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Unveiling Risk: Marital Deception and HIV Susceptibility Among Married Women in Indonesia

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ABSTRACT

Objectives: The Indonesian Ministry of Health reports a significant three-fold increase in newly diagnosed HIV cases among women aged 15 and above, rising from 12,537 cases in 2015 to 35,415 in 2024. Over the past decade, the largest group of new HIV cases in Indonesia has been among women of reproductive age (15–49 years). This trend is largely driven by the widely held and fallacious belief that heterosexual, married women are not at risk of HIV. In this study we aim to challenge this misconception and investigate the complexity of HIV transmission, with a focus on HIV susceptibility among married women in Indonesia.

Methods: Feminist Participatory Action Research was conducted with 24 women living with HIV (WLWH) in Palembang, South Sumatra, Indonesia. Interviews and focus group discussions were employed to assess the impact of the actions of women and men who partake in high-risk behaviors that could result in them passing HIV onto their spouses.

Results: The study shows that among 24 women living with HIV, 14 contracted HIV from male partners who engaged in unsafe sexual behavior, and who often knowingly transmitted HIV. Those male partners may have had extra-marital affairs with women, women sex workers, or with other men or been involved in polygamous marriages. This article provides insight into the vulnerability of married women getting HIV from their spouse and highlights that healthy marital sexual relationships depend on respect, trust, and clear communication.

Conclusions: We argue that improving HIV health literacy in Indonesia, along with open discussions about sexual practices, are crucial. While these conversations may challenge deeply ingrained social, cultural and religious norms regarding sexuality, marriage and ideal gender relations, they are critical for halting the spread of HIV in Indonesia

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Introduction

A long-term, monogamous heterosexual relationship, particularly marriage, is misguidedly assumed to provide protection against HIV and sexually transmitted infections (STIs) (Adimora & Schoenbach, 2012). For instance, research in South Africa found that the HIV incidence rate among married women living with a spouse was 0.27%, which was significantly lower than the rates for other groups, including those who cohabited (2.91%) or were in stable relationships but did not live with a spouse (2.02%) (Shisana et al., 2017). However, data on partner rates of HIV transmission contradict the assumption that marriage protects women from HIV and expose what Higgins et al. (2010) refer to as the norm of the "universal sexual double standard", through men's greater access to extramarital sex (p. 436), and drug use (Ostrach & Singer, 2012). Within a culture of double standards, married women are encouraged to be submissive and to be faithful to their husbands. Men, however, are given a greater degree of sexual freedom, and in this way, society creates a sexual double standard.

For relational infidelity, women are reviled for their actions, while it is more acceptable, or even applauded, when men carry out the same behaviors (Hirsch et al., 2012). The impact of the

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double standard occurs when men contract HIV and pass it on to their spouses, and women are judged to be morally at fault (Lin et al., 2007; Rahmalia et al., 2015). This norm is reinforced by gendered, patriarchal roles and responsibilities in marriage where men are more likely to contract HIV (Lin et al., 2007; Ostrach & Singer, 2012).

Since at least the mid-1960s, the Indonesian government has promoted monogamous, registered, heterosexual marriage, as well as restricted polygamy, and has enshrined these principles in marriage laws. Based on Marriage Law No. 1 of 1974, a man can marry more than one woman while a woman can marry only one man (Government of Indonesia, 1945, 1974). These rules were framed by the government as protecting the rights of women and children from unfair marital practices. In reality, unsafe sexual practices through polygamy and multiple partners became hidden resulting in women's greater vulnerability to HIV (Nurmila, 2009; Rahmalia et al., 2015).

HIV infections among women of childbearing age who do not belong to key populations, such as people who inject drugs (PWID) or those working in the sex industry, are increasing in Indonesia (Davies & Najmah, 2020; Rahmalia et al., 2015). This increase is partly due to the belief that this group is misguidedly considered not at risk of contracting HIV (Davies & Najmah, 2020). Belus et al. (2018) underscore the critical role of mutual respect, trust, and effective communication in maintaining sexual health and mitigating HIV risk within marital relationships. According to Belus et al. (2018), without mutual respect and trust between spouses and ineffective communications can both result in unhealthy relationships that increase the risk of contracting HIV. For instance, married women who feel unsupported or have a fear of being abandoned may be less likely to seek an HIV test or HIV therapy to prevent HIV transmission to their baby. As a consequence of the lack of focus on this group, they become the "silent majority" discovering their HIV status too late, typically after their husbands or children become ill or die, or they themselves become ill (Hidayana, 2012; Hidayana & Tenni, 2015; Munro, 2024).

