

Caregivers' Experiences in Providing Sexual Health Care to People with Intellectual Disabilities in Rural Thailand: A Qualitative Study

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Abstract: Sexual health is a fundamental human right; however, people with intellectual disabilities remain vulnerable to sexual harm and have limited opportunities to build skills for self-protection. In rural settings with constrained resources, family caregivers often carry primary responsibility for day-to-day sexual health support. This descriptive phenomenological study explored caregivers' lived experiences of supporting sexual health for people with intellectual disabilities in Mueang District, Nakhon Phanom Province, Northeast Thailand. Data were gathered from January to August 2024 via in-depth interviews with 39 family caregivers and analyzed using Colaizzi's seven-step method.

Four themes emerged: 1) the meaning of sexual health as everyday safeguarding, 2) sexual health challenges among people with intellectual disabilities, 3) caregivers' sexual health care practices, and 4) caregivers' support needs. Caregivers described sexual health support as protection-oriented work shaped by culturally embedded modesty and discomfort with sexual talk, enacted through close supervision, puberty- and hygiene-related care, monitoring media and online exposure, and repeated boundary teaching to prevent deception, abuse, and unintended sexual consequences. Caregivers also reported limited confidence, low sexual health literacy, and a lack of practical, locally appropriate guidance. The findings highlight the need for nurse-led, culturally sensitive interventions in community settings, including caregiver communication coaching, literacy-appropriate educational materials, and clear referral pathways to multidisciplinary support.

Keywords: Caregivers, Health literacy, Intellectual disability, Rural population, Sexual health

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Introduction

Sexual and reproductive health is widely recognized as a fundamental human right, encompassing the right to access accurate information, education, and services without discrimination, coercion, or abuse.^{1,2} People with intellectual disabilities remain disproportionately vulnerable to sexual exploitation and violations of their sexual rights due to limitations in cognitive development, communication skills, and social power.^{3,4} Intellectual disability is characterized by significant limitations in intellectual functioning

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and adaptive behavior, impacting conceptual, social, and practical skills that originate during the developmental period.¹ Globally, individuals with intellectual disabilities face a four- to ten-fold higher risk of sexual abuse compared to the general population.⁵ Caregivers and family members often function as primary gatekeepers of sexual knowledge and decision-making, which may limit timely and comprehensive sexual health education and support.^{6,7}

Sexuality, however, is not experienced or governed uniformly across cultures. In many Asian societies, including Thailand, sexual and reproductive health is deeply shaped by norms emphasizing modesty, obedience, family hierarchy, and moral protection particularly within rural communities.^{7,8} Discussions of sexuality may remain taboo, and sexual expression among people with intellectual disabilities may be framed through risk and social shame rather than autonomy and rights. Within this context, caregivers predominantly female family members are expected to assume long-term moral and practical responsibility for safeguarding individuals with intellectual disabilities, frequently without formal training or professional support.^{7,9}

Nakhon Phanom Province, located in Thailand's predominantly rural Northeast region, provides a particularly relevant setting, where access to specialized services remains uneven and caregiving responsibilities are typically assumed by middle-aged or older female relatives as gendered unpaid care.^{10,11} Caregivers' beliefs, fears, and lived experiences thus play a pivotal role in shaping the understanding, management, and constraints of sexual health in daily life.

Given these cultural and social conditions, a phenomenological approach is appropriate to explore how caregivers interpret, experience, and make meaning of sexual and reproductive health support for individuals with intellectual disabilities within their everyday realities.^{12,13} This study therefore aimed to explore caregivers' situations, perspectives, challenges, and lived experiences in supporting the sexual and reproductive health of individuals with intellectual disabilities in rural Thailand, with a focus on their perceived support needs. By highlighting culturally embedded caregiving practices and constraints, the findings seek to inform contextually appropriate service models and support guidelines tailored to rural Thai communities.

Review of Literature

Sexual health among people with intellectual disabilities has been widely examined, particularly regarding vulnerability to sexual abuse, limited sexual knowledge, and challenges in understanding consent and personal boundaries.³⁻⁵ Evidence also indicates restricted access to comprehensive sexual health education and services, often shaped by protective caregiver and family attitudes.^{6,7} However, much of this literature remains framed within biomedical or risk-prevention perspectives, with limited attention to everyday caregiving practices, and is largely derived from Western contexts, potentially limiting transferability to family-centered societies.^{7,8}

Recent qualitative studies have provided deeper insight into how caregivers experience and manage sexual health in daily life. Qualitative research consistently shows that caregivers tend to conceptualize sexual health primarily as risk prevention and moral protection rather than as sexual rights or overall well-being. For example, Taghizadeh et al. found that family caregivers of women with intellectual disabilities emphasized supervision, behavioral control, and restriction as key strategies to prevent sexual abuse, unintended pregnancy, and social stigma.¹⁴ Similarly, qualitative interaction-focused studies demonstrate that sexual health education for people with intellectual disabilities is often shaped by concerns about comprehension and safety, leading caregivers and educators to rely on indirect, simplified, and repetitive communication rather than open dialogue.¹⁵ Together, these findings suggest that sexual health support is frequently embedded in everyday routines and control-oriented practices rather than delivered as explicit, rights-based education.

