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NON-DISCLOSURE OF SEXUAL ORIENTATION OF MEN HAVING SEX WITH MEN (MSM): A HIDDEN THREAT OF HIV TRANSMISSION IN PALEMBANG, INDONESIA

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ABSTRACT

Men who engage in sexual relationships with other men (MSM) are consider a high-risk group for HIV transmission, with MSM in Indonesia accounting for 17.9% cases of HIV in 2020. This qualitative study aimed to understand better the factors determining MSMs' motivation to disclose their sexual orientation. This research employed a phenomenological approach to explore the disclosure experiences of MSM in Palembang City. In-depth interviews and observations were conducted with 11 purposively recruited MSM informants and five MSM outreach workers to ensure data triangulation. Documentation and observations of the participants were conducted during various activities at the Intan Maharani Foundation (IMF). MSM participants observed extreme caution when disclosing their sexual orientation and only chose to reveal their sexual orientation to a very limited network, such as close friends, who are MSM, and at risk of HIV transmission. The hesitation to disclosing sexual orientation may be linked to the fact that only a few MSM had ever undergone an HIV test. MSMs, if they choose to, could share their status with Field Outreach (FO) during routine health check-ups. Findings of this study call for further research on barriers that hinder MSM from openly discussing their sexual orientation. Such research can inform policy and program developers on how to improve services, promote health literacy, foster confidence and trust among MSMs, hence facilitating their access to HIV services, enabling them to disclose their HIV status confidentially, safely, and in a respectful environment.

Keywords: Men Who Have Sex with Men (MSM), Status Disclosure, Sexual Orientation.

Introduction

The global HIV infection, caused by the Human Immunodeficiency Virus (HIV), remains a significant concern in public health.[1–3] With particular emphasis on its impact in men who have sex with men (MSM). Over the past decade, there has been heightened concern over the identified epidemic HIV, especially in MSM population. About 23% of MSM individuals worldwide are infected with HIV[4] and are particularly prevalent in Africa, Latin America, and Asia (South and South-East).[3] The UNAIDS Report (2019) noted that in the Asia Pacific Region, the highest number of HIV cases are found in three key groups: MSM (44%), clients of sex workers and their partners (21%), and injecting drug users (IDUs) (17%).[3] In Indonesia, it was estimated in 2020, that there were 754,300 MSM individuals an HIV prevalence of 17.9%. Notably, MSM aged between 25 and 49 displayes the highest HIV prevalence, reaching 66.4%.[5–7]

From January to March 2020, there were 27 new cases of HIV infection in MSMs in South Sumatra province. Of these cases, 26 individuals lived in Palembang City, the provincial capital.[8] Palembang City houses the highest MSM population in the South Sumatra province, with 4,332 individuals, out of which 2,912 individuals are living with HIV (PLWHA).[6] MSMs are 22 times more like to transmit HIV to their sexual partners than other groups.[2,9] In Indonesia, nearly a third (27.2%) of people living with HIV are homosexuals (26.3%) and transgender individuals (0.9%).[2,9] Unprotected anal sex as a receptive carries a higher risk of HIV transmission than unprotected vaginal sex, even ten times higher.[10,11] MSM individuals have a 19 times higher risk of transmitting HIV than the general population.[10]

The increasing rates of HIV and other Sexually Transmitted Infections (STIs) within MSM communities may be attributed to various factors. These include engaging in unprotected anal sex, which carries the highest risk of transmission, as well as oral sex. Other interrelated factors including multiple and concurrent sexual partners, alcohol and drug use, and co-infection with other STIs.[12–16] There has been a significant change in the ways MSM finds sexual partners, with the emergence of new platforms, such as online platforms, mobile applications, gay bars, parks, and baths. These shifts in partner-seeking behaviours increase the risk of HIV transmission in MSM, as they often involve meeting with unacquainted or unfamiliar individuals.[12,17] These circumstances pose significant challenges in effectively reaching out to the MSM communities in HIV prevention efforts. It is particularly challenging to engage with these communities due to their hidden status as a hard-to-reach population.[18] The lack of awareness about HIV transmissions, inadequate knowledge, poor attitudes, and risky sexual behaviors are continued to hinder effective HIV prevention efforts. These factors are often overlooked and require intervention in any prevention efforts.[19]

From January to September 2021, the Minimum Service Standards (MMS) report on health services in Palembang, observed that 1,489 MSM individuals had undergone testing. In January –

March 2020, compared to other regions in South Sumatera Province, Palembang City observed the highest number of MSMs who tested positive for HIV.[8] The increasing diversities within the MSM communities can be associated with their HIV-disclosing attitudes and motivations.

