

Perceived Problems and Needs of the Family Caregivers Who Caregiving of Dependent Older Persons in an Urban Community: A Qualitative Descriptive Study

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Introduction: Dependent older persons with limitations in activities of daily living (ADL) often experience reduced functioning and require ongoing support from family caregivers and community-based care systems.

Purpose: This study aimed to explore the experiences, challenges, and care needs of family caregivers providing care for dependent older persons in urban communities.

Methods: A qualitative descriptive design was employed. Twenty-five family caregivers residing in Bangkok, Thailand, were purposively recruited. Participants were family members who had provided primary care for a dependent older person for at least six months and were able to communicate in Thai. Data were collected through in-depth, semi-structured interviews guided by Donabedian's model of healthcare quality. Each interview lasted approximately one hour, and the interview guide was validated by three experts (content validity index = 0.97). Data were analyzed using conventional content analysis.

Results: Family caregivers reported six significant challenges: limited caregiving knowledge and skills, time constraints, caregiving isolation, declining personal health, financial burden, and difficulties managing the older person's emotional and behavioral problems. Eight key needs emerged: access to reliable health information, online health services, transportation assistance, home healthcare, financial and psychosocial support, home environment modification, and recognition from healthcare authorities. Guided by Donabedian's framework, findings were categorized into inputs (caregiver and system attributes), processes (caregiving activities), and outcomes (quality and continuity of care supported by digital technologies).

Conclusion: Family caregivers of dependent older persons in urban settings face complex, interrelated challenges that affect their well-being. Strengthening integrated community and health support systems, together with evidence-based caregiver empowerment programs, is essential for promoting sustainable, high-quality long-term care.

Keywords: care needs, caregiving challenges, dependent older persons, digital health, family caregivers, urban communities

Introduction

Globally, older persons aged 60 years and above accounted for approximately 13.5% of the population in 2020, with projections estimating an increase to 21.3% by 2050.^{1,2} Thailand has officially entered the stage of a “completely aged society,” where 18.1% of the population are older persons, and it is anticipated to reach “super-aged” status within the next decade.^{3,4} By 2025, the number of older persons in Thailand is expected to exceed 13 million.⁵ Many of these individuals face increasing dependency due to declines in physical and cognitive function, which elevates their risks for disability and mortality.^{2,3} Therefore, strengthening long-term care systems that address both medical and psychosocial needs is critical for supporting sustainable aging.^{2,3}

Thai families are central to caring for dependent older persons, with over 70% living with or near their children and nearly 90% receiving daily family care.⁶ However, rising numbers of older persons living alone and demographic

shifts—such as smaller families and increased mobility—challenge this traditional model⁶. Caregiving demands also differ by setting, with greater burdens reported in traditional villages than urban housing estates.⁷ To address these challenges, the Community-Integrated Intermediary Care (CIIC) model integrates community services and preventive programs to strengthen family caregiving. It serves as a bridge between informal family care and formal health services, providing caregiver training, respite, and follow-up through community networks. The CIIC approach highlights the importance of combining informal support with professional oversight to sustain care quality and reduce caregiver burden.^{6–8}

A review of studies from various countries highlights the precise needs and challenges faced by family caregivers providing home-based care for older adults. For example, a qualitative study among African American caregivers explored their experiences with healthcare services and emphasized the importance of designing culturally tailored interventions.⁹ Research on dementia caregiving has shown that caregivers often experience emotional stress, social isolation, and strained family relationships. Studies in Asia reaffirm that informal caregivers seek community support and culturally appropriate activities to mitigate these challenges^{10–13}. Common issues identified include limited access to services, complexity in medication management, family tension, and cultural norms that shape caregiving roles and expectations. In the United States, a qualitative study among African American dementia caregivers revealed that cultural values, such as the perceived obligation to repay moral debt, were significant. That is why it may intensify psychological burden and discourage help-seeking behaviors due to mental health stigma and strong familial duties.^{9,10} Similarly, African American caregivers of patients with heart failure reported feelings of abandonment in terms of financial, emotional, and logistical support from the healthcare system.¹³

