Jurnal Ners

Volume 20 Issue 4, November 2025, p. 353-362
http://dx.doi.org/10.20473/jn.v20i4.71878

Original Article

Open Access

Roles and success factors of community health nurses in providing health care for people with disabilities in southern Thailand: a qualitative descriptive study

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Responsible Editor: Ferry Efendi

Received: 17 April 2025○ Revised: 30 October 2025 ○ Accepted: 25 November 2025

ABSTRACT

Introduction: People with disabilities (PWDs) are considered a vulnerable group due to their condition, which makes it difficult for them to access the services provided. Community health nurses (CHNs) are considered a key mechanism for supporting the implementation of activities that promote the quality of life of PWDs in the community. Therefore, this qualitative study aims to describe the role of CHNs in providing health care to PWDs in southern Thailand.

Methods: A qualitative descriptive study was conducted from May 2024 to October 2024 in southern Thailand. Data were collected through in-depth interviews, observations, and focus group discussions (FGDs). Data collection continued until saturation was achieved. A total of 39 participants were *divided into* five groups composed of *1)* CHNs; 2) Village headman; 3) Village Health Volunteers (VHVs); 4) PWDs; and 5) family caregivers were recruited based on inclusion criteria using a purposive sampling technique. Data were analyzed using thematic analysis.

Results: Two themes were identified in this study: 1) CHNs' role in providing health care for PWDs, and 2) Key factors affecting the success of CHNs in providing health care for PWDs.

Conclusions: The findings revealed the significant roles of CHNs in providing health care for PWDs. Prioritizing disability care in community settings is essential. Systematic data collection and utilization can enhance care effectiveness. Capacity development programs for CHNs in disability care management are needed, and collaborative partnerships with relevant organizations should be strengthened. Policymakers must develop comprehensive strategies to optimize CHNs' roles in community-based disability care.

Keywords: community health nurses, people with disabilities, health care, qualitative study

Introduction

Today, the world population is over 8 billion people, and approximately 1.3 billion individuals, or 16% of the global population, live with disabilities (United Nations Office for Disaster Risk Reduction, 2023). The number of PWDs worldwide has been increasing due to the rise in non-communicable diseases and longer life expectancy. Furthermore, PWDs tend to have a life expectancy up to 20 years shorter than those without disabilities (United Nations, 2024). In Thailand, there are approximately 4.19 million PWDs, accounting for 6.0% of the country's total population. These individuals can be divided into three major groups: 1) PWDs due to health difficulties or problems, approximately 1.37 million people, or 2.0% of the population; 2) PWDs due to functional impairments, approximately 0.91 million people, or 1.3%; and 3) People with both health difficulties and functional impairments, approximately 1.91 million people, or 2.7% (National Statistical Office, 2023). It is found that most PWDs experience difficulties or health problems, particularly with mobility. Other common challenges include self-care, vision, memory or concentration, and communication.

PWDs often face various problems and risks associated with their disabilities, and have twice the risk of developing conditions such as depression, asthma, diabetes, stroke, obesity, or poor oral health. Additionally, PWDs are at much higher risk of violence, with more than 100 million disabled persons being children. Children with disabilities are nearly four times more likely to face violence compared to their non-disabled peers (World Health Organization, 2020), while adults with disabilities are 1.5 times more likely to become victims of violence than those without disabilities. Adults with mental health conditions are almost four times more likely to experience violence (Senior, Fazel, and Tsiachristas, 2020). Contributing factors that increase the risk of violence for PWDs include stigma, discrimination, lack of understanding about disabilities, and insufficient social support for their caregivers (Auemaneekul *et al.*, 2024). Health inequities arise from unfair conditions faced by PWDs, including stigma, discrimination, poverty, exclusion from education and employment, and barriers faced in the health system itself (Gréaux *et al.*, 2023). In addition, PWDs find inaccessible and unaffordable transportation 15 times more difficult than for those without disabilities, and 50% of PWDs cannot afford health care (United Nations, 2024).