MSM, as a risk population for HIV transmission, needs special attention and care. When MSM individuals feel comfortable with and respected, especially by health providers, various factors come to the fore. These factors include a preference for female providers, the importance of maintaining consistent visits with the same providers, the use of shared humour.[20] It is not typical for MSMs to voluntarily disclose their sexual behaviours to health providers. Such disclosure, however, is important in referring MSMs to HIV testing services and counseling services when requires.[21]

Stigmatization and discrimination against MSMs and PLWH among health providers are widely observed in Indonesia.[22] MSMs may fear the repercussion of disclosing their sexuality. Disclosure can lead to embarrassment, fears of judgment, and concerns about confidentiality.[21,23] These perceptions are typically regarded as not relevant to their medical treatment. This phenomenon may be attributed to a lack of specific guidelines or protocols for healthcare providers and a lack of training and competency among some providers on interacting with MSMs.[24] Least to say, such disclosures are pivotal for effective HIV testing and associated services.[22]

The above discussion raised a question for researchers as well as a research Limited information exists about MSMs in Palembang. At the same time, population movement and migration and the growing number of public facilities where MSM gathers have caught the researchers' attention. To address the data limitation on MSMs in Palembang, this research purpose to explore the disclosure behaviours and attitudes of MSMs living in Palembang City. Additionally, information on sexual behavior, marital status, and HIV testing among MSM individuals were sought.

Methods

This research employed a phenomenological approach to gain insights into the motivations, attitudes, and choices of MSMs regarding the disclosure or non-disclosure of their sexual orientation. This research utilized in-depth interviews to understand better the lived experiences of MSM individuals in Palembang City about disclosing their sexual orientation.

Participants Recruitment

This research consisted of two categories of participants: primary participants/informants and key informants.

Recruitment of MSM Individuals

The selection criteria for the primary participants were MSM individuals aged 19 or older who had gone an HIV test and registered with the HIV/AIDS Information System (SIHA) in

Palembang City. They had a connection with the Intan Maharani Foundation (IMF). MSM participants were recruited from various MSM peer support groups and MSM FO workers associated with the IMF. Due to COVID-19 restrictions, research invitations were distributed through social media. One of the IMF senior officers shared the invitation with MSM peer support groups within their networks.

Potential participants who expressed interest in the research were invited to an introductory meeting with the research team. The researcher explained the research aim, procedure, expectations, and benefits to the participants in this introduction meeting. They also briefly introduced existing HIV policies and programmes. Confidentiality, anonymity, respect to participants' rights were discussed. The participants who agreed to participate were asked to read and sign the consent form. A total of 11 MSMs agreed to participate, and they were aged between 19 and 50. Details of their demographic characteristics are summarised in Table 2, Table 3, and Table 4 below.

The process of selecting key informants for this study involved individuals with extensive experience working with MSM individuals and HIV/AIDS in various capacities within Palembang City. They included FOs and those involved in program policy, implementation, and funding allocation. Five key informants agreed to participate in the research. They were aged between 20 and 60 and had worked in the field of HIV for between five and 27 years.

Among them were two senior officers from the public health office in Palembang, while the remaining three were co-directors of the Intan Maharani Foundation. Of the co-directors, two were actively engaged in HIV programmes, and one was the coordinator for programs with MSM communities in Palembang. Interviews with these key informants were conducted throughout February and March.

One week after the introductory meeting with potential MSM participants, the researcher, assisted by research assistants, began the interview process, which included three phases. An interview guideline was used, and prompt questions were developed to ensure effective interviews.

Phase 1: The initial interview stage involved MSM participants designated as the peer support groups and have received education through mobile voluntary counseling and testing services or discussions with FOs through questions related to HIV/STIs. The narratives obtained from these interviews were transcribed, coded, and analyzed. Emerging themes from the analysis served as a guide for the second phase of interviews with MSM participants.

