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Between Silence and Survival: Social Stigma and Disclosure Dilemmas Among MSM in HIV Prevention Efforts

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ABSTRACT

***Background**: For more than three decades, the HIV epidemic in Indonesia has continued to rise, disproportionately affecting key population groups, including men who have sex with men (MSM). The high prevalence of HIV is driven by several challenges, particularly stigma and discrimination arising from societal concerns. These issues impact access to HIV prevention and treatment services, making it more difficult for MSM to obtain care and increasing the risk of HIV transmission. In this context, self-disclosure is a crucial aspect for MSM to prevent HIV transmission and improve adherence to treatment.* ***Objectives**: This study aims to explore the dynamics of self-disclosure among MSM groups in the context of HIV and AIDS prevention, using the Johari Window theory. The theory explains how hidden areas and blind areas are influenced by experiences of stigma and discrimination from the social environment, family, and health services.* ***Methods**: This study employed a qualitative phenomenological approach, using snowball sampling starting with one MSM participant in Jember Regency, who referred others meeting the research criteria. Data were collected through in-depth interviews, and analysis was conducted using interpretative phenomenological analysis (IPA).* ***Results**: The findings reveal that MSM often conceal their sexual orientation and HIV status due to fear of stigma and discrimination, especially from family, workplaces, and social circles—representing the hidden area. The blind area arises when others perceive or assume their identity without direct disclosure, which can offer support but also reinforce stigma and discrimination.* ***Conclusion**: Self-disclosure among MSM is significantly influenced by stigma, discrimination, and the social environment, which can either support or hinder openness. Therefore, this research contributes to the development of more inclusive health promotion strategies and supports the enhancement of community and healthcare capacity to provide safe spaces that encourage honest and supported disclosure among MSM.*

***Keywords**: HIV and AIDS, MSM, Self Disclosure, stigma and discrimination.*

INTRODUCTION

For more than three decades, the HIV epidemic in Indonesia has continued to rise, disproportionately affecting key population groups such as men who have sex with men (MSM) (Afriana, Luhukay and Mulyani, 2023). The MSM group has a high risk of contracting HIV and AIDS because they often change partners (Wardani, Setiawan and Bistara, 2020). According to the WHO report in 2019, MSM contributed 44% of new HIV infections in Asia and the Pacific, with a transmission risk 26 times higher compared to the general population (WHO, 2019). In line with this, data from the Ministry of Health reported that from January to March 2023, the prevalence of HIV among MSM reached 27.7% of cases (Kemenkes, 2023). Meanwhile, in 2023, there were 10,671 HIV cases in East Java, with the distribution of cases in Jember Regency until April 2023 showing that 14% of them occurred in MSM, totaling 120 cases (Dinas Kesehatan Jember, 2024).

The high prevalence of HIV is driven by several challenges, particularly stigma and discrimination arising from societal concerns (Sianturi and Sianipar, 2023). Stigma is one of the primary barriers to accessing and sustaining HIV prevention and treatment services among MSM. Negative views of HIV, both in the form of attitudes and social beliefs, often trigger discriminatory behavior toward individuals living with

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HIV (Zhu *et al.*, 2024). Stigma not only hinders MSM participation in HIV prevention and care programs but also creates psychological stress that can impede prevention and treatment efforts. It encourages many MSM in Indonesia to hide their identity and sexual orientation. This condition hampers access to HIV prevention and treatment services and increases the risk of HIV transmission (Iott *et al.*, 2022).

In this context, self-disclosure is a crucial aspect for MSM in efforts to prevent HIV transmission and increase adherence to treatment. This openness also contributes to increased social support, reduced psychological distress, and improved health outcomes (Nafisah, Riono and Muhaimin, 2021). Self-disclosure plays an important role in shaping an individual's psychological well-being, thereby positively impacting mental health (Prabandari and Huwae, 2024). Research conducted by Petroll and Mosack (2011) showed that openness about sexual orientation to healthcare providers allows for more comprehensive medical assessments and the provision of appropriate services (Sun *et al.*, 2019). Furthermore, this openness is recommended for individuals living with HIV to reduce risky sexual behaviors, limit the spread of the virus, and increase access to health services (Kalichman *et al.*, 2020).

