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Home Care in Thailand
A Qualitative Study of Patients' Experience of Being Cared
in Their Own Home

Matilda Gäfvert
Caroline Laursen



HÖGSKOLAN I BORÅS
INSTITUTIONEN FÖR VÅRDVETENSKAP

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Authors: Matilda Gäfvert and Caroline Laursen

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Coordinator: Anders Jonsson, Senior Lecture at School of Health Sciences,
University of Borås, Sweden

Examiner: Lars Sandman, Professor at School of Health Sciences, University
of Borås, Sweden

ABSTRACT

This study is sponsored by Minor Field Study (MFS) scholarships from the University of Borås, funded by the Swedish International Development Cooperation Agency (SIDA). Thailand is a densely populated developing country situated in Asia. The relatives are the most important social network in Thailand. People all over the world, including Thai people are in need of aftercare when they have left the hospital. In Thailand this care mostly executed by relatives.

There is not much research done that shows the patient's perspective of home care in Thailand so it is important to do this study. The aim of the study is to illuminate the Thai patients' perspective of being cared in their own home. The qualitative interviews were made with six patients at a hospital in Bangkok. The authors had one in beforehand-prepared question, but had to put in some stimulating questions in all of the interviews. To describe and analyze the result the authors did qualitative content analysis. The criteria to take part in this study were that the interviewees were Thai, over 25 years old and had experiences of being cared in their own home, by relatives or by professionals.

The result is presented with meanings units, codes, sub-categories, categories and content areas. The content areas are; *the patient does not experience any problems with home care* and *the patient experience problems with home care*. The categories are *good experiences and naturally* and *hard experiences*. The authors then made sub-categories and named them; *safety, family as caregiver is expected, solidarity, grateful, sense of guilt, insecure and hard to be dependent*.

The authors found out that all the interviewees experienced home care as something naturally, when it is a part of life to be cared by your relatives in Thailand. This expression fits in under the first content area, but some of the interviewees also expressed feelings that fit in under the opposite content area. In the end of the study the authors discuss different choices that they have done, and the consequences that followed with them, in a discussion of the method. Even the use of an interpreter is discussed in this part. In the discussion of the result the authors discuss the most interesting parts of the result and verify this with references from scientific articles. One thing that the authors found out was that home care in Thailand can be expressed with both positive and negative experiences from the same person.

Keywords: Home care, patient perspective, Thailand, family caregivers, qualitative interviews and qualitative content analysis.

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INTRODUCTION

This study is written by two nursing students from the University Collage of Borås, Sweden. The authors of this study got two Minor Field Study (MFS) scholarships from the University Collage of Borås, funded by the Swedish International Development Agency (SIDA) to do a study in a developing country and where the aim is to work with developing questions. The authors had non earlier experiences with interviews, or conducting studies at this level. The authors have an interest for home care in their own country. They found out that home care by professionals in Thailand is different from the home care in Sweden. In Thailand relatives execute most of the home care and there is literature that illuminates home care in Thailand from the caregiver perspective. After the preliminary literature search they did not find any studies that shown experiences of home care from a patient's perspective. The aim of the study is therefore to illuminate the Thai patients' experience of being cared in their own home.

The study is based on qualitative interviews with patients from a hospital in Bangkok. The collected data were then analyzed with qualitative content analysis in Thailand during Mars to May 2010.

BACKGROUND

Thailand

Thailand is a country situated in Asia and has international boundaries to Malaysia in the south, Cambodia in the east, Laos in the north and Burma in the west (Landguiden, 2010). Thailand is one of the less urbanized countries in Asia and most of the people are living at the countryside. There are regional and cultural variations among the Thai speaking people. (Svanberg & Trankell, 2010).

The area of Thailand is 513 115 km² (Sweden's area is 450 295 km²) and there are 66,1 million inhabitants in Thailand. The capital is Bangkok and with 5,7 million citizens is it the only big city in the country. In 2008 the native population was increased by 0,5 per cent and the expected numbers of inhabitants in 2050 are 68,9 million. The life expectancy in 2008 was 68 years for men and 75 years for women (Mårtensson, 2010). The family has always been, and still is, the most important social network for the Thai people. The pension, child allowance and the unemployment is depending on your employment agreement and is not obligatory. Drug trafficking, child labor and prostitution are all effects of the significant social problems in Thailand (Mårtensson, 2010).

The official language is Thai and the name Thailand means "the country of freedom" (Davies, 2008). Thailand is a monarchy with a parliamentary democratic system. The king is the head of state and the commander in chief. The king is popular but his formal political power is limited (Landguiden, 2010) (Cummings, 1995).

Politic

Thaksin is the name of the former Prime Minister, he and his political party Thai loves Thai (TRT) had the power between 2001 and 2006. Thaksin introduced “the 30 baths reform” which means that every Thai just had to pay 30 baths to go to hospital (Landguiden, 2010). Bath (THB) is the currency in Thailand and one Bath corresponds to 0,25 Swedish crowns (SEK) according to Forex (2010). The 19th of September in 2006 there was a military coup in Bangkok. The coup resulted into that the constitution was abolished, the parliament and government was unseated and the TRT was not longer in the position of the political power. The new reform that came in 2007 after the military coup in 2006 an example is that a Prime Minister cannot be on his post for more than eight years in a row. After the coup in 2006, the human rights were affected in a negative way, for instance the freedom of speech and military laws were introduced in all provinces of the country. After the coup there was an election in 2007, which gave the Chart Thai party the political power in Thailand (Landguiden, 2010).

Religion

The main religion in Thailand is Buddhism and almost 95 percent of the Thai people are practicing the religion (Hagren, 2010). According to Dangdomyouth, Noerager Stern, Oumtanee and Yunibhand (2008) it is important to do well in life, earn merits, to get a good karma. Karma is good or bad luck and depends on how you do your choices in life. That is how a practicing Buddhist thinks, that he or she can affect their next life. According to Persson (2001) and Cummings (1995) Siddhartha Gautama is the founder of the Buddhism and he got the name Buddha which means the “enlightened man”. Buddhism is built upon four original truths. The first one is the truth about Dukkha which means that life is all about pain, sorrow and suffering. The second is the truth about the reason that Dukkha appears. The third truth is about Dukkha’s ending and the fourth and last truth is the one about how to end Dukkha. Persson (2001) and Cummings (1995) further write that a Buddhist believes in rebirth which is an important thing in the religion.