The health service system provides quality, safe, and standards-based care to promote, prevent, treat, and rehabilitate health, covering medical and public health benefits. It emphasizes the development of strong primary care services and efficient support systems from higher-level health care units (World Health Organization, 2008). The health service system in Thailand is divided into five levels: 1) Self-care level, 2) Primary health care level, 3) Primary care level, which includes 9,878 Sub-district Health Promoting Hospitals, 4) Secondary care level, and 5) Tertiary care level (Pokpermdee, 2020). Nurses play a crucial role in providing valuable health care services, with CHNs being essential health professionals working in primary care units. Their responsibilities include providing care to all target population groups in the community. The Nursing Council has established competencies for nurses working in Sub-district Health Promoting Hospitals, enabling them to provide primary care to PWDs and their families. These competencies include: 1) Competency in nursing care for PWDs, 2) Competency in improving the quality of health care for PWDs with complex health problems in the community using evidence-based practices, 3) Competency in managing health data for PWDs in the community, and ethical, professional, and legal competencies, such as: 1) Promoting awareness and understanding of rights among PWDs, 2) Providing nursing care with compassion and considering the best interests of PWDs, etc (Thailand Nursing and Midwifery Council, 2012).

CHNs have a primary role in organizing health care services and providing health care for the public. They target specific population groups based on age, health status, and health problems, including at-risk groups, healthy groups, sick individuals, and those with particular needs(Yodsuban *et al.*, 2023). Their role emphasizes proactive health care rather than reactive care, focusing on disease prevention and health promotion(Pattarateeranon *et al.*, 2021). PWDs are a vulnerable group with specific health issues and needs. CHNs should prioritize the health care of PWDs. Globally, CHNs are recognized as key contributors to disability care within community settings. International evidence demonstrates that CHNs function as bridges between healthcare systems and community resources, providing holistic care that addresses medical, social, and environmental determinants of health for PWDs (McBride, Kilgore, and Oozageer Gunowa, 2024). In high-income countries, CHNs' roles in disability care typically emphasize specialized clinical competencies, individualized care planning, and coordination within professionalized healthcare infrastructures (Khanlou *et al.*, 2023).

In South and Southeast Asian contexts, including Thailand, community-based approaches to disability care reflect collectivist cultural values, family-centered care traditions, and integration of formal healthcare with informal community support systems (Rhodes, Antoine, and Abidin, 2025). The unique configuration of Thailand's primary healthcare system, characterized by extensive networks of Sub-district Health Promoting Hospitals, village health volunteers, and local administrative organizations, creates opportunities for innovative, community-integrated models of disability care that differ substantially from Western frameworks (Hughes, Leethongdee, and Osiri, 2010). However, despite the growing recognition of CHNs' importance in disability care globally, there remains limited empirical evidence documenting how CHNs operationalize their roles within specific socio-cultural contexts, particularly in Southeast Asian community settings. Understanding the contextualized roles and practices of CHNs in disability care is essential to inform the development of culturally appropriate nursing competency frameworks, identify success factors specific to resource-limited settings, and facilitate knowledge translation across similar contexts within the region.

Therefore, this study aims to explore the role of CHNs in providing health care for PWDs in the community, seeking to gain a deeper understanding of their roles, activities, and the factors influencing their success within the distinctive socio-cultural context of southern Thailand. This study contributes to the growing body of knowledge on context-appropriate models of community-based disability care in Southeast Asia.

Materials and Methods

Study design

This study employed a qualitative descriptive study design (Doyle *et al.*, 2020) aimed to describe the role of CHNs in providing health care for PWDs in the community of southern Thailand. This method can access the experiences of CHNs in providing health care for PWDs, of those involved in the community, within the social and cultural context of the community in southern Thailand, to understand the overall picture related to meaning and interpretation, because it is believed that people's behavior is determined by the thoughts of people in society (Streubert and Carpenter, 2011; Holloway and Galvin, 2023). The study was conducted from May 2024 to October 2024. Data were collected through in-depth interviews, observation, and focus group discussions. Data were analyzed using thematic analysis. This study followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong, Sainsbury, and Craig, 2007).