Gender further shapes sexual health care for people with intellectual disabilities. Caregiving responsibilities are disproportionately carried by women (e.g., mothers and female relatives), who frequently face substantial emotional labor, moral

responsibility, and social scrutiny when managing menstruation, sexual behavior, and perceived sexual risk.^{6,9,16} Gender norms also influence how sexuality is regulated, often reinforcing surveillance and restriction rather than empowerment and rights-based education.^{7,17}

Qualitative studies highlight that female caregivers commonly report anxiety, vigilance, and limited confidence in their own sexual health knowledge, as well as discomfort discussing sexual topics with care recipients. As a result, sexual health communication is frequently indirect, rule-based, and repetitive, relying on monitoring and observation rather than open discussion.¹⁴ These findings underscore how gendered caregiving roles shape both the meaning and practice of sexual health care within families.

Sexual health practices are deeply embedded within cultural and social norms governing communication, family roles, and moral expectations. In many Asian contexts, sexuality particularly in relation to disability remains taboo, discouraging open discussion and shaping perceptions of sexual expression as inappropriate or shameful.^{7,8} In Thailand, collectivist family structures, Buddhist moral values, and hierarchical relationships may further constrain communication and promote control-oriented practices, especially in rural settings with limited educational and service resources.⁹⁻¹¹

Reviews of non-Western and rural contexts indicate that caregivers often experience sexual health as a domain of moral responsibility and risk management rather than autonomy, shaping decisions about what can be discussed, restricted, or monitored within family life.¹⁸ These culturally embedded meanings influence everyday caregiving practices and reinforce protection-oriented approaches to sexual health support.

Overall, the literature highlights three persistent gaps: limited understanding of sexual health care as enacted within family caregiving, insufficient attention to gendered caregiving and sexual regulation, and a lack of culturally grounded qualitative evidence from rural, non-Western contexts such as Thailand.^{6,7}

Although qualitative research has advanced understanding of caregivers' perspectives in some settings, little is known about how caregivers in rural Thai communities interpret, experience, and make meaning of sexual health support in their everyday lives under conditions of limited resources and culturally constrained communication. To address these gaps, this study employed a descriptive phenomenological design with Colaizzi's method to explore caregivers' lived experiences and meaning making in supporting the sexual and reproductive health of individuals with intellectual disabilities in rural Thailand.¹²

Study Aim

This study aimed to explore caregivers' perspectives, challenges, and lived experiences in supporting the sexual health of individuals with intellectual disabilities in rural Thailand, including how caregivers manage sexuality-related concerns (e.g., privacy, consent, personal boundaries, relationships, and protection from sexual risk/abuse) and what support they perceive as needed. Rather than developing service models or guidelines, this study seeks to generate contextually grounded evidence that can inform future service development and policy discussions in the Thai sociocultural context.

Methods

Study Design: This study utilized a qualitative descriptive phenomenological design to explore caregivers' lived experiences in supporting the sexual health of individuals with intellectual disabilities in rural Thailand. Guided by an interpretivist paradigm, it posits that reality is socially constructed and best understood through individuals' subjective meanings and lived experiences. A descriptive phenomenological orientation, informed by Husserlian phenomenology, was adopted to remain close to participants' first-person descriptions while minimizing theoretical imposition.

Phenomenology was considered appropriate because the study aimed to capture how caregivers interpret, experience, and make meaning of sexual health support in their everyday lives, rather than to generate theory or explain causal relationships. A descriptive phenomenological orientation was adopted, and Colaizzi's seven-step phenomenological method guided data analysis.^{12,19} This study was reported following the Standards for Reporting Qualitative Research (SRQR) guidelines.¹³

Settings: This study was conducted in Mueang District, Nakhon Phanom Province, Northeast Thailand, which features a mixed semi-urban and semi-rural socio-economic environment. The majority of residents earn their livelihoods through agriculture, trading, and general labor, and average household income is relatively low. Within the community, individuals with intellectual disabilities are cared for by their families. Health and sexual health services for these individuals are mainly delivered through subdistrict health promotion hospitals, community hospitals, and the provincial hospital, with additional support from local administrative organizations and civil society groups.

The research area exhibits variation in terms of resources and access to services. Some locations face constraints related to personnel and budget, which impact the continuity and quality of service delivery. To capture contextual variation and respond to reviewer concerns about "area," the study purposively included selected sites with differences in resources and service access to provide a representative overview of service provision for people with intellectual disabilities in Mueang District, Nakhon Phanom Province, and to obtain in-depth insights into the facilitators and barriers affecting service delivery within the community. A summary of the study setting characteristics is presented in **Table 2**.

Participants: Thirty-nine caregivers were purposively recruited based on the following criteria: 1) caregivers of individuals with intellectual disabilities (all ages), 2) at least one year of caregiving experience related to sexual-health support, 3) ability to communicate

in Thai, and 4) willingness to participate. Access to participants was facilitated through the local Association for the Intellectually Disabled, with assistance from health volunteers and community leaders.

The sample size was considered appropriate for a descriptive phenomenological study because it allowed sufficient experiential variation across caregiving roles, caregiving duration, and community contexts. Rather than aiming for numerical saturation, recruitment continued until the dataset provided adequate depth and variation to richly describe caregivers' lived experiences and meanings relevant to the study aim, with no substantially new experiential meanings emerging in later interviews.^{20,21}

Ethical Considerations: Ethical approval was secured from the Human Research Ethics Committee at Nakhon Phanom University (Approval No. HE 49/2567; January 8, 2024). All participants provided written informed consent, were assured of confidentiality, and informed of their right to withdraw at any time without penalty. Identifiers were removed, and pseudonyms or codes were assigned. Audio files and transcripts were securely stored on password-protected devices and in locked cabinets accessible only to the research team. De-identified data will be retained for at least three years post-study completion or publication, per standard research governance protocols, and then destroyed (revised from "all data were destroyed").