This study aims to explore the dynamics of self-disclosure among MSM groups in the context of HIV and AIDS prevention, using the Johari Window theory. This theory helps to understand how MSM self-disclose, particularly in relation to hidden and blind areas influenced by experiences of stigma and discrimination from social environments, families, and health services. The Johari Window consists of four quadrants: open, hidden, blind, and unknown areas. It provides a framework to analyze how MSM choose to reveal or conceal information about their sexual orientation and HIV status. The hidden area represents personal information known to the individual but kept from others due to fear of stigma. The blind area reflects how others perceive them, even without direct disclosure, which may lead to support or reinforce stigma and discrimination. This theoretical approach illustrates how internalized stigma and discrimination restrict openness, while external perceptions—whether accurate or biased—expand the blind area, influencing MSM's decisions regarding disclosure (Carraher, Smith and DeLisle, 2017).

Practically, this study is relevant to the Global AIDS Strategy 2021–2026, which emphasizes the importance of eliminating stigma and discrimination and increasing access to services for key populations. This aligns with the key populations-based approach that is the focus of national HIV and AIDS prevention policies (UNAIDS, 2023). The results of this study are expected to contribute to the development of more inclusive health promotion strategies, as well as enhance the capacity of health workers and communities to create safe environments and support MSM in disclosing their personal information.

METHODS

This study employed a qualitative phenomenological method to explore how MSM experience and navigate self-disclosure in the context of HIV and AIDS prevention. A snowball sampling technique was used, starting with one MSM participant in Jember Regency who referred others meeting the research criteria. This technique was chosen because MSM are often a hidden and hard-to-reach population; however, it may limit the diversity of the sample due to reliance on participants' social networks.

The study was conducted in Jember Regency, involving one key informant: the Head of the Healthy and Creative Steps Foundation (LASKAR), an HIV and AIDS support organization established in 2010. The main informants consisted of ten MSM aged 22 to 35 years, with varied HIV statuses—positive or negative—and different occupations, such as self-employed individuals, civil servants, farmers, and unemployed persons. Their educational levels ranged from elementary school to college. Additionally, six informants were recruited through the social networks of the main informant, including partners, close friends, fellow MSM, and health workers.

To illustrate how informants were identified and referred, Figure 1 provides

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a flow diagram of the sampling process used in this research.