Setting

The study setting was one specific sub-district in southern Thailand. This area serves as a model for community-based health care for PWDs. It is an area known for its distinctive disability care management and clear outcomes in providing care for PWDs. CHNs' roles are standardized nationwide through the Thailand Nursing and Midwifery Council's competency framework, but implementation varies across local contexts. This area comprises 12 villages, including urban and semi-urban communities. There were a total of 16,057 households, with a population of 34,625 and 967 PWDs (2.79%). The area also has 452 village health volunteers and 22 specifically trained volunteers to care for PWDs.

Participants

The study utilized purposive sampling to recruit participants. There was a total of 39 key participants, five groups composed of 1) Four CHNs with at least 1 year of experience, regularly caring for PWDs; 2) Five village headmen; 3) Ten village health volunteers (VHLs) have worked for at least 1 year and have experience caring for PWDs; 4) Ten PWDs aged ≥18 years, able to communicate, types of disability include physical disability, visual disability, intellectual disability, mental disability, must not be persons with severe mental health conditions, and PWDs who are unable to provide informed consent; and 5) Ten family caregivers who have cared for PWDs for at least 6 months. Although CHNs were the primary focus, multiple stakeholder groups were included to provide comprehensive perspectives on CHNs' roles, as PWDs, caregivers, and community partners interact directly with CHNs and can describe their roles, activities, and impact from different vantage points. All of whom voluntarily participated in this study. The selected informant is someone who can provide information that aligns with the research objectives or is beneficial to the study. The researcher has chosen a general informant involved in community-based care for people with disabilities, who is accessible and feasible to engage.

Research instrument and reliability verification

The research instrument used was an in-depth interview questionnaire. They were directed at key informants and activity respondents concerning the role of CHNs in caring for PWDs in the community. They were developed based on a literature review and consultation with advisors who are experts in qualitative research and community nursing. The following questions were examples used in the interviews: 1) What is the situation of disability care in your community? 2) What are living conditions like for PWDs in your community? 3) In what ways do CHNs engage in community-based partnerships for the health care of PWDs? 4) What outcomes have resulted from the activities carried out by CHNs? 5) Who benefits from the work of CHNs? 6) What is your opinion on the role of CHNs in the health care of PWDs? 7) What are the key factors that influence the success of CHNs in caring for the health of PWDs? Additional questions aligned with the study's objectives were also incorporated to enhance understanding further. To ensure data reliability, multiple data sources were used, and discussions among the researchers were held to achieve triangulation. The data were cross-verified with the original information to ensure accuracy, and the findings were reviewed by experts with experience in caring for PWDs in the community.

Ethical considerations

Before conducting the study, ethics approval was obtained from the Khon Kaen University Human Research Ethics Committee, Thailand. The approval number was HE672030 on 16 April 2024. Before conducting the study, all participants were informed, and written informed consent was obtained from each participant. Key informants were asked to give their consent before participating in the study. The researchers ensured their privacy and respected their decisions throughout the process. Additionally, the researcher ensured the confidentiality of the informants by using codes instead of specific names to protect their identities and by publishing their information anonymously. All documents containing informant information were securely stored to guarantee confidentiality.

Data collection

Individual in-depth interviews were carried out, with the researcher meeting each participant privately. The interviews took place from May 2024, following approval from the institutional review board (IRB), through

October 2024. To create a comfortable and conducive setting, the interviews were held in quiet locations where participants felt at ease. A structured in-depth interview questionnaire was used to interview 27 key informants to gain a deeper understanding of their personal experiences. Each interview lasted between 45 and 60 minutes. Non-verbal cues from the participants, as well as the researcher's observations and feelings, were recorded.

Field notes were taken during the interviews and later incorporated into the analysis and writing to enhance data interpretation. The interviews were audio-recorded to ensure accurate capture of the participants' responses, and the recordings were transcribed immediately after each session. To preserve anonymity, participants' names were replaced with codes during transcription. Data saturation was systematically monitored across all data collection methods. For in-depth interviews, we conducted iterative analysis after every 3-4 interviews within each participant group. Saturation was considered achieved when: 1) no new codes emerged from subsequent interviews, 2) existing themes were consistently reinforced, and 3) the conceptual depth of themes was fully developed. This process was independently verified by three researchers, who concurrently reviewed the interview transcripts. For observations, saturation was reached when observed activities consistently aligned with interview data without revealing new insights. In the focus group discussion, saturation was confirmed as discussions predominantly echoed themes already identified from individual interviews and observations, with no novel perspectives emerging despite probing questions.