Phase 2: The second stage of interviews focused on exploring how participants' education and marital status influenced their sexual orientation disclosure behaviours. De-briefing sessions were conducted after each interview to address any new information or themes that arose. The research advisory group guided modifying prompt questions as necessary to deepen our

understanding of participants' disclosure behaviours. There are four who were also working as the FOs who joined the second stage of this interview.

Phase 3: The third stage of interviews targeted MSM participants living with HIV for follow-up sessions.

All phases were carefully crafted to reflect different MSM groups, their roles, and education levels. Ultimately, information regarding disclosures was gathered, considering the various characteristics of the MSM individuals. Each interview lasted for around 20-50 minutes.

Recruiting a Research Assistant

Before the field research, a research assistant was recruited within the IMF networks. The research assistant [ZA] was selected due to his experiences working as an FO worker and the training he had received in working with the MSM communities. The first author [NA] trained [ZA] about the research aim, methodology, planned data collection and management, and ethics in research. ZA was given a few opportunities to practice running the interviews with three HIV FO workers who were also MSMs to refine the interview schedule based on feedback regarding the appropriate use of language and timing of the interviews.

Data Collection

As noted earlier, the data collection included in-depth interviews with 11 MSM individuals and five FO workers as the key informants. Participants' observations were also carried out during the initial visit to IMF and activities within the VCT services. The first author [NA] was invited to observe activities within the mobile VCT services, where she met with MSM peer support groups. The data collection occurred between February to March 2022. All participants were invited to review their interview transcripts to check for accuracy and could add or extend the information given to the researchers. These data verification approaches allow for data triangulation and the trustworthiness of the data. Researchers did not conduct focus group discussions due to time and resource constraints.

The six-step thematic analysis was used to analyze the data following the work by Braun and Clarke.[25] These steps include familiarising data, initial coding, generating categories, defining and reviewing themes and sub-themes, and writing the research report.

The data analysis stage started with the first author [NA] and the second author [N] independently reading the transcripts, focusing on frequently mentioned keywords regarding experiences, challenges, and feelings relating to disclosing or not disclosing status as an MSM. This guided the basis for the initial coding. The data analysis process included reading and re-reading the transcripts to become familiar with the recurring themes. Transcripts were manually coded, and notes were taken throughout the coding process, discussions, and questions that occurred during the discussion of the themes between NA and N. The final coding and themes were systematically assigned to 'child and parent codes. This research was approved by the Health

Research Ethics Commission, Faculty of Public Health, Sriwijaya University, within Number: 015/UN9.FKM/TU.KKE/2022.

Results

After collecting data from research participants, information regarding MSM individuals' characteristics, risk behaviors, disclosure behaviours and attitudes were used as the central themes. Several tables below illustrate the characteristics of the participants and additional information on sexual behaviours, such as the disclosures of MSM individuals regarding their sexual orientation and the number of sexual partners.

Table 1. Participants' demographic characteristics and HIV related risk (n=11 MSMs)

Characteristics	Number of participants
HIV Positive	1
HIV Negative	10
Age	
≥25 Years	7
15-24 Years	4
Marital Status	
Single	8
Married (as bisexual)	3
Education	
High education (graduated from high school/equivalent or college)	8
Low education (Maximum graduate of junior high school or equivalent)	3
Employment	
Full-time employment	10
Unemployed, student	1

Table 1 shows that only one of the participants was HIV positive at the time of this research. Most are 25 years old, unmarried, have high education level, and are full-time employed. Furthermore, marital status also explained that MSM participants had a bisexual sexual orientation.

Table 2. Disclosure of MSM status to close people (n=11)

As MSM/Transgender individuals/people living with HIV	Participants
Non-disclosure	4
Pretty open category	4
Chose not to answer	3

Regarding disclosing their status, Table 2 shows that four participants had shared their gender identity or sexual preference with their closest family or friends, including MSM friends, sexual partners, distant relatives, and cousins. Four people were relatively open about their status. However, this disclosure is only limited to disclosure of status as PLWHA and transgender, not entirely as MSM. Unfortunately, only 8 of 11 MSM shared their disclosure behaviours and decision

with the researchers because the flow of the conversation between researchers and informants was not always focused on the interview guide.

