BMC Public Health

https://doi.org/10.1186/s12889-026-28687-1

Article in Press

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Received: 26 December 2025

Accepted: 20 July 2026

Published online: 27 August 2026

Cite this article as: Ridwan E.S., Benjakul S., Kengganpanich M. *et al.* HIV disclosure and stigma among couples in Muslim communities in Indonesia: a qualitative study. *BMC Public Health* (2026). https://doi.org/10.1186/s12889-026-28687-1

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HIV DISCLOSURE AND STIGMA AMONG COUPLES IN MUSLIM COMMUNITIES IN INDONESIA: A QUALITATIVE STUDY

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Abstract

Background: HIV-related stigma remains a major barrier to disclosure, prevention, and treatment, yet little is known about how stigma operates within intimate relationships in Muslim-majority settings. Indonesia, home to the world's largest Muslim population, faces a growing burden of heterosexual HIV transmission, with disclosure and prevention being deeply shaped by religious and moral norms.

Methods: We conducted a qualitative study involving individuals from serodiscordant and seroconcordant couples, Muslim religious leaders (Ustaz), provincial health authorities, the Director of YPKDS, and the representatives of Nahdatul Ulama. Data were collected through 14 in-depth interviews (IDIs) with individuals from serodiscordant couples, two focus group discussions (FGDs) with 14 participants from seroconcordant couples, and one FGD with seven representatives from HIV-focused NGOs. Triangulation of data sources and methods was used to enhance the depth and credibility of the findings.Data were analyzed using reflexive thematic analysis.

Results: Stigma emerged across five themes: (1) Stigma Related to HIV Status; (2) Healthcare Provider Stigma; (3) Stigma Related to Condom Use; (4) Serodiscordancy and Disclosure Dynamics; and (5) Community and Religious Actors in Shaping Stigma Narratives. Stigma influenced decisions on disclosure, condom use, and social engagement. Participants emphasized the essential role of Muslim religious leaders and community organizations in shaping perceptions, reducing stigma, and supporting disclosure.

Conclusions: HIV-related stigma in Muslim communities operates across relational, moral, and institutional levels. HIV services should integrate disclosure support into routine care, strengthen couple-based communication and counseling, and engage religious and community leaders in stigma-reduction initiatives. Such approaches may help create safer and more supportive environments for disclosure, prevention, and long-term engagement in HIV care.

Keywords:

HIV, Disclosure, Stigma, Couples, Muslim communities, Indonesia, Qualitative study

Background

Human immunodeficiency virus (HIV) remains a significant public health challenge worldwide due to its complex interaction with social, cultural, and behavioral determinants [1]. HIV-related stigma has consistently been identified as a major barrier to the uptake of prevention, testing, disclosure, care, and treatment services among people living with HIV (PLHIV) and their partners across diverse settings [2]. This stigma manifests at multiple levels, including internalized

stigma within individuals, interpersonal stigma with families and communities, and structural stigma embedded within health systems or cultural norms [3]. These processes are particularly impactful in contexts where HIV is closely tied to moral judgments about sexuality, morality, or behavior, further complicating disclosure and engagement with health services [4].

In many settings, advances in antiretroviral therapy (ART) have shifted public perceptions toward viewing HIV as a chronic, manageable condition [2]. However, this shift is uneven across populations. Stigma remains persistent and deeply entrenched among heterosexual couples, particularly in socio-cultural contexts where HIV is linked to moral judgments, family reputation, and marital fidelity. In Indonesia, the perception of HIV as a chronic illness is heavily constrained within marital and heterosexual relationships, where the infection is frequently interpreted through moral, relational, and gendered lenses [5,6].

Understanding HIV disclosure within heterosexual couples requires examining how relational expectations, gender norms, and fears of social consequences shape decisions around partnership communication [7,8]. This focus is highly relevant in Indonesia, where HIV transmission within marital relationships has become an increasingly critical concern and where disclosure decisions are shaped by socio-cultural norms, gender expectations, and religious beliefs surrounding marriage and family life [9].