Three FGDs (5-8 participants per group) were conducted with village headmen, VHVs, and caregivers, totaling 12 participants, to enable exploration of shared understandings and group dynamics. Each session lasted 60–90 minutes. The researcher conducted the interviews and recorded all FGD data for transcription and analysis. Moderator ensured all voices were heard and managed dominant speakers. The interviews and FGDs were audio-recorded, and after obtaining consent from the key informants, the recordings were transcribed for subsequent analysis. In addition, Observation data were collected to provide contextual validation of reported practices by monitoring the work and activities of those responsible for caring for PWDs in the community, both at their workplaces and in their homes.

Data analysis

Transcripts of the audio recordings were transcribed verbatim and analyzed following Braun and Clarke's six-step thematic analysis (2019): familiarization with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. A single researcher conducted line-by-line manual coding, iteratively developing a codebook while working closely with two qualitative-methods experts who independently reviewed a purposive sample of transcripts and the evolving codebook; any interpretive differences were resolved through discussion until consensus was reached. An audit trail of coding decisions, codebook versions, and analytic memos was maintained throughout, and reflexive notes documented the analyst's perspectives. To enhance credibility, preliminary themes were reviewed with a subset of participants (member checking) and with external qualitative researchers to confirm their confirmability before finalizing the themes reported here.

Trustworthiness

As Lincoln and Guba (1985) determined, the researchers used the four conceptual elements to achieve the trustworthiness of the findings. Regarding credibility through member checking, the obtained data were summarized, and the participants reviewed them. In peer debriefing, the advisory committees and experts validated all research processes and tentative findings. Triangulation was employed through multiple data collection methods, including observation, in-depth interviews, and field notes. Additionally, member checking was conducted to verify the accuracy of the interview data, with key informants consulted for clarification as needed. The analysis results were submitted to qualitative research experts for verification of the data. A peer briefing was used to verify the accuracy of data interpretation, with a focus on alignment with participants' responses. The researcher evaluated quality and credibility by examining the results' data reliability and confirmation, then summarizing the main point after each interview. The data from in-depth interviews that were summarized after the transcription were given to the informants to confirm the accuracy (member checking). The obtained data were then examined with a qualitative research expert to debrief and confirm the knowledge gained. In addition, there was a process of reflexivity during data collection and analysis, by checking the research results against the research objectives and questions, reviewing the research process, and seeking expert advice throughout the research**.**

Results

The results of this study were organized into two themes: 1) Community health nurses' role in providing health care for people with disabilities consisted of 8 sub-themes, and 2) Key factors affecting the success of community health nurses in providing health care for people with disabilities consisted of 5 sub-themes. These themes, along with their sub-themes, are described below (see Table 1).

Theme 1: Community health nurses' role in providing health care for people with disabilities.

Table 1: Themes and subthemes

Theme	Subthemes
1. Community health nurses' role in providing health care for people with disabilities.	1.1 Health care provider 1.2 Health educator 1.3 Rights Facilitation 1.4 Counselor 1.5 Facilitating Collaboration 1.6 Participatory Service Design 1.7 Capacity Building Support 1.8 Manager
2. Key factors affecting the success of community health nurses in providing health care for people with disabilities.	2.1 Collaborative Networks 2.2 Knowledge and skills 2.3 Data collection and utilization 2.4 Resources and equipment 2.5 Participation

This theme described the role of CHNs in providing community-based health care for PWDs. It consisted of 8 sub-themes of their roles, including health care provider, health educator, rights facilitation, counselor, facilitating collaboration, participatory service design, capacity-building support, and manager.