Marital deception in the context of HIV risk refers to acts of concealing or lying about one's HIV status, sexual behaviors, or other factors related to HIV transmission within a marital relationship. More broadly, it encompasses any form of betrayal, dishonesty, deceit, or manipulation that occurs in a marriage (Merriam-webster, 2020). This phenomenon extends across various dimensions of women's individual, interpersonal, and social environments.

Within interpersonal and familial spheres, deception may be perpetrated by a woman's partner or in-laws. On a broader societal level, it is indirectly reinforced by cultural norms such as the "fear of shame" (*takut malu*) and the imperative to "save face" (*jaga muka*) (Davies, 2015; Hirsch et al., 2012). Marital deception is thus a multifaceted issue deeply rooted in the social construction of gender norms and the state ideology that shapes women's lives in the Indonesian context.

Research on marital deception and HIV in Indonesia remains limited. This article seeks to address this gap by introducing the concept of marital deception into the discourse on Indonesian sexuality and HIV research, with a particular focus on Muslim and Malay communities in South Sumatra. It examines how women living with HIV (WLWH) reflect on the sociocultural dynamics of marital deception and its role in HIV transmission in Indonesia. We argue that social structures significantly shape sexual risks and outcomes, contributing to the rising number of HIV infections among women. This trend poses a substantial challenge to achieving the UNAIDS 2030 targets to end new HIV infections (UNAIDS, 2023).

Research methods

Participants' recruitment: women living with HIV (WLWH)

Participants were purposively recruited and included WLWH, healthcare providers (midwives, medical doctors, specialist obstetricians, and a pediatrician), policymakers, and peer-support workers from NGOs. Table 1 outlines the stages of data collection. Given that WLWH are a

Table 1. Data collection.

Number of participants (*n*)	Description of participants	Interviews/FGD/observations
24 Women living with HIV (WLWH)	Aged 24–45 years old 14 married women & seven widow	• Informal interviews with 24 WLWH • 2–3 x virtual interview or informal interviews
Health care providers 12 Midwives 11 General physicians 2 Specialist obstetrician & 1 Pediatrician	Aged 25–49 years old 12 females Aged 26–41 years old 11 Female and one male doctor 5 workers in Puskesmas (primary health service) 3 public hospitals, 3 private hospitals) Length of work within HIV services 10–20 years	• 2 x FGD • 2 x FGD2 x informal interview
12 Policy makers at city level	Aged 30–50 years old 5 Male and 7 females Length of work in years >10 years old	1 x FGD
NGO peer support workers	Aged 20–50 years old 5 Male 7 Female Length of work as support workers: 1–15 years	2 x FGD

hidden population, recruitment was conducted through targeted methods such as advertisements and word of mouth, disseminated via NGOs supporting WLWH and health workers in Voluntary Counseling and Testing (VCT) clinics. However, this approach carries a potential for bias, as participation may be influenced by prior relationships or connections with health workers and NGO staff. To mitigate this bias, the first author conducted individual and group information sessions, providing potential participants with up to two weeks to decide on their involvement. All participants received a Participant Information Sheet (PIS) and were asked to sign an informed consent form before participation.

Theoretical basis of the study

The epistemology of this study is feminist research. Feminist research is interested in examining changes in the underlying structures of oppression and the reduction of injustices against women, and a deeper understanding of the hopes, aspirations, and lives of women who struggle with societal impositions and injustices (Crotty, 1998; Hesse-Biber, 2012). Women are seen as resourceful and resilient, with their own voices and expertise, and capable of promoting informed change relevant to their life contexts and health (Ponic et al., 2010). Common positions in feminist epistemology inform the current research. The next section discusses three points related to feminist research: (1) the plurality of women's unique experiences, (2) feminist research in relation to women's empowerment, and (3) the importance of reflexivity in feminist research.

This study employs Feminist-Participatory Action Research (FPAR), which fosters a nondiscriminatory space and open dialogue to generate rich and nuanced research data (Najmah, 2019). The authors are mindful of how stigma and gender discrimination among WLWH may influence participants' narratives or behaviors, and how unspoken or subtextual judgment often in an institutional, or medical setting can shape participants' reflections (Flax, 1983).

FPAR is rooted in the feminist epistemological perspective (Haraway, 1989) which emphasizes empowerment by acknowledging participants as the real "*knowers*" and "*experts*" in their own experiences, lives and problem-solving. This approach recognizes that social places and spaces in shape participants' knowledge, feelings, and actions (MacKinnon, 1989). By allowing the participants to choose the time, place, and setting for interviews and FGDs, PFAR ensures participants are in a safe and supportive environment where they can freely share their experiences without fears of condemnation, judgment or reprisal.

Data collection

Data collection was conducted between July 2020 and December 2021, September 2023 to September 2024. Prior to the data collection phase, potential participants were invited to information

sessions held at the local NGOs or parks, recommended by local NGOs contacts in Palembang.