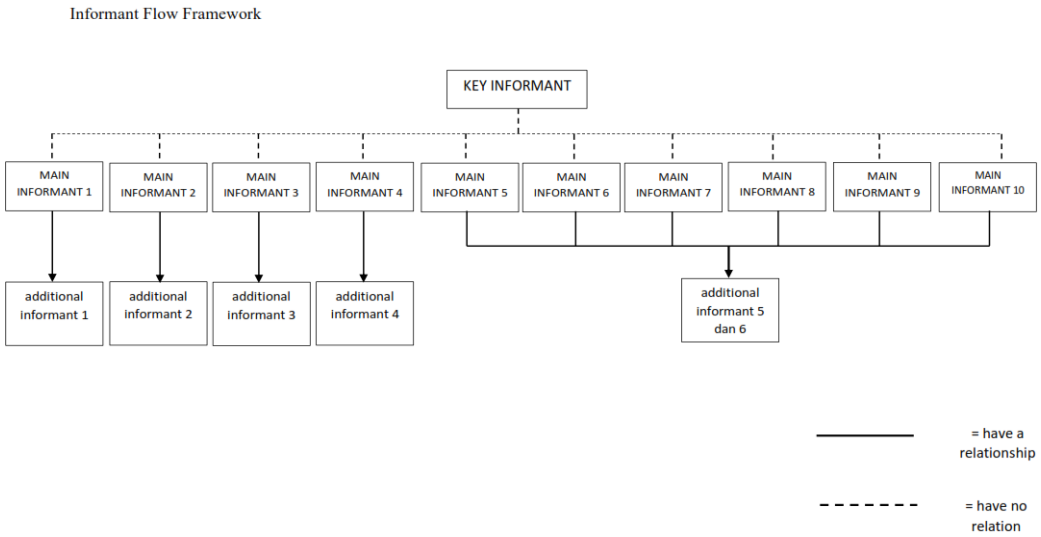

Figure 1. *Informant Flow Framework*

Data were collected through in-depth interviews using a semi-structured guide developed from preliminary research. Each interview lasted approximately 45 to 60 minutes, conducted with careful attention to research ethics and informant confidentiality. The interviews covered key themes such as stigma and discrimination, hidden areas, and blind areas related to self-disclosure.

Data analysis employed the Interpretative Phenomenological Analysis (IPA) method, which consisted of several stages: transcribing interview recordings, re-reading transcripts, noting important points with exploratory comments, identifying emerging themes, creating superordinate themes across participants, and describing these themes. The analysis aimed to interpret and report the findings (Evani *et al.*, 2024). The findings are presented as descriptive narratives supported by direct quotations from informants, reflecting their language and perspectives. This research received ethical approval from the Health Research Ethics Commission (KEPK) of the Faculty of Dentistry, University of Jember, with ethical clearance No. 2863/UN25.8/KEPK/DL/2024.

RESULTS AND DISCUSSION

Informant Characteristics

This study involved one key informant from an HIV and AIDS support institution. Table 1 presents the characteristics of the main informants. All the main informants were male, aged between 28 and 35 years, with a diverse range of educational backgrounds, from elementary school to college. Their occupational statuses varied; some were self-employed, civil servants, or involved in agriculture and other fields. Most had been diagnosed as HIV-positive, and their relationship statuses ranged from single to those in partnered relationships. Additionally, six supplementary informants were included. These individuals were part of the main informants' social environment and included one partner, one peer, two MSM friends, and two health workers.

Table 1. Characteristics of Main Informants

Key Informant	Age (years)	Education	Work	HIV status	Year of HIV diagnosis	Status Connection
1	22	ES	Self-employed	Positive	Year 2017	Coupled
2	35	SHS	Self-employed	Positive	Year 2011	Coupled

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Key Informant	Age (years)	Education	Work	HIV status	Year of HIV diagnosis	Status Connection
3	35	BACHELOR	Civil servant	Positive	Year 2014	Coupled
4	32	JHS	Unemployed	Positive	Year 2011	Single
5	29	S1	Unemployed	Positive	Year 2017	Single
6	27	SHS	Self-employed	Positive	Year 2020	Single
7	33	SHS	Private sector employee	Positive	Year 2015	Single
8	30	S1	Self-Employed	Negative	-	Single
9	33	ES	Private sector employee	Positive	Year 2014	Coupled
10	35	VS	Agriculture	Positive	Year 2017	Coupled

Stigma and discrimination against MSM

Stigma refers to a negative label that devalues a person in the eyes of others, reducing their societal standing and influencing their behavior. In this research, MSM reported experiencing stigma related to sexual orientation and HIV status. Common manifestations included negative comments, sarcasm, behavioral assessments based on gender norms and body gestures, and insults. Based on the results of interviews with informants, the forms of stigma they experience are as follows:

> *"Yes, maybe the stigma is sometimes seen from my body gestures. In the past, I often played with my older sister. Well, from there sometimes comments emerged from siblings or other people, like, 'Why is a boy playing with dolls?' or 'Why is your style like that?' That's what I often experienced and felt directly, like they were judging the way I behaved, as if that was the reason they were suspicious of my sexual orientation"* (IU 5, 29 years old).