Sub-theme 1.1: Health care provider

CHNs provide comprehensive care for PWDs in four dimensions: medical treatment, prevention of complications, rehabilitation, and health promotion. These services are offered at the Sub-district Health Promoting Hospital for PWDs experiencing mild illnesses or discomfort. This role encompasses designing services that emphasize continuous care through planning under local health insurance funds and long-term care funds, with multidisciplinary teams providing treatment, rehabilitation, and mental health support. CHNs collaborate with local health staff, physiotherapists, VHVs, and disability care volunteers to conduct home visits, follow up on treatment progress, observe living conditions, provide advice, and address problems. They coordinate referrals for individuals with complex needs, including facilitating transportation for PWDs requiring emergency care in collaboration with the municipality. Additionally, CHNs regularly monitor the health of PWDs through annual health check-ups, raising awareness about health care and collecting data to identify issues and needs for planning health insurance activities at the local level, as in the quote below:

"*CHNs working in Sub-district Health Promoting Hospital provide treatment, prevention, rehabilitation, and health promotion as part of their professional duties. However, PWDs are a group we do not abandon because when they are sick or unwell, they require more specialized care.*" (CHN2)

"*In normal situations, during home visits, CHNs, physiotherapists, VHVs, and community health workers go together to visit the homes. We observe the living conditions, help resolve problems, and refer them for treatment if necessary.*" (CHN4)

Sub-theme 1.2: Health educator

CHNs educate PWDs and family caregivers about self-care using accessible teaching methods and explicit content. They also train community leaders and VHVs in disability care practices, such as 1) providing knowledge, understanding, and advice on self-care for PWDs and family caregivers, rehabilitating people with disabilities, and creating a safe home environment for PWDs in their daily lives, etc. 2) providing valuable resources that PWDs and family caregivers can access, such as self-care and rehabilitation advice documents, etc., as in the quote below:

"We must ensure that PWDs and their families understand how to care for themselves properly. We use simple language and demonstrations to teach them about medication management, exercise for rehabilitation, proper nutrition, and how to prevent complications. We also provide them with educational materials they can refer to at home." (CHN1)

"*When we visit homes with CHNs, we can see them teaching family caregivers how to care for PWDs. They explain how to help them become more independent and organize the home environment to ensure it is safe and accident-free for people with disabilities. They also share knowledge with us so that we can all help care for PWDs in our community.*" (FGD)

Sub-theme 1.3: Rights Facilitation

CHNs inform PWDs about their legal rights and benefits. They provide guides to accessing these rights and navigating legal procedures, including information on disability certification and rehabilitation and basic care services. One of the nurses stated that:

"*Our role is not only to care for the health of PWDs but also to guide them in accessing the benefits and rights they are entitled to.*" (CHN1)

Sub-theme 1.4: Counselor

CHNs are skilled in counseling techniques, building relationships to gain trust from PWDs and family caregivers, so that PWDs can express their problems, observe, and provide advice on various aspects of behavior, such as self-care, home environment management, etc. They provide guidance to the community on creating an environment suitable for PWDs. CHNs also play an essential role in providing advice to family caregivers, volunteers caring for PWDs, and community leaders in developing a care plan for PWDs, as in the quote below:

"*A meeting was held with the leadership team for the health care of PWDs in the community to create a care plan. CHNs provided various advice, such as organizing the environment to support the rehabilitation of PWDs. They also encouraged everyone to participate in making the community environment more suitable for PWDs.*" (FGD)

Sub-theme 1.5: Facilitating Collaboration

CHNs, alongside the health team, seek opportunities to create partnerships and design proactive and reactive healthcare activities in collaboration with local social resources. These resources include volunteers, local leaders, civil groups, community leaders, local administration organizations (LAO), and disability development centres, aiming for comprehensive care that addresses social, economic, health, environmental, and political needs for sustainable care development, as the quote below:

"*Our centre collaborates with nurses in disability care. Nurses play a key role in planning the care for PWDs, assigning tasks to everyone involved.*" (FGD)

Sub-theme 1.6: Participatory Service Design

CHNs collaborate in designing disability care services in health centres to promote health, prevent diseases, provide screenings, and ensure systematic referral services. This involves working with local and external organizations to meet the needs of PWDs. The service design caters to all groups, from those who are independent and able to work to those who are not, focusing on health promotion and providing the necessary care with family and volunteer involvement. One of the village headmen stated that:

