% of their annual income on cancer treatment, highlighting the significant socio-economic burden they bear (Majumdar et al., 2021).

Social challenges also weigh heavily on cancer patients, disrupting their social lives and normalcy. The study underscores that cancer diagnosis can profoundly impact relationships, daily activities, and the overall sense of normalcy for patients (Tamres et al., 2019). These findings underscore the urgent need for comprehensive support systems that address both economic and social dimensions of cancer patients' lives.

This research holds significant implications for cancer care and support systems. By identifying the socio-economic challenges faced by cancer patients and understanding the effectiveness of existing support systems, this study can inform the development of targeted interventions to enhance the overall well-being and quality of life of cancer patients. The findings may aid policymakers, healthcare professionals, and social workers in designing comprehensive support strategies that cater to the specific needs of cancer patients and their families. This study on the socio-economic challenges and support systems of cancer patients from a regional cancer center holds significant importance in improving cancer care, reducing disparities, enhancing patient support, and contributing to the broader understanding of the impact of socio-economic factors on cancer outcomes.

## 1.5 CHAPTERIZATION

The chapterisation of this research dissertation is as follows:

Chapter 1- Introduction

Chapter 2- Literature Review

Chapter 3- Methodology

Chapter 4- Data analysis and interpretation

Chapter 5- discussion

Chapter 6- Findings, suggestion and conclusion

References

Annexure

## 1.6 CONCLUSION OF THE CHAPTER

This introductory chapter has provided a comprehensive overview of the intricate landscape surrounding cancer, its various dimensions, challenges, and support systems. Cancer, as a multifaceted disease, presents physical, emotional, and socio-economic burdens that affect individuals and societies worldwide. As elucidated through the lens of the World Health Organization (WHO) and renowned figures in the field, the significance of socio-economic interventions within healthcare systems has gained unprecedented recognition. In response to these imperatives, this research seeks to shed light on the efficacy of institutional interventions in alleviating the socio-economic burdens faced by cancer patients.

# CHAPTER II: LITERATURE REVIEW

# CHAPTER II
# LITERATURE REVIEW

## 2.1 INTRODUCTION

The second chapter introduces a crucial process in research: examining past and on-going studies related to the current research topic and identifying areas where further research is needed. This is important to fully understand the issue and improve the quality of research. This chapter aims to show why the current study is necessary by looking at earlier studies with similar themes. The review of literature is conducted using thematic analysis, and this chapter will discuss various themes identified during the review.

## 2.2 THEMATICAL ANALYSIS

### 2.2.1 THE PREVALENCE OF CANCER

Cancer is a disease marked by the uncontrolled growth and dissemination of specific cells within the body, with the potential to spread to different body regions. Originating from any part of the human body, composed of countless cells, cancer disrupts the usual process wherein cells multiply through cell division to create new ones as required by the body. Aging or damaged cells typically give way to new cells after death. However, this well-structured mechanism can falter, causing irregular or damaged cells to multiply abnormally. Such cells can aggregate to form tissue masses, known as tumours, which may be cancerous (malignant) or non-cancerous (benign). Malignant tumours infiltrate adjacent tissues and can metastasize to distant areas, leading to the creation of fresh tumours, while benign tumours do not invade surrounding tissues. Cancerous tumours, also termed malignant tumours, exhibit this invasive behaviour, spreading locally and potentially throughout the body, unlike blood cancers like leukaemia that usually do not form solid tumours. Benign tumours, once removed, typically do not reappear, in contrast to cancerous tumours that may regenerate. Although benign tumours can be sizable and occasionally life-threatening, such as in the case of brain tumours, they do not invade neighbouring tissues (What is cancer? 2021).

This article presents a comprehensive overview of the global cancer burden, utilizing data from the GLOBOCAN 2020 estimates provided by the International Agency for

Research on Cancer. The report highlights the incidence and mortality figures for various cancers worldwide. In 2020, approximately 19.3 million new cancer cases (excluding nonmelanoma skin cancer) were reported globally, leading to nearly 10.0 million cancer-related deaths (excluding nonmelanoma skin cancer). Female breast cancer has become the most commonly diagnosed cancer, accounting for 2.3 million new cases (11.7%). It was followed by lung (11.4%), colorectal (10.0%), prostate (7.3%), and stomach (5.6%) cancers. Despite the change in the most common diagnosis, lung cancer retained its position as the leading cause of cancer-related deaths, causing around 1.8 million fatalities (18%). Colorectal (9.4%), liver (8.3%), stomach (7.7%), and female breast (6.9%) cancers also contributed significantly to global cancer mortality. Cancer incidence rates showed a 2 to 3-fold higher prevalence in transitioned countries compared to transitioning countries for both genders. Mortality rates demonstrated less variation for women and a slight variation for men across these two groups. Notably, mortality rates for female breast and cervical cancers were substantially elevated in transitioning countries, indicating the challenges these nations face in managing and preventing these cancers. The projected global cancer burden for 2040 is estimated at 28.4 million cases, signifying a 47% increase from 2020. The rise is expected to be greater in transitioning countries (64% to 95%) compared to transitioned countries (32% to 56%), primarily due to demographic changes. This could be exacerbated by increasing risk factors associated with globalization and economic growth (Jemal, A., et al., 2011).

The study underscores the critical need for establishing sustainable infrastructures for cancer prevention and care dissemination in transitioning countries. Efforts to control cancer on a global scale should prioritize building effective systems for cancer prevention, early detection, and treatment. Additionally, addressing the emerging risk factors linked to societal changes is essential to mitigate the projected rise in cancer cases. This comprehensive analysis serves as a valuable resource for guiding policies and initiatives aimed at reducing the global cancer burden (Sung, H., et al., 2021).

Cancer death rates in the United States have shown a decline since 1990. To expedite this trend, addressing socioeconomic and racial disparities in risk factors and screening is essential. This study provides an updated assessment of the prevalence of cancer risk factors, screening, and vaccination among U.S. adults, with a focus on educational attainment and race/ethnicity differences. Lower educational attainment is associated with higher prevalence of modifiable cancer risk factors and lower prevalence of screening, in comparison to those with higher education levels. Male individuals without a high school (HS) education have a six-fold higher smoking prevalence compared to female college graduates. Obesity rates are significantly higher among women without a college degree, affecting almost half of them, whereas it's about one-third among college graduates. Obesity is more common among black and Hispanic women, with over 50% affected, compared to 38% of whites and 15% of Asians. Breast, cervical, and colorectal cancer screening utilization is 20% to 30% lower among individuals with less than a high school education compared to college graduates. Screening rates for breast, cervical, and colorectal cancers are also lower among Hispanics, Asians, and American Indians/Alaska Natives compared to whites and blacks. The study highlights the need for enhanced, multilevel efforts to reduce the prevalence of modifiable risk factors and improve screening and vaccination rates, especially among individuals with lower socioeconomic status and racial/ethnic minorities. Addressing these disparities is crucial to further reduce cancer rates and improve overall public health. A comprehensive approach that includes education, awareness campaigns, accessible healthcare, and policies is necessary to bridge these gaps and promote equitable cancer prevention and control. (Sauer, A. G., et al., 2019)

The global burden of cancer is on the rise due to factors such as population growth, aging, and the adoption of cancer-causing behaviours, notably smoking, in economically developing nations. Data from GLOBOCAN 2008 estimates reveal that around 12.7 million cancer cases and 7.6 million cancer-related deaths occurred that year, with 56% of cases and 64% of deaths happening in economically developing regions. Breast cancer is the most frequently diagnosed cancer worldwide, accounting for 23% of total cancer cases and 14% of cancer-related deaths in 2008. Among females, it is the leading cause of cancer death. A significant portion of the global cancer burden can be prevented through the application of existing cancer control knowledge. Implementing programs for tobacco control, vaccination (against liver and cervical cancers), and early detection and treatment are vital. Public health campaigns promoting physical activity and healthier dietary habits can contribute to reducing cancer risk. Clinicians, public health professionals, and policymakers have a critical role in accelerating the global application of these interventions. Addressing the global cancer burden requires collaborative efforts across various sectors, encompassing healthcare, public health initiatives, policies, and individual behaviour changes. By focusing on prevention, early detection, and comprehensive care, we can work towards alleviating the impact of cancer on individuals and communities worldwide (Jemal, A., et al., 2011).

The study emphasizes the importance of aligning cancer research funding with the global cancer burden, advocating for equitable distribution of funding to low- and middle-income countries which carry 80% of the cancer burden. Prioritizing research relevant to these regions and building research capacity is essential. Furthermore, there’s an urgent need to invest more in surgery and radiotherapy research, given their pivotal role in treating many solid tumors. The findings suggest that a strategic allocation of resources can lead to impactful cancer research and improve outcomes for individuals around the world. Cancer is a significant global health concern, causing substantial morbidity and mortality. To better understand the determinants of cancer and the impact of interventions, research plays a crucial role. This study aimed to analyse the global patterns of investment in cancer research, both from public and philanthropic sources. Using data from the Uber Research Dimensions database and Cancer Research UK, the study focused on human cancer research funding awards between January 1, 2016, and December 31, 2020. Included were various award types such as project grants, fellowships, and pilot projects, while awards focused on cancer care operational delivery were excluded. The awards were categorized by cancer type, cross-cutting research themes, and research phases. The funding amounts were compared to the global burden of specific cancers measured by disability-adjusted life-years; years lived with disability, and mortality from the Global Burden of Disease study. During 2016-2020, a total of 66,388 awards were identified, amounting to approximately $24.5 billion. However, the investment showed a year-on-year decrease, particularly notable between 2019 and 2020 (Jemal, A., et al., 2011).

Cervical cancer poses a significant burden in India, accounting for a substantial portion of global cases. Identifying well-defined precancerous stages is crucial for early detection. Human papillomavirus (HPV) is a known risk factor, but factors like age, education, occupation, and reproductive history also contribute. This study aimed to analyse the prevalence and risk factors associated with cervical squamous intraepithelial lesions (SIL) among women in south India using Pap smear screening. A cross-sectional study was conducted, enlisting women from rural and urban areas. Local accredited social health activists motivated these women to attend pre-arranged Pap smear clinics in government hospitals. Pap smears collected were processed at the Regional Cancer Centre, Thiruvananthapuram. Cytology reports were generated, and multiple logistic regression analysis was employed to identify risk factors for SIL and high-grade SIL (HSIL). Among 10,580 women, 67 were diagnosed with SIL, and 39 with HSIL. Several risk factors were identified through the analysis: Higher Education: Women with higher education had a lower risk of SIL (OR: 0.05, 95% CI: 0.01-0.2). Marital Status: Being married but living single increased SIL risk (OR: 5.3, 95% CI: 2.4-11.5). Abortions: Women with over two abortions had a significantly higher SIL risk (OR: 21, 95% CI: 4.5-24). Age at Delivery: A younger age at delivery was associated with higher SIL risk (OR: 0.1, 95% CI: 0.01-0.3). Cervical Health: Unhealthy cervix on per speculum examination increased SIL risk (OR: 16.4, 95% CI: 6.2-42.7). The study underscores the significance of Pap smear screening and identifies specific risk factors for SIL among women in south India. Targeting screening efforts towards women with low education, those married but living single, those with a history of multiple abortions, younger age at delivery, and those with an unhealthy cervix can enhance the efficacy of cervical cancer prevention strategies. This research contributes valuable insights for better targeted healthcare interventions and more effective cervical cancer control in the region (Kalavathy, M., et al.2021).

### Cancer Prevalence and Health Service Planning

In health services planning, alongside measures like disease incidence and mortality, additional indices reflecting care demand are essential for effective strategy development. Prevalence of a disease is one such index, measuring both the absolute number and proportion of individuals in a population affected by the disease, necessitating medical attention. For many cancers, the workload mainly arises within the initial 5 years post-diagnosis due to a majority of cases surviving beyond this period. This article presents global estimates of 1-, 2–3-, and 4–5-year point prevalence in individuals aged 15 years or older in 1990. These estimates offer insights into cancer cases diagnosed between 1986 and 1990 that were alive at the end of 1990.The prevalence figures at 1, 2–3, and 4–5 years are valuable for evaluating initial treatment, clinical follow-up, and the point of cure, respectively, for most cancer types. The computation methodology and data sources used to derive these figures are described and compared to data from two cancer registries. Notably, the highest cancer prevalence is observed in North America, affecting 1.5% of the population within the past 5 years, corresponding to over 3.2 million individuals. Similar prevalence percentages are seen in Western Europe and Australia/New Zealand (1.2% and 1.1% respectively). Japan and Eastern Europe follow with 1.0% and 0.7% respectively, with prevalence rates diminishing in other regions. Cancer prevalence between genders differs in developing and developed countries. In developed nations, prevalence is almost identical for men and women (1.1% of sex-specific population). However, developing countries exhibit about 25% higher prevalence in women, mainly due to cancers with poorer survival rates in males, such as liver, oesophagus, and stomach cancers. The prevalence of cases diagnosed within a year mainly hinges on disease incidence, with regional variation primarily reflecting risk differences. Over the long term, demographic patterns and extended life expectancies in high-income countries lead to higher prevalence even for less common cancer sites like the cervix. This study underscores the importance of understanding cancer prevalence in health service planning, allowing for targeted strategies, resource allocation, and tailored healthcare provisions for diverse populations (Pisani, P., et al., 2001).

### 2.2.2 PHYSICAL ASPECTS OF CANCER

The aging population often experiences increased health-related comorbidities, including those resulting from cancer. However, psychological aspects of geriatric patients with cancer, particularly in the Indian context, remain understudied. This research aimed to assess psychological issues, perceived social support, fatigue, and quality of life in geriatric cancer patients. A cross-sectional study was conducted at a tertiary cancer center. The study included 130 geriatric patients with solid malignancies categorized as older patients (above 65 years) and younger geriatric patients (60-65 years). Several aspects were assessed: depression, anxiety, perceived social support, fatigue, and quality of life, using tools such as the Geriatric Depression Screening Scale, Geriatric Anxiety Scale, Multidimensional Scale of Perceived Social Support, Symbolic Assessment of Fatigue Extent, and the Old People Quality of Life Scale. Statistical analyses included descriptive, cross-tab, correlation, and regression analyses. The study found that a majority of patients (61.5%) had low perceived social support, while 47.7% experienced moderate-severe depression, and 43.1% mild-moderate anxiety. Additionally, 50% of the patients reported poor quality of life. Psychological issues were more prominent in older geriatric patients ($p = 0.000$). A smaller proportion of patients (13.3%) reported a significant impact of fatigue on their daily functioning. Positive correlations were observed between perceived social support, depression, anxiety, extent of fatigue, and quality of life ($r = 0.256$, $p = 0.003$). The study revealed higher psychological problems among older geriatric cancer patients undergoing treatment. Regular screening for specific psychological concerns and tailored interventions could have clinical implications. Future research should focus on evaluating the effectiveness of therapeutic interventions to improve the quality of life of geriatric cancer patients. The findings highlight the importance of addressing psychological well-being alongside medical treatments for geriatric patients with cancer, emphasizing the need for comprehensive care to enhance their overall quality of life (Rajagopal, R., et al., 2021).

Fatigue is a common issue among cancer survivors, impacting their quality of life. Physical activity (PA) has the potential to influence fatigue in cancer patients. This study aimed to assess the prevalence of fatigue and its relationship with PA in individuals diagnosed with early-stage cancer. Using data from the French national population-based study “Vie après le cancer 2,” the study included 1984 patients with early breast (61.1%), prostate (21.5%), and colorectal (17.4%) cancer. Severe fatigue, measured by the European Organization for Research and Treatment of Cancer quality of life questionnaire (EORTC QLQ C30) fatigue subscale, was defined as a score ≥40 at 2 years post-diagnosis. PA was assessed through self-reported PA before diagnosis (active/inactive) and changes in PA since diagnosis (increased/maintained vs. decreased exposure/remaining inactive). Statistical analyses considered clinical and treatment variables. Median age was 52 years, and 51.5% of patients experienced severe fatigue 2 years after diagnosis. Before diagnosis, 87.7% of patients reported that they are physically active. At 2 years post-diagnosis, 53.3% of patients either reduced their PA or remained inactive. Severe fatigue was associated with a decrease or remaining inactive in PA since diagnosis. Patients with decreasing or inactive PA had a higher risk of severe fatigue compared to those with increasing or maintaining PA (adjusted odds ratio of 2.32). Fatigue remains a significant issue for cancer survivors even 2 years after their diagnosis. The study highlights the association between fatigue and reduced PA levels since diagnosis. The findings suggest the importance of interventions aimed at promoting or sustaining physical activity among cancer survivors as a potential strategy to mitigate long-term fatigue. This emphasizes the need for tailored programs to improve the well-being and quality of life of individuals after cancer treatment (Matias, M., et al., 2019)

Colorectal cancer (CRC) is a prevalent form of invasive cancer, impacting patients physically and emotionally. Assessing patients’ quality of life (QOL) is vital, as it reflects their overall well-being. This study aimed to identify factors that predict QOL in individuals diagnosed with CRC. The study employed a cross-sectional design, evaluating 110 CRC patients at the Oncology Department of Razi Hospital in Guilan. Data were gathered through structured interviews with patients and reviews of medical records. The participants' QOL was measured using the short form-36 for generic QOL and the functional assessment of cancer therapy-colorectal for disease-specific QOL. Generalized linear models were used to identify variables linked to QOL. Among the 110 patients, 58.2% were male, with an average age of 58.33 ± 12.39 years. The mean scores for generic and specific QOL were 70.92 ± 15.56 and 95.72 ± 19.18, respectively. Regression analysis highlighted several predictive factors: For generic QOL: age, sex, living conditions, health insurance, hospitalization frequency, Karnofsky performance status, and co-morbidity. For specific QOL: age, sex, living conditions, health insurance, monthly income, family history of CRC, Karnofsky performance status, and co-morbidity. This study identified nine socio-demographic and clinical factors that significantly predict QOL among CRC patients. These findings emphasize the importance of considering these factors in the treatment and care of CRC patients. The results also call for future research and interventional studies to alleviate the negative impact of disease symptoms on QOL. By addressing these predictive factors, healthcare providers can improve the overall well-being and QOL of CRC patients, enhancing their treatment experiences and overall quality of life. (Momeni, M., Kha et al. 2014).

### 2.2.3 SOCIAL ASPECTS OF CANCER

**Social Difficulties Experienced By Cancer Patients**

This study aimed to identify cancer-related social problems from both patient and spouse perspectives, and to compare and analyse differences in their experiences. This cross-sectional internet-based study involved 259 cancer patients diagnosed within the past five years and their corresponding spouses. Data from separate surveys in 2010 (patients) and 2016 (spouses) were matched using propensity scores for age, sex, and recurrence status. The study examined social difficulties experienced by both patients and spouses. The Jiro Kawakita (KJ) method was used to categorize the 60 patient survey items into 14 labels, enabling qualitative synthesis. Patients generally had higher scores on most subcategories of social difficulties. Younger spouses aged 39 or younger and female spouses reported difficulties on many subcategories at levels similar to corresponding patients. The study highlights the need for healthcare providers to address the concerns of both cancer patients and their spouses, especially focusing on young and female spouses. Recognizing and addressing social problems faced by patients and their families can significantly improve the quality of care and support provided during the cancer journey (Takeuchi, T., 2018a).

Caregivers of advanced cancer patients encounter various challenges, including physical, psychological, social, and economic burdens. This study aimed to investigate the quality of life and burden experienced by primary family caregivers of patients with advanced cancer who were receiving inpatient palliative care. The study included 200 patients with advanced cancer admitted to a palliative care center and their primary caregivers. Patients' functional capacities were assessed using the Karnofsky Performance Scale, and their caregiving needs were evaluated with the Katz index. The quality of life of caregivers was measured using the Turkish version of the World Health Organization Quality of Life Instrument, Short Form (WHOQOL-BREF TR). Patients had a median Karnofsky Performance score of 30% and a median Katz Index score of 2, indicating a need for assistance in basic activities. Caregivers' mean scores on the WHOQOL-BREF TR subscales were as follows: 48.96 for physical health, 59.21 for psychological status, and 56.83 for social relations, and 55.67 for environmental domain. Female caregivers had lower scores on psychological and environmental subscales. Education significantly influenced the environmental subscale, and caregiving spouses had lower social relations subscale scores compared to children and siblings providing care. Caregivers with insufficient income had lower environmental subscale scores than those with sufficient income. The study highlighted that all aspects of caregivers' quality of life are compromised, with physical health being the most affected. Caring for advanced cancer patients places a significant burden on caregivers, impacting their overall well-being and various aspects of their lives. This research underscores the need for targeted support and interventions to address the challenges faced by caregivers, promoting their own well-being and capacity to provide effective care to their loved ones (Rajagopal, R., et al., 2021.).

Previous studies have indicated that individuals with depression often experience impaired Theory of Mind (ToM), which is the ability to understand and infer the mental states of others. However, limited research has explored ToM deficits in breast cancer patients, a group prone to depression. This study aimed to compare ToM deficits among women with breast cancer, both with and without depression, against a healthy control group. Conducted at a multi-speciality hospital in Kolkata, this cross-sectional matched control study examined ToM in different participant groups. The study enrolled women with breast cancer and depression (N=39), women with breast cancer but without depression (N=63), and a healthy control group (N=34). ToM performance was assessed using the well-established Reading the Mind in the Eyes test (Eyes Test). Depression diagnosis followed the Mini-International Neuropsychiatric Interview and adhered to the International Classification of Diseases, 10th edition guidelines. Statistical analysis involved chi-square tests and one-way analysis of variances. Both breast cancer patient groups exhibited more pronounced ToM deficits compared to the healthy control group ($p<0.05$). Interestingly, among breast cancer patients, the presence of depression predicted even more severe ToM impairment ($p<0.05$). Additionally, lower income, lower educational attainment, and not being employed outside of homemaking were correlated with greater ToM impairment across all groups ($p<0.05$). This study highlighted that breast cancer patients dealing with depression might face an added challenge of impaired social cognition, affecting their ability to understand others' mental states. This weakened ability to perceive and respond to social cues could hinder their capacity to seek crucial social support during times of need. Addressing this issue is crucial for enhancing the overall quality of life for these patients. Urgent attention is required to provide interventions and support that target both depression and social cognitive deficits, thereby ensuring a better quality of life and emotional well-being for breast cancer patients (Datta, A., et al. (2021)).

### 2.2.4 ECONOMICAL ASPECTS OF THE CANCER

This study sheds light on the substantial economic burden posed by esophageal carcinoma in Iran during 2018. Esophageal carcinoma is a significant health concern globally, impacting healthcare systems and societies due to its economic burden. This study aimed to understand the economic impact of this disease in Iran during 2018. Examining the costs of diseases helps us make better use of resources and decisions. The researchers used a method that looked at how common the disease was to understand its economic burden. They considered both direct costs (like diagnosis, treatment, follow-up, and transportation) and indirect costs (like lost productivity) from the society's point of view. They collected information from various sources, including reports and records. They even considered factors like exchange rates, employment data, and housekeeping rates. The results showed that in 2018, esophageal carcinoma cost Iran around \$69.2 million. Most of this cost, about \$38.7 million (around 56%), was because of things like lost productivity. The rest, about \$30.5 million (roughly

44%), was due to direct expenses. Breaking it down further, the biggest part of the cost was from people dying due to the disease, which made up 49% of the total. Medical expenses directly related to treating the disease were the next biggest at 34%. Other direct non-medical costs were at 10%, and costs linked to people being sick but not dying (morbidity) were at 7%. These findings highlight that esophageal carcinoma had a significant economic impact in Iran during 2018. The costs related to deaths and medical treatments were the main contributors. The study suggests that it's crucial to take action early to detect and treat the disease effectively. This not only helps patients but also saves money. The study suggests that policymakers should focus on initiatives that encourage early diagnosis and better medical care. This approach can lead to better results and cost savings in the long run. This research adds to the information that helps us make informed choices about managing cancer and allocating healthcare resources. (Daroudi, R., et al. 2021).

This text discusses the financial aspects associated with cancer, shedding light on the intricate web of costs patients often face during their treatment journey. The direct medical costs linked to cancer encompass services like hospitalizations, surgeries, physician visits, chemotherapy, and radiation therapy, all contributing to the staggering annual estimate of $124.5 billion in the US. These costs are projected to rise, reaching $157.8 billion by 2020 if current trends persist, or even exceed $172 billion considering declining incidence, improved survival, and increased expenses. Financial burdens are particularly pronounced during the initial phase post-diagnosis and at the end of life, with a noticeable dip in the interim. Various studies delve into the expenses incurred by cancer patients. Low-income elderly individuals, for instance, might expend up to 27% of their income on medical costs. Some patients face out-of-pocket expenses related to pain management, with an average yearly cost of almost $10,000 per patient. Research showcases the diversity of these costs, with one study indicating an average monthly out-of-pocket expenditure of $1266, predominantly due to prescription medication costs. The financial struggle is not limited to medical expenses; it extends to other areas of life as well. Many patients cut back on basic necessities such as food and clothing, while others resort to using savings, borrowing money, or even compromising on prescribed medications. These financial challenges are not uniform, often being influenced by factors like insurance coverage, age, income, and education level. Although options for relief exist, they require active involvement from patients. Open communication with creditors, insurers, and healthcare providers can help alleviate some financial pressure. Patients can work with case managers to navigate insurance benefits, explore cost-effective treatments, and utilize social worker-recommended programs. Patient assistance programs (PAPs) by pharmaceutical companies can aid in accessing medications at reduced costs, but their impact is a topic of on-going discussion.

Beyond medical costs, the financial impact of cancer extends to lost opportunities and resources, affecting not only patients and families but also employers and society. In the US, unlike many other developed countries, provisions for paid sick leave during cancer treatment are lacking. The financial blows of cancer can lead to considerable stress, affecting not only patients but also caregivers and families. This cycle of illness-induced poverty, and vice versa, is a challenging problem with implications spanning generations. Emerging concepts like inbuilt economic resilience aim to address these issues by minimizing the economic fallout of illness and targeting appropriate support (Bcop, L. a. H. P. (n.d.)

### 2.2.5 IMPACT OF CANCER ON SOCIAL ASPECTS OF THE PATIENTS

This study aimed to investigate how cancer diagnosis impacts romantic relationships and marriage among adolescents and young adults (AYAs) in Japan. Semi-structured interviews were conducted with 24 AYA cancer survivors, aged 15-39 at the time of cancer diagnosis, who were unmarried. The participants were diagnosed with various types of cancer. The authors employed inductive thematic analysis to identify themes and categories from the interview transcripts. While the study confirmed previously identified impacts of cancer on romantic relationships, it also revealed cultural factors specific to East Asia and Japan. Traditional perceptions of family succession influence men’s concerns about fertility and parenthood, affecting their romantic and marital choices. Moreover, parental influence on partner selection is common for both men and women, indicating the strong impact of cultural factors on romantic and marital decisions post-cancer diagnosis (Yoshida, K., & Matsui, Y. 2022).

### 2.2.6 CARE HOMES FOR CANCER PATIENTS

Patient-centered home care is a novel model of care that complements traditional hospital-centered approaches, particularly for well-informed and trained patients. This model prioritizes patients’ needs over prognosis and considers emotional and psychosocial aspects of the disease. It can be applied to both elderly patients with comorbidities and younger, healthier patients. A specialized multidisciplinary team, led by experienced medical oncologists, coordinates home care and includes professionals like pharmacists, psychologists, nurses, and social assistance providers, as needed. The patient-centered home care team consists of various professionals, each contributing their expertise to provide holistic care. Additional specialists may be involved based on patient requirements. Effective communication between health professionals and the reference hospital is essential for optimal coordination. Shared evidence-based guidelines ensure safety and effectiveness of care. Patients and caregivers must possess a high level of disease-related knowledge to fully engage in the patient-centered home care approach. Education empowers them to actively participate in their care. This model prioritizes improving the quality of life for cancer patients by addressing their physical, emotional, and psychosocial needs within the comfort of their homes (Tralongo, P., et al., 2011b).