Table 3. Additional information regarding sexual experiences, MSM participants (n=11)

Initial pseudonym	Sexual experiences
T	Experienced the first sexual violence at 28 years of age by a family member and at 30 by a teacher. He has not yet completed elementary school. It is noteworthy that T has never engaged in sexual relations with women.
D	Newly open about being MSM; has previously disclosed having had sexual relations with women (vaginal intercourse).
R	Recently embraced MSM identity; has previously engaged in sexual activities with men because of economic necessity.
F	Had been divorced for 10 years. He previously had a heterosexual marriage. He reconnected with the MSM community recently and actively pursued sexual relationships with men. He is the father of a son who does not identify as MSM.
R	Recently embraced MSM identity; has previously engaged in sexual activities with men because of the "accident" between their friend who is also an MSM.
E	Formerly identified as MSM and has since embraced a transgender identity and engages in sex work (feminine role).
H	He was married at 21 and became a parent to two daughters and an adopted son. They have since transitioned to being transgender and had a history of diabetes and high blood pressure before working as a FO worker.
A	Formerly identified as MSM and has since embraced a transgender identity and engages in sex work (feminine role).
J	Heterosexually married for nine years with one child (7 years old), bisexual. Had difficulties recovering from STIs in 1996.
M	Heterosexually married for ten years; had three children. Their attraction is 70% towards women and 30% towards men. They transitioned from paid activities to consensual engagements.
V	HIV positive in 2019; already have symptoms of fever for a week, diarrhea, and hair loss.

Two of the 11 participants identified themselves as transgender people. Two participants just came out and embraced MSM identity. Participants tended to disclose their HIV status and transgender identity than being MSM. They preferred to introduce themselves as gay before the researcher introduced the term MSM, disregarding them as homosexual, bisexual, or transgender.

V was 22 years old and single. He was the only participant who was living with HIV. He told his distant cousin that he was gay. However, he told his family about his HIV status and not about his having sexual relationships with other men.

> *"...My cousin knows about me (as MSM), I already told him my problem about the same sex, but he is far away (his location). At another time, I told my sister about my status as HIV-positive because it was revealed that there was*

medicine in my closet, my family gathered us together, and I was told to talk about details. "What medicine is this?" I said it was ARV to prevent HIV. "How can you get infected?" I said yes, it could, I had sex with the (woman) prostitutes. And I do not talk when I am with the same sex (the MSM)" (V)

Table 4. Number of exual partners of the MSM participants (n=11)

Number of sexual partners	Participants
Countless (multiple and unable to recall)	7
Counted/newly identified oneself as MSM	4

Four participants, F, A, M, and H, who either had ever been married or were married at the time of this study, identified themselves as bisexual. They had never shared with their wives about their sexual orientation. H was a 43-year-old transgender person, bisexual, and had a wife. He was a FO. The demands of his work had made it hard to spend time with his wife and children. H was confident that their wife did not know about their sexual orientation and that they had sexual relations with men.

"For my wife, right before we married, I initially (already) worked outside a lot, so having separate life with her is normal. For my sexual orientation, maybe she does not know yet… I have three children" (H)

F, a 44-year-old individual, divorced his wife within the past decade. F maintained secrecy about their sexual orientation. They were apprehensive about being discovered by other MSM participants during the research. F desired to be perceived as a "typical heterosexual man" and chose not to disclose their homosexuality.

"Even though I am afraid to gather with the same kind of people like this (MSM who attended the HIV testing clinic), I see people with normal behavior" (F)

The fears of being found out about one's sexual orientation and homosexuality contribute to the invisible and difficulties in reaching the MSM communities.

IN, a program coordinator explained that while the transgender people are visible in the community, MSM, on the other hand, tends to remain hidden.

"They (MSM) had been hidden all this time, especially they are not open. Transgender people are visible, while MSM is not." (IN, IMF program coordinator specifically for MSM, key informant)

Due to COVID-19 interruption, HIV testing and mobile VCT services have decreased, reducing the detection of MSM as a risk group for HIV transmission.