In the first round, participants were invited to focus group discussion sessions (FGDs), each involving five to six participants. Those who could not attend the FGDs for various reasons were offered individual interviews. Each participant was visited one to three times for interviews, depending on their availability with each interview lasted approximately one hour. The timing and location of the interviews and FGDs were at the participants' discretion and included their homes, offices, community health centers, hospitals, restaurants, and parks.

The interviews were transcribed from *koiné* (the Palembang dialect, similar to *Bahasa Indonesia*), into English. Most field notes and explanations were recorded in English. Translating from *koine* was complex, and in some instances, there is no single correct translation (Temple, 2008). As a result, interpretive errors in translating participants' words cannot be ruled out (Marshall & Rossman, 2016). To preserve the uniqueness of the original language, some original quotations are presented in *Koiné.* In keeping with the FPAR approach, keeping the quotations in *Koiné* is intended to maintain both the rigor of the research during the data analysis phase and the centrality of the original voice in the research output.

Ethical issues, including obtaining participants' consent for the use of interview/FGD transcripts, respecting participants' rights to privacy and confidentiality in publications, and minimizing risks to both participants and the researcher, including their right to withdraw from our study, were discussed with the first author. Each participant was given informed consent. Ethics approval was obtained from the Research Ethics Committee of the Faculty of Public Health of Sriwijaya University (Reference no: 002/UN9.FKM/TU.KKE/2021 on 4th January 2021 and No: 386/UN9.FKM/TU.KKE/2023 on 26 September 2024).

Data analysis

A thematic analysis was conducted using the qualitative framework of Terry et al. (2017), whose stages of data analysis, included group discussion transcripts, field notes, and visual outcomes (mind maps, drawings, and collages, as mentioned above). In addition, we employed Saldana's (2016) notion of deep reflection where "qualitative inquiry demands meticulous attention to language and reflection on the emergent patterns and meanings of the human experience" (p. 10). We used this approach to refine coding data into categories that could then be linked to the theory, concepts, and themes in the study in order to generate rich and meaningful evidence (Saldana, 2016). As an adjunct to deep reflection, we have included a diary note, where the first author recounts her experiences of how gendered expectations shaped her role as a mother and housewife. To ensure consistency, regular fortnightly meetings were conducted between the authors to discuss emerged themes, categorization, and links between codes and meanings, and to enhance data interpretation.

Results

This article discusses how women explain marital deception and its connection with HIV infection. The thematic analysis produced three primary themes: (1) marital deception, hidden polygamy and HV risks to married women, (2) shame and taboo, (3) non-disclosure of sexual history.

Participants' characteristics

Of the 24 women living with HIV (WLWH) in this study, all but two identified themselves as *ibu rumah tangga* (housewives), a term that broadly encompasses married women who are either financially dependent on their husbands or engaged in the informal sector. For example, two participants worked as housemaids or ran a small *warung* (a bric-brac stall). Ten were financially dependent on their husbands and 11 worked in the informal sector or had online businesses. Seven widowed participants also regarded themselves as *ibu rumah tangga*, despite being the main breadwinners for their families. Among the fourteen married women, seven were in their second marriage as their first husbands have died. Nine women had deceased husbands who were diagnosed with late-stage HIV. Seven

participants had children living with HIV. The average age of the participants was 36 years, and they had been living with HIV for an average of seven years (Table 2).

Each of the participants said that she was vulnerable to HIV because she had been exposed to one or more risk factors. The fifteen women in the study group believed they had been infected with HIV by their husbands, who were either former IDUs, practicing unsafe sex, polygamous or Men who have sex with Men (MSM), as the women said they had never been exposed to high-risk behaviors related to HIV. Nine of them believed they had been infected by their husbands who had practised unsafe sex while traveling to HIV-prevalent areas in Indonesia. Three of them also reported that their husbands may have practised polygamy and had extramarital sexual partners, sex workers. Five women believed they had contracted HIV in some other way, as their husbands had been tested and found to be HIV negative. Two women believed they had contracted HIV through their own behavior, such as having unsafe sex or injecting illegal drugs. Three of the 24 HIV-positive women were unsure how they had contracted HIV. They suggested that they may have been infected by unsterilized sharp instruments while giving birth in unsafe rural health facilities or while working in beauty salons.

Marital deception, hidden polygamy and the risk of HIV

In Indonesian Islamic culture, marriage and motherhood are seen as forms of worship (*ibadah)*. Women are expected to fulfill their duties as wives and mothers with sincerity (*Ikhlas)* as virtuous women (Nurmila, 2016). Men, as heads of households, are responsible for providing financial support and moral guidance to their wives and children and upholding Islamic teachings within the marriage (Pappano, 2016). This cultural perspective also aligns with Indonesia's gender ideology of "*ibuism"* (motherhood ideology) which emphasizes a view of women's destined role (*kodrat*) as wives, mothers, and primary caregivers (Ichsan Kabullah & Fajri, 2021; Spiller, 2012). These cultural and social expectations continue to shape the experiences and social perceptions of married women in both the domestic and public domains.