Patient-centered home care offers a cost-effective alternative to traditional hospital-centered care. By reducing hospital stays and resource utilization, it provides value to both patients and healthcare systems. Patient-centered home care is a valuable approach to cancer management, providing tailored care to patients based on their needs and preferences. With a multidisciplinary team, effective communication, education, and adherence to guidelines, this model enhances quality of life and promotes the overall well-being of cancer patients while offering cost-effective benefits (Tralongo, P., et al., 2011b).

Nursing homes offer a supportive environment for elderly cancer patients who have stable functional and medical conditions. For many of these patients, basic palliative care is the primary need. However, patients with acute medical complications that necessitate intensive monitoring, technical treatments, or intensive rehabilitation are better suited for hospitals or other specialized facilities with appropriate resources. The principles of palliative care learned over the past 15 years can be directly applied to elderly cancer patients in nursing homes, improving their quality of life and preserving their dignity. Suitability for Nursing Homes is appropriate for elderly cancer patients with stable conditions, providing a supportive and comfortable environment. Basic palliative care is often the main requirement for these patients.

Patients with acute medical complications requiring advanced medical interventions should be treated in hospitals or skilled facilities with the necessary resources. Lessons from the field of palliative care can be applied to elderly cancer patients in nursing homes. Focus on pain management, symptom control, emotional support, and communication with patients and families. Proper planning and setting realistic goals are crucial for providing effective palliative care in nursing homes. Prioritizing the patient’s comfort and quality of life is essential. Adequate palliative care in nursing homes can enhance the quality of life and dignity of elderly cancer patients. Supportive care can alleviate physical and emotional distress. Palliative care principles developed over the years can be adapted to elderly cancer patients residing in nursing homes. While nursing homes are suitable for patients with stable conditions and basic palliative care needs, acute medical complications require specialized facilities. By prioritizing comfort, communication, and realistic goals, nursing home care can significantly improve the quality of life for elderly cancer patients (Care of cancer patients in nursing homes. (1992).

With advancements in cancer treatment, the survival rate of cancer patients has increased. However, as patients live longer, they may experience impairments that affect their quality of life (QOL) and functioning. This emphasizes the importance of focusing on QOL alongside survival. Interdisciplinary teams play a crucial role in achieving patient-centered rehabilitation that optimizes function and QOL, while minimizing impairments and limitations. QOL is of paramount importance for cancer survivors, and rehabilitation can play a pivotal role in achieving it. Interdisciplinary teams are essential in delivering patient-centered rehabilitation that aligns with patient goals. Active participation of cancer patients in therapy and self-management is crucial for successful outcomes. Common impairments in cancer patients include fatigue, pain, cognitive issues, mood disorders, paralysis, difficulties in daily activities, and various bodily dysfunctions. Adaptive equipment, exercise, and training for daily activities can help mitigate activity limitations. The phase of the disease along the continuum of cancer care influences rehabilitation goals. Factors like participation in work, recreational activities, and home life significantly impact QOL. A holistic approach to rehabilitation should consider factors like distress, socioeconomic barriers, and transportation limitations. As cancer patients live longer, their QOL becomes a central concern. Rehabilitation, led by interdisciplinary teams, is crucial in addressing impairments and improving overall well-being. The patient’s active participation, tailored interventions, and consideration of various aspects of life are essential components in achieving successful rehabilitation outcomes and enhanced QOL for cancer survivors (Mayer, R. S., & Engle, J. P. 2022).

Patients with cancer frequently require unscheduled hospital-based care due to treatment-related symptoms and disease progression. The emergency department (ED) often becomes the initial touch point for these situations. However, traditional ED and inpatient hospital-based care models are facing challenges in accommodating the growing needs of this population. Acute home-based care is emerging as a potential solution to provide patient-centric, efficient care to eligible cancer patients. The study employed Porter's Five Forces framework, encompassing factors like the bargaining power of buyers and suppliers, threat of substitutes and new entrants, industry rivalries, and regulation. This framework was used to analyse the factors influencing the adoption and scaling of a home-based cancer care referral model, especially following ED visits. The goal was to identify challenges and opportunities for various healthcare entities to optimize their roles in this emerging care model. The study highlighted significant challenges including workforce shortages, workflow complexities, infrastructure issues, and regulatory hurdles. Addressing these challenges is crucial for the successful implementation of acute home-based cancer care. Ambiguities around payment models and competition also exist. However, promoting factors include the recognized need for innovative models to reduce unscheduled hospitalizations, the adoption of home-based solutions during the COVID-19 pandemic, and a growing acceptance of technology-enabled care. Acute home-based cancer care has the potential to enhance traditional cancer care models. Technological advancements and evolving policies are enabling the expansion of cancer care in the home environment. While challenges exist, understanding these forces provides insights into the risks and opportunities that new entrants and healthcare systems can consider as they develop and implement acute home-based cancer care programs (Baugh, C. W., et al., 2022).

## 2.3 RESEARCH GAP

In the landscape of cancer research, numerous studies have explored various dimensions of the disease, including treatments, socioeconomic challenges, psychological struggles, and palliative care. An extensive body of literature exists that delves into cancer treatments, their efficacy, side effects, and impact on patients' physical and cognitive abilities. Similarly, research has shed light on the intricate socio-economic challenges that cancer patients face during their journey, ranging from financial strain to social isolation. Furthermore, the existing literature tends to emphasize medical and clinical interventions, leaving a void in understanding the potential benefits and impact of care homes or similar facilities in alleviating the financial and social burdens that often accompany cancer treatment. While research may exist on palliative care homes, little attention has been directed towards understanding the specific interventions, services, and support systems that care homes provide to cancer patients during their active treatment phase. This research gap highlights the need for a study that delves into the role and effectiveness of care homes or similar institutional settings in offering socio-economic interventions to cancer patients undergoing treatment at regional cancer centres. Investigating the range of services and support provided by these institutions, such as financial assistance, psychosocial counselling, social activities, and access to community resources, can offer insights into their impact on patients' overall well-being and quality of life. By conducting research in this area, we can gain a better understanding of how care homes contribute to addressing the socio-economic challenges that cancer patients encounter during treatment. This knowledge can inform healthcare policies and practices, shed light on potential best practices for holistic cancer care, and ultimately enhance the support systems available to patients' undergoing treatment for cancer at regional cancer centre Thiruvananthapuram.

## 2.4 CONCLUSION

The literature review chapter thoroughly explored existing research on the study's topic using a thematic approach. It covered various aspects of the subject, including cancer treatment, socio-economic challenges, and patient well-being. By categorizing the literature into sub-themes, the chapter offered a clear and organized overview of cancer patients' lives. This approach deepened our understanding of how these factors interact and impact their overall care experience. Additionally, the research gap identified within the literature serves as a critical foundation for the current investigation. This gap emphasizes the need for further exploration, specifically regarding institutional interventions and socio-economic support from care homes during cancer treatment. This chapter lays the groundwork for contributing to existing knowledge and enhancing comprehensive care and support for cancer patients.

# CHAPTER III:  METHODOLOGY

# CHAPTER III
# METHODOLOGY

## 3.1 INTRODUCTION

A clearly outlined research methodology is a crucial and primary aspect of any research study. This chapter outlines the methodology employed in the current study, providing information about the study's sample, research design, data collection methods and tools, as well as the statistical techniques utilized for data analysis.

## 3.2 TITLE OF THE STUDY

Socio-economic Challenges and Support systems of Cancer Patients from Cancer Care Homes

## 3.3 OBJECTIVES

### 3.3.1 GENERAL OBJECTIVES

- To understand the socio-economic challenges faced and support systems received by cancer patients from Cancer Care Homes

### 3.3.2 SPECIFIC OBJECTIVES

1. To understand the Socio-demographic profile of the respondents.
2. To study the socio-economic challenges faced by cancer patients.
3. To understand the facilities availed by the cancer patients at the institution.
4. To study the socio-economic support provided by institutions for cancer patients
5. To suggest social work interventions for the well-being of cancer patients through institutional care

## 3.4 VARIABLES

- Family support
- Social support

- Economic support
- Institutional support
- Support systems

## 3.5 DEFINITION OF CONCEPTS

### 3.5.1 THEORETICAL DEFINITION

**3.5.1.1 FAMILY SUPPORT**: “Family support refers to the emotional, financial, and practical help that family members offer each other in times of crisis, illness, or other challenging situations” (Centre for the Study of Social Policy).

**3.5.1.2 SOCIAL SUPPORT**: “the perception or experience that one is cared for, valued, esteemed, and part of a social network of mutual assistance and obligations” (Cohen & Wills, 1985).

**3.5.1.3 ECONOMIC SUPPORT:** “Economic support refers to the provision of financial resources, aid, or assistance to individuals or groups who are experiencing economic difficulties or facing financial constraints. It encompasses various forms of financial help, including monetary assistance, subsidies, grants, or loans, aimed at alleviating financial burdens and promoting economic stability.” (Cohen, S., & Wills, T. A., 1985)

**3.5.1.4 INSTITUTIONAL SUPPORT**: “An institution is an organized system of social relationships which embodies certain common values and procedures and meets certain basic needs of the society” (Horton and Hunt, 1964).

**3.5.1.5 SUPPORT SYSTEMS:** “Support systems are the interconnected web of social relationships, institutions, and services that help individuals navigate through challenges and provide them with the necessary resources and encouragement to cope effectively.” (C. Manne et al., 2018)

### 3.5.2 OPERATIONAL DEFINITION

**3.5.2.1 FAMILY SUPPORT:** Emotional, practical, informational support that the family extends to the people suffering with cancer. It can include providing empathy encouragement, reassurance to the patient during their cancer journey, assisting with day today activities such as transportation to medical appointments, preparing meals, managing household chores etc.

**3.5.2.2 SOCIAL SUPPORT:** Social support in this study refers to the assistance, comfort and resources provided by cancer care homes, healthcare professionals and support groups. It includes the frequency and quality of interactions, empathy understanding and practical help.

**3.5.2.3 ECONOMIC SUPPORT:** Economics support in the study refers to the assistance provided to individuals or families affected by cancer to alleviate financial burdens associated with the disease. It can include financial assistance to cover medical expenses, transportation cost, medications, insurance coverage & employment support etc.

**3.5.2.4 INSTITUTIONAL SUPPORT**: In the study, institution refers to any established organization that provides different types of service for economically weaker patients with cancer and their families. The service includes free residential facilities for the patients as well as the bystanders, transportation, meals, etc.

**3.5.2.5 SUPPORT SYSTEMS**: In this study, the support systems refer to the available resources and services for the benefit and care of cancer patients. This can include the support provided by different cancer care homes, parents and family.

## 3.6 PILOT STUDY

A pilot study was undertaken as a preliminary step to validate research procedures and assess the feasibility of data collection methods before initiating the primary study. The pilot study was carried out with a small group of participants residing in Lourdes Matha Cancer Care Home, targeting individuals who had been diagnosed with cancer and were currently living in the care facility. The primary aim of the pilot study was to gain insights into the socio-economic challenges faced by these individuals and to understand how Lourdes Matha Care Home was supporting them in addressing these challenges. During the pilot study, various research procedures, questionnaires, and data collection methods were put to the test and evaluated. The experience of the pilot study prompted adjustments in the selection of the target group, leading to the identification of similar care homes in Thiruvananthapuram that provide comparable services to cancer patients. Participant feedback from the pilot study proved invaluable in refining the questionnaire, clarifying any ambiguous items, and ensuring the seamless administration of the survey. The pilot study played a pivotal role in enhancing the reliability and validity of the research instruments. Additionally, it shed light on practical aspects related to data collection. By implementing changes based on the insights gained during the pilot study, the research team gained confidence in their approach and proceeded to the main study with a streamlined and effective data collection process. The pilot study’s findings and modifications paved the way for a successful main study, allowing for a comprehensive understanding of the socio-economic challenges faced by cancer patients in care homes and the supportive interventions provided by these facilities.

## 3.7 RESEARCH DESIGN

The study employs a quantitative research method, specifically a cross-sectional design. This approach involves the study of multiple cases simultaneously at a single point in time. It is particularly suited for analysing quantifiable data. In this research, the cross-sectional design entails collecting data at a specific moment to gain insights about a specific population or phenomenon. By gathering data at a single point, the study captures a snapshot of the prevailing conditions and concerns. This design is well-suited for swiftly capturing up-to-date data on these issues, allowing for immediate policy recommendations and interventions. Through the utilization of a cross-sectional design, the study aims to efficiently gather information about the socio-economic challenges faced by cancer patients who reside in cancer care homes. By doing so, the research aims to offer valuable insights to guide decision-making and to support targeted interventions that cater to the unique needs of these individuals.

## 3.8 RESEARCH APPROACH

This study, being quantitative in nature, embraces positivism and goes by the deductive approach. The data collection technique used is an interview schedule developed specifically for this study. The interview schedule is a structured questionnaire that includes a set of predetermined questions designed to gather quantitative data from the participants. The interview schedule for this study is developed based on the research objectives and aims to gather information on various aspects related to cancer patients and their treatments. The questions in the interview schedule are carefully crafted to capture relevant data and provide a systematic approach to data collection. By utilizing the quantitative method and an interview schedule, this study aims to provide empirical evidence and numerical data on Socio-economic Challenges and Support systems of Cancer Patients from Cancer Care Homes, thereby contributing to a better understanding of their circumstances and informing potential interventions or support mechanisms.

### 3.8.1 RESEARCH SETTING

The present and former- cancer patients, who are staying in different cancer care homes, and seeking treatment from RCC, Thiruvananthapuram.

### 3.7.2 INCLUSION CRITERIA

- Patients who are under treatment for any type of cancer.
- The respondents are above the age of 30 years.
- The patients who are staying in different care homes

### 3.7.3 EXCLUSION CRITERIA

- The patients who are not seeking treatment for cancer
- The patients who are not accommodated in cancer care homes.
- The respondents were under the age of 30 years.
- The cancer patients who are not seeking treatment from RCC Thiruvananthapuram.

## 3.9 UNIVERSE AND UNIT OF THE STUDY

**3.9.1 UNIVERSE**: All types of cancer patients residing in different cancer care homes in the Trivandrum district of Kerala.

**3.9.2 UNIT**: A Cancer patient who is staying in a cancer care home of Trivandrum district

**3.10 SAMPLE**: Cancer patients who are staying in different care homes in Trivandrum District.

**3.11 SAMPLE SIZE**: 55 cancer patients who are staying in different care homes and seeking treatment from the Regional Cancer Centre Thiruvananthapuram.

## 3.12 SAMPLING METHOD

The research employed a probability sampling approach, specifically utilizing simple random sampling, to gather samples for the study. The study’s target group consisted of 55 cancer patients who were undergoing treatment at the Thiruvananthapuram Regional Cancer Center and residing in various care homes. Out of a total of twelve care homes, seven were selected for participation using the same simple random sampling method. The entire population encompassed approximately 75 individuals. According to Morgan’s table, for a population of 75, the recommended sample size was 63. However, due to certain patients being bedridden and some personal reasons that prevented the researcher from accessing them, the final participant count for the sample was 55. The data collection process was carried out using an interview schedule.

## 3.13 DATA COLLECTION

The data collection involved both primary and secondary sources. Primary data was gathered through interviews with 55 cancer patients residing in 7 care homes, receiving treatment from the regional cancer centre in Thiruvananthapuram. Secondary data was collected from various sources such as articles, journals, books, and websites. For the primary data collection, an interview schedule was used. This schedule included predetermined questions aligned with research objectives and areas of interest, focusing on the socio-economic challenges of cancer patients and care home interventions. The interview schedule was developed based on these aspects. Questions covered socio-demographic, economic, and social factors, and care home interventions. The interviews were conducted face-to-face to enable direct interaction between the researcher and participants. These interviews were carried out systematically, following the sequence of questions outlined in the interview schedule. During the interviews, the researcher systematically recorded participants’ responses using Google Forms.

## I3.14 PRE-TEST

The researcher conducted a pre-test to test the effectiveness of the tool. After conducting a pre-test, the researcher made some changes to the tool. In this study, a pre-test was conducted among 6 cancer patients who are taking treatment from regional cancer care in Thiruvananthapuram and staying in one of the cancer care homes, Lourdes matha care. The purpose of the pre-test was to evaluate the clarity, relevance, and comprehensibility of the interview schedule used for data collection.

## 3.15 DATA ANALYSIS

The gathered data underwent a comprehensive analysis through the application of descriptive statistics. This involved assessing the frequencies, correlations, cross-tabs, and percentages of different variables within the dataset. To execute this analysis, the Statistical Package for the Social Sciences (SPSS) version 22 was utilized. SPSS is a powerful software tool designed to handle complex statistical analyses and aid researchers in understanding the underlying trends and insights within their data.

## 3.16 ETHICAL CONSIDERATIONS

- The data was collected only after obtaining informed consent from all participants.
- Participants were made aware of their right to withdraw from the study at any point.
- The researcher ensured the confidentiality and privacy of participant information.
- The researcher followed ethical guidelines and did not engage in any unlawful or plagiaristic practices.
- The collected data will be solely used for academic purposes.

## 3.17 ASSUMPTIONS, LIMITATIONS AND SCOPE

### 3.17.1 ASSUMPTIONS

- The researcher assumes that the participants provided truthful and accurate responses to the questionnaire.
- It is assumed that the anonymity of the data collection process encouraged participants to provide genuine responses.
- The researchers assume that the chosen sample of cancer patients residing in 7 care homes is a reasonably representative group, sharing similar socio-economic backgrounds, experiences, and challenges.

### 3.17.2 LIMITATIONS

- The study is limited to cancer patients residing in care homes near the Regional Cancer Centre in Thiruvananthapuram.

- Psychological aspects of cancer patients are not addressed in this study.
- The research was conducted within a restricted time frame.
- The study solely focuses on cancer patients receiving treatment at the Regional Cancer Centre.

## 3.18 SCOPE OF THE STUDY

- The study’s scope is concentrated on cancer patients who are also residing in care homes and also receiving treatment from Regional Cancer Centre in Thiruvananthapuram. The goal is to comprehend their socio-economic challenges during their treatment journey.
- The study aims to evaluate the effectiveness of existing care homes and their interventions in supporting cancer patients with their treatment-related challenges.
- Potential future research could explore the topic using qualitative or mixed-method approaches to expand the scope of understanding.

## 3.19 CONCLUSION

This chapter provides an overview of how the research was conducted. It outlines the study’s aim and objectives, along with the formulated hypotheses for investigating these objectives. The chapter explains the research method and design employed, as well as the criteria for including or excluding participants. It details the data collection and analysis process, including the tools and techniques used. Additionally, the chapter covers the scope of the study, underlying assumptions, and its limitations.

# CHAPTER IV: DATA ANALYSIS AND INTERPRETATION

# CHAPTER IV

## DATA ANALYSIS AND INTERPRETATION

## 4.1 INTRODUCTION

In this chapter, the findings obtained from the collected data are presented and examined. The dataset underwent a thorough analysis, employing descriptive statistics to gain insights. This encompassed evaluating frequencies, correlations, cross tabs, and percentages of various variables within the dataset. Beyond this, both descriptive and inferential statistical techniques were applied to unveil intricate patterns and relationships within the data. The Statistical Package for the Social Sciences (SPSS) version 22 served as the analytical tool for this investigation. The outcomes of this analysis are visually represented through diagrams and tables within this chapter. The chapter is divided into following sections;

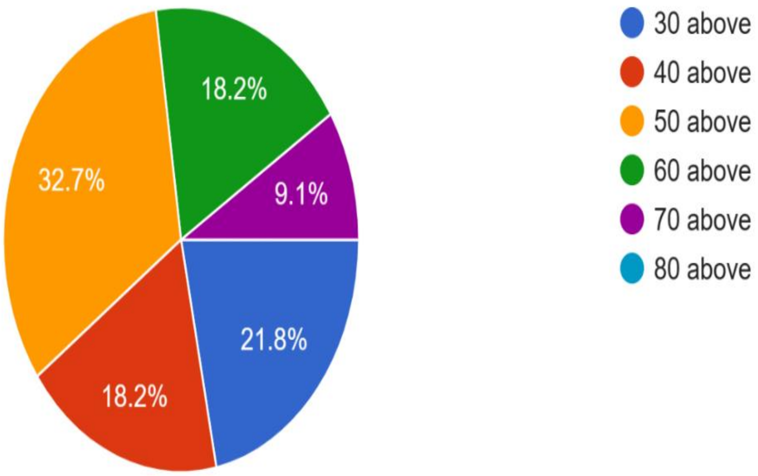
- Exploring Respondents Socio-Demographic Profiles
- Understanding the Social Support Received by Patients in the Institution
- Exploring Facilities Utilized by Cancer Patients and Their Caregivers at the Institution
- Examining Economic Support Offered by Institutions for Cancer Patients

## 4.2 EXPLORING RESPONDENTS' SOCIO-DEMOGRAPHIC PROFILES

The demographic profile of the respondents encompasses both personal and cancer related variables. This profile covers a range of factors including age, gender, religion, marital status, educational qualification, type of cancer, family history of cancer, treatments received, duration of illness, primary caregiver, hospital type, patient's occupation, type of ration card, and household income.

**FIGURE NO 4.1:**

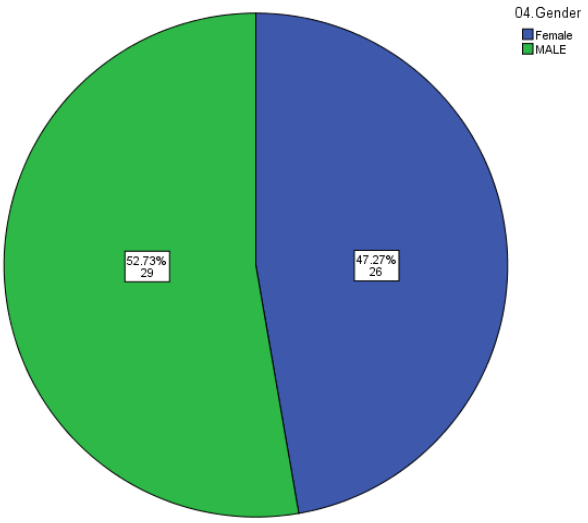
***Age of the Participants***



The figure illustrates the distribution of respondents based on their age categories. The data reveals that the largest proportion of respondents falls within the age range of 50 to 59, comprising 32.7% of the total sample. This indicates that more than one-third of the participants surveyed belonged to this age group. The next age category, comprising individuals within the age range of 30 to 39, represented a smaller proportion of the respondents, accounting for 21.8% of the sample. This suggests that less than one-fourth of the participants were below the age of 40. The age categories of 40-49 and 60-69 both had the same percentage, with 18.2% of the respondents falling into each of these age ranges. This indicates that an equal proportion of the sample belonged to these two age groups. A very few proportions of 9.1% of the respondents were categorized under the age range of 70-79. This suggests that a relatively small number of participants were between the ages of 70 and 79. Interestingly, the figure reveals that there were no respondents above the age of 80. This implies that the sample did not include individuals who were 80 years old or older. Overall, the figure provides a clear overview of the age distribution among the respondents, highlighting the larger proportion of participants in the 50-59 age range and a smaller representation of individuals under 40 and over 70 years old.

## FIGURE NO 4.2 :

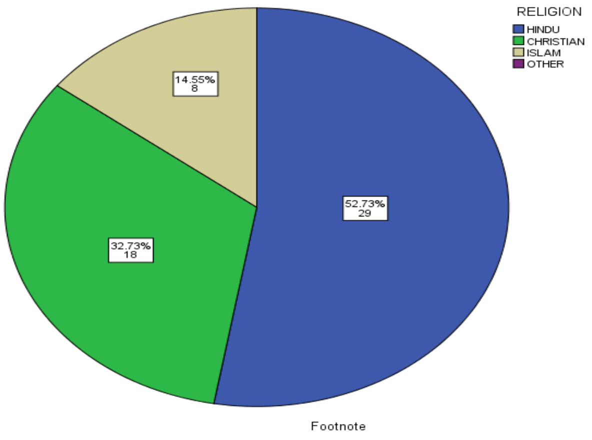
***Gender of the participants***



The given figure indicates, more than half of the participants (52.73%) were identified as male, while less than half (47.27%) were identified as female. Based on this data, it suggests that there was a higher representation of male participants in the study. Furthermore, the statement suggests that this gender distribution reflects a higher prevalence of cancer patients among males compared to females. It implies that a greater number of male participants in the study were identified as cancer patients in comparison to female participants.

## FIGURE NO 4.3:

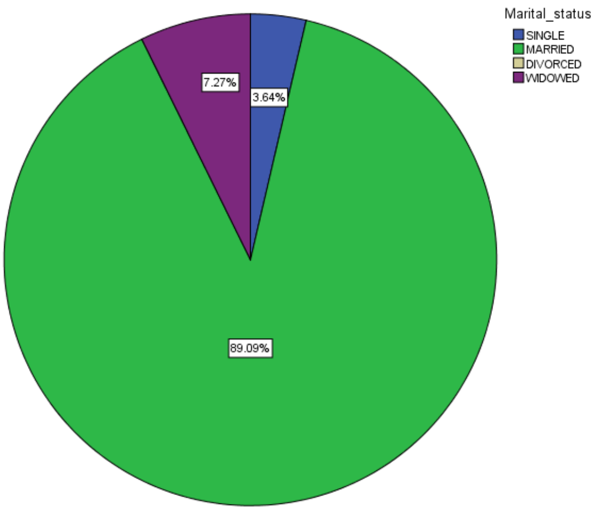
***Religion of the participants***



The figure illustrates the distribution of participants from three different religions: Hindu, Christian, and Islam. According to the data presented, the majority of participants, accounting for 52.73% of the total, belonged to the Hindu religion. On the other hand, participants belonging to the Christian religion constituted less than one third of the total, specifically 32.73%. Lastly, a small percentage of participants, amounting to 14.55%, identified themselves as followers of the Islamic faith. From the given information, it is evident that the study had a higher representation of participants from the Hindu religion compared to the other two religions. Additionally, the number of participants who identified as Muslims was notably lower compared to the Hindu and Christian participants. It is important to note that this information pertains specifically to the participants of the study and does not reflect the overall population distribution of religious affiliations. The study's findings suggest that the sample used in the research had a higher proportion of Hindu participants and a relatively lower representation of Christian and Islamic participants.

**FIGURE NO 4.4:**

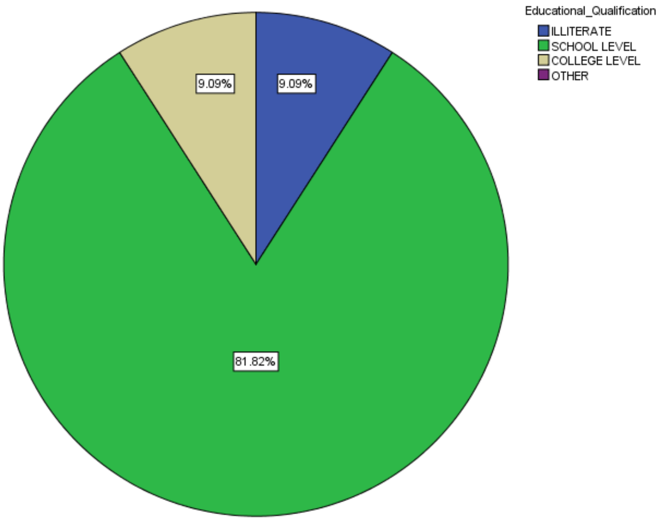
***Marital of the participants***



The information displayed in the figure regarding the marital status of the participants. According to the data, the majority of participants, specifically 89.09% of them, were married. This indicates that a significant proportion of the participants in the survey had a marital status of being married. In contrast, a smaller percentage of participants, amounting to 7.27%, were identified as widowed. This suggests that a relatively small number of participants had experienced the loss of their spouse and were widowed at the time of the survey. Furthermore, the data shows that a minority of participants, accounting for 3.64%, were single, meaning they had never been married. These participants did not have a current or previous marital partner. In summary, the figure presented that the majority of participants in the survey were married, constituting a significant portion of the overall sample. Conversely, the percentages of widowed and single participants were comparatively lower.