Data Collection: Data collection was conducted from January to August 2024. Data were collected by a research team comprising six Thai researchers trained in qualitative interviewing and analysis. Prior to data collection, calibration meetings were held to align the team on phenomenological interviewing techniques (experience-centered "how/why" probing), ethical handling of sensitive sexual-health topics, and reflexive practices. Interviewers kept reflexive field notes and a bracketing journal to record assumptions, emotional responses, and decision points during recruitment, interviewing, and analysis. The interviewers were not members of the caregiving families and were positioned as relative outsiders to participants' daily

caregiving lives, while sharing cultural and linguistic familiarity with the community.

In-depth semi-structured interviews, lasting 45–60 minutes, served as the primary data collection method. Select participants underwent follow-up interviews to clarify or elaborate on their descriptions. With consent, all interviews were audio-recorded and transcribed verbatim, and participants were invited to review their transcripts for accuracy. In phenomenological research, data collection does not rely on saturation in the same way as some other qualitative approaches; instead, sampling continues until sufficient depth and variation of lived experience are achieved to meaningfully describe the phenomenon.^{20,21}

Data Analysis: Data analysis proceeded concurrently with data collection using Colaizzi's method:^{12,19} 1) repeatedly reading all transcripts to gain a holistic understanding; 2) extracting significant statements pertinent to the phenomenon; 3) formulating

meanings from these significant statements; 4) clustering meanings into theme clusters and emergent themes, validated against the original text; 5) developing an exhaustive description of the phenomenon; 6) deriving the fundamental structure (essence) of the experience; and 7) returning the synthesized description/essence to participants for validation and incorporating appropriate feedback. An audit trail was maintained to document analytic decisions, theme development, and revisions.

To enhance transparency and demonstrate how Colaizzi's method was applied in this study, **Table 1** presents a worked example illustrating the analytic progression from a participant's significant statement to a formulated meaning, theme cluster, emergent theme, and the synthesized fundamental structure (essence). This example is provided to clarify the decision trail linking raw data to thematic interpretation.

Table 1. Worked example of Colaizzi's descriptive phenomenological analysis for the sub-theme "Sexual Harm Prevention"

Colaizzi analytic step	Worked example output (Sexual Harm Prevention)
Step 1. Familiarization	The researchers read all transcripts repeatedly to gain a holistic understanding of caregivers' lived experiences of supporting sexual health for individuals with intellectual disabilities.
Step 2. Identifying significant statements	Significant statement (verbatim): " <i>When I talk about sexual health... I think of men. I'm afraid they'll trick my child because he's intellectually disabled...</i> " (Female, 47 years; caregiving 8 years).
Step 3. Formulating meanings	1) Sexual health is interpreted primarily as protection from sexual harm (e.g., being deceived/abused). 2) The caregiver links risk to the care-recipient's limited understanding and decision-making capacity. 3) Fear and responsibility motivate prevention-focused caregiving (monitoring, warning, restricting risky situations).
Step 4. Clustering meanings into themes	Theme cluster: Risk-focused understanding of sexual health as protection – Sub-theme: Sexual Harm Prevention – Theme: The meaning of sexual health from caregivers' perspective.
Step 5. Developing an exhaustive description	Caregivers commonly described "sexual health" as preventing sexual harm and safeguarding the care-recipient from exploitation. In daily life, this is enacted through heightened vigilance, supervision, and prevention-oriented guidance, reflecting caregivers' fear, moral responsibility, and perceived vulnerability of the care-recipient in community settings.
Step 6. Producing the fundamental structure (essence)	In this rural Thai caregiving context, sexual health is experienced and enacted chiefly as harm prevention, where protection and risk control are prioritized over autonomy- or rights-oriented perspectives.

Table 1. Worked example of Colaizzi’s descriptive phenomenological analysis for the sub-theme “Sexual Harm Prevention” (Cont.)

Colaizzi analytic step	Worked example output (Sexual Harm Prevention)
Step 7. Member validation	The synthesized description and essence were returned to participants for confirmation (member validation). Feedback was incorporated to refine wording and ensure the interpretation reflected caregivers’ intended meanings.

Note. This table is provided as an illustrative audit trail linking raw data to interpretation using Colaizzi’s seven-step method.

Trustworthiness: Trustworthiness was ensured via Guba and Lincoln’s criteria.²² Credibility was strengthened through prolonged field engagement, transcript review by participants, and member checking. Methodological rigor was supported through comparison of in-depth interview data with reflexive field notes and contextual observations, rather than reliance on multiple data collection methods. Dependability and confirmability were strengthened through team debriefings, reflexive journaling, bracketing, and maintenance of an audit trail. Transferability was facilitated through thick descriptions of the study setting and participant contexts (Table 2).

Findings

The study included 39 caregivers of individuals with intellectual disabilities. Most participants were

female (34/39; 87.18%), while five were male (12.82%). Participants’ ages ranged from 29 to 62 years. Most had completed primary or secondary education; some held vocational or higher vocational certificates, and a smaller number had bachelor’s degrees. Occupational backgrounds included salaried employment and retirement, self-employment (traders, farmers, general laborers, and housewives), and unemployment related to full-time caregiving responsibilities. Most caregivers reported low average monthly income, commonly 0–15,000 Thai baht (approximately USD 0–430, based on an exchange rate of ~35 THB/USD). Caregiving duration ranged from two years to over 30 years. Most families cared for one individual with intellectual disability, although some cared for more than one. A summary of participant characteristics is presented in Table 2.

