FAMILY HEALTH CARE FOR CHRONIC ILLNESS PEOPLE IN COMMUNITY: QUALITATIVE STUDY

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**Abstract**

***Introduction***

Chronic illness person has trouble in both body and mind, including family system. Therefore, health personnel should provide care for the whole family. However, there is less insight into family health care practice for families with chronic illness persons in community settings. Therefore, the study aimed at describing family health care practices for chronic illness persons from the participants ‘view.

***Method***

Qualitative study was conducted. Participants included chronic illness persons, family members, healthcare personnel, and community leaders. Data collection consisted of in-depth interviews with tape recording, observation, note taking, and focused group interviews. Content analysis was done for data analysis.

***Findings***: The findings displayed three major themes with nine subthemes in relation to the participants’ narration. First, *“prioritizing personal illness severity for providing care at home.” Second, “common disease, more complication, difficult to control, and need special one to provide health care.” And third, the “community strongly participation, supports, follows up, and learns from patients and families’ styles.”*

***Conclusion*:**

The results support nurses and health personnel in gaining insight into family health care in the community setting based on the perception of patients, family members, health personnel, and community leaders. Therefore, an effective family health care model and intervention should thus be developed fitting to the needs and primary health care system.

***Keywords****: Family Health Care, Family Nursing, Chronic Illness, Qualitative study*

**BACKGROUND**

Family is a sub-system in society that is important for healthy development at the national level. The development of a strong family increased a warm and healthy family index, and well-being is one of the primary objectives in the National Economic and Social Development Plans, from the 9th through to the 12th iterations.1 However, nowadays chronic illness, especially, non-communicable diseases (NCDs) such as stroke, ischemic heart disease, diabetes mellitus, and chronic obstructive pulmonary disease is considered one of the crucial health issues to be faced by families and the health service system. During 2012-2015, death rates caused by the 4 NCDs increased per 100,000 population.1,2

When a family has a member with chronic illness, the family encounters physical, mental, and social impacts.3,4,5,6,7 The impacts include the ones felt by the member, varying from feeling unwell to pain,8 dyspnea, fatigue, emotional strain, anxiety, and depressive symptoms,3,9 body changes, and powerlessness,10 and psychological adjustment.11The impacts and changes concerning family systemically are changes in activities of daily living and work lives,12,13,14 earnings the need to tend to the family with illness all day long, role overload and burden in a family member who is responsible for the ill member,15,16,17,18 lessened interactions relations and worse in family, conflict within family concerning how to tend to the member with illness and selecting relevant treatment,12,19,20stress caused by illness and its predictions,17,21economic issues attributable to the expenses caused by treatment and commuting to hospital,22as well as decreased earnings caused by a change of roles in a family member who previously was responsible in earnings. Therefore, a family caregiver has poor well-being.13

The impacts need to be addressed systematically by all relevant registered nurses and health care teams, who need to put priority in designing forms and methods to facilitate efficient care for families with chronic illness.23,24,25In fact, family is especially important to patients and all family members. This is because health behaviors and illness could be learned within family system.26,27When a family member is affected by illness or health issues. Moreover, while family is key factor to health conditions and well-being of all family members, it also affects health conditions of family members, since actions taken by each of the members affect the family holistically.28,29,30,31,32 Efficient healthcare must emphasize on family, not just individually. Health promotion and maintaining of health conditions of family therefore serve as crucial factors for the welfare of social institutions. In this connection, patients, and family both require facilitation in health care and nursing for better health of increased well-being. Moreover, there is evidence supporting the fact that health care and nursing intervention of family with chronic illness persons poses mental and physical effects on both the patients and their family as a whole system.28,33

Family health care is considered as health service for family, employing sciences, family, family health, nursing, and other relevant fields, including liberal arts, to integrated serve for healthcare and health promotion of family. It also emphasizes on capacity development of family to cope with various stress and crisis related to health, by encouraging family to be resilient, to use health support sources, to maintain good health in various conditions of their lives.31In order to provide healthcare and promote family health, nurses and health personnel need to have access to and practice intervention within family system for various types and level, e.g. family as the context of individuals, as family centered care, as family system, and as a part of society.30,31,32,34 Accessibility for providing family health care services depends on several factors, e.g., the location of service providers, family circumstances, and capacity of nurses. General Nurses are capable of practicing family nursing with individuals as targets and families as a context of the individuals. However, to practice family-based nursing, registered nurses require advanced intervention capabilities, in which knowledge and skills in intervention and application of relevant theories on family, family health, as well as family nursing, are of significant necessity.31

