

Getting Married to a Suspected Bisexual Man: A Silent Mode of HIV transmission among Married Women in Indonesia

by Najmah Najmah

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Getting Married to a Suspected Bisexual Man: A Silent Mode of HIV transmission among Married Women in Indonesia

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ABSTRACT

A married woman is susceptible to contract HIV from her husband if he practices unsafe sex, especially with other men. Unsafe sexual practice (heterosexual and homosexual sex) are the major factors of significant increase of HIV in Indonesia for the last decade. The aim of this study is to reveal one woman's story about living with HIV. She contracted from her husband after he was unsafe sex with men.

Feminist Participatory Action Research was conducted in 2017 with HIV positive women, health workers from public and private organisations. Qualitative research methods were used in line with purposive sampling method and thematic analysis.

Men who have sex with men (MSM) may contract HIV through unsafe homosexual practices. Women need to be informed about the risk factors of contracting HIV and Prevention of Mother to Child Transmission-PMTCT of HIV services. In addition, compulsory antenatal HIV testing urgently needed to early diagnosis of HIV among pregnant women and a non-discriminatory practice of comprehensive Prevention of Mother-to-Child Transmission of HIV (PMTCT) services is urgently required to prevent HIV transmission for infants.

Keywords: MSM, bisexual man, a married woman, mother to child transmission, PMTCT service, Indonesia

Introduction

In the past decade, four out of every 10 people diagnosed with HIV in Indonesia were women and the highest number of late stage of HIV (AIDS) suffers are married women or housewife⁽¹⁾. Married women are considered a neglected group in HIV prevention in Indonesia^(2,3). As a consequence of the lack of focus on married women, they have become a 'silent majority' new HIV-positive cases⁽¹⁾. In Indonesia, the majority women living with HIV find out their HIV status after their husband or children die, or after they themselves become ill⁽⁴⁻⁶⁾. Unsafe sexual practices are now the main cause of increases in HIV rates in Indonesia^(1,7). There is a little knowledge about lived stories of a married woman who is more likely to contract HIV from their husband who experiences to have unsafe sex practice with other men in Indonesia context.

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Method

Research Paradigm and Methodology: Feminism is chosen as our epistemological stance and Feminist Participatory Action Research (FPAR) as the research methodology. Feminism includes a philosophical belief system that addresses who can be the real knower of women's problem and solution and care for the relationships between the female researcher and the research participants^(8,9). Feminist research also seeks to contribute to women's empowerment⁽¹⁰⁾, as women have the potential means to contribute to the development of collective consciousness, through their active participation, shared knowledge, and collaboration in the research itself^(9,11). Within FPAR, three main dimensions of social transformation allow the necessary place and space to reposition gender, race and class, "to excavate indigenous cultural knowledge and generate voices"; and "to deploy intersectionality as an analytic tool for transformation"⁽¹²⁾, pp 331. In addition, focusing gender and diversity of women's experience and voices are an integral part of this FPAR in challenging a patriarchal culture⁽¹³⁾.

Participants: This study is a part of the whole study of FPAR that was conducted in 2017 with a group of 18 HIV-positive women, a group of 26 health workers, and a group of nine NGO workers. The voices of these groups were travelled visually to the final group of 12 stakeholders related to HIV in Palembang. Purposive sampling was undertaken to recruit participants in Palembang (capital city of South Sumatra) Indonesia.

Data Collection and Analysis

The methods used included informal or “go-along” or informal interviews⁽¹⁴⁾, focus group discussions and participant observations over four months in Palembang. In addition, participatory visual methods were used during the Focus Group Discussions and interviews. These methods allowed for HIV-positive women and other groups to express their thoughts through visual representations, such as drawing, collages and mind-mapping⁽¹⁵⁻¹⁸⁾. The data collection was conducted by the first author, who was born and raised in Indonesia and was fluent in the local dialect of Palembang. Thematic analysis and reflective analysis were then conducted.^(13, 19-22)

Result

Preventing Mother-to-child Transmission: Mira recalled the time when she started to feel that the labour was coming. Her pain was excruciating, and the contraction came closer to each other. Psychologically, she felt very worried that her baby would be infected with HIV during delivery. Mira, accompanied by Kuyung then rushed to the emergency unit at a public hospital. At the admission, she reported her HIV status: “I am positive HIV, I needed a Caesarean Operation”. The admission nurse at that time, however, did not believe her and Mira insisted for the nurse to contact the Voluntary, Counselling and Testing (VCT) centre where she and her husband had been treated for HIV. The nurse contacted the VCT centre and got confirmation of Mira’s status. She was scheduled to have the caesarean.

During the waiting time, or at about 6 pm, Mira felt her contractions intensified. Yet the nurses kept telling her that she would be fine. Two hours later, at about 8 pm, Mira had delivered her baby naturally. She felt very tired and shaken and after her delivery Mira realised she did not have any meals or drinks since 2 pm as a requirement for the surgery. Following the delivery of

Toleh, Mira’s second child, both the mother and baby were transferred to the maternity ward and shared her in-patient room with other female patients.

Vulnerability and discriminatory practice: During her recovery process, Mira recalled some incidents when she received blame, discriminatory treatments from the nurses. For example, one of the nurses had asked her “*you knew that you were HIV-positive, why did you decide to be pregnant and deliver your baby?*”. Other nurses would give signs to her peers of her HIV status, mocking on Mira, while Mira was present in the room. At the same time, Mira felt hopeless. She was angry and disappointed with the treatment she received, but there was not much she could do then hoping for some ‘empathy’ from the nurses, midwives or doctors at the hospital. After a few months of her recovery, she asked about a family planning of Intra Uterine Devices in the same hospital, however, she got rejection after she disclosed her HIV status. Fortunately, after 18 months of being treated with a preventative HIV medication, her son, was declared HIV free.