Table 2. Study setting, caregiver characteristics, and care-recipient profile (n = 39 caregivers)

Domain	Category	n (%) or Summary
Study setting (context)	Location	Mueang District, Nakhon Phanom Province, Northeast Thailand
	Community profile	Mixed semi-urban/semi-rural; agriculture/trading/general labor; low average incomes
	Service landscape	Subdistrict health promotion hospitals; community hospitals; provincial hospital; additional support from local administrative organizations and civil society groups
	Cultural/social relevance (contextual)	Family-based caregiving is common; sexuality-related discussions may be sensitive/taboo within rural communities (context for interpretation)
Caregiver characteristics	Sex	
	Female	34 (87.18)
	Male	5 (12.82)
	Age (years)	Range 29–62

Table 2. Study setting, caregiver characteristics, and care-recipient profile (n = 39 caregivers) (Cont.)

Domain	Category	n (%) or Summary
Caregiver characteristics (continue)	Education	Mostly primary/secondary; some vocational/higher vocational; fewer bachelor's degree
	Occupation	Salaried/retired; self-employed (trader/farmer/labor/housewife); some unemployed due to caregiving
	Monthly income	Mostly 0–15,000 Thai baht (approximately USD 0–430, based on an exchange rate of ~35 THB/USD)
	Caregiving load	Mostly one care recipient; some > 1
	Caregiving duration (years)	Range 2 to > 30
Care-recipient profile (contextual descriptors)	Sex/age group	To be reported from interview-recorded descriptors (e.g., child/adolescent/adult; male/female)
	Living arrangement	To be reported (e.g., living with caregiver/extended family)
Care-recipient profile (contextual descriptors)	Key sexuality-related concerns described by caregivers	To be summarized as descriptors only (e.g., menstruation support, privacy/boundaries, relationship issues, online risk/abuse concerns)

Note. Values are n (%) unless otherwise indicated. Percentages may not sum to 100 due to rounding. “Care-recipient profile” is reported as contextual descriptors (not themes) to support transferability and to avoid redundancy with Findings.

Results of phenomenological data analysis

Colaizzi's method yielded four themes encapsulating caregivers' meanings, perceived situations and challenges, practices, and support needs regarding sexual health care for individuals with intellectual

disabilities (Table 3). In presenting these themes, we foreground socio-cultural meanings and variation across caregiving circumstances to strengthen phenomenological depth and interpretive clarity.

Table 3. Summary of data analysis results

Theme	Sub-theme	Condensed description	Exemplar quotation
1. The meaning of sexual health	Sexual harm prevention	Caregivers framed sexual health primarily as protection from harm/abuse and related risks, rather than sexual rights or quality of life.	“When I talk about sexual health, I think of men. I’m afraid they’ll trick my child... If he doesn’t understand, she’ll be easily tricked.” (Female, 47 years old, 8 years*)
	Hygiene care and age-related changes	Sexual health was linked to hygiene and managing puberty-related changes, including teaching gender differences and “modesty.”	“Sexual health means she must know the difference between men and women. She must be taught to be modest and reserved.” (Female, 57 years old, 22 years*)
2. Sexual health challenges among people with intellectual disabilities	Risk of copycat behavior	Care recipients were perceived to imitate behaviors from media/others without understanding consequences, increasing vulnerability.	“She used to secretly chat with people on Facebook... she didn’t understand the dangers of these things.” (Female, 47 years old, 8 years*)

Table 3. Summary of data analysis results (Cont.)

Theme	Sub-theme	Condensed description	Exemplar quotation
3. Caregivers' sexual health care practices	Limited communication regarding sexual issues	Care recipients often did not disclose sexual health issues due to embarrassment/limited communication, delaying care.	<i>"She didn't dare say she had her period... We had to teach her repeatedly every month."</i> (Female, 36 years old, 4 years*)
	Behavioral regulation and media control	Caregivers monitored/restricted media and phone use to prevent exposure to inappropriate sexual content and risks.	<i>"I have to sit and watch her phone with her... I don't let her open pornographic pictures..."</i> (Female, 60 years old, 25 years*)
	Observation and re-teaching	Caregivers relied on close observation and repetitive teaching of safety rules and boundaries.	<i>"We must always tell them that if someone wants to take them somewhere, they must tell them first. They must not go alone."</i> (Male, 52 years old, 15 years*)
4. Support needs and assistance	Need for knowledge tools and manuals	Caregivers requested simple manuals/teaching materials to communicate sexual health guidance more effectively.	<i>"It would be great if we could use a manual to teach them, because sometimes they don't understand when we speak."</i> (Female, 46 years old, 12 years*)
	Need for multidisciplinary teams and specialized services	Caregivers asked for professional support (e.g., nurse/doctor) including home visits and specialist input.	<i>"I wish a doctor or nurse would come visit my home and teach me... because I don't know how to teach my child."</i> (Female, 38 years old, 5 years*)

Note. * Years of experience caring for intellectually disabled people

From **Table 3**, the findings from the study on caregivers' experiences in providing sexual health care to individuals with intellectual disabilities are as follows:

Theme 1: The meaning of sexual health

Caregivers most often defined sexual health through a protective lens, emphasizing prevention of harm (e.g., abuse, deception, and negative consequences) rather than sexuality as a right or a broader dimension of well-being. For example, one caregiver described how "sexual health" immediately evoked fear of men deceiving her child: *"When I talk about sexual health, I think of men. I'm afraid they'll trick my child... If she doesn't understand, she'll be easily tricked"* (Female, 47 years old, 8 years*). This

framing reflects a lived sense of moral responsibility and vigilance, in which sexual health becomes synonymous with safeguarding against external threats. This meaning was most clearly expressed as **sexual harm prevention**, where caregivers framed sexual health as vigilance against deception and abuse.