Several concepts and models of family nursing have been applied in Thailand, for instance: the Family Health Nurse model for Primary Health Care, which was announced by World Health Organization (WHO), and have been enacted in Europe33,34,35,36,37guidelines on family health assessment and healthcare by Friedman et al;30Calgary Family Assessment Model (CFAM); and Calgary Family Intervention Model (CFIM).32The mentioned models could be used as conceptual framework applied to family health care and the design of family nursing intervention guidelines in various health circumstances. However, the results of family nursing are still mostly assessed using target individual health and partly family members. Previous healthcare interventions for families with chronic illness persons had adopted model of family healthcare developed in western context and origins such as the concept of self and family management, 33family structure and function, 30 including CFAM and CFIM models.32

However, such concepts as mentioned above have significantly different factors of culture and value, rendering it inadequate to be used in the contexts of Thailand. The concept, moreover, has limitations in its application in assessment and analysis of family health circumstances and needs, in which individuality varies from one family to another. Family process and lifestyle are also integral to family healthcare, especially in the efficient intervention of healthcare for family of members with chronic illness, where partnerships need to be forged between family and registered nurses or health care team. The use of relevant benefit sources is to be coordinated: for instance, cooperation with family members with illness and family members who are clients; the promotion of family to become the owner of its problems and thus responsible for the design of successful self-healthcare advocated by family nurses, and enhanced cooperation with community networks and local organizations which are benefit sources for family. As the research team who takes responsibility in education for student nurses and registered nurses on family health care and nursing. There have both played key roles in providing family healthcare and developing new knowledge on family nursing in accordance with the needs and issues of families in the actual contexts of current Thai communities and society. This study is the first part of situational analysis on the relevant health circumstances, current family health care, family nursing practice, and community participation for family with chronic illness person in community setting. The findings will help nurses and health personals to gain insight in the situation in real setting and then developing the family health care, nursing model and guideline for chronic illness person that fit to primary health care system, especially in community setting further.

**Material and Method**

***Study design***

According to the study which was aimed at understanding the circumstance of family health care for chronic illness persons within the community context, therefore, qualitative study was employed.

***Participants and Study Area***

The participants were selected using purposive sampling, consisting of persons who have experience involving chronic illness healthcare. They included health care personnel who works at Sub-district Health promotion hospital (SHPH) locates in one rural area of Khon Kaen province, northeastern part of Thailand. The health personnel include registered nurses, public health officers, in total of 4 people; chronic illness persons diagnosed of diabetes mellitus, hypertension, chronic obstructive airway disease and have received treatment more than 1 year, in total of 24 persons; family members, in total of 20 persons; and community leaders, i.e., village headman, deputy village headman, monks, folk healers, and village health volunteer (VHVs), in total of 8 persons**.**

***Research team***

The researchers have experience conducting studies and mentoring advisees through philosophy and principle of qualitative and quantitative methods for over 15 years. We are instructors of family and community nursing, supervising both undergraduate and graduate nursing students in primary healthcare service setting. Family healthcare for chronic illness person is a major topic for both teaching and research program. We have good relationships with the participants, especially registered nurses and VHVs, as well as some families with chronic illness persons based on home visits and provision of basic medical care. Good relationship with them is particularly important for the study. Our experience of working with them have nurtured the researchers with more interests and understanding in the phenomenon of interest. The researchers could be highly aware and perceptive of the participants’ narration.

***Research tools***

The tools are comprised of; 1) interview guidelines for persons and families on the illness, healthcare services, health outcomes, satisfaction, and expectations; 2) interview guidelines and topics of discussions for community leaders on participation in healthcare for chronic illness persons and families, and their expectations; and 3) interview guidelines for healthcare personnel regarding care provision for chronic illness persons and their families, including barriers. We prepared to conduct in-depth interview (face-to-face) and focus group interview for data collection. The interview guidelines were then developed and validated by 3 experts in areas of family and community nursing, chronic illness care, and qualitative study. Finally, the interview guidelines were tested for feasibility with the similar 5 participants before proceeding to data collection.

***Data collection***

The researchers requested permission for data collection in the study areas from district public health offices and directors of SHPHs. They conducted in-depth interviews with notetaking of 45-60 minutes per person on chronic illness persons and their families, health service providers, and community leaders. Two in-depth interview sessions were conducted on some families when the researchers found that some analyzed data was inadequately clear. In-depth interviews with tape recording were conducted at homes at the request of the participants. In addition, the researchers conducted 2-hour focus groups interview with notetaking and tape recording on health service provisions related to family healthcare for chronic illness person. All selected participants expressed their willingness to participation.