## FIGURE NO 4.5

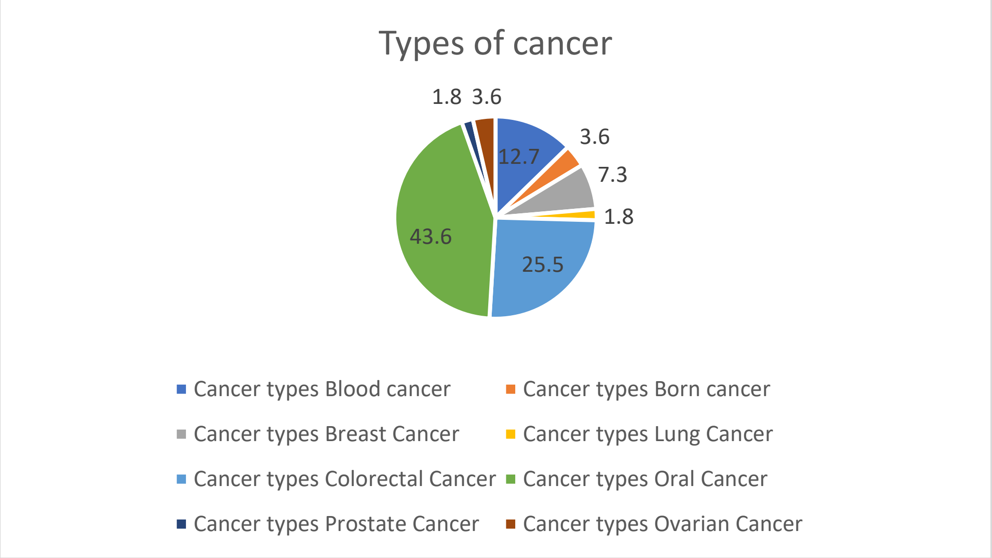
***Education Qualification of the participants***



The figure reveals that the majority of the participants, comprising 81.82% of the total, had received only a school-level education. It further mentions that a small proportion of the participants, specifically 9.09%, were classified as illiterate, while another 9.09% had attained a college-level education. The information suggests that a significant portion of the participants in the survey had completed their education up to the school level. This indicates that they had likely completed their primary and secondary education but did not pursue further studies at a higher level, such as college or university. However, what surprises the author is the finding that among the participants from Kerala, 9.09% were identified as illiterate. This means that a small but notable portion of the participants from Kerala had not received any formal education and were unable to read or write. It is important to note that these findings are specific to the participants of the survey and may not reflect the overall educational attainment of the entire population. Nonetheless, the data suggests that in this particular sample, the majority of participants had a school-level education, with a significant proportion of illiterate individuals among the participants from Kerala.

**FIGURE NO 4.6:**

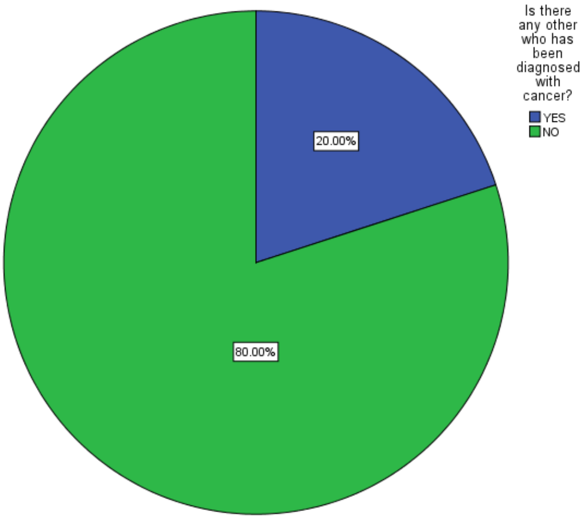
***Different types of cancer among the participants***



The findings presented in a figure, indicating the prevalence of different types of cancer among the participants of a survey. According to the data provided, a very small percentage, specifically 1.8% of the participants, were diagnosed with lung cancer and prostate cancer. Another 3.6% of the participants were found to have been diagnosed with both colon cancer and ovarian cancer. Among the participants, 7.3% were identified as having breast cancer. The figure also reveals that a significant proportion of the participants, specifically one fourth or 25.5%, were diagnosed with colorectal cancer. In comparison, less than half of the participants, accounting for 43.6%, were undergoing treatment for oral cancer. Based on the given information, it can be inferred that the highest number of participants in the survey were suffering from oral cancer, as indicated by the figure. The prevalence of oral cancer among the participants was higher than any other type of cancer included in the study.

**FIGURE NO 4.7**

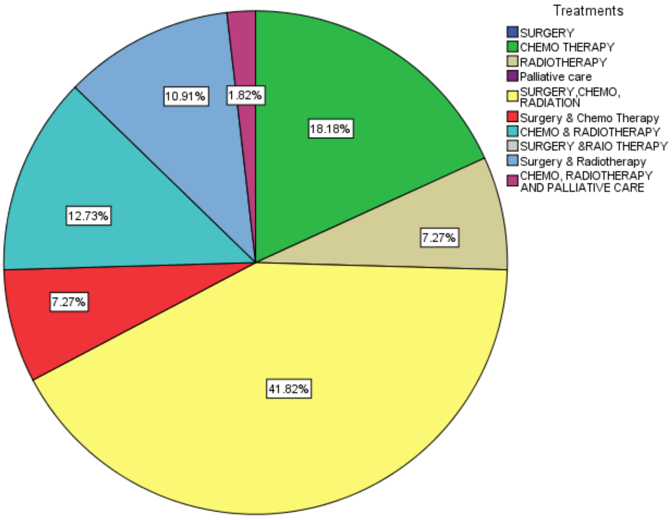
***CA cases in family of the respondents***



The information depicted in this figure, indicating the prevalence of cancer diagnosis within participants' families. According to the data, over three-fourths of the participants' families (80%) had been initially diagnosed with cancer. Conversely, a smaller proportion, specifically 20% less than one-fourth of the participants' families, had experienced a cancer diagnosis in their family members before. These individuals had prior exposure to cancer treatment due to the earlier cases within their families. It highlights that among the participants themselves, 80% were currently battling cancer for the first time. This suggests that they had not previously encountered such a situation and were potentially facing it for the first time. Consequently, the lack of prior experience with cancer could make it more challenging for these participants to cope with their current circumstances. The information provided emphasizes the significant impact of cancer within the participants' families. It sheds light on the difference in experience between participants who had prior exposure to cancer treatment and those who were confronting it for the first time, suggesting that the latter group may encounter additional difficulties in dealing with their cancer diagnosis.

## FIGURE NO 4.8:

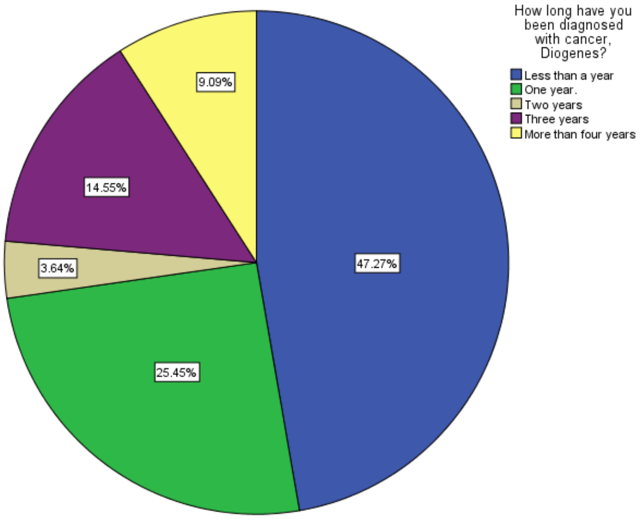
***Treatments of the participants***



The figure describes the treatments undergone by the participants in the study. According to the information provided, less than half of the participants, specifically 41.82%, received all three major cancer treatments, namely surgery, chemotherapy, and radiation. A small percentage, 18.18% of the participants, underwent chemotherapy alone without receiving surgery or radiation. Similarly, 12.73% of the participants underwent both chemotherapy and radiation treatments. Additionally, 10.91% of the participants underwent surgery and radiation, excluding chemotherapy. The 7.27% of the participants received both surgery and chemotherapy, while another 7.27% received radiotherapy only. In total, these two categories accounted for 14.54% of the participants. A very small percentage, 1.82% of the total participants, had undergone all three treatments of surgery, chemotherapy, and radiation and were currently receiving palliative care. This suggests that these participants were in an advanced stage of cancer and were receiving supportive care to manage their symptoms. In summary, the sentence highlights that less than half of the participants in the study underwent the comprehensive treatment approach involving surgery, chemotherapy, and radiation. The remaining participants received various combinations of these treatments or only one of them.

**FIGURE NO 4.9:**

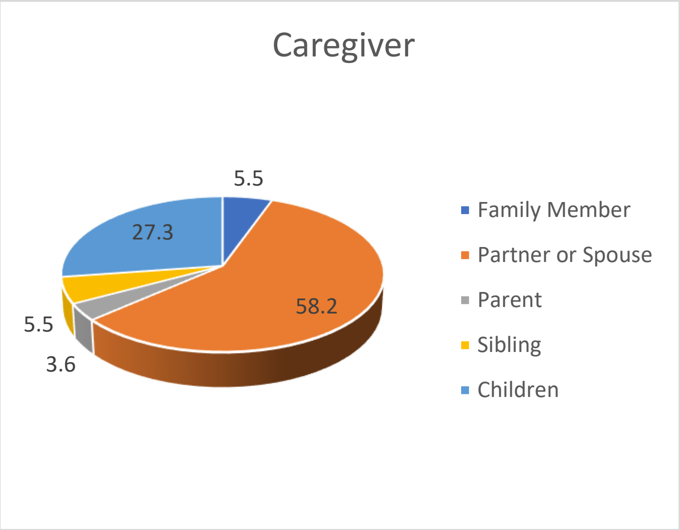
**Diogenes' time of the participants**



According to the figure, less than half (47.27%) of the respondents had been diagnosed with cancer within the past year. This indicates that a significant proportion of the participants were relatively new in their cancer journey, suggesting that they were seeking treatment and support during the early stages of their illness. Early detection and prompt initiation of treatment are crucial in improving cancer outcomes, and this finding implies that a considerable number of respondents were diagnosed at an early stage. One-fourth (25.45%) of the respondents reported being diagnosed with cancer within the past one year. A very small percentage (3.64%) of respondents reported being diagnosed with cancer over two years ago. A minimum proportion (14.55%) of the respondents had been diagnosed with cancer three years ago. This indicates that a smaller group of participants had been living with their cancer diagnosis for a relatively longer period. They may have completed initial treatments, entered into long-term survivorship, or were managing their cancer as a chronic condition. Furthermore, a very small proportion (9.09%) of the respondents had been diagnosed with cancer for more than four years. These participants had been living with their cancer diagnosis for a significant period, indicating long-term survivorship. Their experiences and needs may differ from those in the earlier stages of their cancer journey, with a potential focus on survivorship care and addressing late effects or long-term impacts of cancer and its treatments.

### FIGURE NO 4.10:

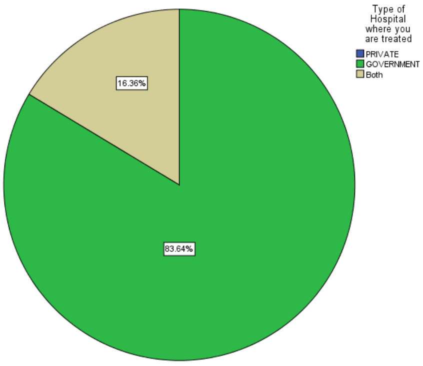
***caregiver of the participants***



The figure presented illustrates the distribution of caregivers among the participants. The data shows that more than half of the participants (58.2%) had their partner or spouse as their primary caregiver. This indicates that a significant proportion of individuals relied on their romantic partners or spouses for caregiving support during their health journey. Additionally, more than one-fourth of the participants (25%) had their children as their caregivers. Furthermore, the data reveals that 5.5% of the total participants had their siblings as their caregivers. This indicates that a small portion of individuals relied on their brothers or sisters for caregiving assistance. Interestingly, another 5.5% of participants had bystanders who were not specifically identified. These bystanders could include other family members, close friends, who took on the role of caregiving. Additionally, 3.6% of participants had their own parents as bystander caregivers. This suggests that a minority of individuals received caregiving support from their own parents, indicating the importance of the parent-child relationship even in adulthood.

### FIGURE NO 4.11:

***Type of the hospital***



The figure illustrates the distribution of participants based on the type of hospital they sought treatment for their cancer. It reveals that the majority of the participants (83.64%) received treatment from government hospitals, indicating a higher proportion of individuals accessing cancer care from public healthcare institutions. On the other hand, a relatively small percentage of participants (16.36%) received treatment from both private and government hospitals, suggesting a smaller subset of individuals who had access to and sought care from private healthcare facilities alongside government hospitals. It is important to note that the data collected for this study specifically focused on participants who sought treatment from a specific regional cancer center (RCC), which could limit the generalizability of the findings.

**Table No 4.1**

***Occupation of the participants***

| Occupation of the participants | Frequency | Percent |
|---|---|---|
| Employed full-time | 7 | 12.7 |
| Employed part-time | 2 | 3.6 |
| Unemployed | 3 | 5.5 |
| Self-employed | 14 | 25.5 |
| Student | 1 | 1.8 |
| House wife | 16 | 29.1 |
| Daily wages | 8 | 14.5 |
| Farmer | 4 | 7.3 |
| Total | 55 | 100.0 |

Based on the participants' responses, the table provides details about the occupation of the patients. A very small percentage of participants (12.7%) reported being full-time employed. This indicates that only a few respondents identified themselves as having a full-time job or occupation. Similarly, a very small percentage of participants (3.6%) reported being part-time employed. This suggests that only a few respondents indicated having a part-time job or occupation. Another small percentage of participants (5.5%) reported being unemployed. This indicates that a limited number of respondents indicated that they were not currently employed. One-fourth of the participants (25.5%)

reported being part-time employed. This suggests that a significant proportion of respondents identified themselves as having a part-time job or occupation. A very small percentage of participants (1.8%) reported being students. This indicates that only a few respondents identified themselves as students. More than one-fourth of the participants (29.1%) reported being housewives. This suggests that a significant proportion of respondents identified themselves as homemakers or housewives. A very small percentage of participants (14.5%) reported being daily wage laborers. This indicates that only a few respondents identified themselves as daily wage laborers. Similarly, a very small percentage of participants (7.3%) reported being farmers. This suggests that only a few respondents identified themselves as farmers.

**Table No 4.2**

***Type of ration card of the participants***

| Type of ration card of the participants | Frequency | Percent |
|---|---|---|
| WHITE/APL Ration Card | 6 | 10.9 |
| BLUE/APL Ration Card | 8 | 14.5 |
| PINK/BPL Ration Card | 32 | 58.2 |
| YELLO/AAY Ration Card | 9 | 16.4 |
| Total | 55 | 100.0 |

Based on the participants' responses, the table indicates the distribution of participants based on the type of ration card they possess. A very small percentage of participants (10.9%) reported having a white/APL (Above Poverty Line) ration card. Similarly, a very small percentage of participants (14.5%) reported having a blue/APL ration card. More than half of the participants (58.2%) reported having a pink/BPL (Below Poverty Line) ration card. A very small percentage of participants (16.4%) reported having a yellow/AAY (Antyodaya Anna Yojana) ration card. This suggests that only a few respondents indicated possessing a yellow/AAY ration card.

**Table No 4.3**

***Household Income (per year) of the participants***

| **Household Income (per year) of the participants** | Frequency | Percent |
|---|---|---|
| ABOVE 2 LACKS | 2 | 3.6 |
| ABOVE 1 LACKS | 1 | 1.8 |
| ABOVE 75000 | 7 | 12.7 |
| ABOVE 50000 | 42 | 76.4 |
| BELOW 10000 | 3 | 5.5 |
| Total | 55 | 100.0 |

Based on the participants' responses, the figure indicates the distribution of participants based on their reported household income per year. A very small percentage of participants (3.6%) reported having a yearly household income above 2 lakhs. Similarly, a very small percentage of participants (1.8%) reported having a yearly household income above 1 lakh. A very small percentage of participants (12.7%) reported having a yearly household income above 75,000. More than three-fourths of the participants (76.4%) reported having a yearly household income above 50,000. A very small percentage of participants (5.5%) reported having a yearly household income below 10,000.

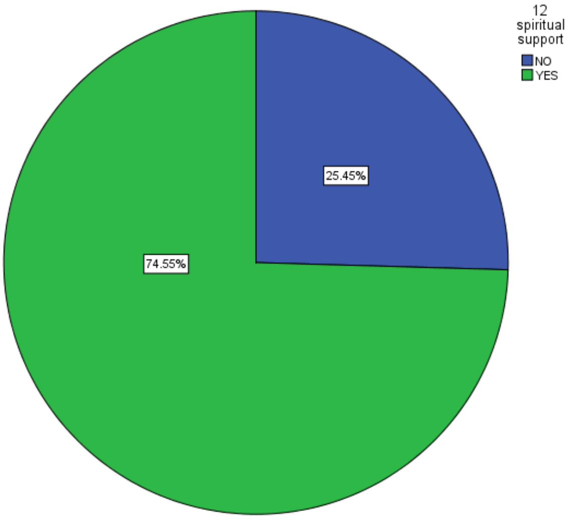
## 4.3 UNDERSTANDING THE SOCIAL SUPPORT RECEIVED BY PATIENTS IN THE INSTITUTION

Indeed, the understanding of the social support received by patients in the institution covers a wide range of variables that collectively contribute to the comprehensive care and well-being of individuals dealing with cancer. Let's take a closer look at these variables:Spiritual Support, Mentoring, Educational Support, Support Groups, Counselling Service, Interaction between Patients, Organized Activities, Belief in Improvement, Emotional and Psychological Support, Institution's Efforts to Address

Needs, Communication and Information Dissemination, and Existing Support Systems for Employment Challenges.

## FIGURE NO 4.12:

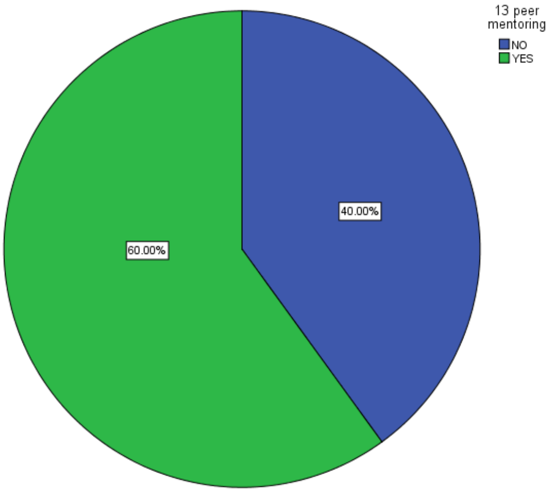
*Spiritual Support availability*



The figure describes the results of a study regarding spiritual support provided by an institution to the respondents. According to the data presented, approximately one-fourth (25.5%) of the participants stated that the institution did not offer any spiritual support. On the other hand, less than three-fourths (74.5%) of the participants reported that they received an adequate amount of spiritual support during their treatment period. This suggests that a majority of the respondents felt that the institution did provide them with the necessary spiritual support during their time there.

## FIGURE NO 4.13:

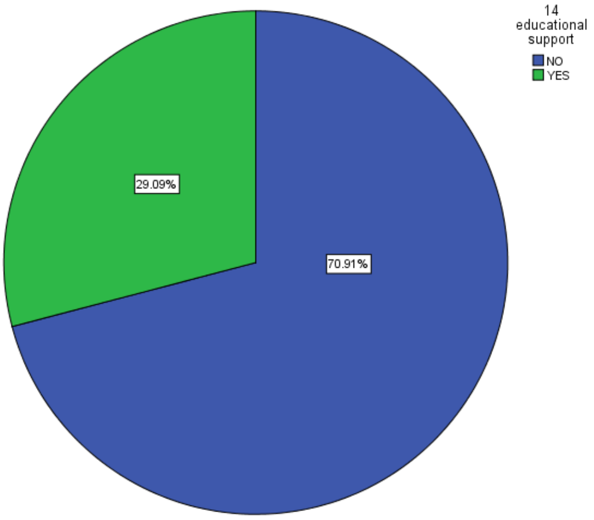
*Mentoring availability*



The figure displays the percentage of respondents who received peer mentoring from the institution. Based on the results presented, more than one-third (40.0%) of the participants reported that the institution did not provide a peer mentoring atmosphere. This indicates that a significant proportion of the respondents felt that there was a lack of support or guidance from their peers within the institution during their treatment period. Conversely, more than half (60.0%) of the participants expressed that they received enough of a peer mentoring atmosphere during their time in treatment. This suggests that a majority of the respondents felt that the institution fostered an environment where peers were able to offer guidance, support, and mentorship to each other.

**FIGURE NO 4.14:**

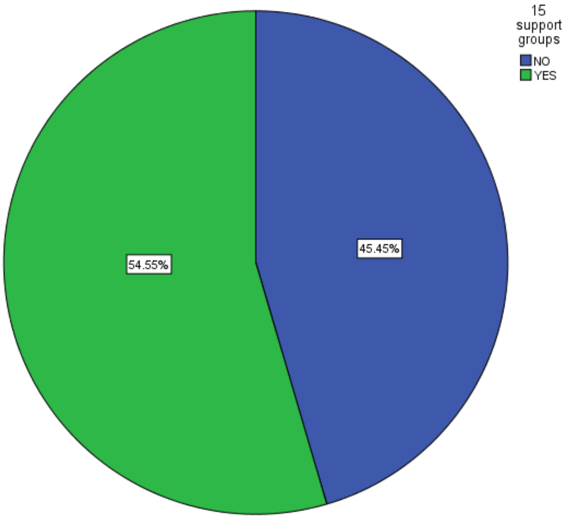
***Educational Support***



The figure, which represents the educational support provided by the institution to cancer patients. A significant majority (70.9%) of the participants reported that the institution did not offer any educational support. This indicates that a large proportion of the respondents felt that they did not receive any form of assistance or resources related to education of their children during their treatment period. It suggests that the institution may not have prioritized providing educational support to its cancer patients. On the other hand, more than one-fourth (29.1%) of the participants mentioned that they did receive sufficient educational support from the institution during their treatment time. This indicates that a minority of the respondents felt that the institution did provide their children with the necessary educational resources and assistance during their treatment.

## FIGURE NO 4.15:

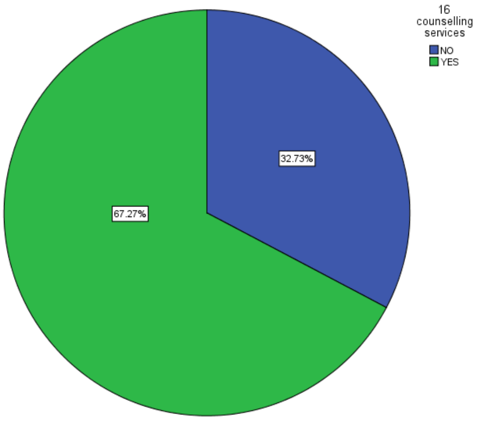
### *Support Groups*



The figure represents the availability of support groups within the institution. According to the figure, less than half (45.5%) of the participants stated that they did not receive any support from the institution through support groups. This indicates that a significant portion of the respondents felt that the institution did not provide them with access to support groups as part of their treatment. This suggests that these individuals did not have the opportunity to engage in a structured group setting to receive emotional, social, or informational support. Conversely, more than half (54.5%) of the participants reported that they received enough support from the institution through support groups during their treatment period. This indicates that a majority of the respondents felt that the institution did offer them the necessary support through these groups. It suggests that they had access to support groups where they could connect with others facing similar challenges, share experiences, and receive guidance and encouragement.

## FIGURE NO 4.16:

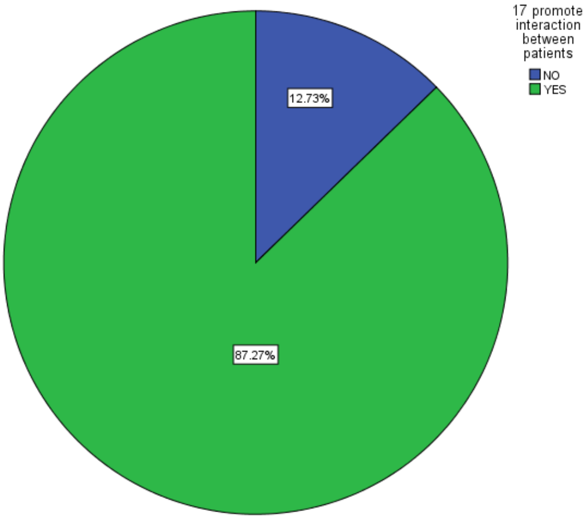
### *Counselling Service*



The figure illustrates the availability of counselling services provided by the institution. Based on the results shown, less than one-third (32.7%) of the participants reported that they did not receive any counselling services from the institution. This indicates that a relatively small portion of the respondents felt that the institution did not offer them access to counselling support. These individuals may have lacked the opportunity to receive professional guidance and emotional support to address their psychological and emotional needs during their time at the institution. On the other hand, a significant majority (67.3%) of the participants mentioned that they did receive opportunities for counselling within the institution. They expressed that they received valuable emotional support, guidance, and direction through the institution's counselling services. This suggests that a majority of the respondents felt that the counselling support provided by the institution was helpful in addressing their emotional well-being and providing them with the necessary guidance during their treatment.

**FIGURE NO 4.17:**

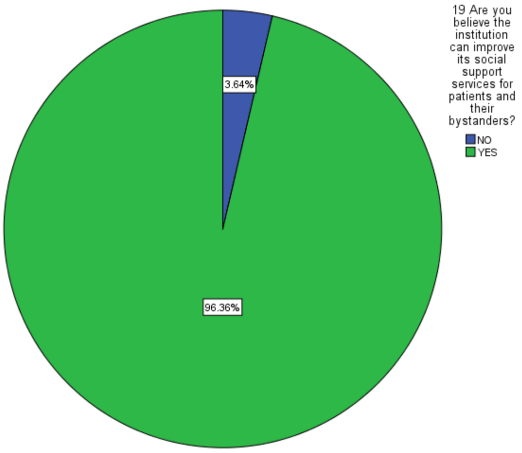
***Promoting Interaction***



The figure, which represents the promotion of interaction between patients within the institution. The results shown, a very small percentage (12.7%) of the participants stated that the institution did not promote interaction between patients. This indicates that a minority of the respondents felt that there was a lack of effort from the institution in fostering connections and facilitating communication among the patients. They may have felt isolated or unable to engage with their peers in meaningful ways. On the contrary, a majority (87.3%) of the participants mentioned that the institution actively promoted interaction between patients. They expressed that this promotion of interaction was highly beneficial for them, as it allowed them to exchange ideas about cancer treatments and learn from others' experiences. This suggests that the majority of respondents appreciated the opportunities provided by the institution to connect with fellow patients, gain insights, and gather information about coping with cancer and its consequences.