Disclosure of HIV status is a critical component of HIV prevention and care because it can facilitate mutual support between partners, promote safer sexual practices, improve treatment adherence, and reduce onward HIV transmission [10]. However, HIV-related stigma often inhibits disclosure due to fear of rejection, discrimination, abandonment, or violence [11]. Evidence suggests that disclosure is not a one-time event but a socially negotiated process shaped by gender norms, relationship dynamics, and perceived risks, particularly for women, who face heightened adverse consequences [12].

Existing research indicates that stigma and disclosure are closely interconnected, anticipated stigma frequently influencing whether, when, and to whom HIV status is disclosed [10,11]. While supportive couple relationships can buffer the negative effects of stigma, unequal power dynamics often constrain communication [13]. Furthermore, stigma influences the uptake of prevention strategies like condom use, which is frequently subject to moral interpretations and social resistance [14]. Despite policy emphasis on partner disclosure, rates remain suboptimal globally due to anticipated stigma and social risks [12].

Indonesia has a concentrated HIV epidemic, with increasing evidence showing that many women acquire HIV within marital relationships, underscoring the growing importance of heterosexual transmission within couples [15]. Cultural norms around sexuality, gender roles, and family structure intersect with HIV stigma, shaping how individuals navigate disclosure within intimate relationships [16]. Religious frameworks play a vital role in shaping these perceptions of HIV, morality, and disclosure within Indonesian Muslim communities [17]. In these settings, HIV is often associated with immorality or social transgression, while condom use remains a morally sensitive issue [18].

A growing body of research in Indonesia demonstrates HIV-related stigma is embedded within everyday social relationships and institutional practices rather than operating solely at the individual level. Studies consistently describe HIV as being linked to moral transgression and personal responsibility, which directly contributes to discrimination and barriers to healthcare access behavior [6, 19]. Beyond healthcare settings, studies highlight the relational dimensions of stigma within families. Decisions about disclosure are negotiated within the context of marital expectations and family reputation [16,20]. Women experience heightened vulnerability to blame,

and stigma frequently extends beyond the individual to affect spouses and family members, beyond health care settings and access to social support [21].

Recent qualitative research shows that HIV-related stigma in Indonesia is layered and closely intertwined with broader social identities and moral values. Studies among PLWH show that stigma intersects with other social identities, resulting in multiple forms of exclusion [22]. Research has also highlighted the experience of moral injury, whereby HIV is interpreted as a violation of religious expectations, generating feelings of shame and psychological distress [23]. These findings underscore the central role of morality, identity, and social belonging.

Despite these insights, comparatively less attention has been given to understanding how different forms of stigma are experienced and negotiated specifically within heterosexual serodiscordant relationships in Muslim communities, and how these experiences shape disclosure, sexual decision-making, and relationship dynamics in everyday life judgment [16,20]. Furthermore, limited research has examined how broader social and institutional influences- including community norms, religious expectations, and healthcare systems- interact to shape stigma experiences and disclosure practices within couple relationships.

This study aims to explore how stigma related to HIV status, condom use, and serodiscordancy is experienced and negotiated among heterosexual couples living with HIV in Muslim communities in South Sulawesi, Indonesia, and how these experiences are shaped by broader social, religious, and institutional influences.

Methods

Study design and setting

This qualitative study explored how HIV-related stigma shapes disclosure experiences and prevention practices among couples living with HIV in Muslim communities in Indonesia. A qualitative interpretive approach was employed to examine participants lived experiences and the meanings they ascribed to HIV status, disclosure, condom use, and intimate relationships within a sociocultural and religious context. Reflexive thematic analysis, following Braun and Clarke's approach, was used to analyze patterns of meaning across participants' accounts, particularly regarding how stigma is socially produced and negotiated within relationships [24]. This design positioned stigma as a relational and socially constructed process rather than an individual attribute, consistent with established conceptualizations of HIV stigma in sociocultural contexts. The study was conducted in South Sulawesi Province, Indonesia, a predominantly Muslim region where religious norms and moral expectations strongly influence social life. South Sulawesi has one of the highest reported HIV burdens in eastern Indonesia, with increasing transmission occurring within heterosexual and marital relationships, reflecting national epidemiological trends. In this setting, HIV is often interpreted through moral and religious frameworks, which shape stigma and influence disclosure within intimate relationships. Data collection was facilitated through collaboration with a local community-based organization, the Peer Support Group Care Foundation (*Yayasan Peduli Kelompok Dukungan Sebaya*, YPKDS), which provides outreach, peer support, and linkage to care for people living with HIV. The organization facilitated participants access through its community networks but was not involved in data analysis, coding, or interpretation, thereby ensuring the independence of the research process. This approach enabled access to individuals and couples navigating HIV-related stigma and disclosure who may otherwise be difficult to reach.