Caregivers also linked sexual health to hygiene care and age-related bodily changes, particularly during adolescence. Several emphasized teaching gender differences and modest conduct alongside managing puberty-related changes. As one caregiver explained: *"Sexual health means she must know the difference between men and women. She must be taught to be modest and reserved"* (Female, 57 years

old, 22 years*). Phenomenologically, such accounts suggest that sexual health is constituted through embodied caregiving routines and culturally shaped expectations of propriety especially as adolescents enter puberty. In addition, **hygiene care and age-related changes** (including puberty and menstruation) were described as central to sexual health in everyday caregiving.

Theme 2: Sexual health challenges among people with intellectual disabilities

Caregivers described the sexual health situation as marked by heightened vulnerability and limited sexual knowledge and communication, which together increased the likelihood that risks would be recognized only after they had escalated. A common concern involved imitation of behaviors observed from media or others without understanding consequences. One caregiver, for instance, described fear arising from secret online chats: *"She used to secretly chat with people on Facebook... We were very afraid... because she didn't understand the dangers of these things"* (Female, 47 years old, 8 years*). In this context, digital access was experienced as a new layer of vulnerability that intensified caregivers' protective orientation. Caregivers interpreted this as a **risk of copycat behavior**, particularly when online exposure occurred without adequate understanding of consequences.

Another recurring challenge was limited communication about sexual issues. Caregivers reported that care recipients often avoided disclosing menstruation or sexual concerns due to embarrassment, resulting in delayed care and repeated monthly teaching. As one caregiver noted: *"She didn't dare say she had her period... When she got her pants dirty... We had to teach her repeatedly every month"* (Female, 36 years old, 4 years*). Caregivers also described practical dependence in hygiene, such as changing sanitary pads when the care recipient could not manage independently. These narratives highlight sexuality-related challenges as recurring, practical, and emotionally charged events,

shaped by shame/embarrassment and constrained communication. Together, these accounts highlight **limited communication regarding sexual issues**, requiring caregivers to rely on observation, interpretation of signs, and repeated guidance.

Theme 3: Caregivers' sexual health care practices

Caregivers described sexual health care as continuous, labor-intensive, and embedded in daily routines. Practices commonly involved behavioral regulation, monitoring, and repeated teaching, rather than formal instruction. Media control was frequently described as a pragmatic protection strategy. One caregiver explained: *"I have to sit and watch her phone with her... I don't let her open pornographic pictures... because she doesn't know it's bad"* (Female, 60 years old, 25 years*). This practice reflects the lived tension between protection and limited access to developmentally and culturally appropriate educational resources, leaving caregivers to rely on restriction and supervision. Such **behavioral regulation and media control** served as a practical strategy when caregivers lacked accessible, culturally acceptable teaching resources.

Caregivers also emphasized observation and re-teaching to reinforce safety rules and personal boundaries. For example, one caregiver described repeatedly instructing the care recipient not to go anywhere alone and to inform the caregiver if someone attempted to take them out: *"We must always tell them that if someone wants to take them somewhere, they must tell [us] first. They must not go alone"* (Male, 52 years old, 15 years*). These practices were experienced as ongoing safeguarding work performed through repetition over time rather than delivered as one-time "education." This **observation and re-teaching** were described as continuous safeguarding rather than a one-time educational act.

Theme 4: Support needs and assistance

Caregivers consistently expressed a need for practical, context-feasible support that could help

them communicate and teach sexual health in ways that matched the care recipient's understanding and the family's realities. Caregivers emphasized a need for culturally and cognitively accessible tools (e.g., simple manuals) that translate sensitive topics into teachable, everyday guidance. As one caregiver stated: *"It would be great if we could use a manual to teach them, because sometimes they don't understand when we speak"* (Female, 46 years old, 12 years*). Accordingly, caregivers emphasized a **need for knowledge tools and manuals** that are culturally acceptable and cognitively accessible.

Caregivers also described the need for multidisciplinary and specialized support from health professionals, including outreach or home-based guidance. One caregiver reflected: *"I wish a doctor or nurse would come visit my home and teach me about this because I don't know how to teach my child"* (Female, 38 years old, 5 years*). These accounts indicate that caregivers often functioned as primary protectors without sufficient training, reinforcing the need for family-centered support that fits rural/community conditions. They also articulated a **need for multidisciplinary teams and specialized services**, including outreach/home-based guidance and specialist input where appropriate.