The Buddhist monastic order is still going strong in Thailand. It is still occurring that sons in Thai families are spending time in the monastery as novices and can be compared to a school education. It is common that one son enters a monastery and become a monk (Hagren, 2010).

Education

The national education commission has the responsibility for the education and is during the Prime Minister (Husén, 2010). Landguiden (2010) says that the school in Thailand is free from charge for 12 years but that many of the young Thai just go to school for eight years. A little bit more than 25 per cent of them who go to school continue with higher education, such as university, after they have finished the first 12 years. The educational level among the adult Thai people is significant lower than for the younger. Even if over 25 per cent of the people continue with further education, the labor market is still in need of more people with higher education.

According to Anders and Kunaviktikul (1999) the history of nursing in Thailand is long. Anders and Kunaviktikul (1999) refer to Muecke and Srisuphan who say that the first nurses belong to the urban nobility, and they were the only one who had three years of education which was needed to become a nurse. The first nursing education for women started in 1896 and it was Queen Sripatchariantra, the queen of Rama V, who initiated nursing as a job for women. At first it was the Buddhist monks who taught men how to execute care and there was no education for women.

The education is today pursued in both schools that are under the Ministry of Public Health and private schools but also in agencies like the Department of the Police and the Department of the Army, the Air force and the Navy (Anders & Kunaviktikul, 1999). Anders and Kunaviktikul (1999) refer Ministry of University Affairs who describe a typical four year nursing education. The students read microbiology, statistics philosophy, public health, pediatrics, gynecology and psychiatric mental health. The education also includes instructions in primary care and in midwifery.

The Thai health care system

Thailand's health care system includes five different levels and is under the authority of the Ministry of Public Health. The levels are *self care* which means that the family are supporting their relatives to care for them self. *Primary health care* which means that voluntaries are providing care for persons in the community. *Primary care* is when professionals are providing care for persons in the community, *secondary care* is care provided by professionals and specialists. *Tertiary care* which means care on a high level (Choowattanapakorn, Nay & Fetherstonhaugh, 2004). Mårtensson (2010) describes that there are many private hospitals in Thailand which are high class and high price and that this is an effect of the few numbers of hospitals in Thailand in 1990.

The care system is supported by four types of programs, *voluntary health insurance*, *obligatory programs* that companies with more than ten employees have to pay, *social welfare programs* which help the poor people in the society, *fringe benefits* which are for people who work for private companies, the government agencies and people working for the state. Even if there is one health financing system for everyone, even for the poor people, it was 23 million people in 2004 that were not enclosed in any of the systems (Choowattanapakorn, et al. 2004).

Home care in Thailand

Most Thai families stay together in one household their whole life through, a family member are therefore the principal caregiver when someone gets sick (Choowattanapakorn, et al. 2004). The main role of home care in Thailand is executed by the family. Lund and Subgranon (2000) describe that home care in Thailand is executed from the bases as; care giving as a part of life, care giving as something that is needed, care giving with love and sympathy, care giving as family support and as managing difficulties in the daily life situation. Lund and Subgranon (2000) continue and say that many studies show that experiences of being a caregiver to a dependent relative are both negative and positive. Many caregivers experience that they can get help from relatives, neighbors and health care providers. Before the patient will leave

the hospital the family will get a short instruction in how the medical care and treatment will be performed at home.

Lund and Subgranon (2000) are describing home care in Thailand from a caregiver's perspective. This perspective have also been described in other studies, for example in the articles by Bolton (2006), Choowattanapakorn, et al. (2004), Maneesriwongul, Ounprasertpong, Panutat, Putwatana, Srirapo-ngam and Williams (2004), Dangdomyouth, et al. (2008).

Central concepts in caring science

Human being and Life world perspective

Eriksson (1994) mean that caring science has a multidimensional view of the human being. According to caring science, the human being is a unity of body, soul and spirit. The human being should always be seen like a unit and not be separated into three different parts. The human being is developing in the relation with other people and their surroundings (Wiklund, 2003). Life world is the world that we live in but it is not the same as the physical reality. All human beings have their own life world because Wiklund (2003) says that the life world is depending on the way you *live* the world. The life world is the way we experience the world through our own bodies and therefore you can never separate the life from the world (Wiklund, 2003).

Caring relationship

It is in the relation to other people that we are growing as human beings. The optimum care is characterized by that the caregiver and the patient have the same aim with the caring relationship and the care. The caring relationship is asymmetric when the patient is in a position of dependence to the caregiver. The caregiver has the power and the patient can feel insulted in the relationship if the caregiver is using his or her power in the wrong way. It is therefore important that caregivers will make reflections about their acting so an unethical situation will not appear. The caring relationship is mutual though the caregiver is offering her help while the patient receives it. The caregiver, with the power, has the major responsibility that the caring relationship will be in a professional way. Some patients can see the caring relationship as a threat against the integrity, and therefore it is important that the relationship is based upon the patient's needs (Wiklund, 2003).

Health, health-resources and health-obstacles

Ericsson (1989) says that health is a part of the life and depending of the human being's relationship to the world. She further describes that the experience of soundness, freshness and wellbeing in relation to the whole human body can be described as the feeling of health. You always have to treat the whole human body and always look at the human being as a body, soul and spirit. The experience of health is subjective and the feeling can be changed for the same person from different points of time. Health is

something that most people do not think about before the feeling of health is threatened. Health is an ongoing process and it is something that you *are* rather than something that you *have*. Eriksson (1989) writes that when you *are* health you will experience yourself as a unit. Further Eriksson (1989) says that you can feel healthy even though you have an illness. Even though professionals or the society describes the person as well or unwell, the person can still feel health or unhealthiness.

Wiklund (2003) says that you can have different types of health-resources and describes these as all the tools that you can use to overcome your suffer and unhealthiness and instead get the feeling of being health. Health-resources are divided into two different parts, one internal and one external. An internal resource can be that you are able to talk about your illness and suffer to increase the insight of your illness. Faith and hope are two other examples of internal resources. External resources are for example love, care and help from family and friends. The opposite of health-resources is health-obstacles. Health-obstacles can be expressed in an approach of body, soul and spirit. One thing that in one way can be captured as a resource can in another way became an obstacle. For example, a caregiver who first is helping the patient may later take over the patient's choices, the autonomy and the ability to make decisions. Stryhn (2007) describes that, autonomy implies self-determination and that the caregiver has an important role to protect this for the patient. Autonomy is an important part of the care. If the caregiver disregards the autonomy, the patient may not be able to do anything by herself and the caregiver will become an obstacle rather than a resource. Wiklund (2003) describes that resources are help to be and to experience health while the obstacles make it more difficult.