**FIGURE NO 4.18:**

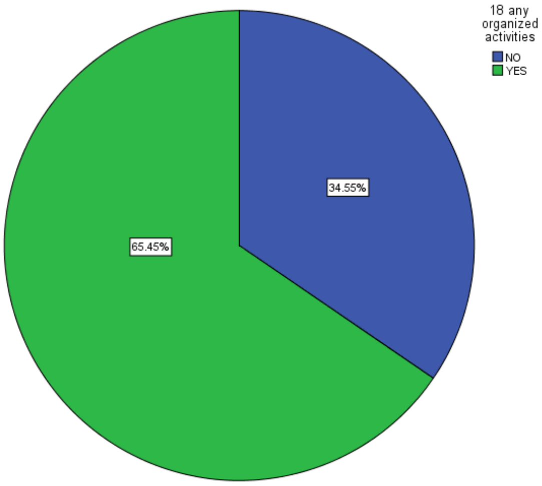
***Organized Activities***



The figure, which represents the availability of organized activities within the institutions. According to the results shown, less than one-third (34.5%) of the participants reported that the institution did not provide any activities. This indicates that a relatively small portion of the respondents felt that there was a lack of organized activities offered by the institution. These individuals may have experienced a limited range of options for engaging in recreational, social, or therapeutic activities during their time at the institution. On the other hand, a significant majority (65.5%) of the patients mentioned that they received many activities from the institution, which helped them overcome mental stress. This indicates that the institution actively provided a variety of organized activities to the patients. These activities likely served as a means for relaxation, distraction, and emotional well-being. They may have included things like art therapy, exercise programs, support groups, and recreational events. The availability of such activities helped the patients cope with their mental stress and improve their overall well-being.

**FIGURE NO 4.19:**

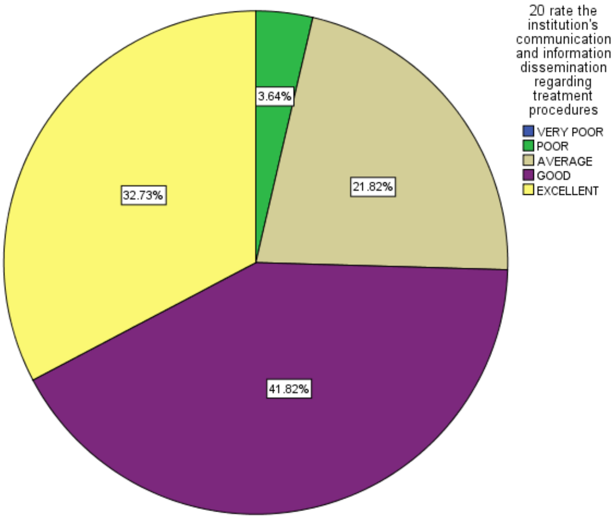
***Organized Activities***



The figure, which represents the participants' beliefs about whether the institution can improve its social support services for cancer patients. According to the results shown, a very small percentage (3.6%) of the participants expressed their belief that the institution is unable to improve its social support services for patients and their bystanders. This suggests that only a minority of respondents held the opinion that the institution is incapable of enhancing its efforts in providing social support to individuals affected by cancer. On the contrary, a vast majority (96.4%) of the participants stated that the institution has the capacity to improve its social support services for patients and their bystanders. This indicates that the majority of respondents believed that the institution has the potential to enhance its existing social support programs. They expressed optimism that the institution can further develop and strengthen its efforts in providing valuable support to cancer patients and their families. This suggests that the respondents recognized the importance of social support and believed in the institution's ability to meet those needs more effectively.

**FIGURE NO 4.20:**

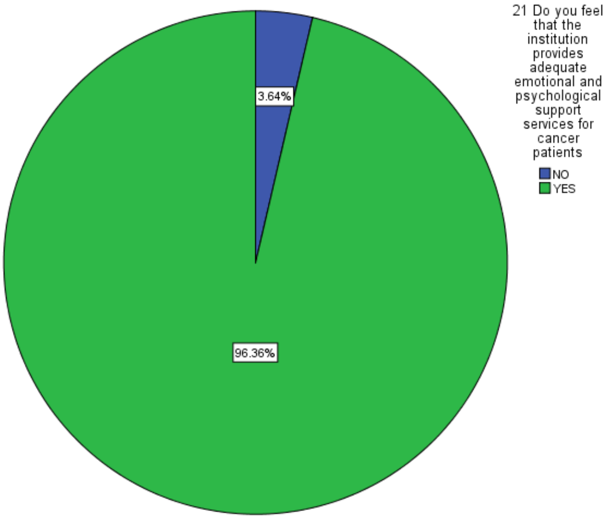
***Communication and Information Dissemination***



The figure depicts the rating of the institution's communication and information dissemination pertaining to treatment procedures. Only a small percentage (3.6%) of the participants expressed dissatisfaction with the institution's communication and information dissemination, perceiving it as poor in regards to treatment procedures, appointments, and updates provided to patients and their caregivers. Furthermore, less than one-fourth (21.8%) of the participants deemed the institution's communication and information dissemination as average in terms of treatment procedures, appointments, and updates. In contrast, a majority (41.8%) of the participants acknowledged the institution's communication and information dissemination as good regarding treatment procedures, appointments, and updates for patients and their caregivers. Lastly, approximately one-third (32.7%) of the participants regarded the institution's communication and information dissemination as excellent with regard to treatment procedures, appointments, and updates provided to patients and their caregivers. Overall, the figure presents the diverse ratings given by the participants regarding the institution's communication and information dissemination practices concerning treatment procedures.

**FIGURE NO 4.21:**

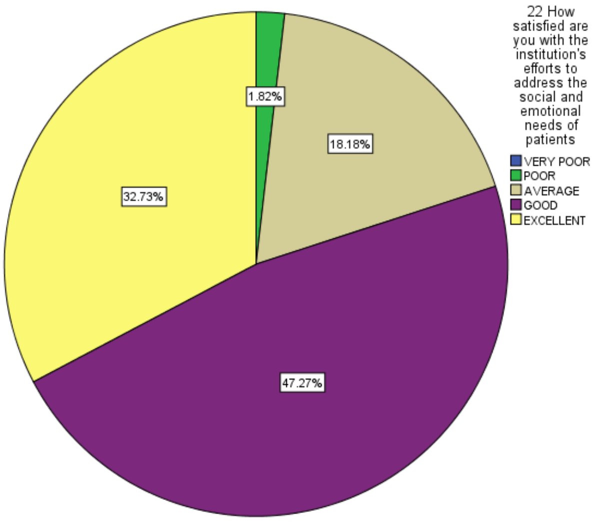
***Emotional and Psychological Support***



The figure illustrates the sentiment expressed by participants regarding the emotional and psychological support services provided by the institution for cancer patients. According to the results, a small percentage (3.6%) of the participants felt that the institution does not offer sufficient emotional and psychological support services for cancer patients and their bystanders. In contrast, the vast majority (96.4%) of the participants acknowledged that the institution does provide adequate emotional and psychological support services for cancer patients and their bystanders. This suggests that the majority of respondents believe that the institution is effectively meeting the emotional and psychological needs of cancer patients and those close to them. They likely feel supported, understood, and equipped with the necessary resources to cope with the emotional challenges that accompany a cancer diagnosis. Conversely, a small minority of participants expressed dissatisfaction with the level of emotional and psychological support provided by the institution, indicating that they believe improvements are needed in this area.

**FIGURE NO 4.22:**

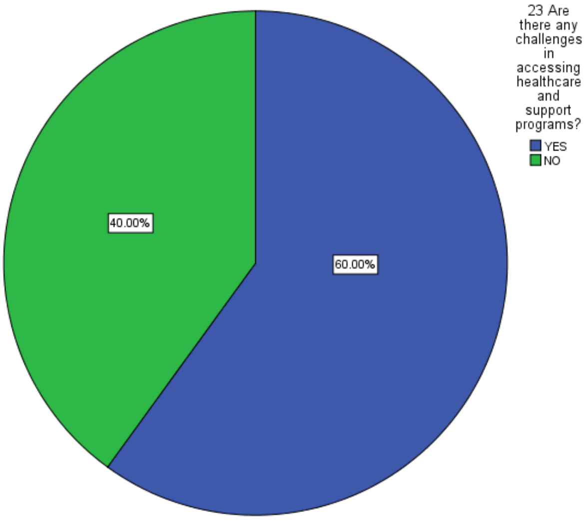
***Efforts to Address social and emotional needs***



The figure represents the institution’s efforts in addressing the social and emotional needs of patients. According to the results, a very small percentage (1.8%) of the participants expressed the opinion that the institution’s efforts to address these needs were poor. Similarly, another small percentage (18.2%) of participants mentioned that the institution’s efforts were at an average level. Conversely, less than half (47.3%) of the participants acknowledged that the institution had made good efforts to address the social and emotional needs of patients and their bystanders. Additionally, less than one-third (32.7%) of the participants mentioned that the institution’s efforts in this regard were excellent. The figure demonstrates varying perspectives among the participants regarding the institution’s efforts to address the social and emotional needs of patients. It shows that a majority of participants recognized the institution’s efforts as either good or excellent, indicating that the institution is actively working to meet the social and emotional needs of patients and their loved ones. However, a small minority expressed dissatisfaction with the level of efforts undertaken by the institution.

**FIGURE NO 4.23:**

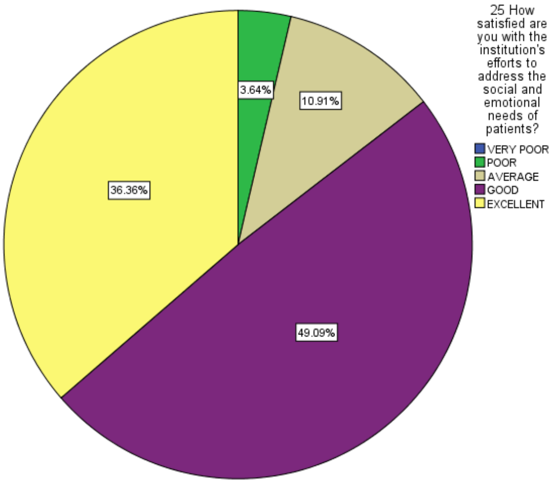
***Challenges in Accessing Healthcare***



The figure represents the challenges faced by participants in accessing healthcare institutions. According to the results, more than half (60.0%) of the participants reported that they did not face any challenges in accessing healthcare and support programs during their treatment. This suggests that a majority of participants did not encounter significant obstacles when seeking healthcare and support services, indicating a relatively smooth access to necessary resources. On the other hand, more than one-third (40.0%) of the participants mentioned that they faced many challenges in accessing healthcare and support programs during their treatment. This indicates that a significant proportion of participants experienced difficulties, barriers, or limitations in accessing the necessary healthcare services and support programs. These challenges could include issues such as long wait times, limited availability of services, financial constraints, lack of transportation, or geographical barriers.

**FIGURE NO 4.24:**

**Support Systems for Employment Challenges**



The figure illustrates the level of satisfaction among participants regarding the institution’s efforts to address the social and emotional needs of patients and their bystanders. According to the results, a very small percentage (3.6%) of the participants expressed poor satisfaction with the institution's efforts. Additionally, another small percentage (10.9%) reported an average level of satisfaction with the institution's efforts. Conversely, less than half of the participants expressed a good level of satisfaction with the institution's efforts in addressing social and emotional needs. Furthermore, more than one-third of the participants reported an excellent level of satisfaction with the institution's efforts in this regard. The figure highlights the range of satisfaction levels among participants, indicating differing perspectives on the institution's effectiveness in addressing social and emotional needs. It suggests that a significant portion of the participants were either satisfied or highly satisfied with the institution's efforts, while a smaller percentage expressed lower levels of satisfaction.

## 4.4 EXPLORING FACILITIES UTILIZED BY CANCER PATIENTS AND THEIR CAREGIVERS AT THE INSTITUTION

The institution has made significant efforts to cater to the needs of cancer patients and their caregivers, providing a range of facilities and services to ensure their comfort and well-being. These include accommodation, accessibility features, transportation services, recreational facilities, financial assistance, clean restroom facilities, designated car parking spaces, rest areas, and clean kitchen facilities, staff guidance and their satisfactory services, wheelchair-accessible entrances enhances the convenience for patients and their companions.

**Table No 4.4**

***Duration of Stay***

| Duration of Stay | Frequency | Percent |
|---|---|---|
| One month/ below | 34 | 61.8 |
| Above two months | 11 | 20.0 |
| Above six months | 4 | 7.3 |
| Above twelve months | 6 | 10.9 |
| Total | 55 | 100.0 |

The table displays the duration of the respondents' stay in the institution during their treatment period. According to the figure, a significant majority (61.8%) of the participants stated that they stayed in the institution for one month. This indicates that the majority of respondents had a relatively short stay, likely for initial diagnosis, treatment initiation, or early stages of their treatment. In contrast, less than one-fourth (20.0%) of the participants reported staying in the institution for more than two months. This suggests that a smaller proportion of respondents required a more extended duration of care, possibly due to the nature of their illness or the complexity of their treatment. Furthermore, a very small percentage (7.3%) of participants mentioned staying in the institution for more than six months, while an equally small percentage (10.9%) stated staying for over twelve months. These participants likely had more complex or prolonged treatment requirements, leading to an extended stay in the institution.

**Table No 4.5**

***Accommodation Types***

| Accommodation Types | Frequency | Percent |
|---|---|---|
| Dormitory | 8 | 14.5 |
| Cubicle | 14 | 25.5 |
| Shared rooms | 4 | 7.3 |
| Single room with toilet | 26 | 47.3 |
| Single room without toilet | 3 | 5.5 |
| Total | 55 | 100.0 |

The table displays the types of accommodation provided by the institution to the participants during their treatment time. According to the results, a very small percentage (14.5%) of the participants mentioned that the institution provided a dormitory system for their accommodation. This suggests that only a minority of participants stayed in a shared living space with communal facilities during their treatment period. Additionally, one-fourth (25.5%) of the participants reported that the institution provided a cubicle system for their accommodation. This indicates that a portion of the participants stayed in individual cubicles or small partitioned areas. Furthermore, a very small percentage (7.3%) of the participants mentioned that they were provided with a shared room for their accommodation. This suggests that only a few participants shared a living space with another person during their treatment. Less than half (47.3%) of the participants stated that the institution provided a single room with a toilet system for their accommodation. This indicates that a majority of participants had their own private room equipped with a toilet. Lastly, a very small percentage (5.5%) of the participants reported that the institution provided a single room without a toilet system for their accommodation. This suggests that a small minority of participants had a private room but without an attached toilet.

**Table No 4.6**

***Accommodation Cost***

| Accommodation Cost | Frequency | Percent |
|---|---|---|
| NO | 2 | 3.6 |
| PARTIALLY | 7 | 12.7 |
| YES | 46 | 83.6 |
| Total | 55 | 100.0 |

The table illustrates the room facilities provided by the institution and whether they are offered for free or not to cancer patients during their treatment time. Out of the total participants, a small percentage (3.6%) reported that the institution did not provide any free accommodation service during their treatment. Another minority (12.7%) of participants stated that the institution offered partially free accommodation services. However, the vast majority of participants (83.6%) indicated that the institution did not provide free accommodation services during their treatment period. This suggests that a significant proportion of cancer patients had to bear the cost of accommodation themselves, potentially adding to the financial burden of their treatment journey.

**Table No 4.7**

***Room Satisfaction***

| Room Satisfaction | Frequency | Percent |
|---|---|---|
| POOR | 1 | 1.8 |
| AVERAGE | 6 | 10.9 |
| GOOD | 29 | 52.7 |
| EXCELLENT | 19 | 34.5 |
| Total | 55 | 100.0 |

The figure presents the respondents' satisfaction ratings regarding the room facilities provided by the institution during their treatment. The ratings are divided into four categories: poor satisfaction, average satisfaction, good satisfaction, and excellent satisfaction. A very small percentage (1.8%) of participants expressed poor satisfaction with the room facilities offered by the institution. Similarly, a relatively low percentage (10.9%) of participants reported average satisfaction with the room facilities. These respondents may have found the accommodations acceptable but not exceptional. More than half of the participants (52.7%) indicated that they had good satisfaction with the room facilities provided by the institution. This indicates that a significant proportion of respondents were content with the quality and amenities of their accommodation. Furthermore, less than one-third of the participants (34.5%) expressed excellent satisfaction with the room facilities. These respondents highly appreciated the quality and services provided by the institution for their accommodation needs during their treatment.

**Table No 4.8**

***Effect of Free Accommodation***

| Effect of Free Accommodation | Frequency | Percent |
|---|---|---|
| NO | 3 | 5.5 |
| YES | 52 | 94.5 |
| Total | 55 | 100.0 |

The figure illustrates the respondents' perceptions regarding the impact of the availability of free accommodation on the overall economic, social, and psychological well-being of patients during the treatment period. A small percentage (5.5%) of participants expressed that the availability of free accommodation did not contribute significantly to improving the overall economic, social, and psychological well-being of patients and their bystanders during the treatment period. These respondents may have perceived that while the accommodation was free, it may not have had a substantial impact on their well-being. In contrast, the vast majority of participants (94.5%) reported that the availability of free accommodation had a positive effect on the overall economic, social, and psychological well-being of patients and bystanders during the treatment period. This suggests that most respondents believed that the provision of free accommodation helped alleviate financial burdens, provided a supportive environment, and positively impacted their mental and emotional well-being during the challenging phase of cancer treatment.

**Table No 4.9**

***Pharmacy Availability***

| Pharmacy Availability | Frequency | Percent |
|---|---|---|
| NO | 53 | 96.4 |

| | | |
|---|---|---|
| YES | 2 | 3.6 |
| Total | 55 | 100.0 |

The figure highlights the availability of a pharmacy within the institution, as reported by the participants. The responses indicate whether the institution provides an on-site pharmacy for the convenience of cancer patients. The results show that the vast majority of participants (96.4%) stated that there is no pharmacy within the institution. This suggests that most of the respondents reported a lack of on-site pharmacy services at the institution where they received cancer treatment. In contrast, a very small percentage of participants (3.6%) mentioned that there is a pharmacy available within the institution. These respondents may have experienced the convenience of having access to medication and pharmaceutical services directly on the premises during their treatment.

**Table No 4.10**

***Medication Storage***

| Medication Storage | Frequency | Percent |
|---|---|---|
| NO | 5 | 9.1 |
| YES | 50 | 90.9 |
| Total | 55 | 100.0 |

The figure illustrates the participants' responses regarding the provisions for keeping medication and other necessary items within the institution. A small percentage of participants (9.1%) stated that the institution had no provisions for keeping medication and other necessary items. This suggests that a minority of respondents experienced a lack of facilities or resources within the institution to store medications and other essential items during their treatment. On the other hand, the majority of participants (90.9%) reported that the institution had many provisions for keeping medication and other necessary items. This indicates that most of the respondents had access to appropriate storage facilities and resources within the institution, making it easier for them to manage their medications and essential belongings during the course of their cancer treatment.

**Table No 4.11**

***Cafeteria and Food Services***

| Cafeteria and Food Services | Frequency | Percent |
|---|---|---|
| NO | 1 | 1.8 |
| YES | 54 | 98.2 |
| Total | 55 | 100.0 |

The figure presents the participants' responses regarding the availability of cafeteria or food services within the institution where they stayed during cancer treatment. A very small percentage of participants (1.8%) reported that there is no cafeteria or food services available within the institution. This suggests that only a few respondents experienced a lack of on-site food options during their treatment. In contrast, the vast majority of participants (98.2%) stated that there is a cafeteria or food services available within the institution. This indicates that the overwhelming majority of respondents had access to cafeteria or food services on the premises, making it convenient for them to obtain meals during their cancer treatment.

**Table No 4.12**

***Food cost***

| Food cost | Frequency | Percent |
|---|---|---|
| NO | 3 | 5.5 |
| PARTIALLY | 52 | 94.5 |
| Total | 55 | 100.0 |

The figure indicates the participants' responses regarding the availability of free food services within the institution where they stayed during the cancer treatment. A small percentage of participants (5.5%) reported that they are not getting any free service for cafeteria or food available within the institution. This suggests that only a few respondents did not have access to complimentary food services during their treatment. In contrast, the vast majority of participants (94.5%) stated that they are getting free service for cafeteria or food available within the institution. This indicates that the overwhelming majority of respondents had access to complimentary cafeteria or food services on the premises, which means they did not have to pay for their meals during their cancer treatment.

**Table No 4.13**

***Satisfaction with Food Services***

| Satisfaction with Food Services | Frequency | Percent |
|---|---|---|
| Very poor | 1 | 1.8 |
| POOR | 1 | 1.8 |
| AVERAGE | 6 | 10.9 |
| GOOD | 20 | 36.4 |
| EXCELLENT | 27 | 49.1 |
| Total | 55 | 100.0 |

Based on the respondents' satisfaction ratings, the figure indicates their level of satisfaction with the food services available in the institution. A very small percentage of participants (1.8%) rated their satisfaction level as very poor, expressing significant dissatisfaction with the food services provided by the institution. Similarly, another very small percentage of participants (1.8%) rated their satisfaction level as poor, indicating that they were not satisfied with the food services offered. A few participants (10.9%) rated their satisfaction level as average, suggesting that they neither had a highly positive nor a highly negative experience with the food services. More than one-third of the participants (36.4%) rated their satisfaction level as good, indicating that they were satisfied with the food services provided by the institution. Lastly, less than half of the participants (49.1%) rated their satisfaction level as excellent, expressing high levels of satisfaction with the food services offered.

**Table No 4.14**

***Prayer and Meditation Area***

| Prayer and Meditation Area | Frequency | Percent |
|---|---|---|
| NO | 5 | 9.1 |
| YES | 50 | 90.9 |
| Total | 55 | 100.0 |

Based on the participants' responses, the figure indicates whether there is a dedicated prayer or meditation area within the institution where they received cancer treatment. A very small percentage of participants (9.1%) reported that there is no dedicated prayer or meditation area within the institution. This suggests that only a few respondents did not have access to a designated space for prayer or meditation during their time at the institution. On the other hand, the majority of participants (90.9%) stated that there is a dedicated prayer or meditation area within the institution. This indicates that the overwhelming majority of respondents had access to a designated space for prayer or meditation, providing them with a tranquil and contemplative environment during their cancer treatment.

**Table No 4.15**

*Ambulance Services*

| Ambulance Services | | Frequency | Percent |
|---|---|---|---|
| Valid | NO | 32 | 58.2 |

| | | |
|---|---|---|
| YES | 23 | 41.8 |
| Total | 55 | 100.0 |

Based on the participants' responses, the figure indicates whether there are ambulance services available for cancer patients at the institution. More than half of the participants (58.2%) reported that there are no ambulance services available for cancer patients at the institution. This suggests that the majority of respondents did not have access to dedicated ambulance services specifically for cancer patients. In contrast, less than half of the participants (41.8%) stated that there are ambulance services available for cancer patients at the institution. This indicates that a smaller proportion of respondents did have access to ambulance services that cater to the transportation needs of cancer patients.

**Table No. 4.16**

***Ambulance services cost***

| **Ambulance services cost** | | Frequency | Percent |
|---|---|---|---|
| Valid | NO | 16 | 29.1 |
| | PARTIALLY | 7 | 12.7 |
| | YES | 11 | 20.0 |
| | Total | 34 | 61.8 |
| Missing | System | 21 | 38.2 |
| Total | | 55 | 100.0 |

Based on the participants' responses, the figure indicates whether the ambulance services provided to cancer patients at the institution are free or not. More than one-fourth of the participants (29.1%) reported that the cancer patients are not getting any free ambulance service from the institution. This suggests that a significant proportion of respondents indicated that the ambulance services provided to cancer patients come at a cost. A very small percentage of participants (12.7%) stated that the cancer patients are getting partially free ambulance service from the institution. This means that some respondents reported that the institution may offer subsidized or discounted ambulance services to cancer patients, but it is not entirely free. Less than one-fourth of the participants (20.0%) mentioned that the cancer patients are getting free ambulance service from the institution. This indicates that a smaller proportion of respondents reported that the institution provides completely free ambulance services to cancer patients.

**Table No 4.17**

***Transportation Services***

| **Transportation Services** | | Frequency | Percent |
|---|---|---|---|
| Valid | NO | 20 | 36.4 |
| | YES | 35 | 63.6 |
| | Total | 55 | 100.0 |

Based on the participants' responses, the figure indicates whether there are provisions for transportation services in the institution for both patients and bystanders. More than one-third of the participants (36.4%) reported that there are no provisions for transportation services in the institution for patients and bystanders. This suggests that a significant number of respondents indicated that the institution does not offer transportation services to facilitate travel for patients and their accompanying bystanders. However, a significant majority of participants (63.6%) stated that there are provisions for transportation services in the institution for patients and bystanders. This indicates that the overwhelming majority of respondents reported that the institution does provide transportation services to assist patients and their companions with their travel needs.

**Table No 4.18**

***Transportation Services cost***

| Transportation Services cost | | Frequency | Percent |
|---|---|---|---|
| | NO | 7 | 12.7 |
| | PARTIALLY | 6 | 10.9 |
| | YES | 27 | 49.1 |
| | Total | 40 | 72.7 |
| Missing | System | 15 | 27.3 |
| Total | | 55 | 100.0 |

Based on the participants' responses, the figure indicates whether the transport facility is free or not for both patients and bystanders at the institution. A small percentage of participants (12.7%) reported that there are no free transportation services in the institution for patients and bystanders. This suggests that only a few respondents indicated that the institution does not offer free transportation options for travel. Similarly, a very small percentage of participants (10.9%) stated that there are partially free transportation services in the institution for patients and bystanders. This means that some respondents reported that the institution may provide partially subsidized or discounted transportation services. Less than half of the participants (49.1%) mentioned that there are free transportation services in the institution for patients and bystanders. This indicates that a significant proportion of respondents reported that the institution does offer fully free transportation options for travel.

**Table No 4.19**

***Recreational Facilities***

| Recreational Facilities | Frequency | Percent |
|---|---|---|
| NO | 2 | 3.6 |
| YES | 53 | 96.4 |
| Total | 55 | 100.0 |

Based on the participants' responses, the figure indicates whether there are recreational or leisure facilities available for cancer patients and their bystanders at the institution. A very small percentage of participants (3.6%) reported that there are no recreational or leisure facilities for cancer patients and their bystanders at the institution. This suggests that only a few respondents indicated that the institution does not offer specific facilities for recreational activities or leisure time. In contrast, the vast majority of participants (96.4%) stated that there are recreational or leisure facilities for cancer.

**Table No 4.20**

***Financial Assistance Services***

| Financial Assistance Services | Frequency | Percent |
|---|---|---|
| NO | 29 | 52.7 |
| YES | 26 | 47.3 |
| Total | 55 | 100.0 |

patients and their bystanders at the institution. This indicates that the overwhelming majority of respondents reported that the institution provides recreational options or leisure activities for patients and their companions to engage in during their time at the facility.

Based on the participants' responses, the figure indicates whether there are financial assistance services available in the institution. More than half of the participants (52.7%) reported that there are no financial assistance services available in the institution. This suggests that the majority of respondents indicated that the institution does not offer specific financial support or assistance to cancer patients. On the other hand, less than half of the participants (47.3%) stated that there are financial assistance services available in the institution. This indicates that a smaller proportion of respondents reported that the institution provides financial support or assistance to help cancer patients cope with the financial burdens associated with their treatment.

**Table No 4.21**

***Accessibility Features***

| Accessibility Features | Frequency | Percent |
|---|---|---|
| NO | 21 | 38.2 |
| YES | 34 | 61.8 |
| Total | 55 | 100.0 |

Based on the participants' responses, the figure indicates whether there are wheelchair-accessible entrances, lifts, and ramps available in the institution where they stayed during cancer treatment. More than one-third of the participants (38.2%) reported that there are no wheelchair-accessible entrances, lifts, and ramps available in the institution. On the other hand, a significant majority of participants (61.8%) stated that there are wheelchair-accessible entrances, lifts, and ramps available in the institution. This indicates that the overwhelming majority of respondents reported that the institution does provide accessibility features to accommodate individuals who use wheelchairs, ensuring that they can access the facilities comfortably.