Participants and sampling

Participants were recruited using purposive sampling to capture a range of perspectives on HIV-related stigma and disclosure within intimate and community contexts. Purposive sampling

was employed to include participants with direct experiential and relational involvement in HIV-related stigma and disclosure, enabling examination of how these processes are negotiated within intimate relationships and sociocultural contexts. The sampling strategy was informed by the study's conceptualization of stigma as a multi-layered phenomenon, encompassing relational, moral, and institutional dimensions.

The study included individuals from couples living with HIV, both serodiscordant and seroconcordant, as well as institutional stakeholders involved in HIV-related programs and community engagement. Including both groups allowed the study to examine stigma within intimate relationships while also capturing how it is shaped and reinforced through broader social and institutional structures.

Eligibility criteria for couple participants were: being aged 18 years or older; currently or previously involved in a heterosexual intimate relationship (married or cohabiting) for at least six months; and having lived experience of HIV within the relationship, either as a person living with HIV or as an HIV-negative partner. The focus on heterosexual relationships reflects the Indonesian context, where HIV transmission within marital relationships is increasingly recognized and where disclosure is shaped by gender norms, expectations of fidelity, and concerns related to family and social reputation within sociocultural and religious settings. Institutional stakeholders were selected based on their roles in HIV prevention, care, advocacy, or community and religious engagement. These participants included representatives from community-based organizations supporting people living with HIV, religious organizations, youth groups, and provincial health authorities. Their inclusion enabled exploration of how stigma is shaped, reinforced, and negotiated within community and institutional contexts, including the influence of religious norms and social expectations.

Recruitment was facilitated through collaboration with YPKDS and its affiliated networks. Outreach workers informed potential participants about the study and invited them to participate voluntarily. Outreach workers were involved only in the initial identification and invitation of participants, while all interviews, data handling, and analysis were conducted independently by the research team to minimize potential recruitment bias. Individuals who expressed interest were provided with detailed information about the study prior to giving informed consent. Participants were informed that the principal researcher was a doctoral student conducting a study on HIV disclosure, stigma, and relationship experiences among couples affected by HIV in Muslim communities.

A total of 39 participants took part in the study, comprising 28 individuals from couples living with HIV and 11 institutional stakeholders. Participation was voluntary, and transportation costs were reimbursed. Sampling and recruitment continued until thematic sufficiency was reached, indicated by the recurrence of key patterns related to stigma, disclosure, condom use, and relational negotiation across interviews and focus group discussions. Thematic sufficiency was understood as the point at which additional data no longer generated substantially new insights but instead deepened and confirmed existing patterns related to stigma and disclosure across relational and sociocultural contexts.

Data collection

Data were collected between February and May 2019 using a combination of in-depth interviews (IDIs) and focus group discussions (FGDs) to capture both individual and collective perspectives on HIV-related stigma and disclosure. This approach enabled comparison of experiences across individual, relational, and institutional contexts, informing the subsequent analysis of how stigma was experienced and negotiated within intimate relationships and broader

community settings. In-depth interviews were conducted with individuals from couples living with HIV to explore personal experiences related to HIV disclosure, stigma, condom use, relationship dynamics, interactions with healthcare services, and the influence of religious and social norms on decision-making. These interviews provided a confidential setting that enabled participants to reflect on sensitive relational experiences, particularly disclosure processes within intimate partnerships, and to articulate the meanings they ascribed to HIV and disclosure in their own terms.