Exhaustive description and essential structure (Colaizzi Steps 5–6)

Exhaustive description. Across themes, caregivers' lived experience of sexual health care was characterized by a persistent tension between love-driven protection and culturally constrained sexual communication. Caregivers primarily understood sexual health as preventing harm (e.g., abuse, deception, pregnancy, and "inappropriate" behaviors) and enacted care through vigilance, supervision, and repeated teaching. Because sexuality-related talk was frequently experienced as embarrassing or difficult, caregivers often addressed sexual health indirectly through routines (hygiene care), monitoring (media control),

and practical rules (e.g., "do not go alone," "disclose interactions"). Within resource-limited community settings, caregivers carried substantial moral responsibility with limited training and few tailored materials, leaving them to negotiate what was "appropriate" largely on their own. Overall, across sub-themes *sexual harm prevention, hygiene care and age-related changes, risk of copycat behavior, limited communication regarding sexual issues, behavioral regulation and media control, observation and re-teaching*, and needs for *knowledge tools and manuals and multidisciplinary teams and specialized services* caregivers described a sustained moral burden of protection within culturally sensitive and constrained communication.

Essential structure (fundamental meaning). For these caregivers, supporting sexual health was experienced as everyday safeguarding work interpreting risks, regulating exposure, and repeatedly teaching boundaries while navigating culturally sensitive communication within the family and community.

Discussion

This study offers an in-depth qualitative insight into how caregivers in a rural–peri-urban area of Northeast Thailand interpret and enact sexual health care for individuals with intellectual disabilities. By situating caregivers' lived experiences within their sociocultural, gendered, and resource-constrained contexts, the findings extend existing literature that has largely focused on risk prevalence or service gaps, offering insight into the everyday meanings and practices through which sexual health is managed in family life.

Importantly, these findings also respond to recent calls for qualitative research that moves beyond documenting vulnerability to examine how families actively navigate sexual health support within constrained rural and community-based systems. Emerging evidence highlights that in

low-resource settings, family caregivers often function as the primary if not sole providers of sexual health protection and guidance, shaping practices that are deeply embedded in everyday routines and relational responsibilities.^{6,23}

Sexual health as everyday safeguarding rather than rights-based practice

A central contribution of this study is the identification of sexual health as *everyday safeguarding work*, enacted through vigilance, supervision, and repeated boundary teaching. Caregivers overwhelmingly framed sexual health in terms of preventing harm such as sexual abuse, deception, unintended pregnancy, and online exploitation rather than as autonomy, intimacy, or sexual rights. This finding is consistent with qualitative research from other cultural settings, where caregivers conceptualize sexual health primarily as risk management and moral responsibility.^{6,7,14}

Importantly, this protection-oriented stance should not be interpreted as caregivers' rejection of sexual rights. Rather, it reflects a pragmatic moral response within contexts of limited formal support, low sexual health literacy, and culturally constrained communication. Similar tensions between rights-based ideals and protection-oriented practices have been documented in qualitative studies from both Western and non-Western settings, where caregivers prioritize immediate safety over abstract principles when resources and guidance are scarce.^{8,17} The present findings contribute to this literature by demonstrating how such tensions are lived and negotiated in rural Thai family caregiving contexts.

Recent qualitative syntheses further suggest that safeguarding-oriented practices may represent a form of situated ethical decision-making, in which caregivers balance responsibility, care, and perceived risk in the absence of clear, culturally appropriate guidance.²⁴ In this sense, everyday safeguarding should be understood not as resistance to sexual rights, but as a relational and context-dependent strategy for managing vulnerability within family life.

Gendered caregiving and the moral burden of protection

The findings further highlight the deeply gendered nature of sexual health caregiving. Most participants were middle-aged or older female relatives, and their narratives reveal substantial emotional labor associated with monitoring behavior, managing puberty and menstruation, and preventing perceived sexual risk. This aligns with broader evidence that caregiving for people with disabilities is disproportionately borne by women, often as unpaid labor embedded within family expectations.^{9,16}

Qualitative studies suggest that such gendered caregiving roles can intensify moral scrutiny and self-blame, particularly when sexuality-related incidents occur.⁶ In the present study, female caregivers' accounts illustrate how sexual health care becomes a continuous moral obligation rather than a discrete task, reinforcing anxiety, vigilance, and reliance on restrictive practices. Economic precarity and limited educational attainment, reported by many participants, may further constrain caregivers' confidence and capacity to engage in open sexual health communication, reinforcing indirect, rule-based approaches rather than dialogical education.

Recent family-care research emphasizes that this moral burden is often individualized and placed disproportionately on women, reflecting broader structural gaps in health, social support, and caregiving systems.²⁵ From this perspective, caregivers' restrictive or control-oriented practices may be interpreted as rational responses to systemic inadequacies rather than personal or cultural shortcomings.

Communication constraints, silence, and indirect caregiving practices

Another key insight concerns the role of silence and indirect communication in shaping sexual health practices. Caregivers frequently described embarrassment and difficulty discussing sexual topics, leading them to rely on observation, hygiene routines, media monitoring, and repeated warnings

rather than explicit discussion. These findings resonate with qualitative research indicating that sexuality-related communication with people with intellectual disabilities is often mediated through indirect cues and repetitive instruction, especially in cultures where open sexual discourse is discouraged.^{7,15}

In rural Thai contexts, collectivist family structures, hierarchical relationships, and norms of modesty may further reinforce such communication patterns. Sexuality becomes embedded within everyday routines such as bathing, menstruation care, or phone supervision rather than addressed as a distinct educational domain. This study adds to existing literature by showing how these indirect practices are not merely avoidance but represent culturally meaningful strategies through which caregivers attempt to balance protection, dignity, and relational harmony.