In the Thai context, research indicates that informal caregivers play a crucial role in supporting dependent older persons at home, often under significant stress. This burden is primarily in large cities where rapid demographic changes and the migration of younger adults to other areas leave the responsibility of caring for older persons to those who remain, most often women. Many of them must balance caregiving with other household duties and often have little or no formal training in caring for older persons. Digital support has shown potential in increasing caregivers' knowledge and reducing stress levels. Likewise, the value of community-based services in reducing caregiver burden and enhancing family engagement in care.⁸ Thai studies also report that older persons are increasingly relying on assistive devices and digital tools in their daily lives. However, disparities in digital access and skills persist, particularly among older adults and their caregivers, highlighting a critical digital divide.^{6,7} While existing research mainly focuses on rural or community-based care models, there is limited understanding of how caregivers in rapidly urbanizing settings adapt, manage challenges, and incorporate digital innovations into home-based elder care. This study aims to address this critical knowledge gap by exploring and describing the experiences, perceived challenges, and care needs of family caregivers of dependent older adults in urban communities within the Bangkok Metropolitan area.

Materials and Methods

This research was conducted in Bangkok, the capital city of Thailand, and employed purposive sampling to recruit 25 family caregivers of dependent older persons. Participants were selected based on predefined inclusion criteria. Data collection took place from February 2018 to October 2021 in the service areas of three Metropolitan Health Centers located in Dusit, Bang Sue, and Phaya Thai districts, which are under the administration of the Bangkok Metropolitan Administration.

Study Design

This qualitative descriptive study aimed to explore and describe the experiences, perceived challenges, and care needs of family caregivers providing care for dependent older persons in urban communities within the Bangkok Metropolitan area, particularly in the context of the digital technology era.^{14,15} Purposive sampling was used to recruit 25 family caregivers residing in Bangkok, the capital city of Thailand. Participants were selected based on predefined inclusion criteria to ensure relevance to the study objectives.

Study Population and Sampling

The study population comprised family caregivers of dependent older persons residing in communities served by public health centers under the Bangkok Metropolitan Administration (BMA). A stratified random sampling technique was first employed to select five public health centers located across three districts—Dusit, Bang Sue, and Phaya Thai. Within these centers, participants were subsequently recruited through purposive sampling to ensure representation of diverse caregiving contexts. Eligible participants met the following criteria: (1) served as the primary caregiver of a dependent older person; (2) were aged 18 years or older; (3) had access to a telephone; (4) were able to read and write Thai fluently; (5) had no communication impairments; and (6) provided voluntary informed consent to participate. In this study, a dependent older person was defined as an individual aged 60 years or older who required partial or complete assistance with activities of daily living (ADLs)—including bathing, dressing, eating, toileting, transferring, and mobility. This classification followed the Thai Ministry of Public Health's functional dependency criteria, which categorize older persons according to their Barthel ADL Index scores; those scoring ≤ 11 were considered partially or wholly dependent and thus eligible for inclusion. Participant recruitment was facilitated through referrals from healthcare professionals (eg, doctors, nurses, and social workers), community outreach activities related to eldercare, and online platforms, including social media groups dedicated to family caregivers. A total of 25 participants were recruited, with the final number determined by the point of data saturation during in-depth interviews.

Data Collection

Following ethical approval from the Institutional Review Board of the Faculty of Medicine, Ramathibodi Hospital, and the Ethics Committee of the Bangkok Metropolitan Administration, the research team coordinated with Metropolitan Health Centers (MHCs) and obtained permission from the center heads. Meetings were conducted with health personnel, village health volunteers (VHVs), and family caregivers who voluntarily agreed to participate, to clarify the study objectives and establish a data collection schedule. During data collection, the research team introduced themselves to participants and explained the study's purpose, procedures, duration, and potential benefits and risks. Those who agreed to participate signed informed consent forms prior to the interviews. Data were collected through semi-structured interviews that used both open- and closed-ended questions to explore the characteristics of dependent older persons and their family caregivers. The interview guide covered five key areas: (1) demographic information of caregivers and care recipients, (2) types and frequency of caregiving activities, (3) challenges and difficulties in providing daily care, (4) available formal and informal support systems, and (5) perceived needs and suggestions for improving community-based care services. Each interview lasted approximately 45–60 minutes and was conducted face-to-face at participants' homes or local health facilities. To ensure accuracy and reliability, all interviews were audio-recorded and transcribed verbatim. The interview guide demonstrated strong content validity, as confirmed by three experts (Content Validity Index = 0.97). Data were analyzed using the conventional content analysis approach.