"*Our community is responsible for supporting PWDs, ensuring they are not abandoned. Those who are independent and able to work and those who cannot work will receive health promotion, and family members and local volunteers will support those who are somewhat independent.*" (VH1)

Sub-theme 1.7: Capacity Building Support

CHNs play a crucial role in building the capacity of community stakeholders involved in disability care. This includes supporting the establishment of community-based training centres and helping to design comprehensive curricula to enhance the skills and competencies of volunteers, caregivers, and family members in providing holistic care for PWDs. The capacity building activities encompass training disability care volunteers in assessment techniques, basic rehabilitation skills, and community-based care approaches, as well as training family caregivers in self-care support and disability care management. CHNs also strengthen the capabilities of community leaders and local health personnel to understand disability issues, as in the quote below:

"The municipality organizes training centres for disability care, with nurses helping to create curricula and provide training for disability care volunteers and family caregivers." (VH4)

"We don't just provide care ourselves; we build the capacity of everyone in the community to provide quality care. We train volunteers on how to assess PWDs' needs, teach caregivers proper techniques for daily care and rehabilitation, and help community leaders understand disability rights and inclusive policies. This way, the care for PWDs becomes sustainable and doesn't depend only on us." (CHN2)

Sub-theme 1.8: Manager

CHNs serve as managers of disability care programs within their catchment areas, responsible for planning, organizing, implementing, and evaluating services for PWDs. Their managerial functions include resource allocation, scheduling home visits and clinic services, supervising village health volunteers and disability care volunteers, maintaining disability registries and health records, and ensuring quality standards are met. CHNs manage budgets from local health insurance funds and long-term care funds, making decisions about resource distribution to maximize impact. They also manage information systems, ensuring accurate data collection and timely reporting. One of the nurses stated that:

"As CHNs, we must manage many aspects of disability care planning monthly schedules for home visits, ensuring we have enough medical supplies and assistive devices, coordinating with volunteers about their assignments, and keeping track of all PWDs in our area through our database. We also need to manage the budget wisely to serve all PWDs who need care." (CHN4)

"The CHNs manage the long-term care (LTC) budget for PWDs in our community. They decide how much money should be allocated for each type of service—home care visits, assistive devices, rehabilitation equipment, or emergency transportation. They work with us to identify which PWDs need urgent support and which services should be prioritized." (FGD)

Theme 2: Key factors affecting the success of community health nurses in providing health care for people with disabilities.

This theme described key factors affecting the success of CHNs in providing health care for PWDs in the community, comprising five sub-themes: collaborative networks, knowledge and skills, data collection and utilization, resources and equipment, and participation.

Sub-theme 2.1: Collaborative Networks

Building a collaboration network with four key organizations to drive the health care for PWDs includes the public sector, local communities, local government, and government agencies. Additionally, partnerships with external networks from both the public and private sectors, as well as academic institutions, are essential to increase awareness of the situation of PWDs in the area and explore ways to help or support improving the quality of life for PWDs, as in the quote below:

"*In caring for PWDs in the community, involving the network partners in their care is essential, including the public sector, local communities, local government, government agencies, and even private organizations and educational institutions. They should be involved in understanding the situation of PWDs and collaborate in providing care. For example, the VHVs are key in helping us monitor and care for PWDs in the community*." (FGD)

Sub-theme 2.2: Knowledge and skills

The professional knowledge and skills of CHNs are crucial to improving the effectiveness of community-based care for PWDs. CHNs need in-depth knowledge of the care required for different types of disabilities, including medical care, physical rehabilitation, and psychological support. One of the nurses stated that:

"*Each type of disability has different problems and needs. We need to have specific knowledge and skills tailored to the care of each type of disability*." (CHN1)

Sub-theme 2.3: Data collection and utilization

The creation and use of databases on PWDs, such as disability records and geographic information systems (GIS) data on disabilities, are essential. This data allows CHNs to analyze the problems and needs of PWDs, ensuring effective care delivery. One of the nurses stated that:

"*Data on PWDs is a crucial part of planning and designing care that aligns with the problems and needs of the disabled individuals*." (CHN4)

