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Faith, fear, and disclosure: Exploring serodiscordant relationships in Indonesia's Muslim society

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Eka Sari Ridwan[1,2], **Chanuantong Tanasugarn**[1], **Sarunya Benjakul**[1], **Mondha Kengganpanich**[1*], **and Masoud Mohammadnezhad**[1,3]

[1]Department of Health Education and Behavioral Sciences, Faculty of Public Health, Mahidol University, Bangkok, Thailand
[2]Hospital Administration Study Program, Faculty of Health Technology, Universitas Megarezky, Makassar, Indonesia
[3]Faculty of Health, Education and Life Sciences, School of Nursing and Midwifery, Birmingham City University, Birmingham, United Kingdom

Abstract

Background: In Indonesia's Muslim society, serodiscordant couples navigate a complex web of faith, fear, and stigma. While HIV care efforts have advanced, understanding how religious beliefs and emotional responses shape disclosure remains limited.

Objective: This study aimed to explore the lived experiences of serodiscordant couples in South Sulawesi, Indonesia, with a focus on how faith, fear, and gender roles influence HIV understanding and disclosure practices.

Methods: A qualitative, phenomenological approach was employed, involving 34 participants who participated in in-depth interviews and focus group discussions conducted between February and May 2019. Data were thematically analyzed to capture emotional, cultural, and relational dimensions of HIV disclosure.

Results: Two main themes emerged. (1) Faith and Fear: Navigating HIV Understanding, which includes knowledge of HIV, emotional responses to an HIV diagnosis, the role of religious teachings in shaping health decisions, and the fear of social exclusion; and (2) HIV Status Disclosure and Its Complexities, highlighting motivations for disclosure, barriers to openness, and the personal impact of revealing one's HIV status to a partner. Disclosure was often delayed or mediated by third parties, driven by fear of rejection, shame, and limited communication skills.

Conclusion: The findings revealed the dual role of faith as both a support and a barrier, and the complex interplay of gender dynamics in disclosure decisions. Community nurses in Indonesia's primary health care settings should then play a critical role in HIV prevention by providing culturally sensitive, Islamic-faith-based counseling, gender-responsive disclosure support, and collaboration with peer support groups to foster trust, reduce stigma, and improve adherence.

Keywords

HIV infections; disclosure; fear; faith; spouses; qualitative research; religion and medicine; Indonesia; nursing care; serodiscordant relationships

***Corresponding authors:**
Mondha Kengganpanich, Ph.D
Department of Health Education and Behavioral Sciences, Faculty of Public Health, Mahidol University, 420/1 Rajavithi, Rajathewi, Bangkok, Thailand 10400
Email: mondha.ken@mahidol.ac.th

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Background

Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) remain significant global public health challenges. In 2023, approximately 39.9 million people worldwide were living with HIV, with 1.3 million new infections (UNAIDS, 2024). In Indonesia, the world's most populous Muslim-majority country, heterosexual transmission within marital relationships accounts for over 50% of new HIV cases, with many women acquiring the virus from their long-term male partners (Ministry of Health of Indonesia, 2024).

Serodiscordant couples, where one partner is HIV-positive and the other HIV-negative, face complex decisions regarding health management, intimacy, and disclosure. These challenges are often exacerbated by stigma, gender dynamics, and limited health literacy (Tariqujjaman et al., 2023). In marital contexts, particularly in Muslim-majority settings, consistent condom use is often discouraged due to cultural and religious norms (Zuo et al., 2020). Inadequate disclosure further compounds the problem, increasing transmission risks and hindering early treatment and adherence. Nurses play a frontline role in these areas, yet most nursing frameworks still lack sufficient cultural and spiritual adaptation to address HIV stigma and disclosure among Muslim serodiscordant couples.

Fear is a central barrier to HIV disclosure. Many individuals delay revealing their status due to concerns about divorce, rejection, or social ostracism (Philpot et al., 2020). Misconceptions, such as believing that antiretroviral therapy (ART) is a cure or that spiritual devotion alone offers protection, further distort understanding of HIV transmission

(Lucas et al., 2024). These beliefs reduce perceived susceptibility and weaken the urgency to seek treatment.

At the same time, religious faith can provide comfort, meaning, and resilience. For some, HIV is interpreted as a test from God or a wake-up call to realign with spiritual values. Thus, faith may function as both a supportive and inhibiting force depending on one's interpretation (Koku, 2024). This dual role makes faith a crucial factor in disclosure decisions.

In Indonesia's Muslim context, disclosure is not merely a personal or clinical matter but also a deeply moral and spiritual dilemma. Many individuals fear being perceived as sinful or impure, while others draw upon religious interpretations to find solace in their condition (Halimatusadiyah, 2019). Gender dynamics further complicate disclosure. In many patriarchal households, women may lack the autonomy to initiate discussions about HIV status or negotiate condom use (Alageel & Alomair, 2024; Ngure et al., 2012). Compared to other religious contexts in Indonesia, such as Balinese Hinduism or Christian-majority areas, Muslim communities may be more influenced by doctrines that emphasize marital submission, social purity, and family honor, all of which shape HIV-related communication and help-seeking behaviors (Hasnain, 2005).

Although previous studies have examined stigma and coping mechanisms among HIV-negative Muslim wives in serodiscordant relationships (Agnes & Songwathana, 2021), few have explored how faith, fear, and gender roles interact from the perspectives of both partners. This study builds on existing work by incorporating the voices of both HIV-positive and HIV-negative individuals in South Sulawesi, an underrepresented region in HIV research. It offers a culturally grounded understanding of how disclosure decisions are shaped by religious values, emotional dynamics, and gendered expectations in everyday couple interactions. The focus on serodiscordant couples is particularly relevant given their unique vulnerability as both potential transmitters and recipients of HIV within committed relationships. Targeted nursing interventions in this area can make a tangible difference.

From a nursing perspective, understanding these lived experiences is critical. Nurses often serve not only as providers of care but also as trusted communicators and educators in HIV management, especially in Indonesia's community and primary care settings. Developing culturally and spiritually sensitive nursing interventions that are grounded in the lived experiences of serodiscordant couples can reduce stigma, support effective disclosure, and improve treatment adherence and emotional well-being. For instance, faith-based counseling integrated with Islamic values and peer-led education facilitated by people living with HIV have been shown to enhance ART adherence and reduce stigma among Muslim communities. These approaches can serve as practical models for nurses working in similar socio-religious contexts (Agnes & Songwathana, 2021). Therefore, this qualitative study aims to explore how faith, fear, and gender roles influence the understanding of HIV and the disclosure process among serodiscordant couples in Indonesia's Muslim society. The findings are expected to inform faith-sensitive, gender-aware, and culturally relevant nursing strategies to improve HIV care outcomes.

Methods

Study Design

This study employed a qualitative phenomenological design, which is well-suited for exploring lived experiences and personal meanings within specific sociocultural contexts (Creswell & Poth, 2016). This approach allowed the researchers to gain an in-depth understanding of how serodiscordant couples in a Muslim-majority setting navigate complex issues related to HIV disclosure, sexual health, and religious values. The study was conducted at the Peer Support Group Care Foundation (YPKDS), a non-governmental organization in Makassar, South Sulawesi, Indonesia, which assists people living with HIV (PLWH). YPKDS operates across ten regions in Sulawesi, supported by more than 45 outreach workers. South Sulawesi was chosen due to its high HIV prevalence, making it a critical site to examine health behaviors and disclosure practices influenced by Muslim cultural norms.