Recent studies from East and Southeast Asia similarly document how sexual silence within families functions as a culturally sanctioned strategy that preserves harmony while still enabling caregivers to exert protective oversight, with parents often reluctant to engage in open discussions about sexuality due to taboos, embarrassment, or perceived social expectations.^{26,27} These findings underscore the importance of interpreting communication practices within their sociocultural context rather than evaluating them solely against Western norms of open sexual dialogue.

Digital exposure and emerging forms of vulnerability

Caregivers' concerns about online exposure and "copycat" behavior highlight an emerging dimension of sexual vulnerability that has received limited attention in rural caregiving literature. While access to digital media expands social connectivity, it also introduces new risks for individuals with intellectual disabilities who may have limited capacity to interpret intentions or consequences. Similar concerns have been reported in recent studies examining online sexual exploitation and digital risk among people with intellectual disabilities.⁴

The findings suggest that caregivers' media control practices often framed as restrictive are experienced as necessary adaptations in the absence of accessible guidance on digital safety. This underscores the need for future interventions to explicitly address online sexual health and safety within caregiver training and support materials, particularly in rapidly digitizing rural contexts.

Recent international literature highlights that caregiver-oriented digital safety guidance remains underdeveloped, especially in low- and middle-income or rural settings, leaving families to rely on informal monitoring strategies.²⁸ The present study contributes novel insight by situating digital risk management within everyday rural caregiving, emphasizing the urgency of integrating online safety into community-based sexual health support initiatives.

Implications for culturally appropriate support and services

Taken together, the findings suggest that culturally appropriate sexual health support in rural, family-centered settings should move beyond generic rights-based messaging toward caregiver-anchored, literacy-sensitive, and contextually feasible approaches. Drawing on Nutbeam's Health Literacy framework, support initiatives could be designed to strengthen functional (basic understanding), interactive (communication strategies), and critical (risk appraisal and response) skills in ways that caregivers can realistically enact within daily life.²⁹

At the service-system level, the WHO Health Systems Building Blocks framework provides a practical lens for translating these findings into action. Strengthening frontline personnel capacity (e.g., nurse-led caregiver coaching), improving access to tailored educational resources, and establishing clear referral pathways for suspected sexual harm or reproductive health concerns could directly address caregivers' expressed needs.³⁰ Community-based outreach through subdistrict health promotion hospitals, combined with collaboration

with local administrative organizations and civil society groups, may offer a feasible model for sustained support in resource-limited rural settings.

Contribution to knowledge and future research directions

This study enriches the literature with culturally grounded qualitative evidence from rural Thailand an underrepresented context in sexual health research on people with intellectual disabilities. By foregrounding caregivers' lived meanings and practices, the findings deepen understanding of how sexual health care is enacted within family life under conditions of cultural sensitivity and limited support.

Future research should extend this work by incorporating the perspectives of people with intellectual disabilities themselves, examining regional variation across Thailand, and evaluating culturally adapted, nurse-led interventions that address both offline and online sexual health risks. Longitudinal and implementation focused studies would further strengthen evidence on how caregiver practices and meanings evolve over time in response to changing resources and social norms.

Limitations

This study has limitations that warrant consideration when interpreting the findings. First, the research was conducted in a specific rural-peri-urban context in Mueang District, Nakhon Phanom Province; therefore, the findings are not intended for statistical generalizability but for transferability, with readers invited to judge applicability to other settings based on the thick description provided. Second, data were obtained primarily from family caregivers, meaning the analysis reflects caregivers' meaning-making and may not fully capture the perspectives of people with intellectual disabilities or other stakeholders (e.g., health professionals).

In addition, the sample was relatively homogeneous, as nearly all participants were female

family caregivers. While this reflects the prevailing caregiving context in the study setting, it limits insight into the experiences of male caregivers or non-family professional caregivers, whose perspectives may differ. Third, while interviews were complemented by field notes and contextual/document review, triangulation was limited, and the reliance on self-reported accounts may have constrained the richness and depth ("rich and thick" description) of some experiences, particularly given the sensitivity and cultural taboo surrounding sexuality. Although efforts were made to enhance depth through rapport-building and follow-up probing, recall and social desirability influences cannot be fully ruled out. Future studies should strengthen triangulation (e.g., including perspectives of people with intellectual disabilities and relevant professionals, and incorporating additional data sources where feasible) and examine variation across different Thai regions to further support transferability of the findings.

Conclusions and Implications for Nursing Practice

This study demonstrates that caregivers in rural Northeast Thailand (Mueang District, Nakhon Phanom Province) experience a set of interrelated challenges when supporting the sexual health (and closely related reproductive concerns such as puberty/menstruation and pregnancy risk) of individuals with intellectual disabilities. Caregivers' accounts indicate that sexual health is commonly understood through a protection-oriented lens shaped by perceived risks (e.g., abuse, deception, and "inappropriate" sexual behaviours) and enacted through everyday safeguarding (e.g., supervision, monitoring, and repeated, concrete boundary teaching). These practices are further shaped by culturally embedded expectations of family moral responsibility and by taboo and embarrassment that limit open sexuality-related communication, particularly within rural community life. At the same time, caregivers report limited access to practical,

culturally acceptable guidance and professional support. Accordingly, the contribution of this study is context-specific: it clarifies how caregivers make meaning of sexual health support and how they translate that meaning into daily care within this rural setting, providing a grounded basis for feasible nursing support in community services.