Focus group discussions were conducted with participants from seroconcordant couples and with institutional stakeholders to elicit shared norms, collective narratives, and community-level perspectives. FGDs with couples facilitated exploration of shared experiences and social expectations surrounding stigma and prevention, while the FGD with institutional stakeholders provided insight into dominant discourses, programmatic responses, and structural challenges in addressing HIV-related stigma. This approach enabled identification of both converging and contrasting perspectives across participant groups. Semi-structured interview and discussion guides were developed based on a review of relevant literature and refined through expert input from researchers with experience in HIV, public health, and community engagement. The guides were organized into key domains, including participants' understanding of HIV, disclosure practices, relational dynamics within couples, condom use and sexual behavior, access to health services, and the influence of sociocultural and religious contexts on stigma and decision-making. These domains reflect the multi-level focus of the study and were consistently applied across interviews and FGDs. The interview and FGD guides are provided as Supplementary File 1. Example questions included: "What do you know and understand about HIV?", "Have you disclosed your HIV status to your partner? Why or why not?", and "How do social or religious norms influence decisions about disclosure and condom use?".

The guides were designed to remain flexible, allowing probing and follow-up questions within interviews to explore emerging issues in greater depth as data collection progressed. All interviews and FGDs were conducted face-to-face in Indonesian by the principal investigator and trained research assistants, audio-recorded with participants' consent, and held in private, mutually agreed locations to ensure confidentiality and participant comfort. This approach was essential given the sensitivity of discussing HIV status, stigma, and intimate relationships within the study context. Interviews and FGDs typically lasted between 45 and 60 minutes. Field notes were taken during and after each session to document contextual factors, non-verbal cues, and initial analytic impressions, which supported subsequent interpretation of the data. A small number of follow-up interviews (n = 3) were conducted with selected participants from the initial sample to clarify and deepen understanding of issues that could not be fully explored during the first interview. These follow-up interviews involved the same participants and were conducted in cases where situational constraints or participant comfort limited the depth of initial responses. Follow-up interactions focused on clarification and elaboration of specific topics rather than repeating the full interview process.

Data analysis

Data were analyzed using reflexive thematic analysis following Braun and Clarke's approach [24]. This approach was selected for its flexibility in examining complex, contextually embedded experiences and its alignment with the study's interpretive qualitative design. Audio recordings were transcribed verbatim in Bahasa Indonesia by a research assistant and subsequently checked for accuracy by the principal investigator (ESR). Transcripts were translated into English by MNQ and ESR. All members of the research team had access to the transcripts and were involved in reading and familiarizing themselves with the data. Data management and coding were

facilitated using Microsoft Excel. Initial coding was conducted independently by ESR and SB based on their reading of the transcripts. The codes were then collaboratively compared and discussed collaboratively to identify similarities, differences, and areas of overlap, and to develop a shared understanding of data coding and interpretation. Coding proceeded iteratively, with codes developed from early transcripts informing subsequent analysis and being continuously refined throughout the analytic process.

Coding was initially informed by key domains reflected in the interview guide, including HIV knowledge, disclosure, relational dynamics, stigma, and condom use. However, analysis was not limited to these predefined areas. Coding remained open, allowing additional patterns, relationships, and meanings to emerge from the data. This analytic approach combined structured coding based on areas of inquiry with data-driven interpretation, enabling themes to be developed inductively from participants' accounts rather than being directly derived from the initial coding framework. Through iterative review and discussion of coded data, related codes were grouped into broader categories based on similarities, recurring patterns, and contextual relationships within the data. ESR led the coding process, while SB was actively involved in reviewing coding decisions, refining categories, discussing emerging interpretations, and contributing to the development of themes. Theme development and interpretation were further discussed with MK, while CT provided methodological oversight and critical reflection on the analytical process. Theme development involved a progression from codes to categories and then to themes, reflecting patterns of meaning across participants and contexts rather than simply reproducing the topics covered in the interview guide. This process ensured that themes were grounded in the data and interpretively developed, rather than representing predefined topical groupings. Data from in-depth interviews and FGDs were analyzed together to enable comparison across individual, relational, and institutional contexts, thereby identifying both converging and diverging perspectives on stigma and disclosure. Follow-up interviews were used in a limited number of cases to clarify or complete information when initial interviews were constrained by practical or contextual factors, and did not constitute a separate stage of analysis.