Suffering

“The etymological conception of *patient* means a ‘suffering human being’, and suffering (not illness or unhealthiness) set as nursing science’s basis.” (Wiklund, 2003, p. 144) (Authors translation)

According to Wiklund (2003) health and suffering are both a part of life. They are not opposites, but in relation to each other. When suffering is a part of every human being's life it is important to talk about it as well for the caregiver as for the patient. The human being herself describes often suffering as a form of threat, insulting or the feeling of lost. One thing that all these feelings have in common is that they can lead to that the human being will be quite and close her feelings inside. Eriksson (1994) who says that you can feel suffering depending on three different sources; *suffering of illness*, *suffering from caring* and *life suffering*.

Eriksson (1994) describes that *suffering of illness* comes with the symptoms and the feeling of being inhibited in the daily life. It can be both the pain from the illness and the fear of not being able to come back to the life as it was before. *Suffering from caring* means that you feel suffering from the care and/or treatment you are given or the absent of these two. This suffering is principal depending on the caregiver and it is something that can prevents. It can, for example, depend on that the patients did not get their medical treatment or that the caregiver did not take the patients' expressions of their

symptoms for real. Patients can feel offended when they feel like nobody is listening or not taking their pain and symptoms seriously. To prevent this suffering it is important that caregivers take time for reflection in how they can change the care to reduce the patient's feeling of suffering. Wiklund (2003) describe *life suffering* as the deepest part of suffering and can be affecting the whole life, the self-image and how we understand the reality. This form of suffering will be actualized when the human get sick and their body, soul and spirit will be threatened. It is in situations like this that questions of existence will be actualized. This can be a difficult subject to talk about, even for the caregiver, but it is a question that is important to lift up for discussion. In the deepest meaning of suffering it can be seen as a fight between life and death. Wiklund (2003) ends with; that this is why you can say that life suffering can affect the whole existence of a human being.

RATIONALE OF THE PROBLEM

A lot of people in the world suffer from unhealthiness and are in need of different kinds of care. There is often a need of aftercare when the patient has left the hospital. Relatives principally execute the home care in Thailand.

There are a lot of researches that show the caregiver's perspective from home care in Thailand. Some of the articles that the authors of this study have found say that there is a need of further research of the patient's perspective of home care. The authors have not found any material that show home care in Thailand from a patient's view. To be able to execute the care in the best way for the patient there is a need of knowing the patient's experience of the care.

AIM

The aim of this study is to illuminate the Thai patients' experience of being cared in their own home.

METHOD

This is an empirical study based on qualitative interviews with patients at a hospital in Bangkok. To describe and show the result the authors made qualitative content analysis. The data for this study were obtained from interviews and then analyzed in Thailand during March to May 2010.

Selection of participants

The authors got in contact with a nurse at a hospital in Bangkok through a nurse in Borås. The nurse helped the authors to get in contact with the patients and then she elected the interviewees after who matched the, in beforehand prepared, inclusion criteria. The inclusion criteria to participate in this study were that the interviewees were Thai, over 25 years old and had lived experience of being cared in their own home, by professionals or by family caregivers.

Participants

The complete size of interviews in this study is six, one man and five women. The interviewees ranged in age from 27 to 74 years, five were Buddhists and one was Christian. All interviews were made in the same hospital in the central of Bangkok. One of the interview was made in an eye ward, one in a surgical ward and the other four interviews were made in an orthopedically ward. Every interviewee lived together with their family members except from one, who lived together with some friends. No one had experience of being cared in the home by professionals they were all cared by relatives.

Data collection

A quantitative approach implies that the author will take a step back when collecting the data for the study, while the author with a qualitative approach are more implicated of the data collection (Lundman & Hällgren Graneheim, 2008). Kvale (1996) thinks that an interview is an “inter view” in a person’s lived experience. To do interviews is a good method to get knowledge about the human’s life world. According to Kvale (1996) and Nyström (2008) the qualitative interview method is usable when the aim is to understand a person’s lived experience from a life world perspective. When that is the aim of this study the authors choose to do qualitative interviews to collect data.

“If you want to know how people understand their world and their life, why not talk with them?” (Kvale, 1996, p. 1)

All interviews were made with one interviewee at the time and this type of interview situation is the most common according to Kvale (1996). Two of the interviewees had one relative each attending during the interview. The authors chose to do a non-structured type of interview. They just prepared one question prior to the interview. This is the interview form that is recommended to use when you do not have earlier experience of the subject that is studied (Bell, 2000). The question that the authors asked was “Can you describe your experience of being cared in your own home?”

Both authors took part in all six interviews. Every interview lasted on between 20 to 40 minutes. All interviews were, after permission from the interviewees, tape-recorded so they could be documented afterwards. The authors tried to not place any of their own values into the interviews. This is, according to Nyström (2008), the way an author should act when he or she makes interviews in a study from a life world perspective, the author should not control the fact but except the “lived experience”. Lundman & Hällgren Graneheim (2008) describe that when people are speaking freely about their lived experience, concerning a specific phenomenon, the type of data collection is called narrative interviews. The authors of this study chose to do qualitative, narrative, interviews with a life world perspective. In all six interviews the authors had to put in some stimulating questions like; “Can you describe more about that feeling?” and “How do you feel then?” When the author stimulates the interviewee he or she will affect the interviewee’s story. But according to Lundman and Hällgren Graneheim (2008) it is

impossible and not either the meaning that the author of a narrative interview should stay outside the situation.

To use an interpreter

The authors of this study do not have any knowledge in Thai and none of the interviewees were comfortable with English. For that reason the authors chose to use an interpreter. The interpreter helped the authors to translate their questions from Swedish to Thai. Kapborg and Berterö (2002) describe that it is important for the author to understand that an interpreter can affect the validity for the result, for example by summarize the answers in the interview.