Data Analysis

This study employed conventional content analysis, as described by Hsieh and Shannon, to examine the perceived problems and needs of family caregivers of dependent older persons.¹⁵ The analysis began with repeated readings of interview transcripts to gain a comprehensive understanding of the content. Subsequently, the data were reviewed line by line to identify meaningful words or phrases, which were then highlighted and assigned initial codes. Codes with similar meanings were grouped into subcategories and further organized into broader categories to reveal emerging patterns. A coding framework was developed to ensure consistency, with clear definitions established for each code and category. Representative quotations were selected to support interpretation, and relationships among categories were analyzed to provide a deeper and more comprehensive understanding of the findings.

Results

The study involved 25 family caregivers of dependent older persons, with a mean age of 58.12 years (SD = 12.59), ranging from 30 to 88 years. Many caregivers were female (80%) and typically had attained either primary (44%) or

secondary education (32%), while smaller proportions held a vocational certificate (12%), a bachelor's degree (4%), or had no formal education (8%). More than half (56%) reported having at least one underlying health condition. Regarding living arrangements, the vast majority (88%) co-resided with their children and shared caregiving responsibilities within multigenerational households, whereas only 4% lived solely with a spouse and 8% were hired caregivers providing paid assistance. The older persons under their care had a mean age of 78.64 years (SD = 10.28), with an age range of 61 to 100 years. Most were classified as having severe dependence in activities of daily living (ADL) (64%), followed by moderate dependence (28%) and total dependence (8%), suggesting that caregivers were providing support to highly dependent individuals. Most caregivers reported mild burden (76%), while 16% experienced moderate and 8% severe burden. Overall, these findings depict a caregiving population composed predominantly of middle-aged women living in extended-family households who, despite personal health concerns, remain actively involved in caring for older relatives with substantial functional limitations. Details of these characteristics are presented in Table 1.

Table 1 Sociodemographic Characteristics of the Study Participants (N = 25)

No.	ID	Gender	Caregivers Age	Education	Underlying Diseases of Caregivers	Living with Extend Family	Older Persons Age	ADL (0–20)	Burden Score
1	001	Female	88	Primary education	Yes	With children (shared care)	86	11	Mild
2	002	Female	54	Primary education	Yes	With children (shared care)	62	11	Severe
3	005	Female	51	Secondary education	Yes	With children (shared care)	76	4	Mild
4	006	Female	57	Primary education	Yes	With children (shared care)	62	11	Mild
5	007	Female	30	Secondary education	Yes	With children (shared care)	76	11	Mild
6	008	Female	59	Primary education	No	Hired caregiver	76	0	Mild
7	009	Female	51	Vocational certificate	Yes	With children (shared care)	85	3	Mild
8	013	Female	72	Vocational certificate	Yes	With children (shared care)	71	4	Moderate
9	014	Female	51	Secondary education	No	With children (shared care)	85	4	Mild
10	017	Female	65	Primary education	Yes	Living alone with spouse only	88	0	Mild
11	019	Female	58	Primary education	Yes	With children (shared care)	88	1	Mild
12	024	Female	43	Secondary education	No	With children (shared care)	87	11	Mild

(Continued)

Table 1 (Continued).