Sub-theme 2.4: Resources and equipment

Fundraising within the community, including financial, human, and intellectual resources, is necessary for managing the care of PWDs. This includes establishing funds and savings groups and supporting PWDs to become members of funds to enhance their welfare benefits. Additionally, local regulations may be created to support budget allocation from the local government to improve the care of PWDs, along with providing medicines, medical supplies, and assistive devices for PWDs. One of the nurses stated that:

"*To provide care for PWDs in our community, we need financial support, as well as medications, medical supplies, and assistive devices for PWDs*." (CHN3)

Sub-theme 2.5: Participation

The participation of PWDs and their family caregivers in the care planning process, including decision-making, ensures that the care provided is appropriate to the needs and circumstances of each type of disability. One of the nurses stated that:

"*Each type of disability has different needs, so it is necessary to involve PWDs and their family caregivers in the care planning process*." (CHN2)

Discussions

The first theme is the role of CHNs in providing health care for PWDs. This study provides comprehensive insights into the multifaceted roles of CHNs in providing health care for PWDs within southern Thailand's unique socio-cultural context. Our findings reveal that CHNs function as integrated care coordinators, community health coordinators, and disability rights advocates, with their success contingent on network partnerships, specialized knowledge, effective data use, adequate resources, and meaningful participation by PWDs. These mechanisms leverage existing social capital, collectivist norms, and decentralized local governance in southern Thailand. Empirical excerpts and observation notes document cases where CHNs facilitated rapid procurement of assistive devices through ad hoc exchanges among village stakeholders, illustrating how CHNs facilitate collaboration, arrange informal resource exchanges, and deliver fast, locally adapted responses that clinic-centered models do not readily produce. These findings both align with and significantly extend existing frameworks for community health nursing in disability care. While established models from high-resource settings emphasize individualized care planning, specialized clinical competencies, and professionally centered service delivery (The Queen's Nursing Institute, 2018), our study reveals unique dimensions shaped by southern Thailand's context that challenge fundamental assumptions embedded in Western frameworks. The prominent role of CHNs as community health coordinating village headmen, village health volunteers, disability care volunteers, and local administrative organizations represents a fundamental departure from clinic-based disability care models prevalent in Western literature (Wodchis *et al.*, 2015). This model leverages existing social capital and collectivist cultural values rather than creating parallel professional structures (Mongklam, Kraithaworn, and Piyatrakul, 2025), challenging the assumption that effective disability care requires centralized, professionally dominated services. Instead, our findings suggest that in community-oriented contexts, relational coordination and cultural congruence may be more critical than specialized clinical infrastructure alone (Hartley and Muhit, 2003). Furthermore, CHNs adopt hybrid professional identities that extend beyond clinical nursing competencies, functioning simultaneously as clinicians, social workers, community organizers, and policy advocates to address the systemic barriers PWDs face (Gréaux *et al.*, 2023; Khanlou *et al.*, 2023). This multiplicity of roles invites reconsideration of nursing competency frameworks for low- and middle-income countries, suggesting that effective community health practice requires explicit incorporation of socio-political dimensions alongside clinical skills (Badu, O'Brien and Mitchell, 2019).

The second theme focuses on key factors affecting the success of CHNs in providing health care to PWDs. The identification of network partnerships, data-driven decision making, and meaningful participation as critical success factors offers essential insights for community-based disability care in resource-limited settings. The quadripartite partnership model involving public sector health services, local communities, local government, and external stakeholders represents an innovative approach to resource mobilization adapted to Thailand's unique governance structures (Khongsateinpong and Wanaratwichit, 2020). CHNs function as facilitating collaboration, actively creating and maintaining horizontal, non-hierarchical connections characterized by voluntary cooperation and mutual resource exchange rather than formal command structures (Moore *et al.*, 2019). The prominence of data collection and utilization challenges assumptions that data systems are primarily relevant in high-resource settings, demonstrating that even relatively simple tools, such as disability registries, GIS mapping, and systematic needs assessments, can substantially enhance care planning when effectively utilized (Tapabut *et al.*, 2018). The emphasis on meaningful participation by PWDs and family caregivers in care planning, service design, and evaluation reflects the principle "nothing about us without us", serving dual purposes: ensuring services align with actual needs and empowering PWDs by recognizing their expertise (Scholz *et al.*, 2018). These findings contribute to ongoing debates about appropriate models of community-based disability care for low- and middle-income countries, suggesting that leveraging existing community structures, building on cultural values of collective responsibility, and supporting hybrid professional roles may offer more sustainable and contextually-appropriate pathways than replicating specialized, resource-intensive models developed in high-income settings (Hartley and Muhit, 2003). This study makes specific contributions to the limited literature on community-based disability care in South and Southeast Asian contexts by providing detailed empirical documentation of how CHNs' roles are operationalized, identifying context-specific success factors, and demonstrating how culturally grounded practices can achieve quality disability care outcomes without requiring resource-intensive infrastructure typical of Western models.