The stigma experienced by MSM regarding their sexual orientation arises from observing other people's behavior, such as body gestures or activity preferences that are considered inconsistent with gender norms. Informants reported being labeled from childhood based on their behavior and interests, which reinforced gender norms and indirectly shaped other people's perceptions of them. Siron et al. (2023) explain that toys given since childhood contain messages about roles, such as boys being directed to play with masculine toys, while girls are encouraged to play with dolls or activities considered feminine.

Meanwhile, MSM also experience stigma related to their health status, as illustrated below:

> *"Maybe there is. At that time, when I was undergoing treatment, I met with fellow MSM friends, and then someone said, Oh, so you have HIV too? So pretentious, like you're the cleanest."* (IU 7, 33 years old)

MSM experience stigma related to HIV status from fellow MSM. They face negative comments and insults that marginalize them because of their health status. Stigma against HIV is not only prevalent among the general public but can also occur within the MSM community itself. Research indicates that individuals with HIV within the MSM group also face potential stigma, and many MSM worry that others will judge them negatively if their HIV status becomes known (Saurina, Asfriyati and Rahayu Sanusi, 2019).

Stigma in practice often leads to the emergence of discriminatory actions. Discrimination refers to unfair treatment

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in the form of exclusion, marginalization, or restriction of access to certain resources or services. The forms of discrimination identified in this study were related to sexual orientation and health status. This is supported by an interview excerpt from the main informant:

> *"I found out that I was HIV positive in 2019. At that time, I worked in the agricultural sector, but in a different company. I was open about my HIV status, and as a result, I was immediately terminated from my job. After that incident, when I applied to the company where I work now, I was afraid to be open again because I was worried that the same incident would happen again."* (IU 10, 35 years old)

MSM attempted to disclose their HIV status but experienced discrimination in the workplace. This aligns with the findings of Suryaman and Waluyo (2020), who state that individuals living with HIV/AIDS, especially MSM, often face negative responses from their environment, which creates fear of disclosure and psychological barriers. Such barriers can also adversely affect HIV treatment, as individuals may feel unsupported.

Additional informants confirmed the main informant's experiences:

> *"….Yes, if we talk about stigma and discrimination, it still exists, but some clients get it, some don't. In the past, there was a fairly strong stigma. For example, people with HIV were considered disgusting…In health services themselves, stigma still exists, although it is more towards fear than outright discrimination. There are health workers who actually understand about HIV and its transmission, but still feel afraid or hesitant when treating MSM patients."*, (IT 6, 28 years old)

This quote reinforces the statement that stigma related to health status is experienced not only from the general public but also within health service environments. This is consistent with the findings of Astuti and Zahri (2020), who note that stigma in health services manifests as feelings of fear and anxiety when dealing with HIV/AIDS patients. Misinformation and judgmental attitudes from health workers can lead to stigma, fear, and unequal treatment of patients with HIV.

Meanwhile, discrimination related to sexual orientation is illustrated in the following interview excerpt:

> *"I have also experienced discrimination because of my sexual orientation, sis. When I was still in school, at first I thought she could accept my condition of liking guys, but it turned out that after finding out, she distanced herself and even stopped greeting each other. From that, I have experienced discrimination such as treatment that includes being teased by male friends, like being groped, I was told to touch them, there were some that they wanted to kiss, even to the point where they came up to me and told me to look at and touch their genitals."* (IU 3, 35 years old)

MSM face discrimination in the form of exclusion by school friends who cannot accept their sexual orientation, as well as meaningful sexual treatment. This aligns with research by Siron et al. (2023) which indicates that stigma causes groups to experience limitations in various aspects of life, influences how individuals view themselves, affects mental health, and can lead to withdrawal from social environments.\

Stigma and discrimination have a significant impact on the lives of people with different sexual orientations and those who are HIV positive. The main informant described the influence of stigma as follows:

> *"For those who are teased, it does affect me because I think it's like disturbing my feelings and thoughts. It also makes me not want to be open because it makes my parents sad ...."*, (IU 5, 29 years old)