**Table No 4.22**

***Satisfaction with accessibility***

| Satisfaction with accessibility | Frequency | Percent |
|---|---|---|
| Very poor | 10 | 18.2 |
| POOR | 8 | 14.5 |
| AVERAGE | 2 | 3.6 |
| GOOD | 12 | 21.8 |
| EXCELLENT | 23 | 41.8 |
| Total | 55 | 100.0 |

Based on the respondents' ratings, the table shows their perception of the accessibility of the institution for individuals with physical disabilities or mobility challenges. A very small percentage of participants (18.2%) rated the accessibility of the institution as very poor for individuals with physical disabilities or mobility challenges. This suggests that only a few respondents felt that the institution's accessibility features were significantly inadequate for individuals with mobility limitations. Similarly, another small percentage of participants (14.5%) rated the accessibility of the institution as poor for individuals with physical disabilities or mobility challenges. A very small percentage of participants (3.6%) rated the accessibility of the institution as average for individuals with physical disabilities or mobility challenges. Less than one-fourth of the participants (21.8%) rated the accessibility of the institution as good for individuals with physical disabilities or mobility challenges. Lastly, less than half of the participants (41.8%) rated the accessibility of the institution as excellent for individuals with physical disabilities or mobility challenges. These respondents highly appreciated the institution's efforts in providing outstanding accessibility features to ensure that individuals with mobility challenges can navigate the facilities comfortably.

**Table No 4.23**

***Staff Guidance***

| Staff Guidance | Frequency | Percent |
|---|---|---|
| NO | 5 | 9.1 |
| YES | 50 | 90.9 |
| Total | 55 | 100.0 |

Based on the participants' responses, the figure indicates whether there is adequate staff within the institution to guide cancer patients and their bystanders. A very small percentage of participants (9.1%) reported that there is no sufficient staff within the institution to guide cancer patients and their bystanders. This suggests that only a few respondents felt that the institution may have staffing issues related to providing guidance and support to patients and their accompanying bystanders. On the other hand, the majority of participants (90.9%) stated that there is sufficient staff within the institution to guide cancer patients and their bystanders. This indicates that the overwhelming majority of respondents reported that the institution has an adequate number of staff members available to assist and guide patients and their companions during their time at the facility.

**Table No 4.24**

***Staff Guidance and Satisfaction***

| Staff Guidance and Satisfaction | Frequency | Percent |
|---|---|---|
| POOR | 2 | 3.6 |
| AVERAGE | 13 | 23.6 |
| GOOD | 20 | 36.4 |
| EXCELLENT | 20 | 36.4 |

| | | |
|---|---|---|
| Total | 55 | 100.0 |

The figure presents the respondents' satisfaction ratings regarding staff services available in the institution. Very few (3.6%) of the participants say that they are having poor satisfaction with their service. Less than one fourth (23.6%) of the participants say that they are having an average level of satisfaction with their service. More than one third (36.4%) of the participants say that they are having a good level of satisfaction with their service. More than one third (36.4%) of the participants say that they are having excellent satisfaction with their service.

**Table No 4.25**

***Waiting areas***

| Waiting areas | Frequency | Percent |
|---|---|---|
| NO | 4 | 7.3 |
| YES | 51 | 92.7 |
| Total | 55 | 100.0 |

Based on the participants' responses, the figure indicates whether the waiting areas of the institution are comfortable and well-equipped. A very small percentage of participants (7.3%) reported that the waiting areas of the institution are not comfortable and well-equipped. In contrast, the vast majority of participants (92.7%) stated that the waiting areas of the institution are comfortable and well-equipped. This indicates that the overwhelming majority of respondents reported that they found the waiting areas to be comfortable and adequately equipped with facilities to meet their needs.

**Table No 4.26**

***Kitchen Facilities***

| Kitchen Facilities | Frequency | Percent |
|---|---|---|

| | | |
|---|---|---|
| NO | 9 | 16.4 |
| YES | 46 | 83.6 |
| Total | 55 | 100.0 |

Based on the participants' responses, the figure indicates whether there are separate kitchen areas specifically designated for cancer patients at the institution. A very small percentage of participants (16.4%) reported that there are no separate kitchen areas specifically designated for cancer patients. This suggests that only a few respondents indicated that the institution may not have separate kitchen spaces dedicated to catering to the dietary needs and preferences of cancer patients. On the other hand, the majority of participants (83.6%) stated that there are separate kitchen areas specifically designated for cancer patients. This indicates that the overwhelming majority of respondents reported that the institution provides separate kitchen facilities to cater to the dietary requirements and considerations of cancer patients.

**Table No 4.27**

***Kitchen Facilities and Cleanliness***

| Kitchen Facilities and Cleanliness | Frequency | Percent |
|---|---|---|
| Very poor | 1 | 1.8 |
| POOR | 2 | 3.6 |
| AVERAGE | 8 | 14.5 |
| GOOD | 21 | 38.2 |
| EXCELLENT | 23 | 41.8 |
| Total | 55 | 100.0 |

The figure presents the respondents’ satisfaction ratings regarding cleanliness and hygiene in the kitchen available in the institution. Very few (1.8%) of the participants say that the level of cleaning and well-maintaining is very poor. Very few (3.6%) of the participants say that the level of cleaning and well-maintaining is poor. Very few (14.5%) of the participants say that the level of cleaning and well-maintaining is average. More than one-third (38.2%) of the participants say that the level of cleaning and well-maintaining is good. Less than half (41.8%) of the participants say that the level of cleaning and well-maintaining is excellent.

**Table No 4.28**

***clean restroom***

| clean restroom | Frequency | Percent |
|---|---|---|
| YES | 55 | 100.0 |

The data presented in Table indicates that all participants who were surveyed confirmed the presence of a provision for clean restroom facilities within the care homes or institutions where they received cancer treatment. This unanimous agreement among the participants highlights a consistent and positive aspect of the care homes’ infrastructure – the availability of clean and well-maintained restroom facilities.

**Table No 4.29**

***Restroom facilities***

| Restroom facilities | Frequency | Percent |
|---|---|---|
| AVERAGE | 5 | 9.1 |
| GOOD | 26 | 47.3 |
| EXCELLENT | 24 | 43.6 |
| Total | 55 | 100.0 |

Based on the participants' responses, the figures indicates the availability and level of cleanliness and maintenance of restroom facilities at the institution. The vast majority of participants (100%) reported that there is a provision for clean restroom facilities at the institution. This indicates that all respondents confirmed the availability of restroom facilities within the institution. A very small percentage of participants (9.1%) rated the cleanliness and maintenance of the restroom facilities as average. This suggests that only a few respondents perceived the restrooms to have a moderate level of cleanliness and maintenance. Less than half of the participants (47.3%) rated the cleanliness and maintenance of the restroom facilities as good. This indicates that a significant number of respondents were satisfied with the cleanliness and maintenance of the restrooms, considering them to be in a good condition. Similarly, less than half of the participants (43.6%) rated the cleanliness and maintenance of the restroom facilities as excellent. This suggests that another significant portion of respondents highly appreciated the cleanliness and maintenance of the restrooms, considering them to be in excellent condition.

**Table No 4.30**

***Parking Areas***

| Parking Areas | Frequency | Percent |
|---|---|---|
| NO | 25 | 45.5 |
| YES | 30 | 54.5 |
| Total | 55 | 100.0 |

The figure indicates whether designated car parking spaces exist for cancer patients and their caregivers at the institution. Less than half of the participants (45.5%) reported that there are no designated car parking spaces for cancer patients and their caregivers. On the other hand, more than half of the participants (54.5%) stated that there are designated car parking spaces for cancer patients and their caregivers. This indicates that the majority of respondents reported that the institution does provide dedicated parking areas to accommodate the needs of cancer patients and their caregivers when visiting the facility.

**Table No 4.31**

***Rest Areas***

| Rest Areas | Frequency | Percent |
|---|---|---|
| NO | 6 | 10.9 |
| YES | 49 | 89.1 |
| Total | 55 | 100.0 |

The figure indicates whether there are designated rest areas for cancer patients and their bystanders at the institution. A very small percentage of participants (10.9%) reported that there are no designated rest areas for cancer patients and their bystanders. On the other hand, the majority of participants (89.1%) stated that there are designated rest areas for cancer patients and their bystanders. This indicates that the overwhelming majority of respondents reported that the institution does provide areas where patients and their companions can rest and take a break during their time at the facility.

**Table No 4.32**

***plan to stay***

| Plan to stay | Frequency | Percent |
|---|---|---|
| One month/ below | 34 | 61.8 |
| Above two months | 7 | 12.7 |
| Above six months | 2 | 3.6 |
| TREATMENT IS OVER | 12 | 21.8 |
| Total | 55 | 100.0 |

Based on the participants’ responses, the table provides details about the duration for which they plan to stay in the institution. A significant proportion of participants (61.8%) reported that they are planning to stay in the institution for one month. A very small percentage of participants (12.7%) reported that they are planning to stay in the institution for more than two months. Similarly, a very small percentage of participants (3.6%) reported that they are planning to stay in the institution for more than six months. Less than one-fourth of the participants (21.8%) reported that they are planning to stay in the institution during their treatment period. This indicates that a portion of respondents planned to stay at the institution specifically for the duration of their cancer treatment.

**Table No 4.33**

***any specific challenges***

| Specific challenges | Frequency | Percent |
|---|---|---|
| YES | 6 | 10.9 |
| NO | 49 | 89.1 |
| Total | 55 | 100.0 |

The figure indicates whether they have encountered any specific challenges or issues while accessing the facilities or services at the institution where they received cancer treatment. A small percentage of participants (10.9%) reported that they are facing specific challenges or issues while accessing the facilities or services at the institution. This suggests that only a few respondents encountered difficulties or obstacles in accessing the necessary facilities or services during their treatment. On the other hand, the majority of participants (89.1%) stated that they are not facing specific challenges or issues while accessing the facilities or services at the institution. This indicates that the overwhelming majority of respondents did not encounter any significant barriers or hindrances in accessing the required facilities or services during their cancer treatment.

**Table No 4.34**

***Overall Facility Satisfaction***

| Overall Facility Satisfaction | Frequency | Percent |
|---|---|---|
| POOR | 2 | 3.6 |
| AVERAGE | 3 | 5.5 |
| GOOD | 26 | 47.3 |
| EXCELLENT | 24 | 43.6 |
| Total | 55 | 100.0 |

Based on the participants' responses, the overall facilities provided at the institution for cancer patients and their bystanders are rated on a scale ranging from poor (1) to excellent (5). A very small percentage of participants (3.6%) rated the overall facilities as poor. Similarly, a few participants (5.5%) rated the overall facilities as average. These respondents may have perceived that while the facilities were acceptable, they were not outstanding or exceptional. Less than half of the participants (47.3%) rated the overall facilities as good. This indicates that a significant number of respondents were satisfied with the facilities provided by the institution for cancer patients and their bystanders. Additionally, slightly less than half of the participants (43.6%) rated the overall facilities as excellent. These respondents highly appreciated the facilities offered by the institution, indicating that they were of high quality and positively impacted the experience of both cancer patients and their bystanders.

**Table No 4.35**

***Accessibility Satisfaction***

| Accessibility Satisfaction | Frequency | Percent |
|---|---|---|

|  |  |  |
|---|---|---|
| Very poor | 1 | 1.8 |
| POOR | 2 | 3.6 |
| AVERAGE | 12 | 21.8 |
| GOOD | 22 | 40.0 |
| EXCELLENT | 18 | 32.7 |
| Total | 55 | 100.0 |

Based on the participants' responses, the satisfaction level with the accessibility features provided by the institution for patients and bystanders is assessed on a scale ranging from very poor (1) to excellent (5). A very small percentage of participants (1.8%) rated the accessibility features as very poor. Similarly, a few participants (3.6%) rated the accessibility features as poor. These respondents may have perceived that the institution's accessibility provisions were inadequate or insufficient. Less than one-fourth of the participants (21.8%) rated the accessibility features as average. This indicates that some respondents felt that the accessibility provisions were neither exceptionally good nor notably lacking. A larger proportion of participants (40.0%) rated the accessibility features as good. This suggests that a significant number of respondents were satisfied with the institution's efforts to provide accessible facilities and services for patients and bystanders. Lastly, less than one-third of the participants (32.7%) rated the accessibility features as excellent. These respondents highly appreciated the institution's efforts in ensuring accessible facilities, indicating that the provisions positively impacted their experience as patients or bystanders during the cancer treatment.

**Table No 4.36**

***Quality of Social Support***

| **Quality of Social Support** | Frequency | Percent |
|---|---|---|

| | | |
|---|---|---|
| POOR | 1 | 1.8 |
| AVERAGE | 11 | 20.0 |
| GOOD | 24 | 43.6 |
| EXCELLENT | 19 | 34.5 |
| Total | 55 | 100.0 |

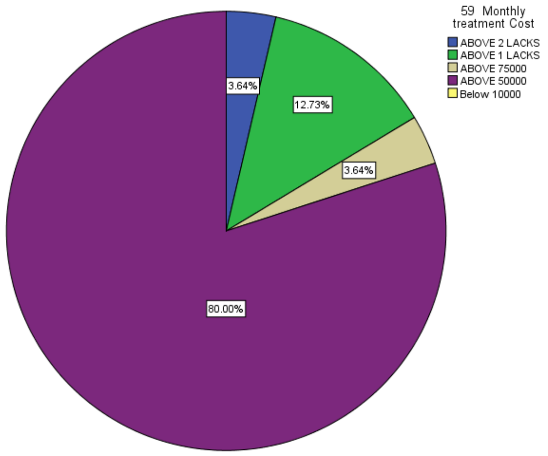
Based on the participants' responses, the quality of social support provided by the institution is rated on a scale of 1 to 5, with 5 being excellent and 1 being poor. A very small percentage of participants (1.8%) rated the quality of social support provided by the institution as poor. This suggests that only a few respondents expressed dissatisfaction with the level of social support they received from the institution. Less than one-fourth of the participants (20.0%) rated the quality of social support as average. These respondents may have perceived that while there was some level of social support, it fell short of meeting their expectations or needs. A slightly larger proportion of participants (43.6%) rated the quality of social support as good. This indicates that a significant number of respondents were content with the social support provided by the institution during their cancer treatment. Less than one-third of the participants (34.5%) rated the quality of social support as excellent. These respondents highly appreciated the level of social support they received from the institution, suggesting that it met or exceeded their expectations and positively impacted their cancer journey.

## 4.5 EXAMINING ECONOMIC SUPPORT OFFERED BY INSTITUTIONS FOR CANCER PATIENTS

The study findings presented in Figures and Tables shed light on the economic aspects of cancer treatment as reported by participants. These insights reflect the distribution of participants' responses on various dimensions of financial impact.

**Figure No.4.25**

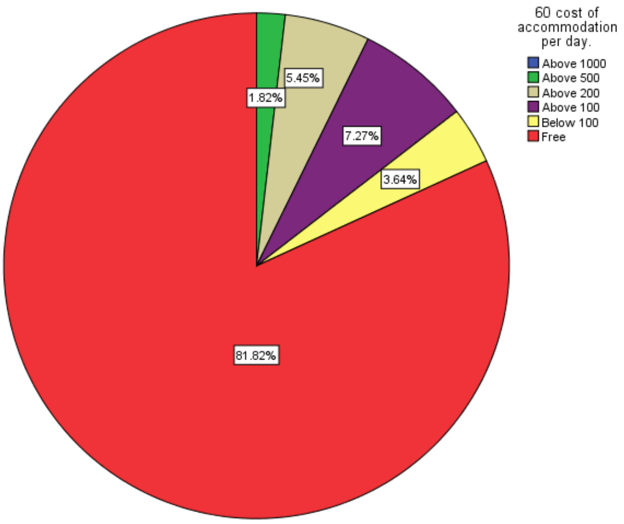
***Monthly Treatment Cost***



Based on the participants’ responses, the provided information indicates the distribution of participants based on the reported cost for their monthly treatment. A very small percentage of participants (3.64%) reported that the cost for their monthly treatment is above 2 lakhs. Similarly, a very small percentage of participants (12.73%) reported that the cost for their monthly treatment is above 1 lakh. Another very small percentage of participants (3.64%) reported that the cost for their monthly treatment is above 75,000. More than three-fourths of the participants (80.00%) reported that the cost for their monthly treatment is above 50,000. This indicates that a significant majority of respondents indicated that their monthly treatment costs are at or above this level.

**Figure No.4.26**

***Accommodation Costs***

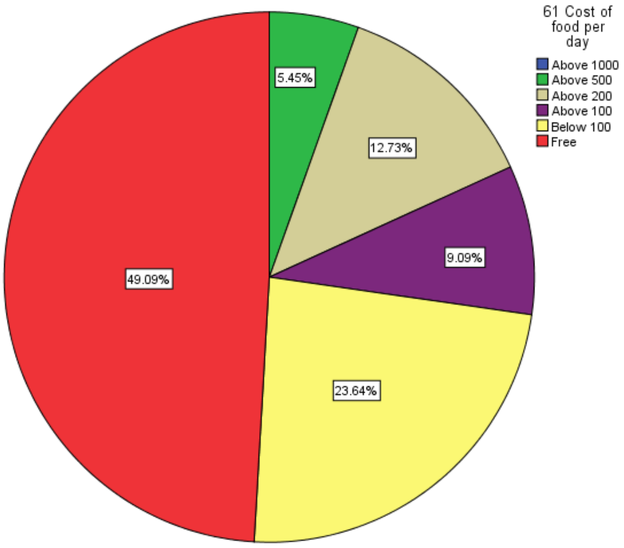


The figure indicates the distribution of participants based on the reported cost of accommodation per day during their treatment period. A very small percentage of participants (1.82%) reported that the cost of their accommodation per day is above 500. Similarly, a very small percentage of participants (5.45%) reported that the cost of their accommodation per day is above

200. Another very small percentage of participants (7.27%) reported that the cost of their accommodation per day is above 100. A very small percentage of participants (3.64%) reported that the cost of their accommodation per day is below 100. The majority of participants (81.82%) reported that they received free accommodation during their treatment period. This indicates that a significant majority of respondents reported not having to pay for their accommodation while undergoing treatment.

**Figure No.4.27**

***Food Costs***



The figure indicates the distribution of participants based on the reported cost of food per day during their treatment period. A very small percentage of participants (5.45%) reported that during the treatment period, the cost of their food per day is above 500. Another very small percentage of participants (12.73%) reported that during the treatment period, the cost of their food per day is above 200. A very small percentage of participants (9.09%) reported that during the treatment period, the cost of their food per day is above 100. Less than one-fourth of the participants (23.64%) reported that during the treatment period, the cost of their food per day is below 100. Less than half of the participants (49.09%) reported that during the treatment period, they received free food service from the institution. This indicates that a significant portion of respondents reported receiving food services without additional cost during their treatment period.

**Table No.4.37**

***Financial Impact of Cancer***

| Financial Impact of Cancer | Frequency | Percent |
|---|---|---|
| 5 significant effect | 1 | 1.8 |
| 4 indicating some effect | 2 | 3.6 |
| 3 indicating a moderate effect | 3 | 5.5 |
| 2 indicating no significant effect | 24 | 43.6 |
| 1 indicating no impact | 25 | 45.5 |
| Total | 55 | 100.0 |

The table indicates the distribution of participants based on the impact of their cancer diagnosis on their financial situation. A very small percentage of participants (1.8%) reported that the cancer diagnosis had a significant effect on their financial situation. Similarly, a very small percentage of participants (3.6%) reported that the cancer diagnosis had some significant effect on their financial situation. Another very small percentage of participants (5.5%) reported that the cancer diagnosis had some moderate effect on their financial situation. Less than half of the participants (43.6%) reported that the cancer diagnosis had no significant effect on their financial situation. Less than half of the participants (45.5%) reported that the cancer diagnosis had no impact on their financial situation. This indicates that a significant proportion of respondents reported that their financial situation was not impacted at all by the cancer diagnosis.

**Table No. 4.38**

*Economic Factors and Treatment*

| Economic Factors and Treatment | Frequency | Percent |
|---|---|---|
| 5 significant effect | 2 | 3.6 |

| | | |
|---|---|---|
| 4 indicating some effect | 1 | 1.8 |
| 3 indicating a moderate effect | 4 | 7.3 |
| 2 indicating no significant effect | 28 | 50.9 |
| 1 indicating no impact | 20 | 36.4 |
| Total | 55 | 100.0 |

The Table indicates the distribution of participants based on how economic factors impact their ability to afford necessary medical treatments. A very small percentage of participants (3.6%) reported that economic factors had some significant effect on their ability to afford necessary medical treatments. Similarly, a very small percentage of participants (1.8%) reported that economic factors had some effect on their ability to afford necessary medical treatments. Another very small percentage of participants (7.3%) reported that economic factors had a moderate effect on their ability to afford necessary medical treatments. Half of the participants (50.9%) reported that economic factors had no significant effect on their ability to afford necessary medical treatments. More than one-third of the participants (36.4%) reported that economic factors had no impact on their ability to afford necessary medical treatments. This indicates that a portion of respondents reported that economic factors had no effect on their ability to afford medical treatments.

**Table No. 4.39**

*Financial Assistance*

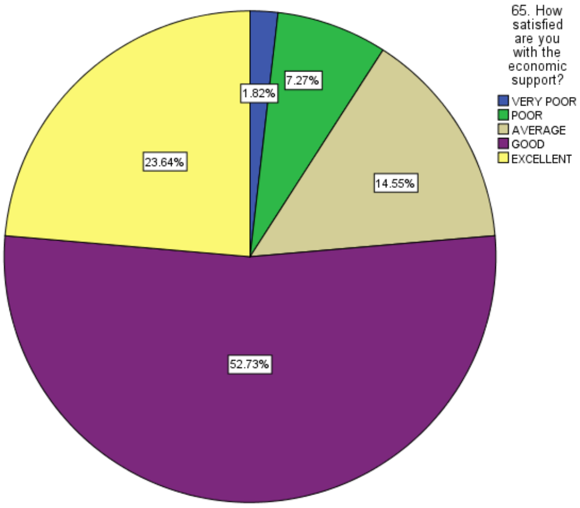
| Financial Assistance | Frequency | Percent |
|---|---|---|
| Financial assistance for medical expenses | 3 | 5.5 |
| Insurance coverage | 1 | 1.8 |
| Assistance with medication costs | 2 | 3.6 |
| Food and accommodation support | 40 | 72.7 |

| | | |
|---|---|---|
| travel support | 2 | 3.6 |
| Education support for children | 1 | 1.8 |
| OTHERS | 1 | 1.8 |
| No | 5 | 9.1 |
| Total | 55 | 100 |

The table indicates the distribution of participants based on the different types of financial assistance they received from the institution to alleviate the financial strain caused by cancer-related expenses during their treatment time. A very small percentage of participants (5.5%) reported receiving financial assistance for medical expenses during their treatment time. Similarly, a very small percentage of participants (1.8%) reported receiving financial assistance for insurance coverage during their treatment time. Another very small percentage of participants (3.6%) reported receiving assistance with medication costs during their treatment time. Less than three-fourths of the participants (72.7%) reported receiving financial assistance for food and accommodation support during their treatment time. A very small percentage of participants (9.1%)reported no need for any financial support. A very small percentage of participants (3.6%) reported receiving financial assistance for travel support during their treatment time. Another very small percentage of participants (1.8%) reported receiving financial assistance for education support for their children. Similarly, a very small percentage of participants (1.8%) reported receiving financial assistance for other things during their treatment time. This indicates that only a few respondents indicated receiving financial aid for miscellaneous expenses related to their cancer treatment.

**Figure No. 4.28**

*Satisfaction with Economic Support*



The Figure indicates the distribution of participants' satisfaction levels with the economic support provided by the institution. The satisfaction levels are rated on a scale from 1 (Very dissatisfied) to 5 (Very satisfied). A very small percentage of participants (1.8%) reported being very dissatisfied with the economic support provided by the institution. Similarly, a very small percentage of participants (7.3%) reported being dissatisfied with the economic support provided by the institution. Another very small percentage of participants (14.5%) reported having a neutral satisfaction level with the economic support provided by the institution. More than half of the participants (52.7%) reported having satisfaction with the economic support provided by the institution. Less than one-fourth of the participants (23.6%) reported being very satisfied with the economic support provided by the institution. This suggests that a smaller proportion of respondents indicated a high level of satisfaction with the economic support.

**Table No. 4.40**

*Government Financial Aid*

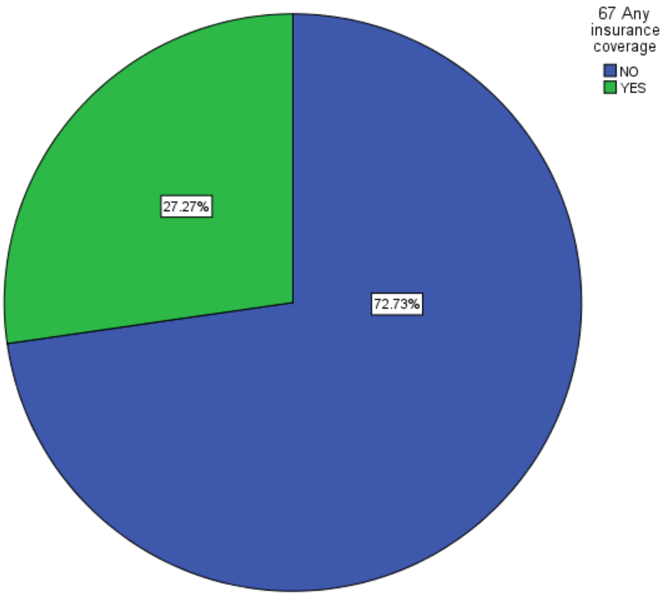
| Government Financial Aid | Frequency | Percent |
|---|---|---|
| NO | 3 | 3.5 |
| YES, Chief Minister's Distress Relief Fund (CMDRF) | 12 | 9.1 |
| YES, Karunya Benevolent Fund | 22 | 61.8 |

| | | | |
|---|---|---|---|
| | YES, Pradhan Mantri Jan Arogya Yojana (PMJAY)/Ayushman Bharat/National Health Protection Scheme | 14 | 20.8 |
| | YES, Rashtriya Arogya Nidhi (RAN) | 1 | 1.2 |
| | YES, Arogyakiranam Scheme | 3 | 3.6 |
| | Total | 55 | 100.0 |
| | System | | |
| Total | | 55 | 100.0 |

Based on the participants’ responses, the Table provides insights into their awareness of government financial aid available for cancer patients to address economic challenges and the specific types of financial support they have received. The vast majority of participants reported being aware of various government financial aid programs available for cancer patients to address the economic challenges they face, very few (3.5%) participants were unaware about the government schemes. Among the participants who are aware of government financial aid programs, very few (9.1%) reported receiving financial support from the Chief Minister’s Distress Relief Fund (CMDRF) for their cancer treatment. A significant percentage of participants (61.8%) reported receiving financial support from the Karunya Benevolent Fund for their cancer treatment. Less than one-fourth of the participants (20.8%) reported receiving financial support from the Pradhan Mantri Jan Arogya Yojana (PMJAY) for their cancer treatment. Very few participants (3.6%) reported receiving financial support from the Arogyakiranam Scheme for their cancer treatment. Another very small percentage of participants (1.2%) reported receiving financial support from Other State Government Schemes for their cancer treatment. This suggests that only a few respondents have benefited from financial assistance provided by other state government schemes.