Women with full-time employment and those working outside the home may share childcare responsibilities with their husbands or grandparents. Those from the middle-upper social classes might afford full-time babysitters or childcare services. Women working from home, such as running a small business or food stall, often multitask between attending to customers and caring for their young children.

The practice of "hidden polygamy", which may involve *nikah siri* (unregistered marriages), was mentioned by some participants as a form of marital deception. Hidden polygamy is referred to in Indonesian communities as "*menikah sembunyi-sembunyi,*" concealed polygamy. This polygamy is common and contributes to an increased likelihood of marital and sexual deception and an increased risk of HIV in all sexually related relationships, especially if safe sex practices are not followed.

Our findings highlight how men's secretive sexual behaviors negatively affect women's well-being and increase their risk of HIV infection. For example, six of the 24 participants believed they contracted HIV from their husbands who engaged in unsafe sex while traveling in HIV high risk areas. Three participants suspected their husbands of concealing polygamous relationships. Rini, 44, knew from a friend of her husband's that he had a wife in Java when he worked outside the city of Palembang for a few years. Bulan, aged 49, discovered posthumously that she was the fifth wife, and her child was the ninth offspring of her husband. Her in-laws had falsely told her that her husband had died of lung cancer. Learning from her experience, ten years after her husband's death, Bulan decided to marry a HIV-negative widower and disclose her HIV status.

> After my husband passed away, I just found out that I was the fifth wife and my child is the ninth child of my husband. Sadly, when my husband passed away, his family did not tell me about the HIV status of my husband; they only said my husband had lung cancer and that I am not the only wife of my husband.

Table 2. Participant's characteristics: WLWH and marital deception.

No.	Pseudonym	Current Marital Status	Socio-economic status	Education	Year of HIV Diagnosis	Age	PMTCT Access**	Number of Living Children	HIV Status of Husband	1st Husband's Work	2nd Husband's Work	Marital Deception
1	Mira	Married	Low	Senior High School	2015	24	Yes	2	+	Runs a bric-a-brac shop (*warung*)	–	LSL concealment
2	Bulan	Widow	Low	Senior High School	2013	49	No	1	$+^{1}$ $-^{2}$	Civil servant^	Driver	Hidden polygamous married (husband passed away)
3	Nika	Divorced	Low	Elementary School	2016	25	Yes	3	–	Builder		Multiple partners (Nika), husband's negative HIV
4	Alung	Married	Middle	Elementary School	2012	40	No	3	–	Manager in private sector		Unsafe injection in the prison when being an illegal TKW (overseas worker) raising HIV-positive child
5	Rini	Widow	Middle	Senior High School	2011	44	No	3	+	Manager in private sector^		Hidden polygamous married (husband passed away)
6	Melati	Married	High	Senior High School	2011	44	No	2	$+^{1}$ $-^{2}$	Businessmen^	Civil servant	Hidden multiple partners (wife and 1st and 2nd husband) Female IDU's concealment (wife)
7	Mela	Widow	Low	Senior High School	2014	45	No	3	+	Driver^		Hidden multiple partners (husband passed away, knowing HIV status one year after husband's death)
8	Nina	Widow	Middle	Senior High School	2012	36	No	3	$+^{1}$ $-^{2}$	Private sector^	Civil servant^	IDU's concealment (husband) Multiple partners (Nina, after husband' death)
9	Mano	Widow	Low	Senior High School	2016	25	No	1	+	Student		IDU's concealment (husband) Multiple partners (Mano, after husband' death, being female sex worker)
10	Oneng	Widow	Low	Senior High School	2016	44	No	6	+	Security staff (*Satpam*)^		Hidden polygamous married Raising one HIV-positive child Oneng passed away too in 2022 during COVID
11	Sinta	Widow	Low	Senior High School	2012	44	No	1	Unknown	Runs a bric-a-brac shop^		IDU's concealment (husband, husband passed away)
12	Mona	Married	Middle	University	2012	33	Yes	2	$+^{1}$ $-^{2}$	Private sector^	Teacher	IDU's concealment (husband, husband passed away)
13	Putri	Married	Low	Senior High School	2007	38	Yes	2	+	Runs a bric-a-brac shop^		IDU's concealment
14	Maya	Married	Low	Elementary School	2015	36	No	3	$+^{1}$ $-^{2}$	Private sector^^	Driver	hidden multiple partners when work in Malaysia (Maya) hidden multiple partners as a driver (2nd husband)
15	Oda	Married	Middle	Senior High School	2017	33	No	3	–	Private sector		Unsafe birth care facilities (using unsterile equipment during delivery baby); raising HIV+ child
16	Xani	Married	High	University	2007	38	Yes	3	+	Manager in a telecommunication company		IDU's concealment (husband still alive)
17	Bunga	Married	Low	Senior High School	2017	33	Yes	1	$-^{1}$	Worker in a mining company^	Restaurant manager	Unknown (husband passed away); raising HIV-positive child
18	Mulan	Married	Middle	Senior High School	2012	31	Yes	1	$+^{1}$ $-^{2}$	Private sector^	A worker in an oil company	IDU's concealment (husband died)
19	Hani	Married	Middle	Senior High School	2018	34	No	3	–	Private sector		IDU's concealment (husband still alive)
20	Nana	Married	Low	Senior High School	2021	35	Yes	2	+	Bread seller		hidden multiple partners (husband) raising HIV-positive child
21	Tia	Married	Low	Senior High School	2018	30	Yes	1	–	NGO worker		LSL concealment (husband) Female sex worker in the past (wife)
22	Nana	Married	Low	Senior High School	2018	30	No	1	–	Private sector		Unknown transmission way; raising HIV-positive child
23	Akbar	Widow	Low	Senior High School	2021	35	No	1	–	Unknown	Illicit Drug selling	IDU's concealment; Unknown transmission way; raising HIV-positive child
24	Riri	Married	Low	Senior High School	2020	30	No	2	+	Private sector		LSL concealment; raising one HIV-positive child and one HIV-negative child