HIV vulnerability: deception in marriage: During her second pregnancy in 2015, Mira recalled going to the community health centre to have a check on her vaginal rashes and itchiness. The test results confirmed she had syphilis and HIV. Her CD4 count of 350 cells/mm³. Feeling shocked, Mira told Kuyung and demanded for Kuyung to take a blood test. Kuyung was diagnosed HIV with a CD4 count of 450 cells/mm³. Mira or Kuyung was likely to be infected with HIV about four years ago year⁽²³⁾. Both Mira and Kuyung were referred to the VCT clinic for Antiretroviral treatment and accessed PMTCT services to prevent HIV to Toleh.

Mira was not sure who whether she or her husband acquired the HIV or syphilis first by saying “I did not know, who got it first, he [Kuyung] is a man”. At some point, Mira was also suspicious she might have acquired HIV from an unsterile syringe used by one of the staff at a family planning clinic. A year prior to her problem, Kuyung had told her about having genital itch and there were reddish-brown sores around his genital area.

HIV vulnerability: norms on heterosexual marriage: To gain further understandings on MSM in Palembang, the first author decided to seek further information and meeting peer support workers and outreach HIV workers who had been working with bisexual and gay communities

and health workers in VCT centres. Learning from lived stories of the insiders, the authors became aware of life of MSM in Palembang that may differ from MSM from other countries, like New Zealand. MSM, either bisexual or gay man, may contract to HIV through unsafe sex practice, have relationship with a female partner and not all of MSM may disclose their sexual orientation and HIV status to their male and female partners.

Discussion

In Mira and Kuyung's marriage, there was a complex interplay of deception, stigma around homosexuality, heterosexual morality and HIV stigma in health setting. Kuyung might have engaged in homosexual sex prior to him marrying Mira, yet there was no knowledge whether Kuyung continued his sexual practice with men after his marriage with Mira. Kuyung also had never disclosed his sexual orientation to Mira nor had he ever seek to do an HIV test although he was infected Syphilis one year prior to Mira.

This spouse was eager to seek Caesarian Section and disclose their HIV status, however they were failed to get one. The risk of Mother To Child Transmission can be reduced from up to 50 % without accessing any treatments to less than 5% by women accessing effective treatment during pregnancy, safe labour practice, and formula milk-feeding (or breastfeeding with certain rules) through PMTCT services^(24,25). Caesarian section is seen main alternative for safe delivery for pregnant women living with HIV in limited CD4 and viral load test⁽²⁵⁾. We suggest in Mira and Kuyung's life were embedded to their 'perception of susceptibility'⁽²⁶⁾. Mira, and most Muslim women, are taught that being a mother is prestigious and a high status job in Islam as per the famous hadith: "Paradise lies at the feet of the mother"⁽²⁷⁾.

HIV among MSM may bridge HIV transmission to married women as this present study also highlights being a bisexual and gay men was a considered as a lifestyle choice by participants. Being bisexual and gay man is perceived as 'abnormal' and 'sinful' within the discourse of heterosexual morality^(28, 29), hence, bisexual and gay men in Indonesia may give up and decided to getting married to adhere to heterosexual normality in Indonesia⁽²⁹⁾. To reduce social risk on their gayness, MSM generally did not open about their sexual orientation in public space, including to their female partners⁽²⁹⁾. Unfortunately, unsafe homosexual practices

may contribute the significant increase of HIV among MSM in Indonesia^(1, 7, 30). The risk of HIV transmission through anal sex is 18 times higher than vaginal sex without use of condom⁽³¹⁾, however, the rate of condom use, which is effective for preventing HIV and other STIs, is very low amongst married couples^(7,32).

Preventing HIV among men having sex with men is still complex as their sexual practices are perceived as immoral and sinful. Consequently, this may actively prevent them from seeking HIV tests or disclosing their sexual orientation to their wives or other sexual partners^(28, 29, 33). As a result, unsafe heterosexual and homosexual relationship, a long period of asymptomatic HIV and deception within marriage may result in 'silent' HIV epidemic among Indonesian women. Another threat of this complexity of HIV transmission is a new mutation of HIV virus or recombinant strain of HIV is more likely to be occurred in Indonesia, like a recent study case among MSM in China⁽³⁴⁾.

Conclusion

This paper indicates that sexual transmission of HIV occurs among married women and men in a number of ways, including unsafe sexual practice between a married woman with a husband who has sex with men. Consequently, heterosexual married women have become a 'silent majority' of new HIV-positive cases. The notion of the shame, sinful, a hidden life-style about being a bisexual or gay man means that people do not talk about HIV and homosexual sex within a marriage. Unfortunately, there is limited HIV screening of pregnant women meaning women unknowingly pass HIV to their babies. Consequently, women need to be informed about the web of risk factors of contracting HIV within a deception and unsafe sex practice of men having sex with men with their heterosexual partners. Women should be empowered to make responsible decisions in their own right to reduce contracting HIV from their partner and transmitting HIV to their babies. In order to reduce of the risk of mothers transmitting HIV to their children and to enhance their early access to PMTCT services, these services need to be aware and address these gender discriminatory factors in their training and policies.

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