**Figure No. 4.29**

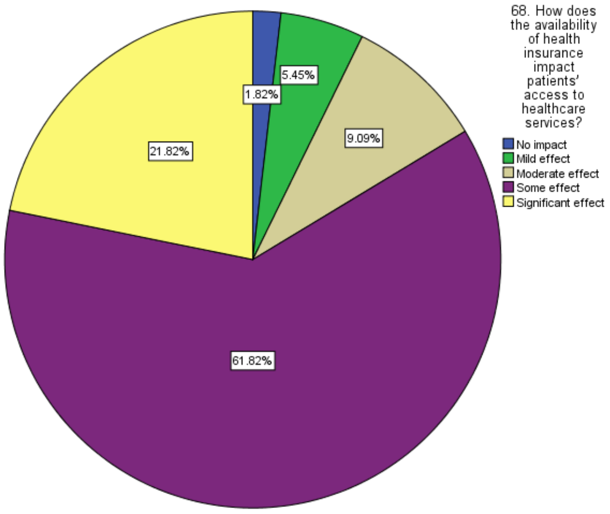
*Insurance Coverage*



Based on the participants' responses, the figure indicates that less than three-fourths (72.7%) of the participants reported not having any insurance coverage. On the other hand, more than one-fourth (27.3%) of the participants reported having insurance coverage. This indicates that a smaller but still notable proportion of respondents have insurance policies that may assist in covering their medical expenses associated with cancer treatment.

**Figure No. 4.29**

*Impact of Health Insurance*



Based on the participants' responses, the table provides insights into how the availability of health insurance impacts patients' access to healthcare services. The percentages indicate the distribution of participants' opinions regarding the impact of health insurance on their healthcare access. A very small percentage of participants (1.8%) reported that the availability of health insurance had no impact on their access to healthcare services. Similarly, a small percentage of participants (5.5%) indicated that the availability of health insurance had no significant effect on their access to healthcare services. A slightly larger percentage of participants (9.1%) reported that the availability of health insurance had a moderate effect on their access to healthcare services. A significant percentage of participants (61.8%) stated that the availability of health insurance had some effect on their access to healthcare services. Less than one-fourth of the participants (21.8%) reported that the availability of health insurance had some significant effect on their access to healthcare services. This suggests that a notable portion of respondents felt that their health insurance had a meaningful impact on their ability to access necessary medical care.

**Table No. 4.41**

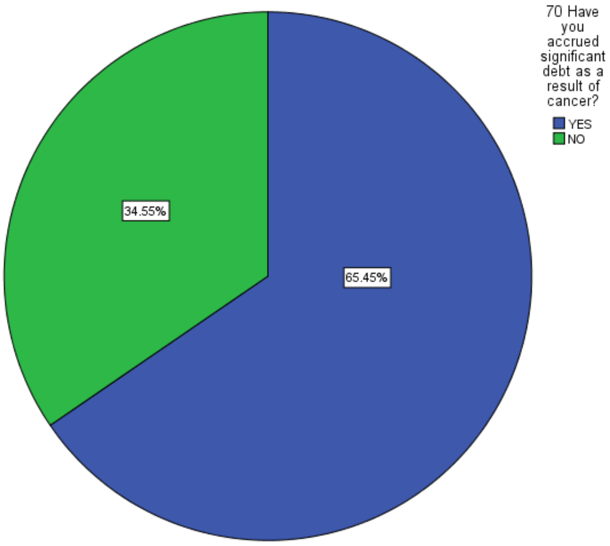
*Economic Factors in Decision-Making*

| *Economic Factors in Decision-Making* | Frequency | Percent |
|---|---|---|
| 5 indicating a significant effect | 1 | 1.8 |
| 3 indicating a moderate effect | 7 | 12.7 |
| 2 indicating no significant effect | 30 | 54.5 |
| 1 indicating no impact | 17 | 30.9 |
| Total | 55 | 100.0 |

Based on the participants’ responses, the table provides insights into how economic factors affect patients’ decision-making when seeking medical care. The percentages indicate the distribution of participants’ opinions regarding the impact of economic factors on their decision-making. A very small percentage of participants (1.8%) reported that economic factors have a significant effect on their decision-making when seeking medical care. Similarly, a small percentage of participants (12.7%) indicated that economic factors have a moderate effect on their decision-making when seeking medical care. A majority of participants (54.5%) stated that economic factors had no significant effect on their decision-making when seeking medical care. This indicates that a substantial proportion of respondents did not perceive economic considerations to strongly influence their choices related to healthcare services. More than one-fourth of the participants (30.9%) reported that economic factors had no impact on their decision-making when seeking medical care. This suggests that a notable portion of respondents felt that economic factors did not play a role in influencing their decisions regarding healthcare services.

**Figure No. 4.31**

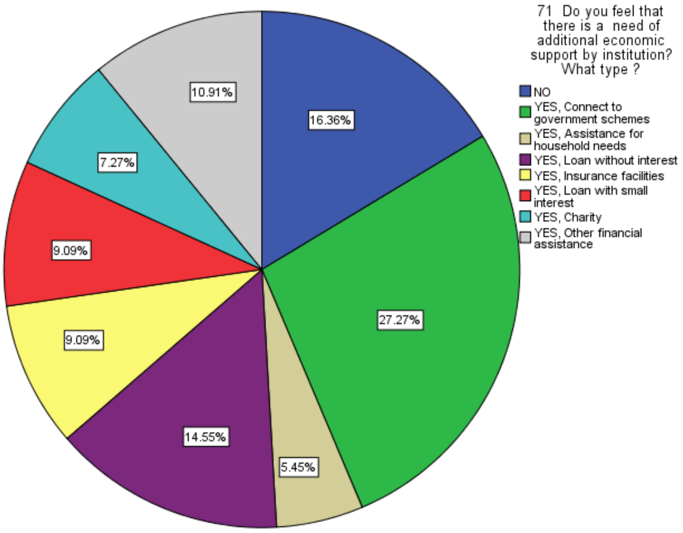
*Accrued Debt*



The figure illustrates participants' responses regarding whether they or their families have accrued significant debt as a result of cancer treatment expenses. The percentages represent the distribution of participants' answers. A significant majority of participants (65.5%) indicated that their families have accrued significant debt due to cancer treatment expenses. This suggests that a considerable portion of respondents' families experienced financial strain and debt accumulation as a consequence of the costs associated with cancer treatment. Conversely, less than one third of participants (34.5%) reported that their families did not accrue significant debt as a result of cancer treatment expenses. This indicates that a smaller proportion of respondents' families managed to avoid accumulating substantial debt while dealing with the financial burden of cancer treatment.

**Figure No. 4.32**

### *Need for Additional Economic Support*

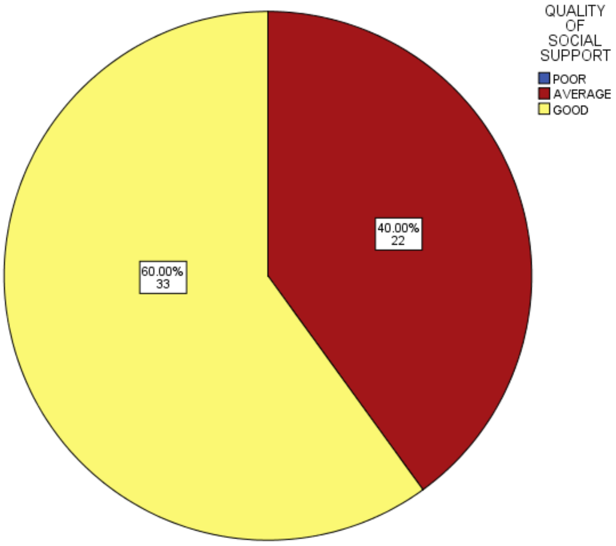


The figure represents participants' opinions regarding the perceived need for the institution to provide additional economic support services for cancer patients.

A significant majority of participants (83.64%) expressed that there is a perceived need for the institution to provide additional economic support services for cancer patients. Conversely, a small proportion of participants (16.36%) felt that there is no perceived need for the institution to offer additional economic support services for cancer patients. More than one fourth of the participants (27.27%) expressed that they believe the institution should assist cancer patients in accessing government schemes as a way to overcome the economic crisis associated with cancer treatment. Several participants (14.55%) felt that the institution should provide assistance to cancer patients in obtaining loans without interest. A similar proportion (10.9%) suggested that financial assistance from the institution could be a way to overcome the economic crisis. A few respondents (9.09%) recommended that the institution should facilitate access to insurance facilities or provide loans with small interest rates (9.09%) to help cancer patients manage their financial difficulties. Additionally, a small portion (7.27%) suggested that charitable assistance from the institution could be a way to alleviate the economic challenges faced by cancer patients. Interestingly, a smaller group of participants (5.45%) believed that the institution should offer support to cancer patients in acquiring household needs to address the economic crisis. These responses highlight the variety of perspectives on how institutions can provide economic support to cancer patients. The suggestions offered by participants range from utilizing government schemes and providing loans to offering charitable assistance and facilitating access to insurance facilities. This diversity of opinions underscores the need for a comprehensive approach to address the economic challenges faced by individuals undergoing cancer treatment.

**Figure No. 4.33**

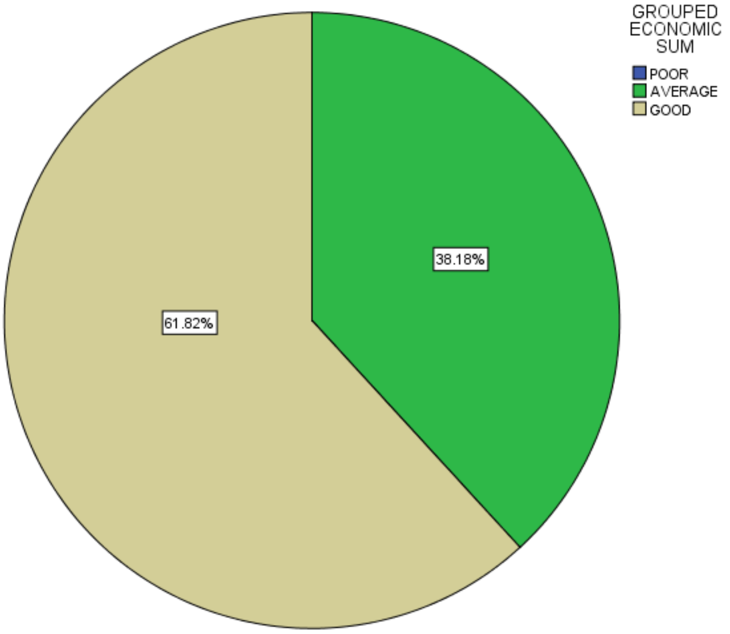
*Sum of quality of social support*



The figure, which represents the participants' perception of the quality of social support received during their treatment time in the institution. According to the results shown, more than half (60%) of the participants expressed that they received a good quality of social support from the institution during their treatment. This indicates that a majority of respondents felt that the institution provided them with valuable social support, including emotional, informational, and practical assistance. This support likely played a crucial role in their overall well-being and coping with the challenges of cancer treatment. Additionally, less than half (40%) of the participants reported an average quality of social support from the institution. This suggests that another significant portion of respondents perceived the social support provided by the institution as satisfactory but not exceptional. They likely felt that the support they received met their basic needs but may have desired more extensive or personalized assistance.

**Figure No. 4.34**

*Sum of quality of economic support*



The provided figure illustrates the participants' viewpoints regarding the quality of economic support they received throughout their treatment duration at the institution. The data shows that a majority of the participants, specifically 61.82% of them, indicated that they had received a high standard of economic support from the institution during their treatment journey. This suggests that a significant portion of the participants were satisfied with the economic assistance provided to them during their medical care. Conversely, a smaller proportion of the participants, accounting for 38.18%, reported that they perceived the quality of economic support they received from the institution to be of an average level. This indicates that while the majority rated their experience positively, there were still participants who felt that the economic support they received could have been better.

## 4.6 CROSSTABS

**Table No. 4.42**

*Social support and Gender*

| GENDER | QUALITY OF SOCIAL SUPPORT | |
|---|---|---|
| | AVERAGE | GOOD |
| MALE | 12 | 17 |
| | 41.4% | 58.6% |

| | | |
|---|---|---|
| FEMALE | 10<br>38.5% | 16<br>61.5% |

The table provides a crosstabulation of the quality of social support received from the institution based on the gender of the participants. The percentages represent the distribution of responses within each category. Among male participants, less than the half male respondents (41.4%) rated the quality of social support as average, while more than the half of the male respondents (58.6%) rated it as good. For female participants, more than one third (38.5%) considered the quality of social support to be average, while significant participants (61.5%) rated it as good. These results indicate that a significant proportion of both male and female participants perceived the quality of social support from the institution to be good. However, there were slightly higher percentages of female participants who rated the support as good compared to male participants. Additionally, a notable portion of both genders rated the support as average. This suggests that while the majority of participants had a positive perception of the quality of social support, there were also some who felt it was at an average level.

**Table No. 4.43**

*Social support and Age*

| | | grouped sum | | | |
|---|---|---|---|---|---|
| | | POOR | AVERAGE | GOOD | Total |
| age | 30 above | 2 | 10 | 0 | 12 |
| | | 16.7% | 83.3% | 0.0% | 100.0% |
| | 40 above | 0 | 9 | 1 | 10 |
| | | 0.0% | 90.0% | 10.0% | 100.0% |
| | 50 above | 0 | 14 | 4 | 18 |
| | | 0.0% | 77.8% | 22.2% | 100.0% |
| | 60 above | 0 | 9 | 1 | 10 |

| | | | | | |
|---|---|---|---|---|---|
| | | 0.0% | 90.0% | 10.0% | 100.0% |
| | 70 above | 0 | 4 | 1 | 5 |
| | | 0.0% | 80.0% | 20.0% | 100.0% |
| Total | | 2 | 46 | 7 | 55 |
| | | 3.6% | 83.6% | 12.7% | 100.0% |

The table shows how the institution’s social support quality is viewed based on participants’ ages. For those over 30, most (83.3%) said the support was average. For those over 40, a majority (90.0%) also said it was average. Among those over 50, more than three-fourths (77.8%) felt the same. For participants over 60, a majority (90.0%) considered it average. For those over 70, over three-fourths (80.0%) rated it as average. Very few (only 3.6%) said it was poor. The majority (83.6%) said it was average, and only a few (12.7%) said it was good.

**Table No. 4.44**

*Social support and Religion*

| | QUALITY OF SOCIAL SUPPORT | |
|---|---|---|
| RELIGION | AVERAGE | GOOD |
| HINDU | 12 | 17 |
| | 41.4% | 58.6% |
| CHRISTIAN | 7 | 11 |
| | 38.9% | 61.1% |
| ISLAM | 3 | 5 |
| | 37.5% | 62.5% |

The table compares how participants’ religion relates to the quality of social support they received from the institution. For Hindu participants, less than half (41.4%) said the support was average, while more than half (58.6%) rated it as good. Among Christian participants, over one-third (38.9%) considered it average, and a significant number (61.1%) rated it as good. Among Muslim participants, more than one-third (37.5%) felt it was average, while a significant portion (62.5%) rated it as good.

**Table No. 4.45**

*Social support and Marital status*

| | | QUALITY OF SOCIAL SUPPORT | | |
|---|---|---|---|---|
| | Marital status | AVERAGE | GOOD | Total |
| SINGLE | | 1 | 1 | 2 |
| | | 4.5% | 3.0% | 3.6% |
| MARRIED | | 20 | 29 | 49 |
| | | 90.9% | 87.9% | 89.1% |
| WIDOWED | | 1 | 3 | 4 |
| | | 4.5% | 9.1% | 7.3% |
| Total | | 22 | 33 | 55 |
| | | 100.0% | 100.0% | 100.0% |

The table compares the quality of social support received from the institution based on the participants' marital status. Very few single participants (4.5%) found the social support to be average, and a similar small number (3.0%) rated it as good. A majority of the 20 married participants (90.9%) considered the support average, and most of the 29 married participants (87.9%) rated it as good. Only a few of the 1 widow participant (4.5%) saw the social support as average, and a small number of the 3 widowed participants (9.1%) rated it as good.

**Table No. 4.46**

*Social support and Educational Qualification*

| | | QUALITY OF SOCIAL SUPPORT | | |
|---|---|---|---|---|
| | Educational Qualification | AVERAGE | GOOD | Total |
| | ILLITERATE | 1 | 4 | 5 |
| | | 4.5% | 12.1% | 9.1% |
| | SCHOOL LEVEL | 20 | 25 | 45 |
| | | 90.9% | 75.8% | 81.8% |
| | COLLEGE LEVEL | 1 | 4 | 5 |
| | | 4.5% | 12.1% | 9.1% |
| Total | | 22 | 33 | 55 |
| | | 100.0% | 100.0% | 100.0% |

The table compares the quality of social support received from the institution based on the participants' education qualification. Only a small number of illiterate participants (4.5%) found the quality of social support to be average, and a similarly small number of illiterate participants (12.1%) rated it as good. The majority of participants with a school-level education (90.9%) considered the social support to be average, while more than three-fourths of participants with a school-level education (75.8%) rated it as good. Very few participants with a college-level education (4.5%) rated the quality of social support as average, and only a few participants with a college-level education (9.1%) rated it as good.

**Table No. 4.47**

*Social support and Types of cancer*

| 6 Types of cancer | | grouped social sum POOR | AVERAGE | GOOD | Total |
|---|---|---|---|---|---|
| | BLOOD CANCER | 1 | 4 | 2 | 7 |
| | | 14.3% | 57.1% | 28.6% | 100.0% |
| | BORN CANCER | 0 | 2 | 0 | 2 |
| | | 0.0% | 100.0% | 0.0% | 100.0% |
| | BREAST CANCER | 1 | 3 | 0 | 4 |
| | | 25.0% | 75.0% | 0.0% | 100.0% |
| | LUNG CANCER | 0 | 1 | 0 | 1 |
| | | 0.0% | 100.0% | 0.0% | 100.0% |
| | COLORECTAL CANCER | 0 | 12 | 2 | 14 |
| | | 0.0% | 85.7% | 14.3% | 100.0% |
| | ORAL CANCER | 0 | 23 | 1 | 24 |
| | | 0.0% | 95.8% | 4.2% | 100.0% |
| | PROSTATE CANCER | 0 | 1 | 0 | 1 |
| | | 0.0% | 100.0% | 0.0% | 100.0% |
| | OVARIAN CANCER | 0 | 0 | 2 | 2 |
| | | 0.0% | 0.0% | 100.0% | 100.0% |
| Total | | 2 | 46 | 7 | 55 |
| | | 3.6% | 83.6% | 12.7% | 100.0% |

The table examines the quality of social support provided by the institution based on the types of cancer that participants have. Only a small number of participants with blood cancer (14.3%) rated the quality of social support as poor, while more than half of blood cancer participants (57.4%) found it to be average. More than one-fourth of blood cancer participants (28.6%) rated the quality as good. A significant majority of participants with bone cancer (100.0%) rated the support as average. For breast cancer participants, one-fourth (25.0%) rated the quality as poor, and a significant majority of them (75.0%) rated it as average. Similarly, a vast majority of lung cancer participants (100.0%) rated the support as average. Among participants with colorectal cancer, the majority (85.7%) rated the support as average, and a small number of them (14.3%) rated it as good. A vast majority of oral cancer participants (95.8%) rated the support as average, and only a small number of them (4.2%) rated it as good. For prostate cancer participants, a significant majority (100.0%) rated the support as average. Similarly, the majority of ovarian cancer participants (100.0%) rated the support as good. Only a few cancer participants (3.6%) rated the quality as poor, while a large majority of them (83.6%) rated it as average. A small number of cancer participants (12.7%) rated the quality as good.

**Table No. 4.48**

*Social support and Treatments*

| 8 Treatments | grouped social sum | | | |
|---|---|---|---|---|
| | POOR | AVERAGE | GOOD | Total |
| CHEMO THERAPY | 1 | 9 | 0 | 10 |
| | 10.0% | 90.0% | 0.0% | 100.0% |
| RADIOTHERAPY | 0 | 4 | 0 | 4 |
| | 0.0% | 100.0% | 0.0% | 100.0% |
| SURGERY, CHEMO, RADIATION | 1 | 18 | 3 | 22 |
| | 4.5% | 81.8% | 13.6% | 100.0% |
| SURGERY & CHEMO | 0 | 3 | 1 | 4 |
| | 0.0% | 75.0% | 25.0% | 100.0% |
| CHEMO & RADIOTHERAPY | 0 | 5 | 2 | 7 |
| | 0.0% | 71.4% | 28.6% | 100.0% |

| | | | | | |
|---|---|---|---|---|---|
| | CHEMO, RADIOTHERAPY & PALLIATIVE CARE | 0 | 7 | 1 | 8 |
| | | 0.0% | 87.5% | 12.5% | 100.0% |
| Total | | 2 | 46 | 7 | 55 |
| | | 3.6% | 83.6% | 12.7% | 100.0% |

The table analyzes the quality of social support offered by the institution based on the treatments received by participants. Only a small portion of participants who underwent chemotherapy (10.0%) rated the quality of social support as poor, while the majority of chemotherapy participants (90.0%) found it to be average. A vast majority of participants who underwent radiotherapy (100.0%) rated the support as average. For participants who had surgery, chemotherapy, and radiation (3 modalities), only a small number (4.5%) rated the quality as poor, while a significant majority (81.8%) rated it as average. A small number of them (13.6%) rated it as good. Participants who had surgery and chemotherapy without radiation had less than three-fourths (75.0%) rating the quality as average, and more than one-fourth (25.0%) rated it as good. For participants who received both chemotherapy and radiotherapy, less than three-fourths (71.4%) found the quality to be average, and more than one-fourth (28.6%) rated it as good. The majority of participants who had chemotherapy, radiotherapy, and palliative care (87.5%) found the quality of social support to be average. Only a small number of them (12.5%) rated it as good. Only a small number of participants with two types of cancer (3.6%) rated the quality as poor, while the majority of participants with cancer (83.6%) rated it as average. A small number of them (12.7%) rated the quality as good.

**Table No. 4.49**

*Social support and Duration since the cancer diagnosis*

| | grouped social sum | | | |
|---|---|---|---|---|
| 9 Diogene’s time | POOR | AVERAGE | GOOD | Total |
| Less than a year | 1 | 24 | 1 | 26 |

| | | | | | |
|---|---|---|---|---|---|
| | | 3.8% | 92.3% | 3.8% | 100.0% |
| | One year above | 0 | 11 | 3 | 14 |
| | | 0.0% | 78.6% | 21.4% | 100.0% |
| | Two years. | 0 | 2 | 0 | 2 |
| | | 0.0% | 100.0% | 0.0% | 100.0% |
| | Three years. | 1 | 6 | 1 | 8 |
| | | 12.5% | 75.0% | 12.5% | 100.0% |
| | More than four years. | 0 | 3 | 2 | 5 |
| | | 0.0% | 60.0% | 40.0% | 100.0% |
| Total | | 2 | 46 | 7 | 55 |
| | | 3.6% | 83.6% | 12.7% | 100.0% |

The table examines the quality of social support provided by the institution based on the duration since the cancer diagnosis. Only a small portion of participants diagnosed with cancer for less than a year (3.8%) during their Diogenes's time rated the support quality as poor. A vast majority of those diagnosed for less than a year (92.3%) rated it as average. A small portion of them (3.8%) rated the quality as good. For participants diagnosed with cancer for one year and above, more than three-fourths of those with one year above (78.6%) rated the quality as average. Less than one-fourth of them (21.4%) rated it as good. For participants diagnosed with cancer for two years, a vast majority of them (100.0%) rated the quality as average. A small portion of participants diagnosed with cancer for three years (12.5%) rated the quality as poor. Less than three-fourths of those diagnosed for three years (75.0%) found the quality to be average. A small portion of them (12.5%) rated it as good. For participants diagnosed with cancer for more than four years, more than half of those with more than four years of diagnosis (60.0%) rated the quality as average. More than one-third of those with more than four years of diagnosis (40.0%) rated it as good. A small portion of participants diagnosed with cancer for two years (3.6%) during their Diogenes's time rated the quality as poor. The majority of participants diagnosed with cancer (83.6%) rated it as average. Only a small portion of them (12.7%) rated the quality as good.

**Table No. 4.50**

Social support and Days of stay

| | | grouped social sum | | | |
|---|---|---|---|---|---|
| | days of stay | POOR | AVERAGE | GOOD | Total |
| | One month/ below | 0 | 32 | 2 | 34 |
| | | 0.0% | 94.1% | 5.9% | 100.0% |
| | Above two months | 1 | 8 | 2 | 11 |
| | | 9.1% | 72.7% | 18.2% | 100.0% |
| | Above six months | 0 | 2 | 2 | 4 |
| | | 0.0% | 50.0% | 50.0% | 100.0% |
| | Above twelve months | 1 | 4 | 1 | 6 |
| | | 16.7% | 66.7% | 16.7% | 100.0% |
| Total | | 2 | 46 | 7 | 55 |
| | | 3.6% | 83.6% | 12.7% | 100.0% |

The table shows how the quality of social support from the institution was rated by cancer patients based on how long they stayed there for treatment. Most of the 32 cancer patients who stayed for more than two months rated the support as average. A small number (2 patients, 5.9%) who stayed over two months rated it as good. A few (1 patient, 9.1%) who stayed over six months rated it as poor, while most (8 patients, 72.7%) rated it as average, and a few (2 patients, 18.2%) as good. Only one patient who stayed over twelve months (16.7%) rated the support as poor. Most (4 patients, 66.7%) who stayed over twelve months rated it as average, and one patient (16.7%) rated it as good. A couple of patients (2, 3.6%) who stayed generally rated the support as poor. The majority (46 patients, 83.6%) who stayed generally rated it as average. A small group (7 patients, 12.7%) who stayed generally rated it as good.

## Crosstabs between sum of economic support of the institution & other variables

**Table No. 4.51**

*Quality of economic support and Age*

| | GROUPED ECONOMIC SUM | | |
|---|---|---|---|
| age | AVERAGE | GOOD | Total |
| 30 above | 5 | 7 | 12 |
| | 41.7% | 58.3% | 100.0% |
| 40 above | 3 | 7 | 10 |

|  |  |  |  |  |
|---|---|---|---|---|
|  |  | 30.0% | 70.0% | 100.0% |
|  | 50 above | 8 | 10 | 18 |
|  |  | 44.4% | 55.6% | 100.0% |
|  | 60 above | 3 | 7 | 10 |
|  |  | 30.0% | 70.0% | 100.0% |
|  | 70 above | 2 | 3 | 5 |
|  |  | 40.0% | 60.0% | 100.0% |
| Total |  | 21 | 34 | 55 |
|  |  | 38.2% | 61.8% | 100.0% |

The table shows how cancer patients who stayed in the institution for different durations rated the quality of economic and social support they received. Among patients who stayed for 30 days or more, about 42% rated the economic support as average, while 58% rated the social support as good. For those who stayed for 40 days or more, 30% rated economic support as average, and a significant 70% rated social support as good. Similarly, for patients who stayed for 50 days or more, around 44% found economic support average, and 56% found social support good. Among patients staying 60 days or more, 30% saw economic support as average, and a significant 70% found social support good. For those who stayed for 70 days or more, 40% rated economic support as average, and 60% rated social support as good. Overall, 38% of patients who stayed in the institution for various durations rated economic support as average, while a significant 62% rated social support as good.

**Table No. 4.52**

*Quality of economic support and Gender*

|  |  | GROUPED ECONOMIC SUM |  |  |
|---|---|---|---|---|
| GENDER |  | AVERAGE | GOOD | Total |
|  | Male | 13 | 16 | 29 |
|  |  | 44.8% | 55.2% | 100.0% |
|  | Female | 8 | 18 | 26 |
|  |  | 30.8% | 69.2% | 100.0% |
| Total |  | 21 | 34 | 55 |
|  |  | 38.2% | 61.8% | 100.0% |

Among the 13 male participants who stayed at the institution for their treatment, less than half (44.8%) rated the quality of economic support as average. On the other hand, for the 16 male participants who stayed for treatment (55.2%), more than half rated the quality of social support as good. Similarly, among the 8 female participants who stayed at the institution for their treatment, more than one fourth (30.8%) rated the quality of economic support as average. In contrast, a significant number of the 18 female participants who stayed for treatment (69.2%) rated the quality of social support as good.