Reflexivity

In line with the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong et al., 2007), reflexivity was integrated throughout the study process. The principal researcher (the first author) is a married Muslim woman of Buginese ethnicity, trained in public health and HIV prevention. This background facilitated rapport with participants but also raised awareness of potential cultural and religious assumptions that might influence interpretation. To address this, the researcher wrote reflexive observations in her field notes after each interview to capture personal reactions, assumptions, and possible biases. For example, after one interview with a female participant, she noted a tendency to feel protective toward the participant, which prompted the team to re-examine the transcript more critically to avoid over-sympathetic interpretation.

Regular team discussions were also held to compare perspectives, particularly when discrepancies in coding or interpretation emerged. For instance, when themes related to Islamic norms on marriage and sexuality surfaced, the team explicitly discussed how their own values and assumptions might influence interpretation. The diversity of the research team, which included members from different cultural and professional backgrounds, further enriched these discussions and helped minimize blind spots. In addition, consultations with academic peers outside the immediate research context provided an external check on the analytic process. Taken together, these strategies—field notes, collaborative team discussions, and external peer consultation—were used to identify and manage researcher bias, thereby enhancing the credibility and cultural sensitivity of the findings.

Participants

Participants included 14 serodiscordant individuals, 14 seroconcordant individuals, and six institutional stakeholders residing in South Sulawesi, Indonesia. For individual participants, the inclusion criteria were: aged ≥18 years; currently or formerly in a heterosexual, sexually active relationship (married or cohabiting) for at least six months; and having lived in a serodiscordant relationship. Notably, some seroconcordant individuals were included because they had previously been in serodiscordant relationships before both partners became HIV-positive. Their retrospective narratives provided valuable insights into how faith, fear, and disclosure practices shaped their earlier experiences.

Institutional stakeholders were selected based on their active involvement in HIV-related community initiatives, including peer support, religious outreach, youth education, women's health advocacy, and drug rehabilitation. These stakeholders contributed contextual perspectives through focus group discussions (FGDs), enriching the sociocultural and spiritual dimensions of the study.

Purposive sampling was used to ensure diversity in disclosure status, gender, marital status, and age among the individual participants, thereby enabling the collection of rich and nuanced data. Recruitment was facilitated by the Peer Support Group Foundation (YPKDS) and a local study group for people living with HIV. A total of 34 individuals participated in the study. All serodiscordant individuals were interviewed through in-depth interviews (IDIs), while FGDs were conducted with seroconcordant participants and institutional stakeholders to support triangulation and broaden the thematic analysis. During the recruitment process, two eligible individuals did not take part in the IDI—one declined to participate, and another was unable to attend due to health reasons. The composition of participants by HIV status, gender, and data collection method is summarized in **Table 1**.

Table 1 Participant categories by HIV status, gender, and data collection method

Participant Categories	HIV Status	Gender	Method	Notes
Serodiscordant individuals	9 HIV-positive, 5 negative	7 men, 7 women	In-depth interviews	All currently serodiscordant
Seroconcordant individuals	All HIV-positive	6 men, 8 women	Focus group	Previously serodiscordant, now both positive
Institutional stakeholders	Not applicable	2 women, 4 men	Focus group	Representatives from six HIV-related organizations

Data Collection

Data were collected using in-depth interviews and FGDs between February and May 2019. The semi-structured interview guide was developed by the research team and reviewed by three independent experts: (1) an HIV specialist familiar with the Indonesian context, (2) a public health professor affiliated with Nahdlatul Ulama, and (3) a UNAIDS representative with expertise in HIV programming. Each expert reviewed the guide separately and provided written feedback. Although not convened in a joint session, the research team held an internal consensus meeting to integrate all input into the final version. Fourteen IDIs were conducted with serodiscordant individuals, both HIV-positive and HIV-negative partners, regardless of disclosure status. Interviews explored participants' understanding of HIV, disclosure experiences, relationship dynamics, condom use, healthcare access, and religious influences on decision-making. Field notes were recorded during and after each session to capture nonverbal cues, setting context, and the researcher's reflections.

FGDs were conducted with 14 HIV-positive seroconcordant individuals and six institutional stakeholders, including representatives from YPKDS, CHCT South Sulawesi, Nahdlatul Ulama, IPPI (a women's HIV-positive group), and other HIV advocacy forums. These discussions explored sociocultural norms, religious influences, stigma, and relationship-level dynamics affecting HIV disclosure.

All interviews and FGDs were conducted by the principal researcher, audio-recorded with consent, and held in private, informal locations (cafés, health centers, homes), lasting approximately 45–60 minutes. Repeated interviews were held with several in-depth interview participants to clarify or deepen responses; these were conducted within 1–2 weeks of the original session. No follow-up sessions were conducted with FGD participants. To protect confidentiality, HIV-negative partners were only included if disclosure had occurred and written consent was obtained from their HIV-positive partners. Those who had not disclosed were excluded from involving their partners. Informed consent was obtained from each participant prior to the commencement of data collection. Participation was voluntary, with confidentiality and the right to withdraw fully respected.

Data Analysis

Data were analyzed using Braun and Clarke's thematic analysis framework (Braun & Clarke, 2006). Audio recordings were transcribed verbatim and checked for accuracy. Transcripts were manually coded using Microsoft Excel, following the stages of familiarization, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the final report.

The use of Microsoft Excel aligned with the study's phenomenological approach, facilitating close engagement with participant narratives. Manual coding enhanced transparency and allowed the research team to collaboratively interpret meanings without over-reliance on automated software. Excel also enabled systematic organization of codes across different participant groups, supporting comparative thematic analysis.

Data from in-depth interviews and FGDs were analyzed together rather than separately. FGD findings were integrated with interview data to validate, enrich, and triangulate emerging themes. The research team collaboratively reviewed codes and themes to ensure analytical consistency and rigor. Although transcripts were not returned to participants for member checking, the study maintained credibility through peer debriefing, triangulation, and team-based reflexive discussions. Participants were not involved in theme validation due to ethical and contextual considerations related to the sensitivity of the topic.

Trustworthiness/Rigor

Rigor was ensured using Lincoln and Guba's criteria: credibility, dependability, confirmability, and transferability (Guba & Lincoln, 1994). Credibility was supported through data triangulation from PLWH, partners, and stakeholders.

Dependability was maintained by consistent interview guides. Confirmability was strengthened through the use of audit trails and peer debriefings. Transferability was addressed by providing rich contextual descriptions. The study followed the COREQ checklist (Tong et al., 2007) to enhance transparency in qualitative reporting.

Ethical Considerations

The study was approved by the IRB of the Faculty of Public Health, Mahidol University (COA. No. MUPH 2018-177). All participants gave written informed consent. Confidentiality was ensured through data anonymization, and participation was voluntary with the right to withdraw at any time before the data collection was concluded.

Results

Participants' Characteristics

The study included 28 participants: 14 took part in IDIs comprising both HIV-positive and HIV-negative individuals, and 14 in FGDs with HIV-positive individuals and stakeholders. To contextualize the findings, the sociodemographic characteristics of participants involved in both IDI and FGD are summarized in **Table 2**.