"HIV screening had decreased in the past three years. First, fears of going to the service, the hospital, or Puskesmas. Second, mobile VCT activities had also

decreased because of the COVID-19 restriction" (IC, HIV program manager, key informant)

According to B, the director of the IMF, while it is not possible to alter one's sexual identity, it remains important to maintain outreach activities and provide health literacy programs to increase awareness among MSM individuals.

"When we see that as humans, what we do is about behavior. It's not easy to change this kind of behavior. Therefore, the only thing that might be able to raise awareness gradually is the need to be healthy." (B, IMF director, key informant)

The FO workers were approached as the key informants in this research. They are vital in connecting with MSM communities and establishing peer support groups. They distribute condoms and offer information about HIV prevention and other STIs. MSM individuals tend to be more comfortable openly sharing their sexual identity and sexual health concerns with the FOs.

"I didn't know the risks before, but there have been risks ever since now. After I joined here (IMF, initially met one of the FO and was appointed being a FO), I already know that the risk is greater if sex does not use protection, what are the effects, Alhamdulillah (Thanks to God). After being at IMF, I just realized that condoms are important. Previously, even though there was a condom, it was never used. The knowledge gained from IMF is beneficial" (J)

A few participants explained that their understanding of condom usage for HIV and STI prevention improved after interacting with a FO.

"In the past, I didn't understand this (using condoms to prevent HIV and STIs). I got to know FO in early 2019. But I started diligently using condoms in 2020. It's mandatory." (E)

Apart from using condoms, since meeting FO, some MSM individuals routinely accessed HIV tests.

"Even though I use condoms, I'm diligent about going to get the VCT because it's still a risk (as MSM)" (E)

M identified themselves as bisexual. He was heterosexually married and had a wife. Initially, he did not use condoms during sexual intercourse. However, after joining the IMF and becoming an FO, he learned the significance of using condoms to prevent HIV transmission.

"Before at IMF, I never used a condom. My fate was fortunate because when I got to know IMF, it was still (HIV) negative. Now I use it. If I don't, I think about it. If something happens, what about my wife, don't let it happen. For now, if it's for that (sexual intercourse with men), I always thought about using a condom." (M)

P, the HIV data officer at the Foundation, actively engages in sexual relationships with other men. P believes that one cannot prevent men from engaging in same-sex relationships. However, P explains the importance of safe sex practices to prevent HIV and STI transmissions.

> *"It's risky, men having sex with men. We also can't ban it, just provide education for them on how to have unsafe sex, to reduce the risk of contracting the disease" (P, Heterosexual Woman, HIV data officer, key informant)*

Through this, apart from the lack of disclosures on the part of MSM with their closest people, at least they can still be open with outreach groups at risk of HIV transmission.

Discussion

The MSM communities are very much hidden in Indonesia. They face extreme challenges, including discrimination and social condemnation when disclosing their sexual identity and HIV status. Their fears and hesitations to disclose their sexual identity are exacerbated by negative narratives against homosexuality through social media.[14]

Poor sexual health literacy, cultural and social norms, and stigma against homosexuality contribute to the rising number of HIV cases in Indonesia.[9,21] The fear of disclosing one's sexual identity and HIV status may lead to the potential economic and social losses that an individual may face, including discrimination from their families, communities, and workplaces.[26] It is pivotal to address stigma and discrimination rounding homosexuality, MSM, and HIV disclosures to promote a supportive and respectful environment, especially the service environment for individuals to disclose their HIV status.[26]

Participants observed extreme caution when disclosing their sexual orientation or HIV status. Only four participants disclosed their sexual orientation to their MSM sexual partners, their FOs workers, and fellow MSMs. The one and only participant living with HIV, chose to share only their HIV status with family, not their sexual orientation. None of the participants who were heterosexually married ever disclosed their sexual identity or HIV status to their wives.[21,27] Having multiple sex partners was reported by many of the participants, including the one and only participant who was HIV positive.