Key: ^: passed away. ^^: divorced.
PMTCT: Prevention of Mother to Child of HIV transmission people who inject drugs (PWID).
$+^{1}$HIV status refer to the first husband, $-^{2}$Free-HIV status refer to the second.

(Bulan, 49 years old, a widow from low-economic status and graduated from senior high school)

The 1974 Marriage Law imposes strict conditions on polygamous marriages, mandating that the husband provide equal support for all wives and children, to obtain consent from existing wife/wives and ensure fair treatment for all. The law permits a second marriage under certain condition, such as the first wife's inability to fulfill her duties, physical disability, incurable diseases, or inability to bear children (Qibtiyah, 2020). Often polygamy is linked to status and wealth (Qibtiyah, 2020). Our research highlights that women in polygamous relationships are vulnerable to unsafe sex practices and HIV transmission, regardless of their socio-economic status, such as employment, income or education.

Shame and taboo

In November 2012 … my husband was diagnosed with AIDS. He lied to me about his past …. He used to inject drugs … In December 2012, I found out that I was also HIV positive, but my daughter was fortunately negative. I was sad. I hated everything in my life. It was hard to accept this curse. My husband died in the same month. He said "sorry" in his last breath. I was kicked out of the house by my laws, and discriminated against. My husband's family wanted to take away my only child … I was an "unsuitable" mother … (Mona, 30 years old, HIV-positive mother, from middle economic status and graduated from university)

The main factors that increase the likelihood of married women's vulnerability to HIV include the non-disclosure of so-called "shameful" behaviors, including homosexuality, intravenous drug use, and extramarital relationships. This non-disclosure is illustrated by the experience of Mona above, who was ostracized by her in-laws, discriminated against, and labeled as an "unfit" mother. Her in-laws even tried to take her only child away from her.

The use of condoms within marriage and the practice of using single-use needles are critical strategies in combating the spread of HIV. By addressing both sexual transmission through condom use and injection-related transmission through clean needles, public health initiatives can significantly reduce new infections and enhance community health. Unfortunately, the importance of these protective measures was absent in Mona's experience. After two years of marriage, her husband fell ill and, for the first time, disclosed his history of drug use. At the doctor's suggestion, an HIV test was conducted for her husband, to which Mona consented. The results were devastating. The doctor recommended that Mona and her daughter also undergo testing. Mona's distress stemmed not only from her husband's behavior but also from the silence of her husband's friends, who were aware of his past drug use but chose not to inform her before the marriage. This combination of betrayal and omission left Mona feeling deeply disappointed and vulnerable.

At the funeral, one of Mona's friends who was aware of her husband's past, apologized for not telling her about her husband's history of drug use. The friend explained that he had persuaded her husband to be honest with Mona, but her husband had feared rejection.

One of my friends, Hasan (pseudonym) who was also my husband's friend came to the funeral. Hasan told me he was sorry, as he did not tell me about my husband's history of injecting drugs. He had already persuaded my husband to tell me about his past, but he was ashamed and afraid that I would reject him (Mona)

Due to the social taboo and stigma surrounding HIV, many WLWH participants chose to remain silent to protect themselves and their families from social gossip and discrimination. Women infected by their husbands often hide their HIV status out of shame and fear. Shame also regulates the expression of sexuality. A woman may marry a man with a history of sex with other men, a behavior that may remain hidden from his wife, as Mira's husband experienced (read Najmah, Davies & Andajani, 2020a).