Table 2 Demographic characteristics of participants in IDI and FGD

No	Code	Type	HIV	Sex	Age	Marital	Status	Job	Education	HIV History	Child
1	1DPG	IDI	(+)	Male	27	Married	D	Unemployed	JH	Drugs	1 Daughter
2	2DPU	IDI	(+)	Male	33	Married	D	Employee	BA	Drugs	1 Daughter
3	3DPJ	IDI	(+)	Male	27	Married	D	Construction	JH	Ex	1 Daughter
4	NPB	IDI	(+)	Male	35	UM	ND	Employee	BA	Free sex	-
5	NPF	IDI	(+)	Male	28	Married	ND	Employee	BA	Free sex	-
6	4DNR	IDI	(-)	Male	45	UM	D	Business	SH	-	1 Son
7	5DNO	IDI	(-)	Male	38	UM	D	Employee	SH	-	-
8	5DNE	IDI	(+)	Female	34	UM	D	Housewife	SH	Ex	1 Son
9	4DPL	IDI	(+)	Female	30	UM	D	Employee	BA	Ex	2 Daughter
10	NPT	IDI	(+)	Female	24	UM	ND	Housewife	SH	Ex	1 Son
11	NPS	IDI	(+)	Female	25	UM	ND	Employee	BA	Ex	1 Son
12	1DNA	IDI	(-)	Female	26	Married	D	Housewife	SH	-	1 Son
13	2DNC	IDI	(-)	Female	43	Married	D	Housewife	SH	-	3 Son
14	6DNM	IDI	(-)	Female	31	Married	D	Employee	BA	-	2 Son
15	FMN	FGD	(+)	Male	34	Married	D	Business	BA	Drugs	1 Son
16	FML	FGD	(+)	Male	37	Married	D	Driver	JH	Free sex	1 Son
17	FMA	FGD	(+)	Male	35	Married	D	Business	SH	Free sex	1 Daughter
18	FMW	FGD	(+)	Male	39	Married	D	Business	SH	Free sex	2 Daughter
19	FMY	FGD	(+)	Male	38	Married	D	Laborer	JH	Tattoo	1 Daughter
20	FMC	FGD	(+)	Male	32	Married	D	Employee	BA	Free sex	-
21	FWI	FGD	(+)	Female	39	Married	D	Housewife	SH	Husband	4 Son
22	FWE	FGD	(+)	Female	31	Married	D	Housewife	SH	Husband	2 Daughter
23	FWM	FGD	(+)	Female	38	Married	D	Business	SH	Ex	4 Son
24	FWS	FGD	(+)	Female	29	Married	D	Construction	JH	Husband	3 Daughter
25	FWA	FGD	(+)	Female	24	UM	D	Unemployed	SH	Ex	2 Daughter
26	FWI	FGD	(+)	Female	32	Married	D	Business	SH	Husband	1 Son
27	FWU	FGD	(+)	Female	26	Married	D	Business	BA	Ex	-
28	FWL	FGD	(+)	Female	35	Married	D	Housewife	SH	Husband	2 Daughter

Note: D: Disclosure; ND: Non-disclosure; JH: Junior High School; SH: Senior High School; BA: Bachelor's Degree; Ex: Ex-husband or ex-wife

To provide deeper context beyond the numbers, the following summary highlights key patterns and notable characteristics from the data: In terms of gender distribution, the in-depth interview (IDI) group comprised nine HIV-positive individuals (5 males, four females) and five HIV-negative individuals (2 males, three females). All FGD participants were HIV-positive, with a slightly higher number of females (8) than males (6). Most participants were married (n=17), including eight HIV-positive females (FGD), eight HIV-positive males (3 IDIs, 5 FGDs), and one HIV-negative female (IDI). Of the three HIV-positive married males (IDIs), two had disclosed their status, while one had not. Eleven were unmarried, including six HIV-positive females (4 IDIs, 2 FGDs), three HIV-positive males (2 IDIs, 1 FGD), and two HIV-negative males (IDIs). Among the six unmarried HIV-positive IDI participants, three had disclosed their HIV status.

In total, six out of nine HIV-positive IDI participants had disclosed their status (two married, four unmarried), while three had not (one married, two unmarried). All HIV-positive FGD participants (n=14) had disclosed their HIV status. Five participants had experienced multiple marriages—four HIV-positive females (FGD) and one HIV-positive male (IDI).

Educational backgrounds ranged from junior high to university degrees. Among HIV-positive IDI participants, five held bachelor's degrees. In the FGD group, four females held bachelor's degrees, while the remainder had completed secondary or junior high school. Regarding transmission, HIV-positive IDI males reported sexual contact (n = 3) and drug use (n = 2); four participants (both genders) were infected by their partners. Among HIV-positive FGD males, four cited sexual transmission, one drug use, and one tattoo-related exposure. Female FGD participants reported infection through current husbands (n = 3), ex-husbands (n = 4), and premarital sex (n = 1). Seven out of nine HIV-positive IDI participants had 1–2 children; two had none. One female had an HIV-negative child due to early intervention, while another had lost a child to HIV-related illness. All FGD participants had 1–4 children. Some females cared for children from multiple marriages and faced stigma-related caregiving challenges; one had lost a child to HIV.

Most participants worked in informal or unstable jobs. HIV-positive IDI males worked as motorcycle taxi drivers, construction laborers, and security guards. Others ran small-scale businesses or were unemployed. HIV-negative IDI participants included two males employed in the private sector and three females who were housewives or unemployed.

Thematic Findings

Two overarching themes were constructed from the data: (1) *Faith and Fear: Navigating HIV Understanding*, and (2) *HIV Status Disclosure and Its Complexities*. These themes were developed through a systematic thematic analysis that drew on both in-depth interviews (IDIs) and focus group discussions (FGDs). Although the data were ultimately integrated, initial coding was conducted separately for IDIs and FGDs to retain the unique characteristics of individual and group narratives. The codes were then compared and cross-checked to identify shared patterns, enrich meaning, and ensure analytic consistency. This process enhanced methodological triangulation and strengthened the credibility of the findings.

Theme 1: Faith and Fear: Navigating HIV Understanding

This theme comprises four sub-themes as follows: 1) knowledge and understanding about HIV; 2) Emotional responses to diagnosis; 3) Role of religion in health-related decisions; and 4) Fear of social exclusion and stigma.

Sub-theme 1.1: Knowledge and understanding about HIV

Participants' knowledge of HIV varied widely, shaped by cultural myths, gendered beliefs, spiritual interpretations, and individual experiences. This sub-theme is further divided into ten categories to capture the diversity of perspectives.

There's a little monster in my body": HIV as a deadly, invisible force. HIV was often described using metaphors rooted in fear and trauma. A woman who contracted HIV from her ex-husband likened it to a "little monster," reflecting her internalized fear:

> *"I feel different from normal people. I have this little monster in my body. It can kill me anytime; I could die just because of stress or getting influenza"* (4DPL, Female, 30, positive)

This metaphor ("little monster") underscores a lack of biomedical understanding and reflects how stigma can internalize fear and reshape identity.

From drug users to housewives: Shifting stereotypes of HIV risk. One participant associated HIV with specific social groups, particularly drug users and businessmen. A HIV-negative housewife described HIV as a "trend" that had shifted from drug users to women like herself—those rendered vulnerable by their husbands' mobility and risky behaviors:

> *"HIV is a drug user's disease. It was a trend. I mean, many people got HIV due to their behavior as drug users. Nowadays, the trend has changed—to partners. You know, the trend of HIV moved from drug users to housewives, the ones whose husbands are busy, working around, maybe doing business in another province, rarely staying at home. It puts their wives at risk of HIV"* (2DNC, 43, Female, HIV-negative)

This participant's reflection highlights how risk perception is shaped by sociocultural roles and gendered assumptions. Although she was HIV-negative, she perceived herself as vulnerable—not because of her own behavior, but because of her husband's lifestyle. This underscores the involuntary vulnerability faced by many women in patriarchal and mobile family structures.