Qualitative content analysis

The authors do not have any earlier experience of making interviews, doing analyses or writing an essay on this level. Lundman and Hällgren Graneheim (2008) think that it is an advantage with qualitative content analysis that the author do not need any earlier experience, but they further describe that the more experience the author has will have affect for the result. Lundman and Hällgren Graneheim (2008) refer to Söderberg and Lundman who say that in caring science it is often made interpretations and analyses of tape-recorded interviews with qualitative content analysis. Lundman and Hällgren Graneheim (2008) say that this is a useable method in caring science.

Lundman and Hällgren Graneheim (2008) say that the reliability for the result depends on how you pick out the participants for the study. They also say that with perspective from both women and men, in different ages, the author should be able to attain the aim of qualitative analysis which is to describe the variations. Lundman and Hällgren Graneheim (2008) further describe that qualitative content analysis with an inductive approach is useable if the author with a human's history in focus will do analyses without any preconceived thoughts.

Central concepts for qualitative content analysis are; *analysis unit*, *content area*, *meaning unit*, *condensation*, *abstraction*, *code* and *category*. The analysis unit is the material to work with, and in this study it is the interviews that are the analysis unit. Content area is a part of the analysis unit, a phase that is responding to a phenomenon. Meaning units are an important part of the analysis unit and can be built upon a single word or content meanings. The size of the meaning units is important for the result. During the process the next step will be condensation and this means that words from the meaning units without a significant meaning will be taken away. That will keep the important parts of the meaning units left and make the text easier to work with for the author. After this, the process goes into abstraction, which means that the author lifts the text to a higher level. The following part for the process is to put a code into a meaning unit. During the last three parts it is important to look over the "new fact" against the analysis unit to control the context. Codes with the similar content built a category and answer the question "*what*". It is an important rule to make different categories so no significant data will be in more than one category or become neglected. This can be difficult to follow when the data is about experiences. At the end you can create themes

that describe meanings that will appear in different categories (Lundman & Hällgren Graneheim, 2008).

The central part of qualitative content analysis is to describe variations when you have found subjects in a text that are different and similar to each other. The differences and the similarities that are found will be put in a row of sub-categories and categories in different levels. When the author makes the sub-categories and categories it is important to not forget the meaning of the context. The context can be compared to a situation that something is found. For example the knowledge about where in the world the study is made, if that is important for the result. Another example for context is what is written before or after a specific statement (Lundman & Hällgren Graneheim, 2008).

Analysis of the collected data

The authors have worked together with every part of the analysis. However, they worked separately on the transcriptions. It is time-consuming to work together with the analysis but Lundman and Hällgren Graneheim (2008) says that this is a good way to increase the reliability in the result.

The analyzing of the data was made according to the qualitative content analysis that is described above. The interviews were translated from Thai to Swedish and then written down and translated to English. The authors read the text several times to get a deeper knowledge about the contents, the spread, the value and the quantity of the collected data. This gives the authors the possibility to see which part of the text that responds to the aim of the study. The authors describe the interviewees' gender, age and home situation and give quotation from the interviews. According to Lundgren and Hällgren Graneheim (2008) this will give the reader a bigger chance to form an opinion about the validity of the study.

The authors took out content areas that were important against the aim from the analysis units. After that they took out meaning units from the content areas. During this process the two authors discussed different meaning units that could be of value for the result. The meaningful information that the authors found were then condensed, which means that you take away the unnecessary words. This made the data easier to work with, to abstract and to put codes on. Every part of the process was saved in the original form, which made it possible for the authors to go back and make sure that every part was significant against the ground material.

The authors did not have any earlier experience of caring in Thailand and they did not have any knowledge about what is significant of Thai family affairs and their circumstances. Even if the authors do not have any specific experience of Thailand, they still have their preconceived thoughts. Nyström (2008) refers to Gadamer who says that the preconceived thoughts are based on our lived experiences. This is how the authors of this study understand the meaning of preconceived thoughts and the importance of reflection. They are therefore doing self-reflections to become familiar with their own preconceived thoughts. Nyström (2008) continues to refer Gadamer who says that we always are affected by our preconceived thoughts. Even if people work hard to become objective their preconceived thoughts will always have a significant meaning.

Lundman and Hällgren Graneheim (2008), who refer to Krippendorff and Kvale (1996) indicate that the meaning of the text will arise through the reader, two different persons will get two different meanings from the same text. Lundman and Hällgren Graneheim (2008) continue to refer Krippendorff who says that both the interpretations can be of value for the result. Kvale (1996) says that the meaning of the text will arise depending on the reader's preconceived thoughts. It is important that the author is open-minded. The honesty, knowledge and experiences of the author can affect the result. With this knowledge the authors of this study try to do the analysis as unbiased as possible. Lundman and Hällgren Graneheim (2008) describe that you cannot see the result in a qualitative interview independent of the author's lived experiences. Nyström (2008) thinks that everything you see and understand as a phenomenon is depending on your earlier lived experience.

Ethical considerations

Every interview started with a presentation of the authors, a description of the aim and how the study will be present, which according to Kvale (1996) is important information before the interview starts. The interviewees were informed that they would be anonymous, that they could stop the interview anytime during the ongoing process and that their participants are voluntarily. Even this information is according to Kvale (1996) important to give the interviewees before starting with the interview. To protect the interviewees' identities and make them feel anonymous the authors just took information about age, gender and home situation, no names or personal code numbers were told and the interviewees were in the result named with numbers. The authors are the only ones who have listened to the tape-recorded interviews and the only ones who have read the original text with some facts that may lead to that the identity will be exposed.

RESULT

The whole result is presented in Appendix 1, and the main result is described in the following text together with strengthening quotations. When all the interviewees just had experience from home caring by relatives and no one had experience of home care by professionals, the authors will from now on talk about home care and then mean home care with relatives as caregivers. With relatives the authors mean friends and family, the once that the interviewee named as their relatives. The authors found two different content areas that they thought were appearance clearly. These content areas are “*The patient does not experience any problems with home care*” and “*The patient experience problems with home care*”. All of the interviewees said things that make sense to the first content area, but some of them said other things that suited in the opposite content area as well. The authors of this study will make clear that to fit in under one content area does not exclude the other, it is not the interviewee that is put in a content area it is just some of the meaning units. The content areas are described together with the sub-categories and the categories in figure 1 here below.