Mira was unsure whether it was she or her husband who acquired HIV or syphilis first: "I did not know who got it first, he [Kuyung] is a man" (Mira). During my second pregnancy, in 2015, I went to the *puskemas* (public health centres) to check my vaginal rashes and itchiness. The test results confirmed I had syphilis and HIV with a CD4 count of 350 cells/mm^3. Feeling shocked, I told Kuyung (Mira's husband) and demanded he take a blood test; Kuyung was diagnosed HIV with a CD4 count of 450 cells/mm^3.

(Mira' story, 22 years old, monogamy marriage from low-economic status and graduated from senior high school)

Riri (30 years old) also knew she had HIV after her daughter was diagnosed with HIV in Puskesmas. Her daughter suffers from small clusters of red, itchy bumps on her body. Riri's husband confessed to the outreach team and VCT health workers that he had been having sexual relations with other men after marrying Riri. Riri did not know about it until now for the sake of the integrity of the household. One of her two daughters was fortunately HIV negative.

Women infected by their husbands often hide their HIV status out of shame and fears of social condemnation. Unfortunately, without access to HIV testing and intervention, a pregnant woman living with HIV may unknowingly risk transmitting the virus to her unborn child (Damar & Du Plessis, 2010; Najmah, Davies & Andajani, 2020b).

As previously discussed, the stigma surrounding "shameful and sinful sexual behaviors," such as homosexuality or extramarital relationships, often compels individuals to conceal practices that elevate the risk of HIV transmission. Among the 24 participants, 13 discovered their HIV status only after their husbands fell ill or died from HIV-related complications. Nine of these women faced the compounded burden of grieving their husbands' deaths while assuming the roles of single parents and sole providers for their children. This challenging situation often forced them into unsatisfactory relationships due to economic hardship and the pressing need to support their families. While these relationships might appear pragmatic or even desirable under such circumstances, they can also be seen as a form of disease-induced and religiously constrained economic servitude, imposed by factors entirely beyond the women's control.

Non-disclosure of sexual history

Non-disclosure of sexual history is not confined to a specific gender. Melati (pseudonym), a young and financially independent divorcee, illustrates the complexity of this issue. Struggling with the stigma surrounding divorce—particularly for a young woman—and determined to avoid bringing shame to her parents, she relocated to Jakarta, Indonesia's capital. There, she experimented with intravenous drugs and had multiple sexual partners, ultimately contracting HIV. Later, Melati entered into an unregistered marriage (nikah siri) with Udik, a civil servant. Initially, she chose not to disclose her HIV status, fearing rejection. Only after gaining confidence in their relationship did she reveal her condition. Udik, feeling betrayed and trapped—especially after engaging in unprotected sex—responded with anger and dismay. Despite being aware of Melati's HIV status, Udik repeatedly refused to undergo HIV testing whenever he became ill, fearing that a positive result would profoundly impact his emotional wellbeing. Six months into their marriage, Melati discovered that Udik had not divorced his first wife, and was also having an affair with another woman, Yasmin. Udik was planning to marry Yasmin, without Melati's knowledge or consent. In 2021, Melati decided to separate from Udik and move to Medan, North Sumatra.

I am very stressed with Udik's previous love affairs. … I cannot sleep, and I am always on the alert … He nearly got married to that woman (Yasmin) I was with him every day, but he was able to have time with her in a hotel during his office hour. How come? I only found out about his affair in April 2017. Now, we both are always in fights. I kick him out of my house, but when I am in a good mood, I let him back in. That is my life now, I feel disturbed (Melati, married from high-economic status and graduated from senior high school).

Melati's account illustrated the complexities of marital and sexual deception involving multiple individuals and the intricate secrecy and concealment surrounding the socially sanctioned sexual practices. Her experiences reveal the profound emotional and symbolic violence that can result from such deception and highlights women's vulnerability to HIV transmission.

Discussion

Marriage is central to Indonesia's social, cultural, and religious structures, but it can also reinforce deception as individuals strive to secure social status and maintain familial

harmony (Djajadiningrat-Nieuwenhuis, 1987). Women infected by their husbands often conceal their HIV status out of shame and fear of social condemnation. Without access to testing and intervention, pregnant women may unknowingly risk transmitting the virus to their unborn children (Damar & Du Plessis, 2010; Najmah, Davies & Andajani, 2020a). HIV remains a taboo topic, making open discussions difficult within families, communities, and healthcare settings (Davies & Najmah, 2020).