The focus group interview comprised of 6-10 persons per group, taking place at the discussion room at SHPHs. There were 3 subgroups in total. During data collection, we had analyzed the data from each case before going to the next participants. The researchers created more interviewing questions for exploring the data until saturation. We had bracketed our experience and background for understanding only emic view of the participants throughout the study process. The researchers had not reviewed any documents regarding family healthcare and chronic illness care until finalizing data analysis. In this regard, the emergent coding and themes emerged from the analysis process*.*

***Data Analysis***

Content analysis was employed for interpretation and grouping of data from open coding, themes, and categories. Content analysis uses a descriptive approach in both coding of the data and its interpretation of quantitative counts of the codes.38,39,40Conversely, thematic analysis provides a purely qualitative, detailed, and nuanced account of data.41The results were then presented by narration. The researchers analyzed data and found multiple coders which could be grouped as themes. We conducted triangulation method (focus group interview), aiming for broader and more complex understanding themes such as *patient priority, not family*, *need skillful person called as little doctor*, *Illness person as the first concern, family as secondary*.

During the phase of coding and grouping for themes, the researchers often had a cognitive conflict. The credibility of the findings could be assessed by selecting significant sections from the participant statements, and the derivation and identification of themes were made explicit. Descriptions of coding and note taking or memory could support how and what the researchers perceived and examined, which further developed understanding of the data. Additionally, the researchers obtained member checking from the participants on the research findings, which adds creditability to the researcher’s interpretations by ensuring that the participants’ own meanings and perspectives are represented and not curtailed by the researchers’ own concept and knowledge. For research reporting, the participants’ quotations are provided from variety of participants to add transparency and trustworthiness to the interpretations or findings of the data.

***Trustworthiness***

This research has been addressed according to the concepts and methodologies which outline a guideline of 3 fields: 1) credibility, by checking data consistency against the interpretation of researchers, the end results need to be confirmed with the participants through member checking method.42,43Prolonged engagement of researchers with study areas continuously for 2 years has led to eradication of biases and understanding of significant issues by persistent observation. In addition, triangulation was conducted by data collection of various methods and participants, the analysis results were also verified with a variety of concepts and theories; 2) dependability of this research has been forged with clear and transparent processes in every step and holds inquiry audit; and 3) conformability of this research could be verified as it used factual data with unbiased evidence.43

***Research Ethics***

The research project approved by the ethical review committee of Khon Kaen University, Thailand; code number HE 552097. The researchers critically emphasize on protection of rights, preservation of benefits, and prevention of possible risks, as well as immediate response to such cases. These include, but not limited to, non-interference with career and work hours, leisure time, exhaustion from the illness, and withdrawal of research participants at any time without any impacts to their reception of health services.

**Research findings**

The general information of the participants which consisted of: Four nurses and public health officers; 24 chronic illness persons; 20 family members; and 8 community leaders (village headman, deputy village headman, monks, folk healers, and village health volunteers)**.** The ill persons averaged age was 66.25 yrs. (SD 1.85) ranging from 43 to 87 yrs. (Max 87, Min 43), and consisted of 10 males and 14 females. Half of illness persons are diagnosed with diabetes mellitus and have received treatment more than 1 year. Regarding family members, they were consisted of 4 women and 16 men, aged between 14 to 72 years old. Most of them are farmers. From the circumstances related to health, health care, and current family nursing for families with chronic illness persons in the context of community; content analysis has shown three major themes and 9 subthemes from the content analysis as follows:

***1. Prioritizing personal illness severity for providing care at home firstly***

As the analyzed data indicates that acknowledgement of circumstances related to healthcare practice for chronic illness persons first, and secondary for families. At the present, the intervention of health care providers put the highest priority on patients. This comprises of treatment, promotion, rehabilitation, prevention, disease control, and treatment, individual and group health recovery. Chronic illness persons undergo, for instance, physical examination, medical history taking, nutritional intake assessment, exercise, stress management, treatment follow-up, and medical consultation. Health service clients are categorized into 3 groups, namely: 1) healthy group; 2) risked group; and 3) ill group. The ill group is further sub-categorized into severely ill group, complications group, and controllably ill group. Additionally, the healthcare providers have health education conducted in chronic illness clinic of SHPHs, as well as in villages. Home visits to patients with complications are arranged and executed jointly with teams of interdisciplinary. However, family health care is of less significance, as could be noticed from these quotes.