Content area	Category	Sub-category
The patient does not experience any problems with home care.	Good experiences and naturally.	<ul style="list-style-type: none"> • <i>Safety.</i> • <i>Family as caregiver is expected.</i> • <i>Solidarity.</i> • <i>Grateful.</i>
The patient experience problems with home care.	Hard experiences.	<ul style="list-style-type: none"> • <i>Sense of guilt.</i> • <i>Insecure.</i> • <i>Hard to be dependent.</i>

Figure 1

The patient does not experience any problems with home care.

Good experiences and naturally

All of the interviewees in this study mentioned that they had some good experience with home care. The thought of being cared for by relatives at home are something natural. Some of them described their experiences as; a feeling of safety, never afraid, and that it was natural that family and friends took care of each other. Good and natural experiences of home care were mentioned in some form by all of the interviewees. Some things they stated could be mistaken for negative thoughts about home care by the authors and become therefore meaning units that were placed in the opposite content area (The patient experience problems with home care) by the authors.

Safety

A feeling of safety was expressed by most of the interviewees. Many of the patients felt safe to be cared at home, but some expressed that their caregivers just got a short instruction in how they would take care of them before they left hospital. In interview number three the interviewee mentioned that she felt safe at home and if something went wrong she could just go back to the hospital. Another patient expressed a feeling of safety to have all her loved ones in her surroundings. She stated;

“My wish is to be at home all the time so I can be closed to my loved ones all the time. They are my family and if someone will know how I will be treated it is my family” (Interview no. 4)

In interview number five the patient explained her feeling of safety with these words:

“My sister helps me at home, we have friends, neighbors, at home who help me and my sister, I live together with my sister. I am very glad that my sister helps me, I am lucky to have her and the neighbors. They make me feel safe.” (Interview no. 5)

Family as caregiver is expected

All of the interviewees explained that home care in Thailand is something that is natural. Most of them further described that it is a part of life to take care of your family if a family member cannot care for themselves. One patient says that the help that she got from her relatives was not a duty, more like something they just do. (Interview no.5)

“I am used to be cared by my sister, and I am used to take care of her. That is the way it is, we take care of each other. We have lived together for all these years and we have had the same neighbors for several of years. We took care of each other even when we were healthy and it is still the same.” (Interview no.5)

The interviewee explains that the fact that they were sisters does not matter; they could be friends or longer distant family and still become caregivers to each other. The interviewee continues to explain that there are no bad feelings for letting the sister or the neighbors take care of her, and further says that to help someone makes you earn merits which are a good thing according to the Buddhism.

Another patient was aware of that her daughter's life had become different but that was something that her daughter was prepared on and the interviewee expected the daughter to take care of her now when she was sick and expressed it like this:

“It is totally naturally that my daughter helps me when I am sick. My daughter's life became different but she has to take

care of me, in Thailand it is a normal part of life to care of your family. We are a normal family and everybody help each other.” (Interview no.1)

One of the interviewee says that there was never a discussion about who should do what in the caregiver relation. The one who was most conformable as caregiver was also the one who took the role. It often depends on the social chemistry. Interviewee number four says that even if someone had the main responsibility for the patient everybody would help each other with the daily work. Interviewee number 4 stated;

“We all live together in the same house and I am not worried that they not will take care of me when it is needed. My daughter is always at home and takes care of me, even if she really has a job to think about.” (Interview no.4)

Solidarity

One of the interviewees were afraid to be left alone and felt that it was more time alone at the hospital then at home. The feeling of loneliness was expressed as something horrible and became anxiety-ridden when the family was away from her. The interviewee experienced that the time of loneliness feels shorter at home than it does at the hospital even if some of her relatives visit the hospital every day. She stated;

“...when I am at home there is not much time I spend alone.”
(Interview no.4)

Then it was expressed that the interviewee was afraid to die alone and meant that one advantage with home care was that she was near to her relatives if something would happened to her. When the interviewee was at home there was no fear of dying because all the people that the she cared about and that cared about her were there. She knew that she would never die alone at home which made her calm.

“At home I always have someone around me. I understand that I am old and sick, but as soon as I can come home I will have everyone around me and what happens with me does not matter.” (Interview no.4)

Grateful

Like the authors described above all of the interviewees expressed that home care is something natural in Thailand. Even if they took this type of care for guarantee most of them expressed gratefulness to their relatives. All of them thanked their relatives and said that they should have done exactly the same if someone in there surrounding would need help. One of the interviewees did not have any possibility to go home to the family when the interviewee got sick her friends became her caregivers and she was now expressed gratefulness to them with words like this:

“- I do not have any family here, only my friends. My family lives far away from here, it was impossible for me to go back home though my back was in huge pain. So I am really grateful that my friends are helping me as much as they do.”(Interview no.3)

The patient experience problems with home care

Hard experience

Even if every interviewee had at least one meaning unit that were fitting under the other content area (The patient does not experience any problems with home care) some of the interviewees also expressed feelings that suited under this content area. They expressed feelings that the authors put in under sub-categories such as; sense of guilt, insecure and hard to be dependent on somebody else.

Sense of guilt

Some of the interviewees expressed a sense of guilt and said that they felt like a burden to their relatives when they had to take care of them. But they soon corrected themselves and said that it was their own feelings and not something that their relatives had said. Deep inside them they knew that their relatives did not see them as a burden or a hinder and that they would help them as long as it was needed. One of the interviewee expressed the feeling of guilt and said;

“I am not worried for myself, I feel worried about my sister. She has to take care of her own stuff, and except from that, now she has to take care of me too. That is what makes me feel bothered... I feel like I am a burden even if I know that I am not. It is not a duty, it is totally normal for her to help me when I need her help. I would do exactly the same for her and the rest of the family.” (Interview no.6)

Another interviewee expressed her feeling of guilt like this;

“But we all live together in the same house so I am not worried that they will not take care of me when it is needed. Now I feel like I am a little bit like a burden for my family...” (Interview no.2)

Insecure

Almost every interviewee expressed a feeling of safety as describes above. It was only one of the interviewees that clearly expressed that the best care was executed at the hospital by the nurses and the doctors. This interviewee wanted to go home soon but felt insecure at home and had therefore asked if it was possible to stay for some extra nights.