The belief that HIV is sinful and a divine punishment reinforces stigma and shame, silencing victims and leading them to fatalistically accept their condition (Desyani et al., 2019). Shame serves as a powerful regulator of behavior, spreading through social networks in what Davies (2015) terms a "kinship of shame" (p. 6), which disproportionately affects women. The stigma, taboo, and shame surrounding HIV often force victims into silence, encouraging them to resign themselves to fate and rely on divine intervention.

Research indicates that women are usually infected by a primary partner. HIV transmission among married couples can occur in several ways. Men who engage in high-risk behaviors, such as unprotected sex with sex workers or male partners, risk contracting HIV and transmitting it to their spouses. Married men may also have extramarital affairs or marry additional wives without informing their existing wives (Nurmila, 2016; Samuels, 2020). The moral stigmatization of infidelity within the idealized framework of monogamous marriage can motivate men to maintain sexual secrecy to avoid public scrutiny and familial conflict (Parikh, 2007). Additionally, work-related mobility and migration increase opportunities for relationships outside of marriage (Wardlow, 2007).

Men often downplay their vulnerability to HIV, and those who contract it through risky sexual practice including low/inconsistent condom use may knowingly transmit the virus to their wives (Najmah et al., 2022). If women are blamed for not satisfying their husbands' sexual needs, they may be further stigmatized for exposing their husbands to HIV. Women often choose silence to preserve family stability and dignity (Davies & Najmah, 2020; Samuels, 2018, 2020; Smith, 2007). Divorced women, in particular, are seen as marital failures and may punish themselves by engaging in behaviors similar to their former husbands, such as multiple partnerships or drug use.

The phenomenon of marital deception is also linked to economic pressures and marital breakdowns. Divorced women may be forced into sex work, contracting or further spreading HIV. The process of being coerced into sex work intersects negatively with the false perception that certain types of women, such as divorced or separated women, widows, and sex workers, are "safe" partners for extramarital affairs, as they are seen as posing no risk to family stability (Phinney, 2008; Wardlow, 2007). However, these women may, however, transmit HIV to their new partners or husbands after remarriage. Therefore, the promotion of positive sexuality among HIV-positive women also requires the development of an awareness of the links between society, culture, politics and women's attitudes and practices with regard to their sexuality (Carter et al., 2018).

Condom use for dual protection against STIs/HIV and unwanted pregnancies remains extremely low in Indonesia, affecting both a key population and the general population (Ministry of Health, 2010, 2013). National trends show that while the majority of contraceptive users are women, only a small percentage (around 4%) use condoms (Ministry of Health, 2023; Praptoraharjo et al., 2016). The study of Brady (2013) highlights that close and frequent sexual contact often leads to an increased risk of infection, particularly when preventive measures such as condoms are not used consistently. Low condom use among married couples is often linked to access issues and stigma. Condoms are stigmatized as a marker of infidelity because they are used in the context of "failure" to abstain or be faithful. These views, reinforced by dominant social, cultural, and religious values, create significant barriers to safe sex practices and further heighten women's vulnerability to HIV infection (Stover & Teng, 2021).

Previous study suggest that negative perceptions of condoms may stem from the lingering effects of the former "ABC" HIV prevention

approach, a public health messaging strategy that described A-abstinence, B-be faithful, and C-use a condom as graded prevention tools. If HIV prevention messages acknowledge existing stigma and reframe condom use as proactive health prevention, condom use may increase (Broderick et al., 2023). Primary sexual partners are critical to the transmission dynamics of Sexual Transmission Infections.

Given the complex sociocultural factors influencing HIV transmission and the low usage of condoms among women, normalizing the use of HIV pre-exposure prophylaxis (PrEP) is essential for women at risk. PrEP is a medication that prevents HIV infection in individuals who are HIV-negative but at risk of exposure (Sheth et al., 2016). Despite its effectiveness, especially for women, its uptake remains limited. To empower women in HIV prevention, PrEP must be made more accessible, widely accepted, and integrated into routine healthcare options. Additionally, it is vital to support women in maintaining consistent PrEP use as their reproductive goals and risk of HIV evolve over time (Mugwanya et al., 2019; Sheth et al., 2016). One reason to use PrEP is that it relieves women from the complex and often challenging task of negotiating condom use in sexual relationships, offering an added layer of protection and autonomy in HIV prevention.

This study thus underscores the critical need to address the pervasive misconception that heterosexual, married women in Indonesia are not at risk of HIV. The findings highlight how the actions of male partners, including unsafe sexual behaviors and marital deception, significantly contribute to the vulnerability of married women to HIV transmission. By amplifying the voices of women living with HIV and exposing the complexities of their experiences, this research challenges harmful stereotypes and calls for targeted public health interventions. These efforts must include comprehensive education, equitable healthcare access, and policies aimed at reducing stigma and promoting safer sexual practices to protect women and advance gender justice in HIV prevention strategies.