**Table No. 4.53**

*Quality of economic support and Religion*

| RELIGION | | GROUPED ECONOMIC SUM | | |
|---|---|---|---|---|
| | | AVERAGE | GOOD | Total |
| | HINDU | 10 | 19 | 29 |
| | | 34.5% | 65.5% | 100.0% |
| | CHRISTIAN | 8 | 10 | 18 |
| | | 44.4% | 55.6% | 100.0% |
| | ISLAM | 3 | 5 | 8 |
| | | 37.5% | 62.5% | 100.0% |
| Total | | 21 | 34 | 55 |
| | | 38.2% | 61.8% | 100.0% |

Among Hindu participants, 34.5% found the quality of economic support to be average, while a significant 65.5% rated it as good. For Christian participants, 44.4% perceived the economic support as average, and a majority of 55.6% considered it good. Among the ISLAM participants, 37.5% felt the economic support was average, while a significant 62.5% rated it as good. In the case of social support, 38.9% of Christian participants found it to be average, and a significant 61.1% rated it as good. Overall, when considering all cancer participants from the three religions, 38.2% saw the economic support as average, while a notable 61.8% rated it as good.

**Table No. 4.54**

*Quality of economic support and Marital status*

| | | GROUPED ECONOMIC SUM | | |
|---|---|---|---|---|
| | Marital status | AVERAGE | GOOD | Total |
| | SINGLE | 0 | 2 | 2 |
| | | 0.0% | 100.0% | 100.0% |
| | MARRIED | 19 | 30 | 49 |
| | | 38.8% | 61.2% | 100.0% |
| | WIDOWED | 2 | 2 | 4 |
| | | 50.0% | 50.0% | 100.0% |
| Total | | 21 | 34 | 55 |
| | | 38.2% | 61.8% | 100.0% |

The majority of the two single participants (4.5%) rated the quality of economic support as good. Among the 19 married participants, more than one-third (38.8%) rated the quality of economic support as average, and a significant 61.2% of the 30 married participants rated it as good. For the two widow participants, half (50.0%) rated the quality of economic support as average, while the other half (50.0%) rated it as good.

**Table No. 4.55**

*Quality of economic support and Education qualification*

| Qualification | Educational | GROUPED ECONOMIC SUM | | |
|---|---|---|---|---|
| | | AVERAGE | GOOD | Total |
| | ILLITERATE | 1 | 4 | 5 |
| | | 20.0% | 80.0% | 100.0% |
| | SCHOOL LEVEL | 18 | 27 | 45 |
| | | 40.0% | 60.0% | 100.0% |
| | COLLEGE LEVEL | 2 | 3 | 5 |
| | | 40.0% | 60.0% | 100.0% |
| Total | | 21 | 34 | 55 |
| | | 38.2% | 61.8% | 100.0% |

Less than one fourth (20.0%) of participants who were illiterate rated the quality of economic support as average, while more than three fourths (80.0%) of participants with 4 years of education rated it as good. More than one third (40.0%) of participants with a school-level education rated the quality of economic support as average, and more than half (60.0%) of participants with 18 years of education at the school level rated it as good. Similarly, more than one third (40.0%) of participants with a college-level education rated the quality of economic support as average, and more than half (60.0%) of participants with 2 or 3 years of college education rated it as good.

**Table No. 4.56**

*Quality of economic support and Types of cancer*

| | GROUPED ECONOMIC SUM | | |
|---|---|---|---|
| Types of cancer | AVERAGE | GOOD | Total |
| BLOOD CANCER | 2 | 5 | 7 |
| | 28.6% | 71.4% | 100.0% |
| BORN CANCER | 0 | 2 | 2 |
| | 0.0% | 100.0% | 100.0% |
| BREAST CANCER | 2 | 2 | 4 |
| | 50.0% | 50.0% | 100.0% |
| LUNG CANCER | 1 | 0 | 1 |

| | | | |
|---|---|---|---|
| | 100.0% | 0.0% | 100.0% |
| COLORECTAL CANCER | 6 | 8 | 14 |
| | 42.9% | 57.1% | 100.0% |
| ORAL CANCER | 8 | 16 | 24 |
| | 33.3% | 66.7% | 100.0% |
| PROSTATE CANCER | 1 | 0 | 1 |
| | 100.0% | 0.0% | 100.0% |
| OVARIAN CANCER | 1 | 1 | 2 |
| | 50.0% | 50.0% | 100.0% |
| Total | 21 | 34 | 55 |
| | 38.2% | 61.8% | 100.0% |

In the survey, participants with different types of cancer provided feedback on the quality of economic and social support they received. For participants with blood cancer, around one-fourth (28.6%) rated the economic support as average, while the majority (71.4%) rated it as good. All participants with born cancer rated the economic support as good. Among those with breast cancer, half (50.0%) found the economic support to be average, and the other half (50.0%) rated it as good. For participants with lung cancer, everyone (100.0%) rated the economic support as average. In the case of colorectal cancer participants, less than half (42.9%) considered the economic support as average, while more than half (57.1%) rated it as good. Moving to oral cancer, less than one-third (33.3%) thought the economic support was average, with a significant majority (66.7%) rating it as good. Similarly, for prostate cancer, everyone (100.0%) rated the economic support as average. In ovarian cancer, half of the participants (50.0%) rated both the economic and social support as average. Looking at the entire participant group, more than one-third (38.2%) found the social support to be average, and the majority (61.8%) rated it as good.

**Table No. 4.57**

*Quality of economic support and Treatments*

| | GROUPED ECONOMIC SUM | | |
|---|---|---|---|
| Treatments | AVERAGE | GOOD | Total |
| CHEMO THERAPY | 3 | 7 | 10 |
| | 30.0% | 70.0% | 100.0% |
| RADIOTHERAPY | 2 | 2 | 4 |
| | 50.0% | 50.0% | 100.0% |
| SURGERY, CHEMO, RADIATION | 10 | 12 | 22 |
| | 45.5% | 54.5% | 100.0% |

| | | | | |
|---|---|---|---|---|
| | SURGERY & CHEMO | 0 | 4 | 4 |
| | | 0.0% | 100.0% | 100.0% |
| | CHEMO & RADIOTHERAPY | 4 | 3 | 7 |
| | | 57.1% | 42.9% | 100.0% |
| | CHEMO, RADIOTHERAPY & PALLIATIVE CARE | 2 | 6 | 8 |
| | | 25.0% | 75.0% | 100.0% |
| Total | | 21 | 34 | 55 |
| | | 38.2% | 61.8% | 100.0% |

In the participant group receiving three chemotherapy sessions, 30.0% found the economic support quality to be average, while 70.0% rated it as good. For those who underwent two sessions of radiotherapy, 50.0% found the support to be average, and the other 50.0% rated it as good. In the case of participants who had surgery, chemotherapy, and radiation (10 individuals), 45.5% rated the economic support as average, while 54.5% rated it as good. Among those who received four sessions of chemotherapy and radiotherapy, 57.1% considered the support quality average, and 42.9% rated it as good. In the group undergoing chemotherapy, radiotherapy, and palliative care (2 individuals), 25.0% found the social support quality to be average, while 75.0% rated it as good. Additionally, 38.2% of the 21 cancer participants rated social support as average, and 61.8% of the 34 participants found the quality of social support to be good.

**Table No. 4.58**

*Quality of economic support and Duration since the cancer diagnosis*

| | GROUPED ECONOMIC SUM | | |
|---|---|---|---|
| Diogene’s time | AVERAGE | GOOD | Total |
| Less than a year | 12 | 14 | 26 |
| | 46.2% | 53.8% | 100.0% |
| One year above | 2 | 12 | 14 |
| | 14.3% | 85.7% | 100.0% |
| Two years. | 1 | 1 | 2 |
| | 50.0% | 50.0% | 100.0% |
| Three years. | 3 | 5 | 8 |
| | 37.5% | 62.5% | 100.0% |
| More than four years. | 3 | 2 | 5 |
| | 60.0% | 40.0% | 100.0% |
| Total | 21 | 34 | 55 |
| | 38.2% | 61.8% | 100.0% |

Among the cancer participants who had been dealing with the condition for less than a year, 46.2% found the support quality to be average, while 53.8% rated it as good. For those who had experienced cancer for more than a year but less than two years (14.3% of 2 participants), 14.3% rated the support as average and 85.7% considered it good. Among participants dealing with cancer for exactly two years (1 individual), 50.0% rated the support as average and the other 50.0% rated it as good. In the case of participants facing cancer for three years (3 individuals), 37.5% found the support quality to be average, while 62.5% rated it as good. Among those enduring cancer for more than four years (3 participants), 60.0% considered the support quality average, and 40.0% rated it as good. Additionally, 38.2% of the 21 cancer participants rated the support as average, and 61.8% of the 34 participants found the quality of economic support to be good.

## 4.7 CONCLUSION

Each of these variables contributes to a holistic approach to patient care, recognizing that cancer affects not only the physical body but also various aspects of patients' lives. By addressing these aspects, the institution aims to provide a comprehensive support system that empowers patients to navigate the challenges of cancer while maintaining a good quality of life. This multifaceted approach acknowledges the diverse needs and experiences of patients, promoting a sense of community, empowerment, and emotional well-being.

# CHAPTER V: DISCUSSIONS

# CHAPTER V

# DISCUSSIONS

## 5.1 INTRODUCTION

This Chapter delves into the socio-demographic overview of the research participants, the institution’s social support services; the facilities availed by cancer patients at the institution, and the economic support provided by the institution. The socio-demographic analysis highlighted the participants’ age distribution, gender representation, marital status, religion, education, occupation, and economic status. It also showcased the prevalence of different types of cancers within the sample and the impact of cancer on participants’ families. The institution’s social support services, the data emphasized the significance of spiritual support, peer mentoring, patient interaction, educational assistance, support groups, counselling services, and structured activities in aiding patients’ emotional and psychological well-being. The positive impact of these services on patients’ overall recovery journey was evident, with high levels of satisfaction reported. The facilities availed by the patients at the institution, covering aspects such as accommodation options, pharmacy access, food services, prayer and meditation spaces, transportation services, recreational facilities, and accessibility features. The economic support provided by the institution was a significant focus, showcasing how the institution’s financial assistance, collaboration with government schemes, provision of accommodation and food services, and addressing patients’ suggestions contributed to easing the economic burden of cancer treatment. Participants’ satisfaction with economic support services was also explored.

## 5.2 TO UNDERSTAND THE SOCIO-DEMOCRATIC PROFILE OF THE RESPONDENTS

The objective was to understand a comprehensive socio-demographic overview of the participants involved in a research study. The data is presented through a series of figures and tables, each shedding light on different aspects of the participants’ characteristics and backgrounds. These socio-demographic factors can play a crucial role in shaping the context of the study and influencing its outcomes.

The largest proportion of participants falls within the age range of 50 to 59, constituting 32.7% of the total sample. This suggests that a significant portion of the participants belong to middle adulthood. The next prominent age category is 30 to 39, accounting for 21.8% of the sample. It's notable that there were no respondents above the age of 80, indicating the absence of participants aged 80 or older in the study. This age distribution reflects the maturity of the sample and highlights the dominance of individuals in their 50s. The data shows that more than half (52.73%) of the participants are male, while less than half (47.27%) are female. This gender skew suggests a higher representation of male participants in the study, potentially indicating a higher prevalence of cancer among males compared to females. The majority of participants (89.09%) are married, indicating a significant portion of individuals with spouses. A smaller proportion (7.27%) is widowed, and even smaller percentages (3.64%) are single, suggesting a limited number of unmarried participants.

The majority of participants (52.73%) belong to the Hindu religion, followed by Christian participants (32.73%). Participants identifying as Muslims make up a smaller portion (14.55%) of the sample. This highlights a higher representation of Hindu participants and a lower representation of Christian and Islamic participants in the study. The majority of participants (81.82%) have received a school-level education, suggesting that most have completed primary and secondary education. Small portions (9.09%) are illiterate, particularly among participants from Kerala. Another 9.09% have attained a college-level education, indicating a smaller number of individuals with higher education.

The majority (29.1%) are housewives, followed by those who are part-time employed (25.5%) and full-time employed (12.7%). This reflects diverse occupational statuses among participants. The majority (58.2%) possess a pink/BPL (Below Poverty Line) ration card, indicating a significant proportion of participants with lower economic status. The majority (76.4%) have a yearly household income above 50,000, suggesting a diverse income range within the sample.

Oral cancer has the highest prevalence (43.6%), followed by colorectal cancer (25.5%), breast cancer (7.3%), and others. This distribution showcases the prevalence of oral and colorectal cancer in the sample. A significant proportion (80%) of the families has experienced a cancer diagnosis, implying a substantial impact of cancer within participants’ families. Less than half (41.82%) have received all three major treatments (surgery, chemotherapy, radiation), indicating varying treatment approaches among participants. A significant proportion (47.27%) has been diagnosed within the past year, indicating a relatively high number of recent diagnoses. A considerable portion (58.2%) relies on their partners/spouses for caregiving, and 25% have their children as caregivers. This highlights the importance of close family members in caregiving roles. The majority (83.64%) received treatment from government hospitals, emphasizing the prevalence of accessing cancer care from public healthcare institutions.

## 5.3 TO COMPREHEND THE INSTITUTION’S SOCIAL SUPPORT RECEIVED BY THE PATIENTS AND THEIR BYSTANDERS.

The data says that, the institution’s involvement plays a pivotal role in dealing with the social dimensions of individuals with cancer. A large majority (74.5%) of participants received meaningful spiritual support during their treatment, underlining its importance. Spiritual assistance is especially valuable for those who find strength, comfort, and hope in their spiritual beliefs. More than half (60.0%) of the respondents encountered a positive environment of peer mentoring, offering shared experiences and emotional aid. A significant majority (87.3%) affirmed the institution’s success in encouraging patient interaction, facilitating sharing of experiences and insights. Interaction among patients imparts knowledge about treatment options, side effects, and coping mechanisms. These exchanges combat loneliness and help patients build a network of empathetic peers. Peer mentoring fosters solidarity, empowerment, and mutual growth among patients. A significant proportion (70.9%) indicated a lack of educational support, signifying a need to address the educational needs of patients’ children. Offering educational assistance underscores the institution’s commitment to the holistic well-being of families. Over half (54.5%) had access to beneficial support groups, providing structured outlets for emotional sharing and coping strategies. Patients gain comfort from realizing they aren’t alone in their journey and acquire valuable insights for effective coping.

A notable majority (67.3%) received counselling services, helping navigate the intricate emotional landscape of cancer diagnosis and treatment. Professional guidance aids in managing anxiety, depression, and psychological distress. Counselling equips patients with tools for coping, amplifying emotional well-being and the overall treatment experience. A majority (65.5%) reaped benefits from structured activities like art therapy and support groups, easing mental stress. Engaging activities beyond medical treatments enhance holistic well-being and overall life quality.

A vast majority (96.4%) expressed confidence in the institution's potential to enhance its social support services. This positive outlook nurtures hope and trust, emphasizing a collaborative partnership between patients and the institution. Ratings for communication varied: 41.8% rated it as good, 32.7% as excellent, 21.8% as average, and 3.6% as poor. Effective communication aids in understanding treatment procedures, appointments, and updates, curbing anxiety. Transparent information sharing establishes trust among patients, caregivers, and the institution. Nearly all participants (96.4%) felt the institution provided substantial emotional and psychological backing. Patients feel heard, validated, and equipped to manage emotional challenges. Emotional support significantly contributes to mental well-being and overall recovery. A majority (47.3%) acknowledged the institution's commendable efforts in addressing social and emotional needs. A majority (65.5%) reaped benefits from structured activities like art therapy and support groups, easing mental stress. Engaging activities beyond medical treatments enhance holistic well-being and overall life quality. While 60.0% faced minimal healthcare accessibility challenges, 40.0% encountered hurdles that necessitate rectification. A little over half (52.7%) perceived existing support systems to tackle employment-related obstacles. These systems assist in navigating work-related difficulties, augmenting self-esteem and life quality during and after treatment. Satisfaction levels with addressing needs were diverse: 36.4% highly satisfied, 43.6% satisfied, 10.9% moderately satisfied, and 3.6% dissatisfied. High satisfaction indicates a thoughtful alignment with patients' needs, nurturing positive treatment experiences. Such contentment solidifies the institution's favourable reputation within the patient community.

The institution's comprehensive approach significantly enhances the social aspects of patients with cancer, encompassing emotional, psychological, spiritual, and practical needs. These initiatives foster a nurturing environment that elevates patients' overall well-being and quality of life during their cancer journey.

## 5.4 TO UNDERSTAND THE FACILITIES AVAILED BY THE CANCER PATIENTS AT THE INSTITUTION

The data shows that variety of accommodation options was available, including dormitories, cubicles, and shared rooms, single rooms with and without toilets. The majority of participants (61.8%) stayed in the institution for one month, likely for initial diagnosis, treatment initiation, or early stages of treatment. Fewer participants stayed for more extended periods, indicating more complex or prolonged treatment requirements. Different types of accommodation were provided. The most common was a single room with a toilet system (47.3%), followed by a cubicle system (25.5%). Dormitory and shared room options were less common. A significant proportion of participants (83.6%) reported that the institution did not provide free accommodation services, adding to the financial burden of their treatment. Over half of the participants (52.7%) had good satisfaction with room facilities, while about one-third (34.5%) expressed excellent satisfaction. A vast majority (94.5%) believed that free accommodation positively impacted economic, social, and psychological well-being during treatment.

Most participants (96.4%) reported no pharmacy within the institution, potentially affecting medication access. The majority (90.9%) had provisions for medication storage, indicating good accessibility to necessary items. Almost all participants (98.2%) had access to cafeteria or food services within the institution. A significant majority (94.5%) received free food services, easing financial burdens during treatment. The majority rated food service satisfaction as good (36.4%) or excellent (49.1%). A substantial portion also reported receiving free food services, contributing to the financial ease of patients. Overall, participants were highly satisfied with the food services available at the institution.

The majority (90.9%) had access to designated spaces for prayer and meditation. While less common, some participants (41.8%) reported availability of ambulance services for cancer patients. A smaller proportion (20.0%) had access to free ambulance services. The majority (63.6%) reported provisions for transportation services for patients and bystanders. About half (49.1%) had free transportation services available.

The majority (96.4%) reported availability of recreational facilities.  Less than half (47.3%) had access to financial assistance services. Most participants (61.8%) reported wheelchair-accessible entrances, lifts, and ramps. Satisfaction with accessibility was generally high. Adequate staff for guidance was reported by most participants (90.9%), with good satisfaction ratings (36.4%).Waiting areas and restroom facilities were generally rated as comfortable, well-equipped, and clean. This suggests the institution is paying attention to hygiene. A little over half (54.5%) reported designated car parking spaces. The majority (89.1%) had designated rest areas for patients and bystanders. Patients and their families need comfortable spaces to relax. Most participants (43.6%) rated overall facilities as excellent, indicating a positive experience. This indicates that the institution is well-prepared to cater to patients' needs. Satisfaction with accessibility features was generally good, with 32.7% rating it as excellent. This shows the institution is making a significant positive impact. Most participants (34.5%) rated the quality of social support as excellent. Emotional support is crucial during such times.

The data collectively highlights the institution's efforts to provide a range of services and facilities to mitigate socio-economic challenges for cancer patients and their bystanders. While there were areas for improvement, such as accessibility and financial assistance, could be improved, the majority of responses indicate a positive impact on patients' well-being during their treatment journey.

## 5.5 TO STUDY THE ECONOMIC SUPPORT PROVIDED BY INSTITUTIONS FOR CANCER PATIENTS'

The data reveals that a significant percentage of participants reported monthly treatment costs above a certain threshold. A noteworthy observation is that more than three-fourths of the participants reported monthly treatment costs above 50,000. Similarly, a majority of participants received free accommodation and food services during their treatment period. This indicates that the institution recognizes the financial burden that cancer treatment can impose on patients and seeks to alleviate it by providing free accommodation and food services.

A substantial number of participants reported that their financial situation was not significantly impacted by the cancer diagnosis. This could be due to the availability of financial assistance and support services provided by the institution, which likely helped mitigate the economic strain caused by cancer-related expenses.

More than half of the participants reported receiving financial assistance from the institution to alleviate the financial strain caused by cancer-related expenses. This suggests that the institution recognizes the importance of providing financial aid to patients and is actively working to support them in managing the economic challenges associated with their treatment.

The data indicates that various types of financial assistance were provided by the institution to help cancer patients. These include assistance with medical expenses, insurance coverage, medication costs, food and accommodation support, travel support, education support for children, and more. This comprehensive approach to financial aid underscores the institution's commitment to addressing the multifaceted economic challenges that patients face.

A notable percentage of participants expressed satisfaction with the economic support provided by the institution. While there were some respondents who reported being dissatisfied or neutral, the majority indicated at least a moderate level of satisfaction. This suggests that the institution's efforts to provide economic support have been appreciated by a significant portion of the patients.

The data indicates that a substantial number of participants are aware of government financial aid programs available for cancer patients. Additionally, a significant percentage of participants reported receiving financial support from government schemes such as the Chief Minister's Distress Relief Fund (CMDRF), Karunya Benevolent Fund, and Pradhan Mantri Jan Arogya Yojana (PMJAY). This highlights the collaborative effort between the institution and government initiatives to provide economic relief to cancer patients.

The data reveals that while a majority of participants do not have insurance coverage, having insurance doe's impact patients' access to healthcare services. This suggests that insurance coverage plays a role in facilitating access to medical care, which can be crucial for cancer patients. The findings indicate that for a significant proportion of participants, economic factors did not have a significant effect on their decision-making when seeking medical care. This could imply that the institution's efforts to provide financial assistance and support are helping patients prioritize their health needs over economic considerations.

A notable percentage of participants reported that their families have accrued significant debt due to cancer treatment expenses. This underscores the financial strain that cancer treatment can place on patients and their families. The majority of participants expressed a perceived need for additional economic support from the institution. Their suggestions ranged from accessing government schemes to providing interest-free loans, demonstrating the varied ways in which the institution could further assist patients. The institution has taken proactive measures to address the economic challenges faced by cancer patients. These measures include providing financial assistance, collaborating with government programs, offering free accommodation and food services, and considering patients' suggestions for additional support. The data underscores the institution's commitment to holistic care that encompasses not only medical treatment but also economic well-being, ultimately contributing to an improved treatment experience for cancer patients.

## 5.6 TO SUGGEST SOCIAL WORK INTERVENTIONS FOR THE WELL-BEING OF CANCER PATIENTS THROUGH INSTITUTIONAL CARE

Here are some social work interventions that could contribute to the well-being of cancer patients through institutional care.

- Provide opportunities for counselling or guidance for patients who desire it.
- Ensure that professional counsellors are available to address the emotional and psychological needs of patients and their families.
- Offer individual and group counselling sessions to help patients cope with the emotional challenges of cancer diagnosis and treatment.
- Organize support groups or sessions that focus on finding spiritual meaning and coping strategies during illness.
- Develop formal mentoring programs where cancer survivors or experienced patients can provide guidance and support to newly diagnosed patients.

- Create peer-led support groups to foster a sense of community and shared experiences among patients.
- Collaborate with educational institutions to ensure that patients’ children receive appropriate educational support during their treatment period.
- Offer information and resources for patients and families to navigate treatment challenges that may arise due to the illness.
- Increase the availability of support groups that cater to different types of cancer, stages of treatment, and emotional needs.
- Provide both in-person and virtual support group options to accommodate diverse preferences and circumstances.
- Create spaces within the institution where patients can interact and connect with each other in informal settings.
- Organize social events, workshops, and recreational activities to encourage positive interactions among patients.
- Develop a diverse range of organized activities, such as art therapy, exercise programs, and wellness workshops, to promote mental well-being.
- Establish clear and efficient communication channels to provide patients and caregivers with accurate information about treatment procedures, appointments, and updates.
- Ensure that information is accessible and understandable, taking into consideration patients’ varying levels of health literacy.
- Regularly assess and evaluate the effectiveness of the institution’s efforts in meeting the social and emotional needs of patients.
- Collaborate with mental health professionals to develop and implement strategies for continuous improvement.
- Identify and address barriers that patients face in accessing healthcare and support services, such as financial constraints, transportation issues, or language barriers.
- Provide assistance or resources to overcome these challenges, ensuring equitable access to care.
- Continuously gather feedback from patients and their families to evaluate their satisfaction with the institution’s efforts. Use feedback to make informed changes and improvements in the delivery of social support services.

- Create recreational and leisure programs that offer patients and their families opportunities to engage in enjoyable activities, fostering a sense of normalcy and providing distractions from the challenges of treatment.
- Arrange nutrition and cooking classes tailored to the dietary needs of cancer patients. This empowers patients to make healthy food choices and prepares them for managing their nutritional needs post-treatment.
- Provide training for staff members to enhance their understanding of the unique challenges faced by cancer patients and their caregivers, enabling them to provide more empathetic and effective care.
- Implement holistic well-being programs that focus on the mind-body connection, incorporating practices like yoga, meditation, and mindfulness to reduce stress and anxiety.
- Social workers can work with patients to ensure they have appropriate health insurance coverage. They can guide patients through the process of selecting insurance plans that adequately cover cancer treatment costs and assist them in understanding policy details.
- Collaborate with government agencies to ensure that eligible patients are aware of and have access to various financial aid programs. Social workers can facilitate the application process and provide necessary documentation to avail benefits.
- Establish partnerships with hospitals and cancer treatment centres to negotiate reduced accommodation and food costs for patients. Social workers can ensure that patients have access to free or affordable accommodation and nutritious food during their treatment.
- Offer emotional and psychological support to patients and families dealing with the stress of financial burden. Social workers can provide counselling, support groups, and coping strategies to manage the emotional impact of financial challenges.
- Develop a comprehensive resource guide that lists local NGOs, charitable organizations, and community initiatives that offer financial assistance, food support, and other services to cancer patients.
- Collaborate with advocacy groups to influence policy changes that could reduce the economic burden on cancer patients. This could involve advocating for increased government funding, insurance coverage improvements, and enhanced support for cancer patients.

- Organize workshops to empower patients with financial literacy skills, such as understanding medical bills, insurance claims, and negotiating medical expenses.
- Establish a system of regular follow-ups with patients to assess their on-going financial needs and provide assistance as required.
- Remember that each patient’s situation is unique, so social workers should approach each case with sensitivity and adapt interventions to meet individual needs. Additionally, continuous collaboration with healthcare professionals, financial experts, and government agencies is essential to ensure comprehensive support for cancer patients.

## 5.7 CONCLUSION

The chapter concluded by underscoring the pivotal role institutions play in supporting cancer patients, both socially and economically. The comprehensive approach taken by the institution positively impacted patients’ well-being, quality of life, and overall treatment experience. The analysis highlighted the importance of holistic care that extends beyond medical treatment, acknowledging the challenges patients face and offering a supportive environment throughout their cancer journey.

# CHAPTER VI: FINDINGS, SUGGESTIONS, AND CONCLUSION

# CHAPTER VI

# FINDINGS, SUGGESTIONS, DISCUSSION AND CONCLUSION

## 6.1 INTRODUCTION

The primary objective of this study was to assess how institutional intervention influences the resolution of socio-economic obstacles encountered by cancer patients undergoing treatment cancer care homes. This chapter seeks to concisely outline the key discoveries of the study. Additionally, it aims to present suggestions, recommendations, and implications based on these findings, while also delivering an overarching summary of the entire research endeavor.