“When I am at home, my daughter helps me but she only got a short instruction how to take care of my eye. It can never be exactly the same as the care at the hospital which is why I am a little bit worried at home... I understand that I do not get the same professional care at home as I do here.”(Interview no.1)

Hard to be dependent on somebody else

Several of the interviewees were used to take care of themselves. Some of them also had big families that they had taken care of for many years. The interviewees that normally could take care of themselves expressed that it was a hard feeling that they now were depended on somebody else. They felt like they were a burden or in some way a hinder for the rest of the family. Most of the interviewees said that they wanted to be independent again so that their family did not have to take care of them.

“Even if my family takes good care of me at home, I think it is a little bit tough, I want to be able to take care of myself and not be depended of the help from my family.”(Interview no.2)

DISCUSSION

Discussion of the method

In the discussion of the method the choice of participants, the interview situation, the using of an interpreter, the qualitative content analysis and the ethical considerations will be discussed. The authors will further describe why they did some choice during the time they worked with this study and describe the positive and the negative effects that the choices resulted in.

The participants

The authors of this study did not have any problems to find participants for the study. The inclusion criteria were made in beforehand and the authors informed the nurse at the hospital about the criteria, and the nurse picked out the participants from these criteria. The criteria were formed in consideration to the aim. It was six participants in this study. Unfortunately only one man was in the study. This can be seen as a limitation for the result. The authors do not think that the nurse was affected about their being women themselves when she picked out more women than men to participate in the study. The nurse had better contacts with other nurses at the women's wards than at the men's wards. The authors think that the main reason might have been that they were not clear enough with the nurse that they wanted a spread of the gender by the participants. This misunderstanding may depend on that the authors did not have that much experiences of doing interviews. If they would have had more experiences of interviewing they might have been able to see earlier in the process that the spread of gender was not enough. Except from the fact that the hospital was divided into women's and men's wards the authors do not think that it had any effect on the result that the interviews were made in three different types of wards (surgical ward, eye ward and orthopedic ward).

The authors are satisfied with the spread of the age by the interviewees though they were from an age of 27 to 74. Two of the interviewees were under 40 years, one was 46 years, and the other three were over 60 years. One of the interviewees was Christian and five of the interviewees were Buddhists. The authors think that this is a good spread of the religion by the participants when the main religion in Thailand is Buddhism, and when over 90 percent of the inhabitants are Buddhists. All of the interviewees had experience of home care by relatives but none had experience of home care by professionals. The authors wish there were more patients who had home care by professional. This was unfortunately not possible when all the patients at the hospital where the interviews were made were cared by their relatives.

Two interviewees that the nurse recommended for the study were not responding to the inclusion criteria and are therefore not included in the study. When the authors started the interview they found out that the interviewees did not have any experiences of home care, but just had experience of care by relatives during the time at the hospital. Unfortunately these two were men.

The qualitative interviews

The choice of method was between doing observations or interviews, as described before the choice to do interviews was chosen. The optimal method would have been to do interviews and then complete these with observations in the interviewees' own homes. The authors thought that this was not a possible option when this study is in bachelor level and the collected data would have been too much to handle. Just to do interviews can be seen as a limitation for the result. But the authors think that the non-structured types of interviews that have were done with one prepared question were a good interview form to use when they wanted the patients to express their own experiences of home care. The authors found it hard sometimes to not put in follow-up questions to some of the answers. Like it is described in the method the authors sometimes had to put in stimulating questions to make the interviews go on, but they tried to make these questions as objective as possible. It could for example be a question like: "Can you describe more about that feeling?". The authors tried to affect the answers as little as possible. When every thought that they have was based on their own preconceived thoughts, it is important to not express them and make the answers from the interviewees as genuine as possible. Lundman and Hällgren Graneheim (2008) describe that it is impossible for the interviewer not to affect the interview situation. This statement makes the authors feel comfortable to put in the stimulating questions without the feeling of worry that they will influence the result too much. One thing that the authors experienced that was positive was that the interviewees were open minded and did not have problems to talk about their life and their daily life situation. This made it possible for the authors to use the method, with one prepared question, that was planed. In the method the authors described according to Nyström (2008) that they would try to not put in any values into what appears in the interview, and now afterward they think that this is something that they did well.

To document the patients' experiences the authors used a tape-recorder during every interview. The interviewees were informed that the authors should use a tape-recorder and the importance for them to have it. The authors did not experience that the interviewees seemed to be bothered by the tape-recorder or not either that it affect what was said during the interviews, and thereby not either affected the result.

All the interviews were made with one interviewee at the time. The authors think that this was good for the result when the interviewees did not affect each other. One disadvantage may be that the interviews were made in rooms with other patients and not in single rooms. This may affect what the interviewee decided to talk about, but after the authors judgement they do not think that this affected the content in the interviews. Two of the interviewees had their relatives by them during the interview situation. It may have been better if they would not have been there. The authors felt that it was wrong to ask them to leave so they decided to let them stay. The relatives were not speaking during the interviews and when it felt like the interviewees spoke from their hearts and took no notice of their relatives company. The authors made the judgment that the relatives' presence did not have any effect on the interviews.

One of the interviewees said that she was not a good participate for this study when she felt that she was strong and healthy even if she was sick and got home care. The authors think that this is in agreement with what Wiklund (2003), who refers to Eriksson,

describes when she says that you can feel healthy even if you are sick. The authors clarify to the interviewee that she was good for this study when they were searching for differences and similarities. This woman and the rest of the interviewees were clearly informed that the authors wanted the experience of home care and that it was no right or wrong answers.

All the interviews were going on for different long time but this is not something that matters when the contents in the interviews and the time of interviewing not are in relation to each other. The complete number of interviews in a study like this can vary, and the authors of this study felt that after six interviews the same information recurrent and therefore thought that the material for the study was enough. The authors thought that they may have to complete the collected data with more information, but when they read the interviews afterwards they thought that the material was good and enough. The authors think that the optimal way to do the interviews would have been to do them in respective home, that might have done the interviewees more relaxed and comfortable and the interviews could have been completed with observations. Mulhall (2003) says that people are always affected by their physical environment, and if the authors would have completed the interviews with observations in the interviewees' homes they might have seen how the environment affected the interviewee.