“*If family is to be a priority. I do not think so. It needs to use this principle: if the patient does not control and take care own self, it will affect own health. But if we merely depend on the relatives’ help, family is only a minor part of the problem. Regarding food, we investigate food because we want to know whether the patient likes the food or not, or it is all the food available in the community. It all depends on the patient; we need to try making the patient think of oneself, for example, ‘don’t cook sweet food for me’ or ‘what should I eat? It is the most important to make understandings with the patient first not family*” (Nurse 1)

***Subtheme 1.1: Involving families when the patients cannot help themselves***

Nurses and health personals have families take part in interventions when there are complications and limitations with the patients, e.g., unable to self-care, incapable of controlling diseases, being elderly. A family folder is created with information on family tree, medical records, and healthcare intervention by home-visits, and counseling on patient care for relatives or caregivers, home environment management. By working collaboratively with healthcare networks, such as VHVs, family health promotion hospital officers, and local administrative organizations.

*If the patients can help themselves, we do not usually get in touch with their families. But if they are elder, accompanied by relatives, we will give information to the relatives on what they need to do. Mostly we will do follow-up in case we go on home-visits, for home-visit cases, our home-visit teams, we will have a talk with caregiver who is family member.”* (Public health officer 3)

***Subtheme 1.2: Focusing on a family member who has high power to primarily participate in all activities of patient care***

Health personnel has worked within the family which has patient of complicated health status to participate in processes from health and problem assessment. By informing of and pointing out problems of patient to jointly explore for solutions. For this to succeed, such family member must be the one with high power in his/her family.

*If family does not agree, the patient will face hardships. Whatever we suggest, if the family does not follow, it all ends. Therefore, if we really want to solve problems, it is a must to include family to participate in all activities. From the start to assessment and whatever, problem recognition, joint problem analysis, joint exploration of solutions, let them participate in all of these. The important thing is finding the person with high power in the family, to talk about those things with them. For we talk with the patient, we talk with others are useless, if the one power does not cooperate with us.*” (Public health officer 2)

***Subtheme 1.3: Good to focus on caring family health, but have several barriers of practice***

Putting emphasis on family in service provision is a good thing if it is practical. There are several barriers, e.g., families are lack of awareness in healthcare, families need to work and therefore have no time to focus on healthcare, nurses practice on an offhand basis and have inadequate time to find the member with power within a family, as well as the number of patients are too high and thus rendering problem analysis on a case-by-case basis difficult.

*It is a good to focus on family, since it needs family’s attention for better health of the patient. The patient may be interested in self-care, but the family may not, it is like a psychological matter. If the awareness is rather on money, tasks, family, and economy, thus less or none on health, it will be this way. It has several barriers of practice.* (Public health officer 4)

***Subtheme 1.4: Assess family health by focusing exclusively on patients, while unable to solve family health problems***

Healthcare providers assess and record information on community environment, community map, village layout, genogram, accommodation information, annual assessment of diabetic patients, assessment and treatment of diabetic mellitus, biography and social information of chronic illness patients, ADL assessment form, elderly people, annual health screening results (of people with 15 years of age and higher), individual health records, and home visit record forms.

*As my routine work focuses to assess patient, home and community environment, family genogram, health, and treatment history. I look for and diagnosis patient’s health problems and provide cares first, or refer, or consult doctors. For family problems, I see from the assessment data but difficult and no time for solving them. I need to help their personal problems first*. (Public health officer 3).

***2. Common disease, more complication, difficult to control, and need special one to provide health care***

Families view chronic illnesses; diabetic mellitus, and hypertension as common among people, untreatable, must maintain mental strength, must prevent more complicated illnesses. For instance, one must take medications, follow up at appointment time, avoid sweet-salty-oily-spicy food, eat vegetables like medication, and eat fish as priority.

*If one does not always do so the illnesses will be unstable, e.g., blood sugar level keeps getting high and low. Most families help each other to make sure patients conduct themselves to contain the illnesses by, for instance, arrange meals in accordance with the illnesses, and take patients to appointed health check-ups. However, such measures are hardly practical at times since families work outside the house, so it is difficult to always take care and check on the patients*. (Nurse 2)

***Subtheme 2.1 Common among people, untreatable, must prepared, but difficult to do***

Patients and family members view chronic illness as common among people, untreatable, must depend on continuous roles of medical practitioners, take medications for relief, and maintain mental strength. Moreover, they must take care and control the illness to not worsen and/or be coupled with complications by controlling food, proper care of themselves, but could be hardly controlled in the real world.