Immunity by belief: Denial and masculinity in HIV prevention. A male participant perceived himself as immune to HIV infection, expressing that prevention measures, particularly condom use, were unnecessary. His statement reflected not only a denial of personal risk but also an underlying influence of masculinity norms that framed HIV as a concern for others, not himself. He shared:

> *"Why use a condom? I'm not sick. I need more than just a condom. I believe most people living with HIV don't want to use condoms. Why do people keep asking to use them when they're so uncomfortable?"* (4DNR, Male, 45, HIV-negative)

This quote reveals a perspective where condom use is associated with illness, and the absence of visible symptoms is equated with being safe. His resistance to condom use appeared to be reinforced by masculine ideals that downplay vulnerability and associate strength with sexual freedom. For him, HIV was something that happened to "others", typically women or those already perceived as sick, thereby justifying his rejection of prevention tools.

Condom-free prevention: Cleansing rituals and nightly routines. A unique form of prevention was narrated by a young HIV-negative woman who practiced self-initiated rituals instead of using condoms. Her "nightly routine" was believed to protect her from transmission.

> *"Before sleeping, I had my nightly routine, I would go to the bathroom, and check my vagina... So, if he asked me to have sex, I had been ready for clean protection... Even if he has an injury but I don't have it, it would save me from infection, so no need to use a condom"* (1DNA, 26, Female, negative)

This illustrates an embodied and gendered understanding of prevention, where the woman assumes full responsibility for protection without involving her partner. The act of "vaginal inspection" reflects internalized pressure to remain healthy and "clean."

"Warm-up first": Avoiding injury as an HIV prevention strategy. The perception that HIV can be transmitted by injury was illustrated by a positive male participant. The "warm-up session" before sex was thought to be one step in avoiding injury during sex. His experience of living as a serodiscordant couple for almost 2 years convinced him to act. He believed that having "a warm-up session" would change the condom's function.

> *"HIV can be transmitted if you and your partner have an injury during sex. Even if you use a condom, there is still a chance of getting infected. Therefore, having a "warm-up" session before having sex is helpful to avoid injury"* (1DPG, Male, 27, positive)

Hope in a cure: Misunderstanding ART as a complete remedy. Another common theme was the belief that ART could cure HIV, rather than manage it. This misunderstanding significantly shaped attitudes toward prevention, risk, and transmission. A woman who remained HIV-negative for 8 years after marrying a positive partner believed HIV was similar to other treatable diseases:

> *"Since I got married 8 years ago, I'm still free of HIV. I test once a year. So, no need to worry too much. HIV is just like other diseases; it still has ARV to cure it. You should pay more attention to other diseases like TB or hepatitis, they can infect you just by talking"* (6DNM, Female, 31, negative)

Her statement reveals optimism about ART but also a misconception that it provides complete protection, even for seronegative partners. Similarly, a male participant downplayed the severity of HIV:

> *"I believe my behavior affects my health, but still, risk isn't my priority. We have the medicine to cure it, so what's the function of ART? I never feel scared of HIV"* (5DNO, Male, 38, negative)

Even among PLHIV, misunderstanding persisted. One woman who hadn't disclosed her status to her current partner believed ART would neutralize the virus:

> *"Sure, I know I'm sick because I have HIV inside my body. That's why I enrolled in ART—to cure the virus. In my understanding, condoms aren't the only tool to prevent transmission. ART can also help wreck the virus inside the body"* (NPS, Female, 25, positive)

"I don't have semen": Gendered misconceptions in transmission

Some female participants believed that women were less likely to transmit HIV due to biological differences, particularly the absence of semen. Four women explained the difficulties of HIV transmission from women with HIV positive to men with HIV negative. They believed that HIV could only be transmitted by a man's semen (sperm). Although they were sexually active, it was impossible to transmit the man's negative status. Women participants concluded that HIV transmission is easier for them than for men.

> *"You know, I am HIV-positive, and I am a woman, so it's difficult to transmit this virus to my partner. It will be different if the positive was him because he has semen... However, for me, I don't have the semen, so it's difficult to transmit it to him"* (5DNE, Female, 34, positive)

This understanding reflects a gendered lens of sexual biology that underestimates the risks posed by vaginal fluids or blood. It also reflects the common belief that HIV is more easily transmitted from men to women, rather than bidirectionally.

Risk perception shaped by gender roles and power dynamics. Women, especially housewives, described themselves as passive recipients of risk, lacking the power to negotiate safety.

> *"Being a housewife made it easier to experience stress, which increased my risk"* (1DNA, Female, 26, Negative)

> "Many housewives contract this disease due to their husbands' behavior... They acquire the infection not directly because of their own behavior" (NPB, Male, 35, positive)

These quotes highlight how societal expectations limit women's agency in negotiating safe practices.

Getting it right: Biomedical understanding and proactive prevention. Despite the prevalence of myths, a few participants expressed accurate biomedical knowledge. One male PLHIV explained transmission routes clearly, highlighting his educational background:

> *"HIV can be transmitted through the sharing of needles during tattooing, drug use, and unprotected sexual intercourse. However, it is not transmitted through saliva"* (NPF, Male, 28, positive)

Another woman emphasized the importance of testing and status awareness:

> *"I believe he already has the virus… It will be good if he knows his status, then he can take ART soon"* (5DNE, Female, 34, positive)

These statements reflect how knowledge, particularly among educated individuals or those exposed to health systems, can shape proactive behavior and reduce stigma.

Self-protection is the way you stay alive: Women taking control. A female participant demonstrated remarkable personal agency in protecting her health while living in a serodiscordant relationship. Despite not knowing her husband's HIV status before marriage, she took proactive measures to remain HIV-negative by combining sexual abstinence, condom use, and personal boundaries. She shared:

> *"Being negative was a privilege for me because I didn't know his status before marriage. So, I tried to do my best. Sure, condom use without compromise—and I stayed faithful. Sometimes, if he asks for sex, I always consider the timing—just once in two weeks. I limited our sex to prevent transmission. Self-protection—it was the way to keep myself alive"* (2DNC, Female, 43, HIV-negative)

Her narrative reflects agency, resilience, and strategic self-care as she navigates a high-risk relationship. The phrase "self-protection—it was the way to keep myself alive" underscores the emotional and physical labor she undertook to survive and thrive within the constraints of her relationship.