Interpreter

The interviewees were Thai-speaking and none of them were comfortable with English. The authors were Swedish and have no knowledge in Thai. To be able to do the interviews it was necessary to use an interpreter. The best way to translate and to get the content in the interviews as correct as possible is certain to use as few translations as possible though every language puts their own character on what is said. The interpreter for this study was a native-born Thai and Thai was his first language. He also spoke Swedish fluently though he had lived in Sweden for many years. The authors decided to translate from Swedish to Thai and from Thai to Swedish in the interview situation. They did then translate the interviews from Swedish to English to put them in this study.

Kapborg and Berterö (2002) refer to Freed who says that different cultures have a significant affect at the interview situation. The best way, if it is possible, is to have an interpreter from the same culture as the interviewees. As describes above the authors experienced the interviewees as open- minded and this may be an effect of that the interpreter spoke the same language and had the same culture as the interviewees.

The interpreter did not have any experiences with home care. The authors think that this is something positive though it made it easier for the interpreter to be more objective in the interview situations. When all the interviews were done the interpreter told the authors that he shortly had explained to the interviewees about the relationship in Swedish families and about the Swedish home care system. He had done that because the interviewees had wondered why the authors had asked the questions that they did. It might have had a negative effect for the result when the authors did not have any possibility to guide this discussion between the interpreter and the interviewees.

The authors found it frustrating to not be able to have the conversation with the interviewees themselves. The authors had to trust in that the interpreter translated correctly when the interviews were the base for the result. When the authors, because of language differences, could not speak directly to the interviewees they put more attention to the interviewee's body language instead. What the authors could observe from the non-verbal signs seemed to agree with the answers that the interpreter gave them, and therefore do the authors judge the quality of the translations as high.

Data analysis

When the aim of this study is to illuminate the lived experiences from a patient's perspective and to present this with similarities and differences the authors thought that the qualitative content analysis was a good method to use. The transcriptions from the tape-recorded interviews were the only part of the study that the authors did apart, the transcription went quicker than the authors had expected, but it was still time consuming. The authors did every following part of the analysis together, they took out meaning units, put codes on them and then finally made categories. When the authors just have two categories and when the categories are opposite to each other, the authors could not make any themes and choose. They did therefore stay on the category level. Even if the work with the analysis was time consuming though the authors did every part together they, as well as Lundman and Hällgren Graneheim (2008), think that it will make the study more reliable. Early in the work with the analysis, the authors found two content areas that were opposites of each other, clearly separated the experiences of home care and described the content in the interviews. That the authors have divided the content of the interviews into two obvious content areas gave the study a good overview and makes it easier for the reader to follow the result.

The authors described the analysis process in the method according to Lundman and Hällgren Graneheim (2008). The authors described it closely and think that the description will give the reader a bigger chance to judge the validity of the result. The authors have followed the analysis process well and thought that it was easy when it was clearly described in the text by Lundman and Hällgren Graneheim (2008). The only thing that the authors found a little bit hard was to put every meaning unit into separate codes, because sometimes many meaning units seemed to be able to have the same code. The authors have read other studies afterwards, where it describes that the authors do the analysis process apart and then discussed findings. This might be a better way to do the analysis process but the authors of this study have, during the process, questioned each other's thoughts and discussed every single word. They think that this way to do the analysis process is the same as if they would have worked with it together or not.

Ethical considerations

The authors of this study think that it is important to be exactly with the ethical consideration in every single interview and to treat the last interviewee with the same respect as the first one, even if it feels repetitive to the authors and to the interpreter to say the ethical considerations time after time. The authors of this study think that they did well with following the ethical considerations in every interview situation.

Discussion of the result

The authors of this study spontaneously think that one of the categories in the result can be generalized against most of the Thai people. This category is that *all* the interviewees' experienced home care as something natural and this is also something that the authors have heard during their time in Thailand even from people who not took part in this study. Kvale (1996) says that it is impossible to generalize the findings of an interview when the participants are too few. The result of this study can therefore not be generalized over all Thai people, since the authors did qualitative interviews with six interviewees in a limited area.

The result that the authors present are including two different content areas and these are; "*The patient does not experience any problems with home care*" and "*The patient experience problems with home care*". All of the interviewees expressed experiences that fit in under the first content area, and that the interviewees found it good and natural to be cared by their relatives in their home. The most interesting part of the result is that even if all of the interviewees had experiences that suited under the first content area, some of the interviewees also expressed feelings about home care that fit in under the second content area. This part of the result shows that even if you have good experiences and are satisfied with the home care, you can still experience the same thing as something hard. The authors found this interesting when there were experiences that were complete opposites of each other even if it was the same phenomenon that were studied.

The authors think that the differences in the experiences are depending on importance of the family for the Thai people, which make the experiences of home care as something good. When they deep inside also feel like they are a burden to their families it also makes the experiences of home care as something hard. Even if the interviewees describe home care by relatives as something good, the authors sense that there is a cleavage in the experiences of home care in Thailand. The authors think that this is something that has to do with the Thai culture, when it is an old tradition that the families live together and take care of each other. Lund and Subgranon (2000) say that it is most common that women are the principal caregivers in Thailand and that the family is expected by the society to take care of their relatives, even Theinpichet and Wacharasin (2008) say that women are most presented as the family caregiver. This is something that the authors of this study can agree with when the principal caregivers for the interviewees mostly was women in the shape of a sister or a daughter. Lund and Subgranon (2000) further say that the family and the people in the surrounding help the principal caregiver with things like the daily work, and this is something that also appeared in our interviews when often the whole family helped each other. The authors found out from the interviews and have read in earlier research that home care in Thailand is something culturally and are never questioned. The authors think that when there is something that is of culturally or historically importance it is hard to express feelings against it, and maybe this made the interviewees sounding more positive about home care than what they are in real life.

Another, less widespread but interesting, thing that appeared in the result was that only one interviewee said that she was afraid of the death. When the result cannot be generalized the authors cannot express if this is grounded in the religion, in the

personality or in the grade of sickness. This interviewee was Christian, and the authors think that her fear of death may depend on that she had a different religion from the others who felt calmer and did not even mention the death, but as described, this thought cannot be established. The authors thought that the Buddhism would have a bigger role in the fact that the relatives were the caregiver. They probably got this thought from a study by Dangdomyouth, et al. (2008) who says that Buddhism is the reason why the home care in Thailand is executed by relatives. They also say that a caregiver earns merits and that this is another reason why relatives are the caregivers. But only one interviewee in this study mentioned that the religion had an importance in why she was cared by her relatives. That the religion is not as significant for the interviewees' experiences of home care as the authors thought lead to that the culture seems to have a bigger meaning for their experiences of home care.