No.	ID	Gender	Caregivers Age	Education	Underlying Diseases of Caregivers	Living with Extend Family	Older Persons Age	ADL (0–20)	Burden Score
13	025	Female	43	Secondary education	No	With children (shared care)	77	2	Mild
14	030	Male	72	No formal education	No	With children (shared care)	74	5	Moderate
15	060	Female	80	Primary education	Yes	With children (shared care)	85	1	Moderate
16	074	Female	61	Primary education	Yes	With children (shared care)	84	1	Mild
17	076	Female	67	Primary education	Yes	With children (shared care)	64	4	Mild
18	077	Male	51	Secondary education	Yes	With children (shared care)	84	9	Mild
19	084	Male	48	Secondary education	No	With children (shared care)	83	8	Mild
20	091	Female	52	Bachelor's degree	No	Living alone with spouse only	61	11	Mild
21	092	Male	51	Vocational certificate	No	With children (shared care)	72	4	Mild
22	093	Female	51	No formal education	No	Hired caregiver	85	2	Mild
23	094	Female	63	Primary education	No	With children (shared care)	90	1	Mild
24	095	Female	69	Primary education	Yes	With children (shared care)	100	4	Severe
25	100	Male	66	Secondary education	Yes	With children (shared care)	65	2	Moderate

This study examined the perceived problems and care needs of family caregivers of dependent older persons in urban communities, employing a conventional content analysis guided by Donabedian's framework. Findings were organized into two overarching themes—Perceived Problems and Identified Needs—which reflected caregiving experiences across the structure, process, and outcomes of care. Caregivers encountered a variety of interconnected challenges, including limited knowledge and caregiving skills, time constraints, social isolation, declining health, financial strain, and difficulties managing the emotional and behavioral problems of older persons. Many caregivers reported lacking confidence in performing clinical tasks such as catheter care, rehabilitation exercises, and monitoring for complications like pressure sores. One participant shared, “Sometimes the older persons are stubborn... but their hearts,” while another noted, “They're forgetful, quite difficult to take care of.”

Balancing caregiving with employment and household duties was another significant difficulty: “I have to go to work for income... but no one else can take care of the older person, who is bedridden.” Physical strain was common, with several caregivers reporting back and shoulder pain from lifting patients without assistive equipment: “The older persons

are big... lifting them is difficult.” Environmental barriers, such as narrow entrances and inaccessible pathways, further complicate patient transport to hospitals. Financial hardship emerged as a dominant concern; caregivers often struggled to afford medical supplies, assistive devices, or special diets. Emotional strain was also pervasive, as caregivers described frequent conflict and fatigue when caring for noncompliant or irritable older adults: “Sometimes they don’t cooperate—they quarrel and scold regularly.” These problems illustrate the multidimensional burdens caregivers experience within both structural and process components of care.

Qualitative findings elaborated on caregivers’ expressed needs and suggested solutions, summarized. Eight interrelated domains were identified, encompassing access to practical health information, telehealth and online consultation services, transportation and mobility support, home-based care, financial and psychosocial assistance, social respite support, environmental accessibility, and emotional recognition from healthcare and government agencies. Participants highlighted the need for explicit, easy-to-understand caregiver education materials and their dissemination through familiar media platforms such as YouTube, television, and social media. They emphasized the importance of developing teleconsultation systems, mobile medical units, and in-home healthcare services to enhance continuity of care and reduce travel-related burdens. Financial strain—particularly in households caring for multiple dependent older adults—was frequently mentioned, underscoring the necessity of sustained financial support and caregiving allowances. Beyond economic and logistical challenges, caregivers expressed a deep desire for empathy, acknowledgment, and emotional support from health professionals and policymakers. Many felt overlooked, digitally excluded, or unsupported by the system, with one caregiver expressing, “I just wish someone would listen and truly understand what caregivers go through.”

Collectively, these findings point to significant structural and procedural gaps in service accessibility and digital health support that affect the continuity and quality of care. Guided by Donabedian’s framework, they underscore the urgent need for an integrated, compassionate, and technology-enabled community-based care system that supports both dependent older persons and their family caregivers, as illustrated in [Table 2](#).