*Diabetes, hypertension is common among so many people. Now it depends on doctors that is to take medications as they told and be relieved day-by-day. I want to stop, they said not to stop, but keep on taking meds. Whoever cannot maintain mental strength, it will be tiresome. I am not able to take care of myself, it keeps getting worse and worse ...it needs to be cautious about livelihood and eating. I must**be careful of own self. I know what to do, just not how to… For farmer like me, it goes, but when I get ill it comes quickly.* Sometimes, I cannot control it. Doctor told me not to eat too much sweet. Sometimes the illness shows, I know it is wrong. But when I eat it, my body will really freshen up, eating sweets...yes!” (Diabetic mellitus patient 7)

***Subtheme 2.2 Unable to control illness due to complexity of family***

Incapability of illness control is due to several causes. These include: 1) irregular intake of medications due to forgetfulness caused by rush at work, being elderly, being economical, having no family caregivers to acquire medications, and seeing no symptoms of illness; 2) using alternative treatment, such as herbal medicine (liquid chlorophyll, enzyme, extracted Lingzhi mushroom, mangosteen juice), per believe it could cure the illnesses; 3) lack of exercises, due to aches at knees, legs, and back, and having no time because of work; 4) incapable control of food ingestion due to regret of left food, eating and feeling fresh, eating and showing no irregularities, eating whatever the family arranges, family does not warn or take care thinking the patient can take care of themselves, conflict when family prohibit eating what patient desires.

*Only those things, Lingzhi mushroom which I bought to eat ...enzyme I bought for 3,000 baht per box ...my son heard on radio, so he called and bought it… I eat all the things, but they are still not good enough. This one is very painful… Kourtonmax, treats gout and diabetic mellitus… my beloved son bought it*” (Diabetes mellitus and arthritis patient 3).

*The problem is he cannot stand not eating it, like in the season of sugar apples. When I pick up the fruits, he cannot stand not eating them, then he complains to himself. I cannot stand it. But when I see the fruits, I regret leaving them there****.*** *I have a regret syndrome. When it is out of sugar apples’ season, it is time for mangoes. I pick up them up to eat. This is my father bad point preventing him from doing that.”* (Son of diabetes mellitus patient 3).

***Subtheme 2.3. Expectations in health service provision***

Patients and families need to be completely treated from illnesses. Clinical service at SHPHs should have doctors conduct diagnosis and treatment daily, for adequate time of inquiry and consultation. In addition, they need monthly and regular clinical service for chronic illnesses in their villages. They note the significance of home visits, health counseling on all topics for everyone at home both ill and healthy ones, e.g., alcohol rehabilitation request, and health check-up for healthy people.

*Care for chronic illness peoples in villages by diagnosis and treatment should be provided. Supporting and listening to both patients and relatives alike, teaching and counselling in the conducts of patients and their relatives; for example: pain reduction, emotional care, complication management, and behavioral control for patients especially of their food ingestion. These are among the needs of patients and their families*. (Nurse 3)

***Subtheme 2.4 Receiving good medications, being strong, and full recovery***

Patients and family members expect health teams to care and treat with medications to fully recover, to be healthily strong.

*“Doctors and nurses should care, cure, and do whatever to fully recover, to be healthily strong.*..” (Wife of diabetes mellitus patient 1).

“*If there are good medications, I want to get them, to take them for quick recovery...should give me. Health counselling, encourage and motivation both patient and relatives, complication prevention is needed, especially, good drugs.”* (Diabetes mellitus and arthritis patient 3)

***Subtheme 2.5 Health visits, care and treat, education, counseling, and encouragement***

Patients and family members expect health teams to conduct health check-ups, provide treatment, do follow-ups, address health problems, dispense medications, provide counseling on various conducts, e.g., food ingestion, exercise, pain management, health recovery, and encouragement.

*“Come to give support power is the most important thing, I think it is encouragement… It is a first-class medicine. Come and ask for updates, give advice of that and this, I should do that and this, they come to advise me this. Patients will follow the advice to get better. If I just sit and lie down all day with no one to tell or advise me, I cannot figure it out. I need someone to give me advice of what to do to recover when my legs are in pain. It is doctors who come to advise what to do to get better.*” (Diabetes mellitus and arthritis patient 3).