These findings are context-dependent and may be transferable only to settings with similar community structures and governance arrangements. Policy implications include developing funding mechanisms and performance indicators that recognize CHNs' network-weaving and intersectoral coordination functions, and adapting training curricula to include community mobilization, intersectoral negotiation, and culturally competent facilitation alongside clinical competencies. Future research should test the explanatory mechanisms identified here in other Thai provinces and comparable settings to assess transferability and scalability.

Conclusion

This study demonstrates that CHNs in southern Thailand function not only as clinical service providers but as integrated care coordinators, community health orchestrators, and disability rights advocates. These context-specific roles and success factors identified network partnerships, data-informed planning, and meaningful PWD participation require a substantive rethinking of CHN practice, education, and policy to support holistic, rights-based, community-oriented disability care. CHN role descriptions and workload metrics should be expanded to explicitly incorporate care coordination, network weaving, advocacy, and community organizing. They should include routine activity logs that capture non-clinical tasks to inform staffing and supervision. Nursing education and continuing professional development must be revised to include community mobilization, participatory care planning, intersectoral negotiation, disability rights, and practicums in community settings that demonstrate measurable competencies. At the policy level, a multi-stakeholder task force should establish context-appropriate CHN-to-PWD staffing standards, amend job descriptions and performance indicators to reflect network and advocacy functions, and create sustainable local funding mechanisms linking provincial budgets, social insurance, and long-term care resources to support flexible community interventions such as small network grants. Operational improvements should also include simple district-level disability registries and core indicators (e.g., time-to-assistive-device provision, PWD participation rates), as well as formal PWD advisory panels to ensure co-design and accountability. Finally, comparative and implementation research across regions with varying resource levels is needed to test transferability, evaluate proposed staffing and financing models, and refine scalable approaches. Pilot-testing these recommendations with rigorous evaluation will be essential before national scale-up.

Acknowledgments

We would like to express our sincere gratitude to the PWDs and their families' caregivers, as well as to those involved in caring for PWDs in the community. Also, we would like to express our sincere appreciation to all individuals who kindly agreed to provide information. This research has received no financial assistance for the project.

Funding source

This study was not funded by any source.

Availability of data and materials

The datasets generated and analyzed during the current study, including interview transcripts, observation notes, and focus group discussion records, are not publicly available due to ethical considerations and participant privacy protection. The data contains sensitive information about PWDs. However, anonymized and aggregated data supporting the findings of this study are available from the corresponding author upon reasonable request and with permission from the Khon Kaen University Ethics Committee Human Research.

Authors' contributions

T.T: Conceptualization, literature review, design, sampling, data collection, data analysis, manuscript writing, review, references, final approval of the manuscript; L.P.: Study supervision, data analysis, manuscript writing, review, references, final approval of the manuscript; K.N: Study supervision, data analysis, writing original draft, review, final approval of the manuscript.

Declaration of Interest

The authors have declared no conflicts of interest.

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How to cite this article: Tongyoy, T., Piyabanditkul, L. and Nuntaboot, K. (2025) 'Roles and Success Factors of Community Health Nurses in Providing Health Care for People with Disabilities in Southern Thailand: A Qualitative Descriptive Study', *Jurnal Ners*, 20(4), pp. 353-362. doi: http://dx.doi.org/10.20473/jn.v20i4.71878