The main informant feels the

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emotional impact of stigma and discrimination, including feelings of fear that influence decisions about whether to be open with family or society regarding their health status and sexual orientation. This is consistent with Siron et al. (2023), who state that stigma can cause affected groups to face limitations in various aspects of life, influence self-perception, impact mental health, and lead individuals to withdraw from social interactions. It also reinforces the "hidden area," which refers to aspects of the self that are known to the individual but not shared with others due to fear of social rejection or stigma. Additionally, stigma can expand the "blind area," which includes parts of the individual that are not recognized by themselves but are visible to others—such as withdrawn behavior or suppressed emotional expression—which can negatively affect social interactions and overall psychological well-being.

Meanwhile, another main informant stated that stigma and discrimination do not significantly impact their life, as shown below:

> *"If there is stigma, I prefer to keep quiet, it's been a long time so I don't care if it doesn't affect me. As long as it doesn't bother me, okay.",* (IU 1, 22 years old)

This indicates that acceptance of stigma varies among MSM. Some individuals choose to accept the existence of stigma by ignoring it and not allowing it to affect them. Research by Sembiring et al. (2023) shows that each person's response to stigma depends on personal motivation and the support they receive from those closest to them. The way individuals cope with stigma also varies; some develop specific strategies to overcome it or choose to ignore it (Sembiring et al., 2023).

Hidden Area

The hidden area represent personal information that an individual knows but chooses not to disclose. For MSM, this often includes sexual orientation and HIV status, particularly when interacting with family, social circles, or in the workplace. This is done because of fear of social stigma and negative views. The interview results show, as follows:

> *"Yes, what I hide from my social environment is my sexual orientation. Especially about my health status, I also don't tell just anyone, only those who are really close know.",* (IU 6, 27 years old)
> *"Yes, I am not open about my sexual orientation and health status, especially to my family.",* (IU 7, 33 years old)

The main informant tends to hide personal information related to sexual orientation and health status from the social environment and family. MSM share information with people who are really close to them, such as close friends and partners. This reflects the existence of a hidden area within the informant regarding certain aspects that are hidden to avoid the influence of stigma that may arise due to hiding. Homosexual individuals often keep their distance in the social environment as an effort to protect themselves because they are influenced by the stigma that exists around the individual (Tubuon, 2023).

Some MSM choose not to come out to their families because they fear angry and fearful reactions and also because their families are still unaware of their sexual orientation and HIV status. This is also related to the Johari window theory, that MSM try to maintain a hidden area to avoid perceived social consequences. Hiding sexual orientation or homosexual identity is often triggered by fear of negative consequences that may arise in the family (Flores, Meanley and Wood, 2020). The findings demonstrate that expanding the open area where personal information is shared with others requires a supportive and nonjudgemental environment. Only

when MSM perceive sufficient safety and acceptance do they reduce the hidden area and increase oppenes, which is vital in HIV prevention and treatment contexts.

Blind Area

The blind area refers to how others perceive an individual often in ways that the individual themselves may not realize. The blind area shows information known about the informant that others, but not realized by the informant. The

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views of additional informants on self-disclosure carried out by MSM are mixed and depend on the level of trust. There are interview results seen from additional informants, namely:

> *"As far as I've seen, MSM usually only tell people they trust, for example me and WY, because we're both MSM, it's easier to be open. But if it's with other people, especially those who don't seem trustworthy, they definitely keep to themselves."* (IT 4, 30 years old)

The view of the person who first knew the identity of the main informant regarding health information or sexual orientation carried out by the main informant. MSM is open to fellow MSM or the environment they trust. This is in line with research (Noviyani, 2023), shows a theory that states that a person tends to disclose their feelings, problems, and personal aspects to people who are considered close.