***Subtheme 2.6 Need doctor of family or knowledgeable person for visiting and caring at home***

Patients and family members expect health teams to have doctors or nurses responsible exclusively of family. They are to be acquainted with and be able to recollect families, as well as to visit families for care and some treatment services, and for providing feeling of comfort and decreasing suffering.

*“I want to have rural doctors and some doctors who remember our families that includes nurses. So, I can be at ease. I want to have nursing officers responsible of each of the families. I want health officers, both doctors andnurses to visit patients at homes, to see how they live and solve health problems.”* (Diabetes mellitus patient 6)

***Subtheme 2.7 Need of community health personnel who is “expert, knowledgeable, and provides good care like as ‘mhor noi’ (little doctor)***

There are needs for health personnel with expertise to educate both patients and caregivers/families, to allocate time for listening to relatives and giving explanations/suggestions, to clearly provide information on practices with language appropriate to patients and families. Moreover, it is noted that VHVs should be capable in offering suggestions and providing care in case of primary illness in community. In case of emergency, VHVs are needed to assess and coordinate with other sectors to refer patients for timely treatment.

*“I want someone to coordinate referring patients during the day, as my children and grandchildren are not home. Nowadays we have the village headman do all the things. Hospital is far away. I want health officers to visit my home every day or per week. But it seems difficult since there are not many health officers. So, it must rely on VHVs still. It would be nice to have nurses who are skilled; diagnose quickly; conduct measurement of blood pressure and venipuncture skillfully. VHVs cannot do these things, nurses are essentially needed like as ‘mhor noi (Little doctor).’* (Wife of diabetes mellitus patient 1)

***Subtheme 2.8 Being considerate of health personnel, having no needs***

Some patients do not expect or need anything apart from regular services, due to being too considerate and believing they can take care of themselves.

*“Consideration, I am too considerate. I do not want to let others into my family because I am courteous of them. Nurses come as their duties and time dictate, just like that. It is all up to the care people. I do not think that I want them to come does that and this. I am afraid it may be too troublesome for them.” (Diabetes mellitus patient, 5).*

***3. Community strongly participation, support, follow up, and learn from patients and families’ styles***

Community leaders involved in community health, especially, VHVs, who have undergone primary skills training and play key roles in coordinating among public health officers to find lists of population who are 35 years of age and older, to conduct screening of chronic illnesses, coordinate among sectors, prepare operating sites, and jointly operate when executing proactive clinic in communities. The joint operations include measurements of weight, height, and blood pressure; fingertip blood tests; home visits for follow-ups of chronic illness persons, in which issues are frequently found, e.g., patients do not attend to appointed health check-ups, lack of medication, ill behavioral adjustment in food ingestion, and lack of attention from family as family members do not recognize impacts and disadvantages of the illnesses. All the mentioned issues are as the followings suggest:

*“If there are patients in the area, we must go see and take care. Or if there are patients who cannot help themselves, VHVs must report on them to nurses at heath stations, to conduct follow-ups and home visits. Nurses will then visit, bringing things for the patients. Like our village 5, we have old man who is incredibly old and cannot move and go anywhere. So, we make home visits to take care of them. We also have Granny 100-something years old; we visit her home too. She is the great woman that I can learn from her*” (VHV 1).

In addition, there are folk doctors, gurus, spiritual doctors, who provide care and act as mental and spiritual supporters, for example, decreasing the feeling of distress by using rituals to consider what illness is involved with. If there is an unwell mind, they will use rituals to solve karmas. There are also spiritual doctors (*Pho Kajum*) who arrange a ritual to pay respects to the *‘Pho Pu’* (senior elder man), in case of untreatable patients in the village. The people who received the effects of the rituals will feel well, be at ease, and encouraged in their ways of life.

*“That one felt pain in the legs, walked to do it with me. I ran the rituals, seeing a big misfortune. So, I made holy water and bathed that one in it, prayed, it is a misfortune solving ritual, to uphold the mind. If a patient goes to hospital, sleep at hospital, right here I sit, they say it is the soul to call for the spirits. They ask, so they take me to call for the spirits. If the spirits do not come, even if they take meds or sleep at hospital, it will take long. If the spirits come, take meds, it will be relieved quickly.”* (Spiritual doctor).

***Subtheme: 3.1 Follow-up, home visit, suggestion, recovery, and learning of family health styles***

Community leaders expect increased provision of chronic illness treatment services. Physicians should visit regularly. SHPHs are to conduct activities to educate about chronic illnesses, visit homes, follow up on and make suggestions for patients and health recovery for elderly people, and learn about families in the aspect of health for communities, and to have every sector perceives the significance of caring for chronic illness persons.