It is also important to remind readers of the challenges individuals face when navigating sexual encounters, as highlighted in our interviews. The fear of rejection, concern about hurting a partner's feelings, and anxiety over implying something negative can all create significant barriers to open communication about sexual health. These "social interactive works," as Goffman (1959) and other social interaction theorists describe, have profound consequences for individuals' health decisions, influencing behaviors like condom use or even leading to unwanted sex. Acknowledging these interactional dynamics is essential in public health, sex education, and healthcare, as they shape individuals' ability to assert their sexual rights and make informed decisions about their health (see also Ford, 2021).

Study limitations

All the participants in this study were residents of the city of Palembang, South Sumatra, predominantly Muslims and of Malay ethnicity. Further research is needed in various provinces in Indonesia with diverse ethnic and religious backgrounds to broaden the knowledge on marital deception and HIV transmission across diverse social and cultural contexts. HIV-related stigma and discrimination is pervasive in Indonesia, which may lead people to deliberately conceal information or describe their stories in a more favorable light. These circumstances are not new to qualitative research. It is important to note that participation was voluntary, and no participant was forced to disclose information they did not feel comfortable sharing.

Summary and recommendations

Marital deception significantly amplifies HIV risk among women, driven by interconnected structural and systemic factors. Many policies and programs incorrectly classify married women as low risk by assuming heterosexuality and monogamy, while overlooking the risky behaviors of their male partners. Fourteen participants in this study reported contracting HIV from their husbands, who engaged in unsafe sexual practices such as drug use, bisexuality, polygamy, and extramarital affairs. To address this, health policies, programs, and HIV surveillance must move away from gender-based assumptions and adopt

gender-transformative reforms. A gender-transformative approach to the prevention of mother-to-child transmission (PMTCT) is essential in reducing women's HIV risk by equipping health-care providers with the skills to offer rights-based sexual and reproductive health services. Secondly, shame, HIV stigma, discrimination and secrecy reinforce concealment, with many of these women's husbands hiding their status, refusing HIV tests, thus leaving their wives at risks of contracting HIV. The shame and stigma associated with HIV means that discussions about HIV are deeply distressing, suppressing open dialogue and access to vital information and services.

A combination of education, empowerment, advocacy, transformational leaders in all sectors and community support is needed to achieve social change. For example, joint efforts are necessary across multi-ministerial partnerships and institutes, such as the Ministry of Health (MoH), Ministry of Education Culture, Research and Technology (MoECRT), Ministry of Women Empowerment and Child Protection (MoWECP), Ministry of Communication and Informatics (MoCI), The National Commission on Anti Violence Against Women (*Komnas Perempuan)*, the Ministry of National Development Planning (*BAPPENAS)* as well as professional bodies and educations, such as the Indonesian Midwives Association (IBI), the Indonesian Midwifery Council is critical for preventing of HIV in pregnant women and Indonesian Society of Dermatology and Venereology (INSDV or PERDOSKI). These agencies address various aspects of HIV prevention, health care access, education, gender empowerment and information and communication, national plan and policy integration (Wilopo et al., 2020). Similarly, the integration of the Triple Elimination Programme or EMTCT (HIV Elimination Mother-to-Child Transmission) to include HIV, Hepatitis B and Syphilis in 2017 will require capacity building and intersectoral collaboration, as well as strengthening the leadership of various agencies at the national, provincial and district levels. Community-based-organisations play important roles in education, empowerment, advocacy and peer support, such as working with IPPI (*Ikatan Perempuan Positif Indonesia, Indonesian Association of Positive Women* https://ippi.or.id/about-us/), The Positive Indonesia Network or Jaringan Indonesia Positif (JIP) and others.

HIV prevention for married women also needs to address deeply rooted socio-cultural barriers, particularly in religious societies. The role of faith leaders, such as Muslim women clerics (dai'yah) and imams, is crucial in facilitating open discussions on how religious values can support public health goals, particularly women's sexual and reproductive health and their rights to health, dignity and nondiscrimination. Collaborations such as that between UNFPA and Nahdlatul Ulama (one of Indonesia's largest Islamic organisations) provide valuable models for promoting sexual and reproductive health (UNFPA Indonesia, 2021). In addition, positive secular influences from local government leaders, community elders and employers can help shift societal narratives, challenge harmful masculinity norms and disrupt patriarchal structures that disadvantage women. Engaging men in these conversations and encouraging them to adopt gender-sensitive approaches is essential to address persistent structural barriers and ensure equitable, inclusive HIV prevention efforts.

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