Sub-theme 1.2: Emotional responses to diagnosis

Participants described a range of emotional responses upon learning of their HIV status. These were categorized into three main types:

Acceptance with regret, I cannot have fun anymore, I need to take medicine every day. A 35-year-old male informant (NPB), previously active in both work and study, described how his diagnosis drastically changed his lifestyle. He withdrew from social circles and replaced physical activities with a strict medication routine:

> *"Sometimes I feel sad, I think it's not myself. I was an active person; I could do everything I wanted. Unfortunately, now I need to consider my health. I need to take medicine every day, which I never did before. Having this also limits my activities. I cannot have fun anymore or just hang out with my friends—it's too difficult"* (NPB, Male, 35, HIV positive)

> *"I infected my wife... it's not fair"* (3DPJ, Male, 27, HIV Positive)

FMA, a male participant living in a serodiscordant relationship, expressed deep guilt for unknowingly transmitting HIV to his wife. This guilt fueled his feelings of regret:

> *"It was not easy. Honestly, I feel uncomfortable with this relationship. You know, your wife was normal, then you infected her… It's not fair. I mean, I thought that I was so selfish. I accept this virus because I don't have many choices"* (FMA, Male, 35, HIV positive)

A female informant, FWL, recounted the trauma of learning she was HIV-positive after giving birth. The shock was intensified by prior mixed messages from healthcare providers:

> *I was shocked because he told me I was positive (HIV). Previously, I had prepared myself for the possibility of being positive, but then the doctor said I was negative. So, when I prepared myself for a negative result, suddenly the doctor gave me a positive one. It felt like I would kill myself* (FWL, Female, 35, HIV positive)

Positive with hope. In contrast, other participants adopted a more hopeful outlook. Their acceptance was framed by spiritual beliefs, support systems, or access to antiretroviral therapy (ART), which served as a symbol of a second chance in life. A male participant, formerly a drug user, saw ART as a lifeline. The deaths of his peers had instilled fear, but knowing that ART could prolong life gave him motivation:

> *"I just admit this virus due to my status as a drug user. Most of my friends passed away due to HIV, so I thought I would get the same condition. However, I still have a chance because I heard that ARV can help me cure this HIV. So, I enrolled in ART soon after I got my test result."* (1DPG, Male, 27, HIV positive)

Philosophical acceptance was also evident in the narrative of a 34-year-old male business owner (FMN) in a serodiscordant marriage:

> *"Don't let HIV take over your mind. Take it easy, try to enjoy your life. We never know our future—even I am positive, but who knows? Maybe you (HIV negative) will die before me. All will die, having it or not. So I couldn't find any reason why I should regret this infection"* (FMN, Male, 34, HIV positive)

Surrender/common feelings

Participant reported a sense of surrender, shaped by the emotional and practical support of loved ones. Acceptance was not resignation but a coping mechanism to prevent further mental distress. 5DNE, a 34-year-old woman, credited her partner's support with helping her maintain mental well-being:

> *"What can I do? I have a boyfriend who loves me a lot. So, I try to eliminate the negative feelings that can affect my health. Sometimes I think that having nothing (no HIV knowledge) is better. We don't need to worry about anything"* (5DNE, Female, 34, HIV positive)

Sub-theme 1.3: Role of Religion in Health Decisions

Religious beliefs emerged as a significant influence in how participants processed their HIV diagnosis and made subsequent health-related decisions. Many participants interpreted their diagnosis not solely in medical terms but through a spiritual and religious framework, which provided both comfort and complexity in navigating their condition. For some, the diagnosis was viewed as a test or trial (ujian) from Allah to strengthen their faith and correct their life path. Others considered it a form of balasan (retribution) for past transgressions, particularly related to previous risky behaviors such as drug use or extramarital sex. This spiritual framing helped individuals to make sense of their illness in a culturally and personally meaningful way.

Spiritual awakening through illness: "Having this virus has motivated me to get closer to Allah". For several participants, the HIV diagnosis marked the beginning of a spiritual transformation. Rather than dwelling in despair, they reinterpreted their health condition as an opportunity for Hijrah—a conscious effort to become a better person in the eyes of God. A 32-year-old male informant, who had previously lived a high-risk lifestyle, described how HIV became a spiritual catalyst for inner change:

> *"In Islam, we call this situation 'Hijrah', which means changing ourselves to become a better person. Having this virus has motivated me to get closer to Allah (God)."* (FMC, 32, Male, Positive)

This transformative process often involved increased religious practices, such as more frequent prayers, repentance, fasting, and attending religious study groups (pengajian). For many, this spiritual engagement helped them cope with fear, guilt, and uncertainty, allowing them to maintain a sense of purpose and emotional balance despite living with a chronic condition.

Divine purpose and second chances: "HIV is a wake-up call from God". The concept of HIV as a blessing in disguise or a divine "wake-up call" was frequently voiced. This shift in perception altered the narrative from one of shame and punishment to one of redemption and hope. A 27-year-old male informant who previously used intravenous drugs described his diagnosis as a turning point:

> *"Having this virus is like a wake-up call. I feel like God still gives me a second chance to live in the right way"* (1DPG, Male, 27, Positive)

For this participant and others, the illness was not merely an endpoint but a beginning—an opportunity to leave behind destructive behaviors and adopt a more spiritually aligned life. These insights reveal how religious belief systems can provide a constructive coping mechanism, enabling individuals to rebuild self-esteem and reframe their identity.

Religious faith and adherence to treatment: "ARV is one of the ways Allah helps us". Notably, religion was not perceived as conflicting with biomedical treatment. Instead, some participants integrated religious reasoning to support ART adherence. They believed that while the illness may be a divine test, the availability of ARV was itself a manifestation of God's compassion and mercy. A 28-year-old male informant articulated this synthesis:

> *"If Allah gives this test, He must provide the cure. ARV is one of the ways Allah helps us, so I take it as part of my responsibility"* (NPF, Male, 28, Positive)

This belief encouraged participants to take a proactive role in their health while maintaining a sense of religious devotion. It also reduced stigma by framing treatment as a faithful act rather than a medical surrender.

Tension between faith and treatment: "I thought repentance could heal me without medicine". However, not all religious interpretations facilitated ART initiation. A minority of informants expressed hesitation or delayed starting treatment due to strong beliefs in divine healing through repentance and moral purification. A 35-year-old woman who contracted HIV during pregnancy described her initial doubts about lifelong treatment:

> *"I thought, if I repent and live according to Islamic principles, I may not need to take medicine forever"* (FWL, 35, Female, Positive)

This tension led to delayed ART initiation and inner conflict, suggesting the need for healthcare interventions that engage respectfully with patients' spiritual frameworks.

Sub-theme 1.4: Fear of Social Exclusion and Stigma

Stigma as a powerful social force. One of the most consistently expressed concerns among participants was the pervasive fear of stigma and the potential consequences of social exclusion following an HIV diagnosis. The fear was not merely abstract or imagined; it was rooted in observed and anticipated reactions from their communities, peers, and even family members. Many participants described carrying the burden of an "invisible label" that, if exposed, could lead to devastating social repercussions. This internalized stigma shaped their behavior, decision-making, and emotional well-being—often leading to silence, isolation, and hesitation in accessing care or disclosing their status. For some, the fear of being ostracized was so intense that they chose secrecy over social support, even at the cost of their own health. A 35-year-old male participant reflected the psychological weight of this fear:

> *"If people know I am positive, they won't talk to me again. I will lose my friends, maybe my job"* (NPB, Male, 35, Positive)

This statement highlights the tangible risks perceived by participants—particularly in workplaces and social networks where HIV is still heavily stigmatized and misunderstood. Silence became a survival strategy.

Stigma intensified by moral judgment: "They will think I'm a sinner". For women, especially in religious and conservative communities, the experience of stigma was often compounded by moralistic assumptions surrounding the source of infection. A 34-year-old female participant shared her fear of community judgment:

> *"I can't tell anyone. If they know, they will think I'm a sinner. They won't let their children near me"* (5DNE, Female, 34, Positive)

In this context, HIV was not seen merely as a medical condition but as evidence of immoral behavior, particularly linked to sexual promiscuity or drug use. The association between HIV and "sin" rendered individuals morally tainted in the eyes of others, leading to both social and spiritual marginalization.