The MSM group also disclosed themselves to health workers because of the need to stay healthy and prevent HIV and AIDS. This is shown from the interview results, as follows:

> *"Alhamdulillah, most of those who come to our services have started to open up. Maybe because we are already trusted by the MSM community as a safe place. They usually reveal their sexual orientation or health status during the counseling process. However, there are also those who only open up because their condition is already sick, usually stage 3 or 4, so they feel the need to seek treatment.",* (IT 5, 42 years old)

The views of additional informants regarding the openness of sexual orientation and health status to health workers because they are HIV positive. This is in line with Pujilestari (2021), which explains that self-disclosure by PLWHA is usually driven by certain motivations and goals. PLWHA who declare themselves open tend to prevent the transmission of HIV and AIDS, compared to PLWHA who are closed. This limited openness actually risks increasing the blind area, because there is important information or health needs that the individual is not aware of, but are known to others. This condition can hinder early detection and prevention of HIV and AIDS, because individuals may not be aware of risky behavior or the importance of access to health services.

From the Johari Window perspective, this contributes to the blind area, where the environment forms assumptions supportive or stigmatizing about the individual. If the environment is supportive as in health services trusted by MSM, this perception can encourage individuals to shift information from the blind to the open area through disclosure. Conversely, in unsupportive or stigmatizing settings, assumptions made by others can lead to enacted stigma and discrimination, even before MSM are aware of how they are perceived. This, in turn, reinforces fear, expands the blind area further, and solidifies the hidden area, ultimately discouraging health seeking behavior and reducing the effectiveness of HIV prevention efforts

The blind area also includes additional informants who provide perceptions of the sexual orientation experienced by the main informant, as follows:

> *"From a health perspective, their sexual orientation is actually a risk, because it is transmitted through oral transmission. But back again, now it's about how they can understand the risks of every sexual behavior they engage in and how to prevent the transmission of diseases, especially HIV and AIDS",* (IT 6, 28 years old*)*

Based on the above quotation, it can be seen that there is rejection and acceptance of MSM sexual orientation from some additional informants from a religious and health perspective. Although there are differences from a health perspective, most additional informants still show acceptance, by understanding that even though MSM sexual orientation is considered contrary to certain norms, the most important thing is MSM's understanding of the risks and how to prevent the transmission of disease. Similar research on LGBT reveals that from a religious, moral, and ethical

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perspective that considers orientation as a deviation and a major sin, there is also an awareness of the importance of healing and recovery efforts for sexual behavior that is considered deviant, as well as providing protection to LGBT as part of citizens (Hanum, Rahmaddian and Fitria, 2022). These findings suggest a duality in society's view of sexual orientation. This is relevant to HIV and AIDS prevention efforts, as acceptance can help create an environment for MSM to gain access to information and health services. Conversely, rejection can hinder prevention efforts by discouraging MSM from seeking help or health information.

CONCLUSION

Self-disclosure among MSM is strongly influenced by stigma, discrimination, and the broader social environment, which can either facilitate or inhibit openness. Many MSM choose to conceal their sexual orientation and HIV status due to fear of rejection or negative consequences. In line with the Johari Window framework, the hidden area reflects this concealment, driven by internalized stigma and social norms. MSM typically disclose sensitive information only to individuals they deeply trust, such as close friends and partners. The blind area reveals how others' perceptions of MSM may influence their experience, regardless of whether disclosure has occurred. Some environments, especially among peers and healthcare providers, can foster acceptance and facilitate openness. However, in less supportive contexts, perceived stigma may intensify secrecy and reduce health-seeking behavior.

These findings underscore the importance of understanding the hidden and blind areas within the Johari Window framework. Fear of stigma and discrimination often leads MSM to intentionally conceal their sexual orientation and HIV status. Recognizing these dynamics can guide the development of safer, nonjudgmental environments that promote voluntary disclosure and improve access to services. Meanwhile, awareness of the blind area how others perceive MSM without explicit disclosure emphasizes the need for sensitization programs for communities and healthcare providers to reduce assumptions, bias and enacted stigma.

Therefore, this research contributes to the development of more inclusive health promotion strategies, and supports the enhancement of community and healthcare capacity to provide safe spaces that encourage honest and supported disclosure among MSM.

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