*“I want those health stations and sub-district hospitals to do some follow-ups. Normally, there are just this group of VHVs, and another from sub-district hospitals, that is I want doctors to really be attached there. That is, whenever we go, like that time last week, my mother had never said she got diabetes mellitus. But then she was tired so my younger one took her there. They checked my mother and found sugar was 400 and more, even though she never had it before. Every time she comes, she got pricked, why this time it got so high. So, they sent her to hospital, receiving saline so sugar decreased. That is, I want more**follow-ups. Those officers in health stations conduct visits. It is quite good. But I want more to be added like suggestions on how to use medications, cooking, exercises, like these. I proposed that day that is which family behaves well in health matters, exercises, we should have that family as a model; food, eating and living pattern.* (Community leader 1).

**Discussions**

The findings display three major themes and nine subthemes based on content analysis from the participants’ narration. However, the researchers aim at discussing the interested 6 themes that consist of: 1) healthcare for patients as the first priority, and secondary for families; 2) Involving families when the patients can’t help themselves; 3) patients have difficulties in controlling illness due to complexity of family; 4) family needs doctor or health personnel who is knowledgeable and provides good care, known as *‘mor noi’*; 5) families are considerate of health personnel, leaving some family needs unattended; and 6)community supports by conducting patient care and follow up, visit homes, and learn health pattern of families. These emerged themes could be discussed as follow:

Firstly, the theme of ‘healthcare for patients as the priority, secondary for families;’ from the circumstances of service provision for family with chronic illness persons, findings indicate that *patient is the primary focus of healthcare, while family receives less emphasis***.** When patients cannot take care of themselves, cannot control the illnesses well, or if they are elderly which need to be dependent, service providers will have relatives, caregivers, or families to participate in problem recognition. Moreover, there is access to relatives/caregivers by finding only family members who have power. Access to family is a context of patients. However, each of the chronic illness persons and families have complex problems,44both at individual and family levels such as incapability in controlling levels of blood sugar and blood pressure, incapability in behavioral adjustment despite being informed of it, conflicts and arguments between patient and his wife about inappropriate conduct. Family nursing for family with chronic illness persons thus needs family accessibility in the level which is more than family nursing with family as the context.14,31,44,45Health personnel thus needs to assess family health and troubles and then provide care and support, including strengthening family function. Family wellness will be achieved with both patients and family as the whole system.

From the situational analysis, chronic illness patients have troubles both in body and mind. However, health care providers have emphasized on providing care, cure, prevention, and rehabilitation for the patients first, excluding their families. Their perception and practice could be based on their workload in primary health care service setting in the current days of Thailand.46 There are several challenges facing Thai health system, including rapid increase of ageing population; increase of people living with chronic conditions; and growing demand of services provided in home and community settings. Moreover, in 2026, nurses are likely to be in critical shortages. The Human Resource for Health (HRH) requirements is likely to match with the supply.47Additionally, there is many patients to be serviced. Operations are therefore conducted on offhand basis, only members with power in family were the focus, and problems and needs particular to each family are unable to be analyzed. The issues reflect that healthcare for families with members of chronic illnesses needs to develop concept on community-based family health care intervention; facilitate capacity building of service providers in information analysis and linkages for better understanding and diagnosis of health problems, and the provision of family healthcare as a whole system,27on a case-by-case basis.

As the findings displayed, health care personnel have an opinion that family healthcare is a good concept, though hardly practical due to several obstacles, e.g., tools utilizing family folders comprise various and duplicated evaluation lists. Family evaluation in practice is still lack of significant informationintegral to whole system analysis of family health circumstances on a by-case basis. For instance, relationships among family members, family roles and duties, ecology and benefit sources of family, family health perception and behaviors, and lack of analysis linking information on patient and family on important matters such as cases of dependent patients whose family members are not prepared, and thus need to conduct assessments and explore for more benefit sources. Resolution to family health problems is thus hardly successful. If there is analysis linking information and problem on health of patients and family system, it could lead to the designing of care guidelines to solve health problems of patients and families as a whole system.28,48

The theme of families getting involved when the patients cannot help themselves reflects that family system of chronic illness person has managed and provided care based on clinical symptoms and self-care ability of the ill member. It is common practice of family in community setting, especially in rural area, due to limitation of socioeconomic status. Family members of chronic illness person have several functions, particularly working hard for making money to support basic needs of all family members. Hence, family delays to involve providing care and support for the ill member. However, family will be active and more involved with the chronic illness members depending on clinical severity and inability of self-care function.