Gendered stigma: "They won't believe it came from my husband". Gender roles played a significant role in shaping experiences of stigma, especially for women in domestic roles who had little agency or autonomy in health decisions. A 43-year-old seronegative female participant, who contracted HIV from her husband, explained her reluctance to be open about her status:

> *"I am just a housewife. If my neighbors know, they will think I got it from cheating. They won't believe it came from my husband"* (2DNC, Female, 43, Negative)

This quote illustrates how stigma intersects with patriarchal bias, limiting women's ability to defend themselves.

Silence within intimate relationships: "I didn't want to talk about it". Stigma was also internalized to such a degree that it affected disclosure within marriages. Participants feared judgment, blame, or abandonment by their closest partners. A 28-year-old male participant expressed his hesitation in telling his wife about his status:

> *"I didn't want to talk about it. Even to my wife. I was scared she would leave me if she knew"* (NPF, Male, 28, Positive)

Such fears show how stigma can erode trust in the most intimate spaces, preventing support and endangering both mental and physical health.

Theme 2: HIV Status Disclosure and Its Complexities

Sub-theme 2.1: Barriers to Disclosing HIV Status

Participants described several interrelated barriers that hindered open communication about their HIV status. These included fear of divorce and gossip, fear of rejection, stigma, and limited communication skills.

Fear of divorce and partner spreading HIV rumors. Fear of divorce emerged as a salient barrier among married participants, particularly men living with HIV. For these individuals, disclosure was often withheld due to the belief that revealing their status would lead to separation, loss of access to children, and widespread gossip about their condition. The fear was not hypothetical; it was shaped by observing the consequences experienced by other people living with HIV (PLHIV) in their communities. A 35-year-old married man explained:

> *"Mostly, they [people living with HIV] were rejected, divorced from their wives. The worst thing is that they didn't allow the husband to meet his children. His wife also spread his status as HIV positive to people. All of that makes me scared to disclose my status. Spreading our status to other people—it's the most sensitive issue in our relationship"* (NPB, Male, 35, Positive)

Another male participant echoed this concern, emphasizing the professional and social risks associated with disclosure, particularly if his partner were to expose his status:

> *"I worried that it would affect my career. I am a working man; I have many colleagues. HIV is an embarrassing disease. Then, my wife—I worried that she would reject me because we don't have a child yet. So it's easy for her to leave me, then find another husband. I am okay with that. However, I worried that she would spread the rumors, and people would know my status"* (NPF, Male, 28, Positive)

Interestingly, fear of divorce was also acknowledged by HIV-negative female partners, suggesting that disclosure could destabilize relationships from both ends. One female participant noted how her husband delayed disclosure out of fear that she would leave him:

> *"He said that he didn't reveal his status to me before marriage because he worried that I would leave him"* (1DNA, Female, 26, Negative)

Another woman described her internal conflict upon learning her husband's status:

> *"I thought people worry that their partner will refuse their status. They may get a divorce or anything. My husband told me he worried that I would break up our marriage. Actually, I also considered divorce after he told me his status. But I couldn't—I love him"* (2DNC, Female, 43, Negative)

These findings suggest that fear of relationship breakdown is a shared emotional burden, regardless of HIV status, and often reinforces a cycle of secrecy within couples.

Fear of partner's rejection. For participants in new or non-marital relationships, particularly HIV-positive women, the dominant barrier to disclosure was fear of being rejected by their current partners. Disclosure was perceived as a high-risk act that could result in emotional abandonment, judgment, or the loss of much-needed emotional support.

A 24-year-old single mother, who was widowed and diagnosed after her husband's death, shared the emotional complexity of maintaining a new relationship without disclosing her status:

> *"I am not ready yet. It's good to disclose your status, but we need to consider many things. I have no idea how to tell my life story in the past. My life is just filled with sadness. I really need someone who can support me now. I'm not ready to lose him. I want to enjoy this moment, even if I know it will be short"* (NPT, Female, 24, Positive)

Another young woman expressed how social stereotypes about HIV transmission, particularly those linking it to drug use or sex work, increased her fear of being judged by her partner:

> *"Many things... You know my position as a woman living with HIV. I worried that if I told him, he would think I was not a good girl, like having free sex or using drugs. I told him my ex-husband passed away because of cancer, not HIV. I never expected this relationship. It's been almost one year with him. Now I'm stuck in this situation. I'm falling in love, and I'm scared he will stay away after knowing my HIV"* (NPS, Female, 25, Positive)

These narratives illustrate how fear of moral judgment and emotional loss leads many individuals to postpone or avoid disclosure altogether, even in long-term relationships.

Stigma surrounding HIV was a significant barrier to disclosure, as reported by all four HIV-positive informants. Participants shared how deeply ingrained societal prejudice against HIV affected their self-perception and deterred them from revealing their status. HIV was often associated with immoral behavior—such as extramarital sex or drug use—which made participants fear judgment, rejection, and social ostracization. One male participant expressed deep concern about how being identified as HIV-positive could tarnish his reputation both socially and professionally:

> *"HIV is such an embarrassing disease. I'm afraid that if people know, they won't talk to me anymore. I might lose my job and friends. They will think I deserve this because I did something wrong"* (NPB, Male, 35, Positive)

For some, the stigma was intensified by religious and cultural values, which led to internalized shame and self-blame. A female informant described how the fear of being seen as a "bad woman" kept her from telling her partner:

> *"I'm worried he will think I was promiscuous or used drugs. People don't think a 'good woman' can get this virus. So, I told him my husband died of cancer instead"* (NPS, Female, 25, Positive)

These findings indicate that stigma is not only an external social force but also becomes internalized, influencing emotional well-being and decision-making. The fear of being morally judged or socially excluded created a climate of silence that made open conversations about HIV nearly impossible.

Lack of communication skills. Two informants also identified a lack of communication skills as a barrier to disclosing their HIV status, particularly in how to approach sensitive conversations with loved ones or new partners. These participants struggled to find the right words, time, and emotional space to communicate their diagnosis, often delaying disclosure due to fear of conflict or misunderstanding.

A young female informant explained that although she wanted to be honest with her partner, she lacked the confidence and strategy to do so:

> *"I don't know how to start. I practice what to say, but when I see him, I freeze. I don't want to lie, but I'm afraid he won't understand"* (NPT, Female, 24, Positive)

Another informant highlighted the emotional complexity involved in initiating disclosure, especially when the relationship was still new and emotionally fragile:

> *"It's hard. You want to tell the truth, but you also don't want to ruin something good. I don't want to scare him away. I just wish there were someone who could help me say it in the right way"* (NPS, Female, 25, Positive)

These accounts emphasize that, beyond psychological fear and social pressure, practical communication skills play a crucial role in the disclosure process. Without proper support and training, individuals living with HIV may continue to delay disclosure, further affecting treatment adherence and emotional health.

Sub-theme 2.2: Experience of Disclosing HIV Status to Partner

This sub-theme explores the strategies and outcomes of participants who had disclosed their HIV status. Two distinct approaches emerged: (1) direct disclosure and (2) disclosure with assistance.