Table 2 Summary of Caregivers’ Needs and Suggested Solutions

Theme	Identified Needs	Suggested Solutions
1. Access to Information	- Lack of accessible and easy-to-understand caregiver education materials- Need for wider educational channels	- Provide simple, accessible materials on older persons care- Use popular platforms (eg, TV, online media)
2. Online Health Services	- Need for teleconsultation services- 24/7 accesses to physicians or nurses via video call	- Develop older persons-friendly telehealth platforms- Implement emergency online consultation systems
3. Transportation Support	- Difficulty accessing hospitals- Need assistance transporting or lifting bedridden patients- Need new wheelchairs	- Deploy mobile medical transport units with trained personnel- Provide mobility aids (eg, wheelchairs)
4. In-home Healthcare	- Request for home visits (eg, medication, wound care)- Difficulty traveling to healthcare facilities	- Offer home-based healthcare services- Allow medication pickup by relatives
5. Financial Support	- Inadequate financial assistance for older persons care- High-cost burden in multi-patient households	- Increase older persons care allowance- Provide long-term support for households with multiple patients
6. Social Support	- Lack of support staff- Caregivers left alone without assistance throughout the day	- Establish rotating volunteer or staff support programs
7. Accessibility & Infrastructure	- Inaccessible housing and narrow roads- Lack of internet or digital devices at home	- Provide digital tools on loan to households- Deploy outreach workers in underserved areas
8. Recognition & Empathy	- Need for emotional support and empathy from government agencies- Feeling overlooked by the system	- Create structured feedback channels for caregivers- Regularly acknowledge and respond to concerns

Discussion

This study aimed to explore and describe the experiences, perceived challenges, and care needs of family caregivers providing care for dependent older persons in Bangkok's urban communities within the context of community-based care systems. The findings revealed two overarching categories—Perceived Problems and Identified Needs—that together illustrate the multifaceted realities of family caregiving in modern Thai society. These results highlight how caregivers balance traditional care expectations with the new demands and opportunities.

First, the study found that caregivers faced complex and interrelated problems encompassing physical, emotional, social, and financial dimensions. Many participants reported limited knowledge and confidence in performing essential caregiving skills, such as catheter care, wound management, and rehabilitation, leading to dependence on healthcare providers. The physical strain of lifting or repositioning patients without proper equipment, combined with time constraints and employment duties, contributed to exhaustion and social isolation. Emotional distress was common when caring for older adults who were resistant or forgetful, while financial strain arose from uncovered expenses such as adult diapers and wound supplies. These challenges mirror those reported by Hailu et al who observed that caregivers in resource-limited contexts experience high physical and emotional burdens,¹⁶ and by Chan et al, who emphasized the need for adequate training and support systems for family caregivers.¹⁷

Second, to address these challenges, caregivers expressed eight major areas of need: (1) access to clear and practical health information, (2) online and telehealth services, (3) transportation support, (4) home-based healthcare, (5) financial assistance, (6) social support, (7) access to technology and infrastructure, and (8) recognition and empathy from health authorities. These findings suggest that while caregiving remains rooted in familial and cultural responsibility, digital solutions are increasingly seen as essential tools to reduce caregiver burden. Participants emphasized the value of accessible health education through familiar media such as YouTube, television, and LINE, and requested home visits and teleconsultation systems for better continuity of care. This aligns with the importance of strengthening digital literacy among caregivers to minimize the digital divide and promote self-care in aging societies.¹⁸