As the authors found in their study the family seems to be expected as care caregivers. Lund and Subgranon (2000) found in their study that care by relatives is a normal part in the daily life. They think that it is an unavoidable thing and the care for your relatives is by love and sympathy. This makes the authors of this study even more sure that care by relatives are something that has a culturally base rather than a religious.

The authors found out that the instruction before the patient could leave the hospital was fast and limited. This is also described in the articles by Lund and Subgranon (2000) and Dangdomyouth, et al. (2008). Many of the interviewees expressed a feeling of safety even though the instruction that the relatives got was short and the knowledge of medicine is not the same as by the professionals at the hospital. The authors of this study think that one reason to the feeling of safety is depending on a strong caring relationship between the relatives, and according to Wiklund (2003) is the care relationship important for a good care. The authors experience that some of the interviewees think that relatives as caregivers are the best caregivers. Dangdomyouth, et al. (2008) who refer to Browne and Courtney, Sethabouppha and Kane, and Doornbos who think that the family is closest to the patient and the once who know the patient best and are therefore most suited as the primary caregiver. Maybe relatives and the patient can build a caring relationship faster and stronger than what a professional and a patient can do? To many of the interviewees it implies a reduced life suffering to be cared in the own home by relatives when the family is an important source to sense well-being. But at the same time it can imply increase the suffering from caring and the suffering of illness when they do not get the same professional care by their relatives as they would get from professionals. From the interviews can the authors see that the interviewees rather have a worse medical treat which may include suffering from caring and suffering from illness, if that means that they can be close to their loved ones and take away that life suffering it means if the family are not around. This is something that becomes clear to the authors when the interviewees describe home care by relatives with both negative and positive experiences. Wiklund (2003) says that life suffering is affecting the whole existence of the human being, while suffering from caring and suffering from illness do not threaten the existence but give limitations for the patient. The authors think that the feeling of a reduced life suffering is the reason why the patients are satisfied with the care from the relatives.

The conclusion that the authors made after they did this study is that home care in Thailand can be expressed with both positive and negative experiences from the same person. In the beginning every interviewee starts with the positive experiences of home care but when the authors continues with the interviews it appears that everything is not as good as they first expressed. Every one mentioned home care by relatives as something positive but some of them also expressed some more negative feelings. The authors hope that this study will have the effect that the patient perspective of home care will be illuminate in Thailand by further research.

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Appendix 1

Table 1

Meaning Unit	Condensation	Code	Sub-category	Category
Content area: The patient does not experience any problems with home care.				
-It is okay, they are five family members who take care of me at home.	It is okay.	Good feeling.	Safety	Good experiences and naturally.
-But if there is anything special they help me and my husband, there is never a problem and that makes me feel safe.	If there is anything they help me. There is never a problem, which makes me feel safe.	Feeling safe.		
-And I am never afraid at home.	I am never afraid at home.	Never afraid.		
-I feel safe.	I feel safe.	Feeling of safety.		
-I think it is the best way to be cared, to be cared at home.	The best way to be cared is to be cared at home.	Satisfied with the home care from relatives.		
-I do feel like I am in good hands, with my sister.	I am in good hands.	In good hands.		
-I feel safe with my friends as my caregivers; they will support me as long as I need their help.	Feel safe with my friends as caregivers, they help and support me.	Thankful for help and support from friends.		
-But we all live together in the same house and I am not worried that they not will take care of me when it is needed.	I am not worried. I know they will take care of me.	Not worried.		

-If someone will know how I will be treated it is my family.	My family knows best how to treat me.	Best care from the family.		
-It was naturally that my family should help me, when I got sick.	Naturally that my family helps me.	Family as caregiver is a matter of course.	Family as caregiver is expected	
-It is totally naturally that my daughter helps me. When I got sick my daughter's life became different but she have to take care of me, in Thailand it is a normal part of life to take care of your family. We are a normal family and everybody help each other.	It is naturally that my daughter helps me. It is a part of life to take care of your family. We help each other.	Part of life to help family members.		
-I have no bad feeling for letting them help me with everything I cannot do now when I am sick.	I have no bad feelings about letting them help me.	No bad feelings.		
-At home there is not much time that I spent alone.	I do not spend much time alone at home.	Do not feel lonely.	Solidarity	
-I am very glad that my sister helps me, I am lucky to have her, and the neighbors.	I am lucky to have my sister and neighbors that helps me.	Lucky to have relatives as caregivers.	Grateful	
- So I am really grateful that my friends are helping me as much as they do.	Grateful that my friends help me.	Grateful for help from friends.		

Meaning Unit	Condensation	Code	Sub-category	Category
Content area: The patient experience problems with home care.				
-I am not worried for myself, I feel worried about my sister. She has to take care of her own stuff, and except from that, now she has to take care of me too. That makes me feel bothered.	I am not worried for myself but for my sister. She has to take care of me. That makes me feel bothered.	Feels bothered to be a burden.	Sense of guilt.	Hard experiences.
-I feel like I am a burden for my family, even if I know that I am not.	I feel like a burden for my family.	Feels bothered to be a burden.		
-But my daughter is always at home and takes care of me, even if she really has a job to think about.	My daughter is home even if she has work to do.	Feelings of being a hinder.		
-Now I feel like I am a little bit like a burden for my family.	I feel like a burden for my family.	Feelings of being a hinder.		
- I do feel a little bit worried even at home because I may fall again.	I feel a little bit worried to fall when I am at home.	Feels worried.	Insecure	
-When I am at home, my daughter helps me but she only got a short instruction how to take care of my eye. It can never be exactly the same as the care at the hospital which is why I am a little bit worried at home... I understand that I do not get the same	My daughter has not the same profession as the nurses and the doctors here. I feel a little bit worried to be cared at home.	Lower competence makes me feel worried.		

professional care at home as I do here.				
-I have never been depended on somebody before but now I am, so what can I do? It is a tough feeling to know that you are depended on somebody.	It is a tough feeling to know that you are depended on somebody.	Tough to be depended on somebody.	Hard to be depended on somebody else.	
-I think it is a little bit tough, I want to be able to take care of myself and not be depended of the help from my family.	I think it is tough to be dependent on my family.	Feeling bothered of being dependent.		