Talking to partner directly. Participant preferred to disclose their status personally, believing that direct communication was more respectful and intimate, especially within a committed relationship. Two male informants living with HIV and one HIV-negative informant emphasized that talking directly to their partner allowed for honest emotional expression and preserved the confidentiality of the relationship. They believed that personal disclosure built trust and gave the partner a safe space to process the information. One HIV-positive participant shared his approach:

> *"We were in the room, and I gathered all the strength that I had. I grabbed his hand and said, 'Honey, will you accept all my weaknesses?' Then I told the truth. I thought it's better to talk heart to heart instead of asking someone for help. You are the person who knows your partner well and how to comfort her"* (1DPG, Male, 27, Positive)

Another participant who was HIV-negative but involved in a serodiscordant relationship supported this view, although he acknowledged that not everyone may have the communication skills to do it effectively:

> *"It's better to talk personally. I mean, it's a private matter. Imagine how your partner would feel if you invited someone else to explain it for you. I'm a logical person. However, you must prepare yourself before doing it. If not, you might fail. But believe me, it works. My partner accepted me this way"* (5DNO, Male, 38, Negative)

These accounts highlight that personal disclosure requires emotional readiness and communication ability, but is perceived as more respectful and empowering when done successfully.

Involving someone for help. In contrast, other participants, two HIV-positive males and one HIV-positive female, opted to involve a third party to assist with disclosure. These individuals lacked confidence in their communication abilities and were concerned that they might say the wrong thing or provoke an adverse reaction. The third party, often a facilitator or peer supporter knowledgeable about HIV, was seen as a mediator who could explain the medical and emotional aspects of the diagnosis clearly and calmly. One male participant described how he involved his partner in support group activities before eventually disclosing his status with the help of a facilitator:

> *"I didn't reveal my status directly. I knew she might reject me. So, I tried to involve someone who had good skills in HIV disclosure. I also invited her to accompany me to a group meeting. After I felt she had a good understanding of HIV, I took her to meet Bams (our facilitator). Disclosing HIV status also needs the ability to express feelings. Lucky me, she accepted my status"* (2DPU, Male, 33, Positive)

Another participant shared her experience of disclosure in a public setting:

> *"I remember it was a Sunday. I asked my facilitator to meet A and help me disclose my HIV status. I chose to ask her for help because she could explain HIV well. I just didn't want to make a mistake. So, we went to a café, and my friend started explaining about my condition. I was sitting far from him—I didn't want to look into his eyes. I told him I would give him time to reflect and make a decision. I was surprised when he came to me, sat in front of me, and held my hand. We walked out of the café together. Nothing has changed. Even though he didn't say anything, I knew he accepted me"* (4DPL, Female, 30, Positive)

However, not all experiences involving a third party were positive. Two female informants described how this strategy led to regret and unintended consequences. FWM, who had previously used a facilitator to disclose her status to an ex-partner, experienced rejection and public disclosure of her HIV status. This traumatic experience made her change her approach with her current partner:

> *"I have been through all the sadness in my life. I was rejected by my ex-boyfriend because I didn't think about privacy. Sometimes we need to keep things private and not involve others because it can be dangerous or lead to misunderstandings. That's why I decided to reveal my HIV status directly to my current husband"* (FWM, Female, 38, Positive)

These narratives show that the choice of disclosure strategy is context-dependent. Both methods, direct or assisted, carry potential for acceptance or rejection.

Discussion

Summary of the Findings

This study is one of the first to capture both partners' perspectives in serodiscordant Muslim couples in Indonesia, revealing how faith and fear intersect with gender and disclosure dynamics in novel, culturally specific ways. This dual-perspective approach enriches our understanding by highlighting the emotional, relational, and spiritual struggles experienced by both HIV-positive and HIV-negative partners within Muslim-majority communities.

The lived experiences of HIV among serodiscordant couples in this study are shaped not only by biomedical knowledge but by religious beliefs, socio-cultural norms, and emotional distress. Our findings reveal that both faith and fear operate simultaneously as motivators and inhibitors in the decision-making processes related to HIV disclosure, treatment adherence, and relationship maintenance.

Participants described HIV as a "little monster inside the body," reflecting a deep psychological burden that echoes recent studies linking HIV diagnosis with mental distress and social isolation (Fauk et al., 2022). Misinformation regarding antiretroviral therapy (ART) was also prevalent; for example, some believed ART could cure HIV, while others assumed immunity due to their partner's status. These misconceptions, particularly among HIV-negative men, reflect persistent gaps in health literacy—issues previously highlighted as significant barriers to HIV prevention in Southeast Asia (Rajah et al., 2019).

In Muslim society, fear of HIV disclosure is intricately linked with moral and spiritual stigma. Participants associated their diagnosis with punishment from God (*balasan*), testing of faith (*ujian*), or a wake-up call (*teguran*), aligning with *Surah Al-Baqarah* 2:155, which speaks of states: "And We will surely test you with something of fear and hunger and a loss of wealth and lives…" suggesting that hardship, including illness, is part of divine will to test patience (*sabr*) and faith (*iman*). Some also referred to *Surah Ash-Shura* 42:30, viewing illness as a consequence of past actions. These beliefs led to feelings of guilt, particularly among women, and contributed to delayed disclosure and treatment.

At the same time, faith provided comfort. *Surah Az-Zumar* 39:53 emphasizes divine mercy, encouraging hope and resilience. Participants engaged in religious routines—praying (*shalat*), fasting, and attending *pengajian*—as coping strategies. However, reliance on spiritual healing sometimes replaced medical care. Thus, religious beliefs shaped both empowerment and hesitation in navigating HIV-related decisions.

Religious beliefs played a dual role in shaping participants' health behaviors. For some, faith encouraged acceptance, treatment adherence, and spiritual transformation (hijrah). One participant remarked that taking ARV was a way of honoring Allah's will—echoing Qur'anic values of seeking knowledge and preserving health (QS. Al-Mujadila: 11). This highlights how religious motivation can be harnessed to promote positive treatment outcomes when aligned with biomedical understanding.

Conversely, other participants delayed initiating ART, believing that repentance and spiritual discipline alone could purify the body from illness. This finding aligns with Koku (2024), who emphasized the importance of integrating faith-based reasoning within medical counseling. When religious interpretations contradict biomedical advice, patients may postpone treatment or avoid disclosing their status altogether.

Stigma and social fear were particularly acute among women. Participants feared that disclosure would result in divorce, loss of child custody, or being labeled as immoral. This fear was not unfounded; in a Muslim society that places a high value on chastity and marital loyalty, women diagnosed with HIV are often assumed to have committed adultery or engaged in drug use. This stigma, rooted in both religious and cultural values, contributes to internalized shame and secrecy. For instance, one participant chose to tell her new partner that her previous husband had died of cancer, not HIV, to avoid being morally judged. This finding supports prior work by Noor et al. (2024), who documented how gendered expectations and moral assumptions create additional barriers for women in serodiscordant relationships.

Communication emerged as a significant challenge. Many participants expressed a lack of confidence in disclosing their status, particularly in early-stage relationships. While some were able to talk directly with their partners, others relied on facilitators or peer support personnel. These divergent strategies reflect the broader need for emotional preparedness and tailored disclosure training, especially within culturally conservative settings where stigma is high (Murzin et al., 2022). Furthermore, disclosure is not a linear process; it is influenced by relationship quality, power dynamics, and social perceptions. Women, particularly housewives with limited education, often lacked the agency to negotiate disclosure or safer sex practices—reinforcing patriarchal gender norms (Motaharinezhad et al., 2024).

Fear also extended to the workplace and community. Participants worried that if their status became known, they would be ostracized, lose their jobs, or be excluded from religious and social circles. These fears mirror the intersectional stigma described by Dada et al. (2024) and highlight the need for broader community education to dismantle stereotypes linking HIV to moral failure.