The third theme of analysis is related to patients who have difficulties controlling illness due to complexity of family. In communities of Thailand, patients and families usually recognize that chronic illnesses—especially diabetes mellitus and hypertension—are common among people and untreatable. Therefore, they need to be mentally strong, and do them seriously, but hardly practical due to complications and barriers affecting patients and their families. There are needs for good medications, good health, full recovery from illness, health visit, treatment and care, education, suggestion, and encouragement. In real setting, family lifestyles vary according to living pattern and influencing factors.49Family has difficulties in controlling health behavior of each family member in daily living due to work which is commonly outside of home. Some patients live alone during daytime until evening that family members come back home and have dinner together. Thus, in the morning and lunch, patients have breakfast or not based on individual lifestyles. Therefore, food habit, exercise, and stress reduction are difficult to promote and solve by only health education from health personnel. The issue is particularly important and challenging for creating health care service system which is effective and fitting to the nature of chronic illness person and family system.

As for the subtheme, participants note the needs for doctors and health personnel, particularly nurses (*mor noi or little doctor*) who are “skillful, knowledgeable, and able to provide good care”, to conduct home visits, offer time, care for, facilitate, and provide healthcare for everyone in family. Physicians and nurses are needed to be acquainted of and be able to recollect health situation of family. They should be residents or family physicians who the family, patients, and community respect and trust to help and support their health with satisfaction and effectiveness. This theme is consistent with the health policy of healthcare reform in Thailand in the aspect of family healthcare team which aims at providing healthcare for people in primary care setting. It consists of family doctor, nurse, pharmacist, physiotherapist, and other health personnel, including community leaders and volunteers. Their roles focus on healthcare for new health problems, preventive care, referrals to other healthcare professionals, enhanced accessibility, and patient-centered care model.50The policy could support people in term of individual health needs more than family unit or even provide care for family system. Therefore, people in community setting just need family physician who can provide and support their health effectively. In addition, they need health personnel who have knowledge and skills to provide and support them and their family members’ needs, not just only doctor.

As the subtheme, families are considerate or *krengjai (in Thai word) to* health personnel. The action of consideration or *krengjai* is common among Thai people, connoting a feeling of not wanting to trouble someone with their own matter. *Krengjai* is a social practice, a concept within a framework of critical discourse analysis.51 By limiting the social context, semiotic meanings, and dispositions of the actors, the use of *krengjai* as an explanatory factor in Thai social relation can best be understood. In phenomenon of family health care for chronic person in community setting, some family and ill person feel considerate to health care personnel who come to provide care at home. They therefore would say “*krengai*” to express no need of home visits.

For the third major theme of situation of community strong participation in caring for chronic illness patients and for Thai community. Community leader and community healthcare volunteer are team members of primary care cluster (PCC) who have several roles, both formal and informal, such as supporters for chronic illness person and family as emergency care. Some VHCs help family in taking persons with illness to follow-up appointments at primary care unit; and conducting home visits at home as friend, neighbor, or relative. Therefore, community has several roles, more variety of participation, and support for patient with chronic illness and family healthcare in Thai society today.51The participation and role of community can help in learning patient and family health patterns, which in turn can strengthen effective work of health care providers.52

**Conclusion and Suggestions**

The findings included the views of healthcare providers as “prioritized personal illness severity for providing care at home.” The family view that they will involve in providing care based on self-care ability and symptoms of the ill person. Both the patients and their families perceive that chronic disease is common, untreatable, and must prepare for the worst. They need good medications, and not trouble from diseases; receiving home-visited for health check-ups, and care, to be educated, advised, and supported mentally. They need person who have specialized on providing healthcare that call as *‘mhor noi’* (little doctor) or nurse. For community leaders, specific as village health volunteers (VHV) who works collaboratively with health personnel to screen, and home-visiting for taking care for chronic disease patients. So, they need more knowledge and skills for effective working. As the findings help the researchers to gain insight in the situation of family health care practice, nursing, and community participation in health care. Therefore, the effective model of family nursing care for family with chronic illness person in community setting and primary healthcare is challenge for health care service system, especially, the family nursing model for family with chronic illness person should focus to provide care as a total system for health outcomes of both the ill person and family system that will result to family health as the major goal of health professional and nursing.

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