Marital status does not guarantee the protection of MSM individuals to unsafe sex behaviours and HIV transmissions. As a husband, MSM can transmit HIV and STIs to their wives. Unfortunately, the social portrayal of 'good' wives often hinders recognizing and addressing HIV risks in heterosexually married women.[19,28] In this research, participants exercised greater caution in disclosing their sexual orientation than HIV to their close family members and friends. Comparable findings were reported in a research conducted with 34 MSMs in China, where 20.6% (7 out of 34 participants) were extremely fearful of disclosing their sexual orientation but more willing to disclosing their HIV status to their closest family members and friends.[22]

Our findings suggest that the fears of disclosing one's sexual orientation are far greater than disclosing one's HIV status. Several factors may contribute to this phenomenon, including the public homophobic nature and religious and cultural perceptions against homosexuality as immoral and sinful[29], leading to deeply ingrained stigma and discrimination against homosexuality in Indonesia.[23] MSM who still live at home with their families face great anxieties and fears regarding the potential of being found out of their sexuality, let alone coming out. They fear disclosing their homosexual identity will bring shame, dishonour, dissapointment, and social condemnation against their families.[22]

The participants were all associated with the IMF activities and outreach programmes. They were assumed to have adequate knowledge about HIV transmission and prevention, having undergone HIV test. However, they did not rule out the possibility of remaining private about their MSM status to those closest to them. The MSMs communities seem to have a good understanding of this phenomenon.

The research strengths of this qualitative study include employing careful interview stages and a gradual approach to interviews. Before conducting the participant recruitment, the researchers observed and engaged with the IMF activities to better understand the research context and location. Pilot interviews were conducted to examine the appropriateness of the interview schedule. Recruiting the research assistant from the MSM communities was proven sensible in ensuring contextual input and comprehensive data analysis. Substantial training of the research assistant on conducting in-depth interviews allowed by gentle and empathetic attitudes to interviewing where simple wordings and utterances were used in the interviews and clarification was provided to the participants. Participants were offered to review their transcripts and add or amend them, ensuring inclusive and consultative respectful practice towards the participants.

There were limitations in the research, including some informants being less open, challenges in conducting interviews during working hours, and difficulties in finding HIV-positive MSM willing to disclose their status. This research topic was sensitive yet of significant importance to HIV prevention efforts. As discussed earlier, three of the 11 participants did not provide information on their HIV or MSM disclosure behaviors. Probing and specific questioning about disclosures and piloting of the interview schedule could be considered to address this.

The in-depth interviews were chosen over the focus group discussion as a preferred data collection method for various reasons. Given the sensitive nature of disclosing one's sexual orientation and HIV status, in-depth interviews provide privacy and allow for a deeper understanding of the individual's attitudes, unlike group discussions, where participants are likely to feel self-conscious and hesitant to express themselves for fear of judgment.

Conclusion

The disclosure of one's sexual orientation and HIV status is multifaceted. While some individuals choose to share their sexuality with selected close family members and friends, others choose to keep it private. These hidden MSM communities and persistent stigma and discrimination against homosexuality in Indonesia contribute to the increasing rate of HIV/AIDS.

This research endeavour was made possible by the meaningful support of FO workers and peer support groups. These groups play a crucial role in reaching out to MSM communities while providing a safe environment, establishing trusting relationships and providing HIV education and information, promoting condoms use, and advocating healthy sexual behaviours.

This research highlights the importance of proactive engagement of MSMs and groups and people living with HIV in the HIV prevention efforts within the MSM communities. By building community empowerment and collective actions, we can foster a supportive environment that encourages the full participation of the members of MSM communities in finding solutions and shaping programmes' directions and deliveries.

Findings from this study yield potential intervention strategies to expand education programmes, enhance communication and education media and promote effective training for FOs and other health professionals. Adequate training and mentoring programmes with the necessary skills to engage effectively with MSMs to promoting disclosure, including building trust and addressing discrimination-related concerns. Furthermore, reorient health service policies and deliveries to be more accountable to the beneficiaries (MSM individuals and partners) using a gentle and empathetic approach and education platform to promote safe sex practice and access to VCT services. For example, VCT services may need to explore different opening hours and locations. Lastly, encourage behaviour change at the wider societal level, focusing on mitigating risk for the communities due to disclosures of HIV status.[28] For example, a good understanding of safe sex practices and easily accessible condoms can encourage safe sex practices.

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Conflict of Interest

The authors declare no conflict of interest.

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