Importantly, this study introduces culturally unique preventive practices such as the genital cleansing "nightly routine" and pre-intercourse "warming up," which participants believed reduced the risk of transmission. These practices are informed by religious teachings on cleanliness (*thaharah*) and purity before intimacy, consistent with Islamic guidance in hadith literature. Although these methods lack biomedical validation, they reflect adaptive behaviors rooted in cultural and religious beliefs. As such, health interventions should be respectful of these practices and incorporate culturally grounded counseling strategies (Moshabela et al., 2015).

The inclusion criteria of six months in a serodiscordant relationship aimed to ensure participants had sufficient lived experience to reflect on their dynamics, challenges, and coping strategies. In a Muslim society where cohabitation outside of marriage is rare and often stigmatized, the six-month threshold also reflects a socially acceptable minimum for relationship stability and trust-building.

This study makes several original contributions. First, it centers on both HIV-positive and HIV-negative partners, offering a rare dual narrative in serodiscordant relationships. Second, it situates these experiences within a distinct Muslim context, where religious doctrine, community perception, and gender roles converge to shape health behavior. Third, it reveals spiritual reinterpretations of ART, faith-based resistance to treatment, and the strategic use of third-party facilitators in disclosure—insights not previously well-documented in Southeast Asian or Islamic settings.

Based on the findings of this study, community nurses in Indonesia's primary healthcare settings can play a crucial role in supporting HIV/AIDS prevention efforts, particularly in counseling prospective or engaged couples where one partner is HIV positive. The narratives revealed that many participants experienced emotional distress, uncertainty, and fear of rejection when attempting to disclose their status to their partners. These challenges highlight the urgent need for nurse-led interventions tailored to the cultural, spiritual, and relational dynamics found in Muslim-majority communities.

Specifically, nurses can be trained to provide structured counseling sessions that integrate Islamic values, promote non-judgmental dialogue, and offer private, flexible settings—such as home visits—for individuals struggling with disclosure. In addition, nurses can collaborate with peer support facilitators and religious leaders to strengthen trust, reduce stigma, and reframe antiretroviral therapy (ART) adherence as a moral and spiritual responsibility (*amanah)*. These interventions, derived from the lived experiences of serodiscordant couples in this study, position community nurses as central figures in bridging biomedical care with culturally sensitive psychosocial support in HIV prevention programs.

Implications of This Study for Nursing Practice

This study highlights the essential role of community nurses in providing culturally and spiritually sensitive HIV care. In Muslim-majority settings, nurses are not only biomedical educators but also spiritual mediators who can align health messaging with Islamic values of compassion, responsibility, and the preservation of life (*hifz al-nafs*).

Counseling programs should integrate religious literacy, tailored communication skills, and non-judgmental support—especially for women who face disproportionate stigma and lack decision-making power. Flexible options such as home visits or private sessions can facilitate disclosure in sensitive environments.

Furthermore, participants in this study described peer support groups led by people living with HIV (PLHIV) as especially meaningful. While individual counseling offers privacy and tailored support, peer-led sessions were often perceived as more emotionally relatable and empowering. Many participants expressed greater trust in peer educators, who they felt genuinely understood the lived experience of HIV. These findings support the involvement of PLHIV as peer educators in counseling programs, particularly in Muslim communities where principles such as brotherhood (*ukhuwah*) and compassion (*rahmah)* reinforce the value of mutual support. Partnerships with faith leaders and PLHIV peer educators should be formalized to promote HIV awareness and reduce stigma through religious frameworks. Nurses can also help reinterpret ART adherence as a moral duty (*amanah*), further encouraging treatment compliance. An example of such an integrated intervention would be a structured counseling program delivered by trained community nurses in collaboration with Islamic leaders and PLHIV peer educators. This model combines biomedical education on ART adherence, psychosocial support through peer storytelling, and spiritual guidance rooted in Islamic teachings on compassion (*rahmah*), responsibility (*amanah*), and self-preservation (*hifz al-nafs*). A previous study has shown that this approach can reduce stigma, improve trust, and promote timely disclosure among couples living with HIV in faith-based communities (Fauk et al., 2021). Future nursing programs should prioritize engaging faith leaders, empowering peer educators, and equipping nurses with culturally respectful tools to support safe and effective HIV disclosure—particularly among women.

Limitations

While the study provides rich insights, it has several limitations. First, as a qualitative inquiry, the findings are context-specific and not intended for generalization beyond the study setting. The participants were recruited through support groups, which may have excluded individuals who are less connected to healthcare or community networks—particularly those who may be more isolated or unwilling to disclose their status. Second, the sensitive nature of HIV-related disclosure in a Muslim society may have introduced social desirability bias, as participants could have downplayed or omitted specific experiences due to stigma or fear of judgment. Third, the study focused solely on heterosexual serodiscordant couples in South Sulawesi, limiting the applicability of findings to broader gender identities, sexual orientations, or regional cultural differences.

Conclusion

This study offers a culturally grounded insight into how Islamic faith, moral expectations, and gender roles shape HIV disclosure among serodiscordant Muslim couples in Indonesia. Religious beliefs were found to play a dual role—providing spiritual strength while also reinforcing fear, stigma, and delayed treatment, particularly for women. These findings underscore the need for nursing interventions that are not only medically sound but also aligned with Islamic values such as *rahmah* (compassion), *amanah* (responsibility), and *ukhuwah* (solidarity). The findings emphasize the importance of culturally sensitive nursing interventions that integrate Islamic values, promote peer-led education, and create safe spaces for disclosure. Community nurses, working alongside peer support groups and faith leaders, can help bridge the gap between biomedical care and lived experience, ultimately fostering trust, empathy, and improved HIV-related outcomes in Muslim-majority settings.

Declaration of Conflicting Interest

The authors declare that they have no financial conflicts of interest or personal relationships that could have influenced the research presented in this paper.

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Authors’ Biographies

Eka Sari Ridwan, SKM, M.Kes. is a Doctoral Student of Public Health Faculty of Mahidol University, Thailand. She is also affiliated with the Hospital Administration Study Program, Faculty of Health Technology, Universitas Megarezky, Makassar, Indonesia.

Assoc. Prof. Chanuantong Tanasugarn, Dr.P.H., is a Lecturer at the Department of Health Education and Behavioral Sciences, Faculty of Public Health, Mahidol University, Bangkok, Thailand.

Asst. Prof. Sarunya Benjakul, Ph.D, is a Lecturer at the Department of Health Education and Behavioral Sciences, Faculty of Public Health, Mahidol University, Bangkok, Thailand.

Assoc. Prof. Mondha Kengganpanich, Ph.D., is a Lecturer at the Department of Health Education and Behavioral Sciences, Faculty of Public Health, Mahidol University, Bangkok, Thailand.

Associate Professor Dr. Masoud Mohammadnezhad, PhD, is a Lecturer at the Faculty of Health, Education and Life Sciences, School of Nursing and Midwifery, Birmingham City University, Birmingham, United Kingdom. He also serves as the Adjunct Professor (Health Education and Behavioral Sciences) at Public Health Faculty, Mahidol University.

Data Availability

Due to the sensitive and confidential nature of the qualitative interview data, full transcripts are not publicly available but may be provided in anonymized form upon request.

Declaration of Use of AI in Scientific Writing

The authors utilized ChatGPT to enhance readability, refine sentence structure, and verify grammatical consistency during manuscript preparation. However, the authors take full responsibility for the content, analysis, and interpretation of the data presented.

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