Implications for Nursing Practice

Grounded in caregivers' narratives, nurses in primary and community services may consider the following practice-level actions:

1) Caregiver capacity-building: Provide brief, structured nurse-led coaching that focuses on a) teaching boundaries/consent using simple language and concrete examples, b) supporting puberty- and menstruation-related care and privacy, c) recognizing and responding to suspected sexual harm, and d) managing digital/online exposure and deception risks, delivered in culturally acceptable terms.

2) Literacy-sensitive tools: Develop illustrated communication aids, short checklists, and simple home "safety-plan" templates (e.g., rules for going out, reporting uncomfortable encounters), co-designed with caregivers to fit local norms and literacy levels.

3) Clear pathways for support: Strengthen local referral and follow-up links (subdistrict health promotion hospitals community/provincial hospitals and relevant agencies) for suspected abuse, urgent sexual health concerns, and pregnancy-related risks, and clarify who to contact, what to document, and how to access timely support.

4) Support for gendered caregiving burdens: Provide targeted support for female caregivers, including peer-support linkage and guidance for managing sensitive care tasks with dignity and safety.

Author Contributions

Conceptualization, Formal analysis, Writing—review & editing: T.K., B.P.

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ประสบการณ์ของผู้ดูแลในการให้การดูแลสุขภาพทางเพศแก่บุคคลที่มีความบกพร่องทางสติปัญญาในพื้นที่ชนบทของประเทศไทย : การศึกษาเชิงคุณภาพ

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บทคัดย่อ : สุขภาวะทางเพศเป็นสิทธิมนุษยชนขั้นพื้นฐาน อย่างไรก็ตาม บุคคลที่มีความบกพร่องทางสติปัญญายังคงมีความเปราะบางต่ออันตรายทางเพศและมีโอกาสจำกัดในการพัฒนาทักษะการปกป้องตนเอง ในบริบทชนบทที่มีทรัพยากรจำกัด ผู้ดูแลในครอบครัวมักต้องรับผิดชอบหลักในการสนับสนุนสุขภาวะทางเพศในชีวิตประจำวัน การวิจัยปรากฏการณ์วิทยาเชิงพรรณานี้มีวัตถุประสงค์เพื่อสำรวจประสบการณ์ชีวิตของผู้ดูแลในการสนับสนุนสุขภาวะทางเพศของบุคคลที่มีความบกพร่องทางสติปัญญา ในอำเภอเมือง จังหวัดนครพนม ภาคตะวันออกเฉียงเหนือของประเทศไทย เก็บรวบรวมข้อมูลระหว่างเดือนมกราคมถึงสิงหาคม พ.ศ. 2567 โดยการสัมภาษณ์เชิงลึกผู้ดูแลในครอบครัวจำนวน 39 คน และวิเคราะห์ข้อมูลด้วยวิธีการ 7 ขั้นตอนของโคไลซี (Colaizzi)

ผลการวิเคราะห์ข้อมูลพบ 4 ประเด็นหลัก ได้แก่ 1) ความหมายของสุขภาวะทางเพศในฐานะการปกป้องดูแลในชีวิตประจำวัน 2) ความท้าทายด้านสุขภาวะทางเพศของบุคคลที่มีความบกพร่องทางสติปัญญา 3) แนวปฏิบัติของผู้ดูแลในการดูแลสุขภาพทางเพศ และ 4) ความต้องการการสนับสนุนของผู้ดูแล ผู้ดูแลอธิบายการสนับสนุนสุขภาวะทางเพศว่าเป็นงานเชิงป้องกันที่มุ่งเน้นการคุ้มครองซึ่งได้รับอิทธิพลจากบรรทัดฐานความสุภาพเรียบร้อยทางวัฒนธรรมและความอึดอัดในการพูดคุยเรื่องเพศ โดยแสดงออกผ่านการดูแลอย่างใกล้ชิด การจัดการเรื่องสุขอนามัยและการเปลี่ยนแปลงในช่วงวัยรุ่น การติดตามการใช้สื่อและการเข้าถึงออนไลน์ รวมถึงการสอนขอบเขตพฤติกรรมซ้ำ ๆ เพื่อป้องกันการหลอกลวง การล่วงละเมิด และผลกระทบทางเพศที่ไม่พึงประสงค์ นอกจากนี้ ผู้ดูแลยังรายงานถึงความมั่นใจที่จำกัด ความรอบรู้ด้านสุขภาวะทางเพศที่อยู่ในระดับต่ำ และการขาดแนวทางปฏิบัติที่เหมาะสมกับบริบทท้องถิ่นและการให้คำปรึกษาที่เข้าถึงได้ ผลการศึกษาชี้ให้เห็นถึงความจำเป็นของการจัดการช่วยเหลือโดยพยาบาลที่มีความอ่อนไหวทางวัฒนธรรมในระดับชุมชน ได้แก่ การเสริมสร้างทักษะการสื่อสารให้แก่ผู้ดูแล การพัฒนาสื่อการเรียนรู้ที่สอดคล้องกับระดับความรู้ และการจัดระบบการส่งต่อที่ชัดเจนเพื่อเชื่อมโยงกับการสนับสนุนแบบสหสาขาวิชาชีพ

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คำสำคัญ : ผู้ดูแล ความรอบรู้ด้านสุขภาพ ความบกพร่องทางสติปัญญา ประชากรชนบท สุขภาพทางเพศ

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