Third, while Donabedian's framework¹⁴ was applied conceptually rather than evaluatively, it provided a useful lens to understand how structural factors (eg, income, service access, digital tools) influence caregiving processes (eg, daily activities, communication with health services) and outcomes (eg, caregiver well-being and continuity of care). In this study, structural barriers such as limited digital access, unstable financial resources, and inadequate home infrastructure directly affected caregiving practices. Some caregivers demonstrated adaptability by using mobile communication applications to contact health workers, yet many felt excluded due to low digital literacy or lack of devices, reflecting persistent inequities in digital access. Finally, this study contributes new evidence to gerontological nursing by focusing on urban family caregivers, a group often neglected in Thai research dominated by rural contexts. By integrating both perceived problems and identified needs, the findings extend understanding beyond the concept of "caregiver burden" to encompass the interplay between digital inequality, social isolation, and structural limitations. The research thus bridges micro-level experiences of caregivers with macro-level dynamics of urbanization and technological change. Practically, these results have implications for policy, education, and service design: policy-makers should integrate digital health solutions into community-based care; educators should embed digital health literacy in caregiver training; and healthcare systems should foster collaboration between caregivers, health professionals, and community networks through technology-supported platforms.^{18–20} In conclusion, supporting family caregivers represents not only a public health priority but also a vital foundation for building resilient and age-friendly communities in Thailand. The findings underscore the urgent need for integrated long-term care systems that combine empathy, accessible health information, and effective support mechanisms to ensure sustainable and high-quality care for dependent older persons in rapidly urbanizing societies. Evidence from recent regional research supports these conclusions. For example, this research identified caregiving as a strategic policy priority across Asian countries, emphasizing the importance of developing coordinated social and health systems to strengthen caregiver capacity and enhance the quality of older persons' care.²¹

Limitation

As with most qualitative research, this study is inherently subjective, relying on participants' perspectives and interpretations. The findings reflect the specific viewpoints of those who participated in the study, and other family caregivers in similar roles may encounter different challenges or prioritize different issues. Additionally, the limited sample size typical of qualitative designs means that the insights drawn may not be fully generalizable to all caregivers in comparable situations.

Conclusion

This study highlights the complex and multifaceted experiences of family caregivers providing care for dependent older persons in Bangkok's urban communities. The findings reveal that caregivers face significant challenges in four main areas: limited caregiving knowledge and skills, physical and emotional strain, financial hardship, and restricted access to healthcare and social support services. Despite these difficulties, caregivers expressed clear needs across eight domains—access to practical health information, transportation and in-home healthcare services, financial and social support, adequate caregiving resources, suitable home environments, and recognition from health authorities. These findings underscore that caregiving for dependent older persons in urban settings involves not only physical and emotional effort but also substantial social and financial responsibility. Strengthening caregiver capacity, therefore, requires integrated support systems that combine health, social, and community resources. Developing structured caregiver education, improving access to essential care services, and enhancing coordination among families, communities, and health professionals are key strategies to sustain family-based long-term care. In conclusion, this study contributes to a deeper understanding of the realities of family caregiving in urban Thailand. It provides evidence to guide the development of community-based eldercare programs and policies that are responsive, equitable, and supportive of both caregivers and older persons.

Abbreviations

BMA, Bangkok Metropolitan Administration; CICC, Community-Integrated Intermediary Care; CVI, Content Validity Index; MHCs, Metropolitan Health Centers; VHV, Village Health Volunteers.

Data Sharing Statement

The data used and analyzed in this study can be obtained from the corresponding author upon reasonable request.

Ethics Approval and Informed Consent

The study was approved by the Human Research Ethics Committee of the Faculty of Medicine, Ramathibodi Hospital, Mahidol University (COA. MURA2017/675), and the Ethics Committee of the Public Health Nursing Division, Bangkok Metropolitan Administration. The research was conducted in accordance with the ethical principles of the Declaration of Helsinki. Written informed consent, which included permission for the publication of anonymized responses and direct quotes, was obtained from all participants. Participation was voluntary, with the right to withdraw at any time, and confidentiality was maintained with coded identifiers.

Consent for Publication

All participants gave their consent for their responses to be published, with strict measures implemented to maintain confidentiality and safeguard their identities during the reporting process.

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Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work. Supichaya Wangpitipanit led the study's conceptualization, drafted the initial manuscript, co-prepared the final version, and coordinated communication with the editor; Kamonrat Kittipimpanon supervised the study, supported the writing process, and provided critical revisions; and Nipawan Chankollawee contributed to data collection, validation, manuscript preparation, and editorial assistance.

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Disclosure

The authors declare that there are no potential conflicts of interest with respect to the research, authorship, or publication of this article.

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