## 6.2 FINDINGS

- The majority of respondents (32.7%) fell within the age range of 50 to 59, indicating that this age group was the largest represented in the study. The next significant age category was 30 to 39, making up 21.8% of the sample.
- More participants were identified as male (52.73%) compared to female (47.27%). This suggests a higher prevalence of male participants in the study and potentially indicates a higher rate of cancer among males.
- The majority of participants were Hindu (52.73%), followed by Christian (32.73%) and Muslim (14.55%).
- Most participants were married (89.09%).
- Oral cancer was the most prevalent type (43.6%), followed by colorectal cancer (25.5%).
- The majority (80%) of respondents’ families had experienced a cancer diagnosis, indicating a significant impact of cancer within their families.
- 41.82% received all three major treatments (surgery, chemotherapy, radiation). Various combinations of treatments were reported, with 1.82% receiving all three and palliative care.
- The majority (58.2%) had their partner/spouse as the primary caregiver, while children (25%) and siblings (5.5%) were also common caregivers.
- Most participants (83.64%) received treatment from government hospitals, with a minority (16.36%) seeking care from private and government hospitals.

- The majority of the participants were housewives (29.1%), followed by part-time employed (25.5%), full-time employed (12.7%), daily wage laborers (14.5%), farmers (7.3%).
- The majority (58.2%) had a pink/BPL (Below Poverty Line) ration card.
- The majority of participants (81.82%) had completed only a school-level education.
- Most participants (76.4%) reported a yearly household income above 50,000.
- A significant majority of participants (74.5%) reported receiving adequate spiritual support during their treatment. This indicates that the institution has recognized the importance of catering to the spiritual needs of patients.
- On the other hand, a minority (25.5%) felt that the institution lacked in providing sufficient spiritual support. This highlights a potential area for improvement in addressing the diverse spiritual preferences and needs of patients.
- More than half of the participants (60.0%) experienced a positive atmosphere of peer mentoring. This suggests that the institution has successfully fostered an environment where patients can share their experiences and support each other.
- However, 40.0% of participants reported a lack of peer support. This indicates that there is room for enhancing the establishment of peer connections, which can contribute to patients' emotional well-being.
- A significant majority (70.9%) of participants felt that the institution lacked in offering educational support. This might reflect a potential gap in addressing the educational needs of patients, particularly those with children. This finding underscores the importance of not only providing medical care but also considering the educational well-being of patients and their families.
- Over half of the participants (54.5%) had access to beneficial support groups, indicating that the institution has recognized the value of creating structured outlets for emotional sharing and coping strategies.
- However, 45.5% of participants did not receive support through such groups. This suggests the need for expanding support group availability to further cater to patients' emotional needs.
- A considerable majority (67.3%) of participants received counseling services. This signifies the institution's commitment to addressing the intricate emotional landscape that accompanies cancer diagnosis and treatment.

- Nevertheless, 32.7% of participants missed out on this valuable support. This finding highlights the potential for enhancing access to counseling services for a more comprehensive patient experience.
- The data showed that a substantial proportion (87.3%) of participants felt that the institution promoted interaction between patients. This emphasizes the institution’s success in creating an environment where patients can share experiences and insights.
- A majority (65.5%) of participants benefited from organized activities, which indicates that these activities are positively contributing to patients’ mental well-being and overall treatment experience.
- However, 34.5% did not have access to such programs, suggesting that there is room for improvement in expanding the availability of these activities to a broader range of patients.
- The majority (96.4%) of participants believed that the institution had the potential to improve its social support services. This positive outlook indicates a collaborative partnership between patients and the institution, with room for growth and enhancement.
- Ratings for communication varied, with 41.8% rating it as good, 32.7% as excellent, 21.8% as average, and 3.6% as poor. Effective communication is crucial for patient understanding and reducing anxiety.
- Nearly all participants (96.4%) felt that the institution provided adequate emotional and psychological support. This underscores the importance of emotional well-being in the overall recovery process.
- The 60.0% of participants did not face significant challenges in accessing healthcare. This indicates a relatively positive healthcare accessibility experience for the majority of patients.
- However, 40.0% encountered obstacles, suggesting potential areas for improvement in ensuring seamless access to medical services. The institution can make improvements
- Over half of the participants (52.7%) believed that the institution offered support systems, which suggests the institution’s commitment to helping patients navigate challenges related to employment and other factors.
- On the contrary, 47.3% thought otherwise, indicating that there might be a perception gap in the effectiveness of the support systems provided.

- The majority (47.3%) of participants acknowledged the institution's efforts to address social and emotional needs, and 32.7% found these efforts excellent. This indicates that the institution is making strides in catering to patients' holistic well-being.
- The majority of participants stayed in the institution for one month, suggesting that a significant portion of patients had relatively short stays, likely for initial diagnosis, treatment initiation, or early stages of treatment.

- The majority of participants stayed in the institution for one month, suggesting that a significant portion of patients had relatively short stays, likely for initial diagnosis, treatment initiation, or early stages of treatment.

- The institution provided a range of accommodation types, including dormitory, cubicle, shared room, and single rooms with or without toilets. This variety of options caters to different preferences and needs.
- The availability of free accommodation was perceived to have a positive impact on participants' overall well-being, including economic, social, and psychological aspects. This underscores the importance of such support in alleviating the financial and emotional burdens of cancer treatment.
- A significant proportion of participants expressed good and excellent satisfaction with the room facilities, suggesting that the institution's efforts to provide comfortable and satisfactory accommodations were generally well-received.
- The majority of participants reported the absence of an on-site pharmacy within the institution. This finding points to potential challenges patients might face in accessing medication conveniently.
- The institution's provision of medication storage facilities was well-received, as most participants reported having access to such facilities. This likely contributed to easier management of their treatment regimens.
- The availability of cafeteria and food services within the institution was highly prevalent, indicating that patients and caregivers were well-catered for in terms of meals and sustenance during their stay.
- The majority of participants reported receiving complimentary cafeteria or food services, highlighting the institution's efforts to ease the financial burden associated with meals during treatment.

- A considerable percentage of participants expressed high levels of satisfaction with food services, suggesting that the quality and availability of meals were generally well-regarded.
- The institution’s provision of dedicated spaces for prayer and meditation was positively received by the majority of participants, indicating the importance of such areas for emotional and spiritual well-being.
- While a portion of participants reported the availability of ambulance services, a majority did not have access to this transportation option, which could potentially impact the convenience of traveling to and from the institution. A significant proportion of participants indicated that ambulance services were not entirely free, underlining potential financial considerations for transportation during treatment.
- The availability of transportation services was reported by a majority of participants, suggesting that the institution recognized and catered to the travel needs of patients and caregivers. A substantial percentage of participants reported access to free transportation services, which likely contributed positively to their overall experience.
- The high prevalence of access to recreational facilities indicates that the institution acknowledged the importance of providing opportunities for leisure and relaxation during treatment.
- A significant percentage of participants reported the absence of financial assistance services, highlighting potential gaps in providing support for patients facing financial challenges.
- The provision of wheelchair-accessible features was well-received by the majority of participants, indicating efforts to ensure a comfortable environment for individuals with mobility challenges.
- Participants generally felt that there was sufficient staff available to guide and support them, indicating that the institution recognized the importance of assistance for patients and caregivers.
- High levels of satisfaction were reported regarding staff services, with a considerable percentage expressing excellent satisfaction.
- The vast majority of participants found waiting areas to be comfortable and well-equipped, contributing positively to their overall experience.
- The institution’s provision of separate kitchen facilities was well-received by most participants, enhancing their ability to meet dietary needs and preferences. The majority

of participants reported high levels of satisfaction with the cleanliness and maintenance of kitchen facilities.

- 100% of participants confirmed the presence of clean restroom facilities, and the majority expressed satisfaction with the cleanliness and maintenance of these facilities.
- The availability of designated rest areas was widely appreciated by participants, enhancing their comfort during their time at the institution.
- A significant proportion of participants planned to stay for one month, indicating that the institution’s services were aligned with the anticipated duration of their treatment.
- A substantial percentage (47.3%) of participants expressed high levels of satisfaction with the overall facilities provided by the institution.
- A notable percentage of participants reported excellent satisfaction with the institution’s accessibility features, suggesting that efforts in this regard were well-received.
- A considerable proportion (43.6%) of participants expressed high levels of satisfaction with the quality of social support provided by the institution, highlighting its positive impact on their experience.
- The majority (80.00%) of participants reported spending more than 50,000 per month on their cancer treatment. This highlights that a significant portion of the respondents is dealing with substantial financial commitments to manage their treatment.
- The majority of participants (81.82%) reported receiving free accommodation during their treatment, indicating that a significant proportion of respondents are being provided accommodation without extra financial burden.
- Less than half (49.09%) of the participants reported receiving free food service during treatment, highlighting that a substantial proportion of respondents are benefiting from food services without incurring extra costs.
- More than half (43.6%) of participants reported no significant impact on their financial situation due to the cancer diagnosis. This shows that a substantial portion of respondents managed to navigate the diagnosis without a substantial financial setback. Almost an equal percentage (45.5%) reported no impact at all on their financial situation, highlighting that a considerable number of individuals did not experience any financial disruption due to their cancer diagnosis.

## 6.3 SUGGESTIONS

- Expanding peer support initiatives could benefit the 40% of participants who did not experience such support, further promoting emotional well-being and information sharing among patients.
- To cater to the 32.7% of participants who missed out on counseling, the institution could consider offering more accessible counseling services.
- To address the 45.5% of participants who did not receive support through groups, the institution could expand the availability of support groups, ensuring broader access to emotional support.
- Recognizing the overall positive sentiment regarding emotional and psychological support, the institution could continue developing comprehensive holistic support initiatives for patients.
- Considering the 40% of participants who faced challenges in accessing healthcare, the institution could work to eliminate obstacles and ensure smoother access to medical services.
- Given the majority's belief that the institution could improve its social support services, the institution should actively seek patient feedback and engage in continuous improvement efforts.
- Addressing the challenges related to transportation services, the institution could explore options for improving the accessibility and affordability of transportation for patients.
- To fill the gap in financial assistance services, the institution could establish dedicated resources to help patients navigate financial challenges effectively.
- Based on the feedback about staff availability and assistance, the institution could continue providing personalized and empathetic patient support.
- Given the importance of comfortable waiting areas, the institution could consider further improvements to waiting spaces to enhance patients' comfort and experience.
- Maintaining the high standard of restroom facilities and cleanliness is essential, as this directly contributes to patient satisfaction and overall well-being.

- Since a significant proportion of participants planned to stay for a month, the institution could develop specialized programs to support patients during this period, focusing on their evolving needs.
- Acknowledging the positive sentiment regarding facilities, the institution should continue to maintain high standards to ensure patient comfort and satisfaction.
- Ensure the presence of trained social workers within the institution who can provide emotional support, offer guidance on available resources, and assist patients in navigating complex medical systems.
- Collaborate with financial advisors and organizations to provide information and assistance regarding financial support options, including grants, insurance claims, and government aid. This can help alleviate the financial burden associated with cancer treatment.

## 6.4 CONCLUSION

In the realm of healthcare, particularly in the context of cancer treatment, the significance of patient-centric facilities and services cannot be overstated. The data extracted from the various tables within this study echo this sentiment loud and clear. While the majority of participants reported positive experiences and a recognition of the institution's efforts, it's equally apparent that there remains an undeniable scope for improvement across certain domains. Financial support, accessibility concerns, and the expansion of specific services emerge as areas that warrant particular attention.

Looking at the larger canvas, the institution's endeavours to offer accommodations, amenities, and services that align with the unique needs of cancer patients and their caregivers have been met with a commendable degree of positivity. This, in turn, plays a vital role in shaping the overall well-being and journey of these individuals through their treatment processes.

Stepping into the specifics of the study's findings, it's evident that cancer patients encounter a diverse range of challenges that extend beyond the purely medical aspects of their condition. This research, then, delves into how these challenges are met head-on through a variety of provisions, interventions, and support mechanisms.

The research not only underscores the role of various facilities provided by care institutions but also emphasizes their significance in alleviating socio-economic challenges during the treatment phase. The gamut of offerings - spanning accommodations, transportation, food services, accessibility enhancements, and more - serves as a buffer against the financial and social strains that often accompany cancer treatment. Although a notable proportion of participants expressed satisfaction with these facilities, the findings unmistakably indicate areas ripe for enhancement. The expansion of free services, the enrichment of pharmacy and transportation options, and the targeted resolution of accessibility issues are but a few avenues for improvement. Ultimately, the provision of comprehensive and supportive facilities within care institutions exerts a positive impact on the well-being of both cancer patients and their companions as they navigate the intricate labyrinth of treatment.

The economic dimension of the study offers a stark reminder of the daunting financial hurdles that often accompany a cancer diagnosis. The revelations that a majority of participants reported considerable treatment costs and incurred debt highlight a significant challenge. Yet, there’s a silver lining in the form of the satisfaction expressed by many with the economic support rendered by institutions. The contribution of government schemes and health insurance in easing the weight of these financial burdens cannot be ignored. However, it’s equally evident that the economic landscape influences healthcare access and decision-making for a significant cross-section of respondents.

Perhaps the most resounding message is the evident call for additional economic support from institutions. The suggestions offered by participants span a wide spectrum, from facilitating access to government schemes to providing interest-free loans. This diversity of perspectives underscores the need for a comprehensive and adaptive approach that can address the unique economic needs of individual patients. Such an approach is essential in ensuring holistic and effective support for cancer patients, serving to enhance their well-being throughout the intricate dance of treatment.

In a broader sense, the conclusions drawn from this research underline the institution’s unwavering commitment to alleviating the socio-economic challenges faced by cancer patients. The data unequivocally supports the claim that the institution’s interventions are multi-faceted and profoundly impactful. By offering a spectrum of accommodations, economic assistance, transportation services, and recreational outlets, the institution is proactively addressing the myriad of socio-economic hurdles that accompany cancer treatment. The outcome is an elevated emotional well-being, an avenue for meaningful social interactions, and a lightened financial load for patients and their families.

Furthermore, this study offers a glimpse into the institutional philosophy of patient-centered care. The institution's willingness to step beyond the confines of medical treatment and embrace a more comprehensive approach speaks volumes about its dedication to the welfare of its patients. This is encapsulated in the institution's commitment to empower cancer patients to focus solely on their recovery, without the looming spectre of financial duress and social isolation.

In essence, the findings of this research illuminate a path forward. They not only underscore the existing achievements of the institution but also provide valuable signposts for the journey ahead. By addressing both the social and economic dimensions of cancer treatment, the institution not only promotes patient well-being but also fulfils its promise of being a true partner in the arduous yet hopeful journey towards health and recovery.

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# ANNEXURES

# ANNEXURES

## OBJECTIVE: TO UNDERSTAND THE SOCIO-DEMOCRATIC PROFILE OF THE RESPONDENTS.

1 AGE OF THE PARTICIPANT

- ○ 30 and above
- ○ 40 and above
- ○ 50 and above
- ○ 60 and above
- ○ 70 and above
- ○ 80 and above

2 GENDER

- ○ Male
- ○ Female
- ○ others

3 RELIGION

- ○ Hindu
- ○ Christian
- ○ Islam
- ○ others

4 MARITAL_STATUS

- ○ Single
- ○ Married
- ○ Divorced
- ○ Widowed

5 EDUCATIONAL QUALIFICATION

- ○ Illiterate
- ○ School level
- ○ College level
- ○ others

6 TYPES OF CANCER

- Blood cancer (Leukemia, Lymphoma, Multiple Myeloma, Myelodysplastic Syndromes, Myeloproliferative Neoplasms
- Born cancer
- Breast Cancer
- Lung Cancer
- Colorectal Cancer
- Oral Cancer (mouth, tongue, and throat)
- Cervical Cancer
- Prostate Cancer
- Ovarian Cancer

7 IS THERE ANY OTHER FAMILY MEMBER WHO HAS BEEN DIAGNOSED WITH CANCER?

- Yes
- No

8 TREATMENTS

- Surgery
- Chemo or targeted therapy
- Radiotherapy
- Palliative care
- Surgery, Chemo & Radiation
- Surgery, Chemo
- Chemo & Radiation
- Chemo & Radiation & Palliative care

9 HOW LONG HAVE YOU BEEN DIAGNOSED WITH CANCER, DIOGENES?

- Less than a year.
- One year
- Two years
- Three years
- More than four years

10 WHO IS THE CAREGIVER?

- ○ Partner or Spouse
- ○ Parent
- ○ Sibling
- ○ Children
- ○ Friend
- ○ Professional Caregiver
- ○ Paid Caregiver
- ○ Family Member

11 TYPES OF HOSPITAL WHERE YOU ARE TREATED

- ○ Private
- ○ Government
- ○ Others

12 OCCUPATION OF THE PATIENT

- ○ Employed full-time
- ○ Employed part-time
- ○ Unemployed
- ○ Self-employed
- ○ Student
- ○ Retired
- ○ House wife
- ○ Daily wages
- ○ Farmer
- ○ Other (please specify)

13. TYPE OF RATION CARD

- ○ White/APL Ration Card
- ○ Blue/APL Ration Card
- ○ Pink/BPL Ration Card
- ○ Yellow/AAY Ration Card

14. HOUSEHOLD INCOME (PER YEAR)

- Above 2 Lacks

- Above 1 Lacks
- Above 75000
- Above 50000

**OBJECTIVE: TO COMPREHEND THE INSTITUTION’S SOCIAL SUPPORT RECEIVED BY THE PATIENTS AND THEIR BYSTANDERS.**

15 SPIRITUAL SUPPORTS

- ○ Yes
- ○ No

16 PEER MENTORING

- ○ Yes
- ○ No

17 EDUCATIONAL SUPPORTS

- ○ Yes
- ○ No

18 SUPPORT GROUPS

- ○ Yes
- ○ No

19 COUNSELLING SERVICES

- ○ Yes
- ○ No

19 PROMOTE INTERACTION BETWEEN PATIENTS

- ○ Yes
- ○ No

20 ANY ORGANIZED ACTIVITIES

- ○ Yes
- ○ No

21 ARE YOU BELIEVE THE INSTITUTION CAN IMPROVE ITS SOCIAL SUPPORT SERVICES FOR PATIENTS AND THEIR BYSTANDERS?

- ○ Yes

○ No

22 RATE THE INSTITUTION'S COMMUNICATION AND INFORMATION DISSEMINATION REGARDING TREATMENT PROCEDURES

○ 1 (Very Poor)
○ 2 (Poor)
○ 3 (Average)
○ 4 (Good)
○ 5 (Excellent)

23 DO YOU FEEL THAT THE INSTITUTION PROVIDES ADEQUATE EMOTIONAL AND PSYCHOLOGICAL SUPPORT SERVICES FOR CANCER PATIENTS

○ Yes
○ No

24 HOW SATISFIED ARE YOU WITH THE INSTITUTION'S EFFORTS TO ADDRESS THE SOCIAL AND EMOTIONAL NEEDS OF PATIENTS

○ 1 (Very Poor)
○ 2 (Poor)
○ 3 (Average)
○ 4 (Good)
○ 5 (Excellent)

25 ARE THERE ANY CHALLENGES IN ACCESSING HEALTHCARE AND SUPPORT PROGRAMS?

○ Yes
○ No

26 ARE THERE ANY EXISTING SUPPORT SYSTEMS TO TACKLE YOUR EMPLOYMENT-RELATED CHALLENGES?

○ Yes
○ No

27 HOW SATISFIED ARE YOU WITH THE INSTITUTION'S EFFORTS TO ADDRESS THE SOCIAL AND EMOTIONAL NEEDS OF PATIENTS?

- ○ 1 (Very Poor)
- ○ 2 (Poor)
- ○ 3 (Average)
- ○ 4 (Good)
- ○ 5 (Excellent)

**OBJECTIVE: TO UNDERSTAND THE FACILITIES AVAILED BY THE CANCER PATIENTS AT THE INSTITUTION.**

28 HOW MANY DAYS DID YOU STAY IN THE INSTITUTION FOR TREATMENT?

- ○ One month/ below
- ○ Above two months
- ○ Above six months
- ○ Above twelve months

29 FROM THE INSTITUTION, WHAT TYPE OF ACCOMMODATION DO YOU RECEIVE?

- ○ Dormitory
- ○ Cubicle
- ○ Shared rooms
- ○ Single room with toilet
- ○ Single room without toilet

30 IS IT FREE SERVICE?

- ○ Yes
- ○ Partially
- ○ No

31 ARE YOU SATISFIED WITH THE ROOM FACILITIES?

- ○ 1 (Very Poor)
- ○ 2 (Poor)
- ○ 3 (Average)
- ○ 4 (Good)
- ○ 5 (Excellent)

32 DID THE AVAILABILITY OF FREE ACCOMMODATION CONTRIBUTE TO IMPROVING THE OVERALL ECONOMIC, SOCIAL, AND PSYCHOLOGICAL WELL-BEING OF PATIENT?

- Yes
- No

33 IS THERE A PHARMACY?

- Yes
- No

34 PROVISIONS FOR KEEPING MEDICATION

- Yes
- No

35 IS THERE FREE FOOD SERVICES?

- Yes
- Partially
- No

36 ARE YOU SATISFIED WITH THEIR SERVICE?

- 1 (Very Poor)
- 2 (Poor)
- 3 (Average)
- 4 (Good)
- 5 (Excellent)

37 PRAYER ROOM AVAILABILITY

- Yes
- No

38 AMBULANCE SERVICES AVAILABILITY & IS IT FREE SERVICE?

- No
- Yes, not free
- Yes, Free service

39 PROVISIONS FOR TRANSPORTATION SERVICES; IS IT FREE SERVICE?

○ No
○ Yes, not free
○ Yes, free service

40 RECREATIONAL OR LEISURE FACILITIES

○ Yes
○ No

41 AVAILABILITY OF FINANCIAL ASSISTANCE SERVICES

○ Yes
○ No

42 WHEELCHAIR-ACCESSIBLE ENTRANCES, LIFTS, AND RAMPS

○ Yes
○ No

43 RATE THE ACCESSIBILITY OF THE INSTITUTION FOR INDIVIDUALS WITH PHYSICAL DISABILITIES

○ 1 (very Poor)
○ 2 (Poor)
○ 3 (Average)
○ 4 (Good)
○ 5 (Excellent)

44 STAFF AVAILABILITY

○ Yes
○ No

45 ARE YOU SATISFIED WITH THEIR SERVICE?

○ 1 (very Poor)
○ 2 (Poor)
○ 3 (Average)
○ 4 (Good)
○ 5 (Excellent)

46 AVAILABILITY OF COMFORTABLE WAITING AREAS

○ Yes
○ No

47 AVAILABILITY SEPARATE KITCHEN

○ Yes
○ No

48 ARE THEY CLEAN AND WELL-MAINTAINED?

○ 1 (Very Poor)
○ 2 (Poor)
○ 3 (Average)
○ 4 (Good)
○ 5 (Excellent)

49 AVAILABILITY RESTROOM FACILITIES

○ Yes
○ No

50 ARE THEY CLEAN AND WELL-MAINTAINED?

○ 1 (Very Poor)
○ 2 (Poor)
○ 3 (Average)
○ 4 (Good)
○ 5 (Excellent)

51 AVAILABILITY CAR PARKING SPACES

○ Yes
○ No

52 AVAILABILITY REST AREAS

○ Yes
○ No

53 FOR HOW MANY DAYS DO YOU PLAN TO STAY IN THIS INSTITUTION?

○ One month/ below

- Above two months
- Above six months
- Above twelve months

54 ANY SPECIFIC CHALLENGES FACED FOR ACCESSING THE INSTITUTION

- Yes
- No

55 RATE THE OVERALL FACILITIES PROVIDED AT THE INSTITUTION

- 1 (Very Poor)
- 2 (Poor)
- 3 (Average)
- 4 (Good)
- 5 (Excellent)

56 HOW SATISFIED ARE YOU WITH THE ACCESSIBILITY FEATURES PROVIDED BY THE INSTITUTION?

- 1 (Very Poor)
- 2 (Poor)
- 3 (Average)
- 4 (Good)
- 5 (Excellent)

57 HOW WOULD YOU RATE THE QUALITY OF SOCIAL SUPPORT PROVIDED BY THE INSTITUTION?

- 1 (very Poor)
- 2 (Poor)
- 3 (Average)
- 4 (Good)
- 5 (Excellent)

**OBJECTIVE: TO STUDY THE ECONOMIC SUPPORT PROVIDED BY INSTITUTIONS FOR CANCER PATIENTS'**

59 MONTHLY TREATMENT COST

- ABOVE 2 LACKS
- ABOVE 1 LACKS

- ABOVE 75000
- ABOVE 50000
- Below 10000

60 COST OF ACCOMMODATION PER DAY.

- ○ Above 1000
- ○ Above 500
- ○ Above 200
- ○ Above 100
- ○ Below 100

61 COST OF FOOD PER DAY

- ○ Above 1000
- ○ Above 500
- ○ Above 200
- ○ Above 100
- ○ Below 100

62 DID THE CANCER DIAGNOSIS HAVE AN IMPACT ON YOUR FINANCIAL SITUATION?

- ○ 5 Significant effects
- ○ 4 Moderate effect
- ○ 3 minor effects
- ○ 2 Mild effect
- ○ 1 No impact

63 HOW DO ECONOMIC FACTORS IMPACT PATIENTS' ABILITY TO AFFORD NECESSARY MEDICAL TREATMENTS?

- ○ 5 Significant effects
- ○ 4 Moderate effect
- ○ 3 Minor effect
- ○ 2 Mild effect
- ○ 1 No impact

64 Are you sought financial assistance from the institution, What type of assistance?

- ○ No

- Yes, Financial assistance for medical expenses
- Yes, Insurance coverage
- Yes, Assistance with medication costs
- Yes, Food and accommodation support
- Yes, Education support
- Yes, Travel support
- Yes, Other (please specify)

65. HOW SATISFIED ARE YOU WITH THE ECONOMIC SUPPORT?

- 1 (Very Poor)
- 2 (Poor)
- 3 (Average)
- 4 (Good)
- 5 (Excellent)

66. ANY GOVT FINANCIAL AID AVAILABLE FOR CANCER PATIENTS? WHAT KIND OF FINANCIAL SUPPORT?

- No
- YES, Chief Minister’s Distress Relief Fund (CMDRF)
- YES, Karunya Benevolent Fund
- Yes, Pradhan Mantri Jan Arogya Yojana (PMJAY)/Ayushman Bharat/National Health Protection Scheme
- YES, Rastriya Arogya Nidhi (RAN)
- YES, Arogyakiranam Scheme

67 ANY PERSONAL INSURANCE COVERAGE

- Yes
- No

68. HOW DOES THE AVAILABILITY OF HEALTH INSURANCE IMPACT PATIENTS’ ACCESS TO HEALTHCARE SERVICES?

- 5 Significant effects
- 4 Moderate effect
- 3 Minor effect
- 2 Mild effect

- 1 No impact

69 HOW DO ECONOMIC FACTORS AFFECT PATIENTS’ DECISION-MAKING WHEN SEEKING MEDICAL CARE?

- 5 Significant effects
- 4 Moderate effect
- 3 Minor effect
- 2 Mild effect
- 1 No impact

70 HAVE YOU ACCRUED SIGNIFICANT DEBT AS A RESULT OF CANCER?

- Yes
- No

71 DO YOU FEEL THAT THERE IS A NEED OF ADDITIONAL ECONOMIC SUPPORT BY INSTITUTION? WHAT TYPE?

- No
- YES, Connect to government schemes
- YES, Assistance for household needs
- YES, Loan without interest
- YES, Insurance facilities
- YES, Loan with small interest
- YES, Loan with small interest
- YES, Loan with small interest