Trustworthiness and Rigor

Trustworthiness was established in accordance with Lincoln and Guba's criteria of credibility, dependability, confirmability, and transferability [25]. Reporting followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) [26]. Reflexivity was embedded throughout the research process. The principal researcher (first author) is a married Muslim woman of Buginese ethnicity with formal training in public health and HIV prevention. This positionality facilitated rapport with participants while also requiring critical awareness of how cultural, gendered, and religious assumptions might influence data collection and interpretation. Reflexive field notes were written after each interview and focus group discussion to document initial impressions, emerging assumptions, and potential biases. These notes were used to support ongoing reflection during data analysis.

These reflexive practices were supported by a collaborative analytic process. Regular team discussions were held to compare perspectives and resolve discrepancies in coding and interpretation. When themes related to Islamic norms on marriage, sexuality, and morality emerged, the team explicitly examined how their own values and assumptions might shape analytic decisions. The multidisciplinary composition of the research team further enriched these discussions, and consultations with academic peers outside the study context provided an external check on the analytic process. Credibility was strengthened through triangulation of data sources and methods, including in-depth interviews with serodiscordant individuals, focus group

discussions with seroconcordant couples, and a focus group with institutional stakeholders. These multiple perspectives enabled cross-verification of emerging themes across private lived experiences and collective social and institutional narratives. All interviews and discussions were audio-recorded, transcribed verbatim, and supplemented with detailed field notes capturing nonverbal cues, emotional tone, and contextual observations.

Methodological rigor was further enhanced by using differentiated data collection tools. Separate semi-structured guides were used for in-depth interviews and focus group discussions to ensure ethical and contextual appropriateness. The interview guides for serodiscordant participants focused on highly sensitive experiences related to HIV status, disclosure, intimacy, and fear of stigma, whereas the FGD guides addressed shared perceptions, community norms, religious interpretations, and stigma in social and healthcare settings. This approach enabled triangulation between personal narratives and collective meanings while protecting participants from inadvertent disclosure. Dependability was ensured through the consistent use of interview and FGD guides within each data collection format and systematic documentation of recruitment, data collection, and analytic procedures. The reflexive thematic analysis followed an iterative and transparent process in which transcripts were repeatedly reviewed, coded, compared across data sources, and refined through team discussions.

Confirmability was supported by maintaining an audit trail that included audio recordings, transcripts, coding files, reflexive field notes, and records of analytic meetings, allowing interpretations and themes to be traced back to the original data. Transferability was addressed by providing rich descriptions of the study context, participant characteristics, and the sociocultural and religious environment of Muslim communities in South Sulawesi. Participants were purposively selected to achieve maximum variation in age, gender, education, occupation, HIV status, and relationship type, enabling readers to assess the applicability of the findings to similar contexts.

Results

Participants

The characteristics of participants are presented in Table 1. Participants described complex and intersecting forms of HIV-related stigma that influenced disclosure decisions, interpersonal relationships, healthcare experiences, and everyday social interactions. Data from 14 in-depth interviews with serodiscordant individuals, two focus group discussions involving 14 seroconcordant participants, and one focus group discussion with seven institutional stakeholders revealed that stigma was experienced as a relational and social process rather than merely as an individual fear or misunderstanding. Tabel 1: The characteristics of the study participants

No	Code	Sex	HIV	Age	Job	Educ	HIV History	Marital Status	Type
Disclosure									
1	Ali	Male	(+)	27	Unemployed	Junior High School	Drugs	Married	IDI
2	Rizal	Male	(+)	33	Employee	Bachelor's degree	Drugs	Married	IDI
3	Fajar	Male	(+)	27	Construction	Junior High School	Ex	Married	IDI
4	Budi	Male	(-)	45	Business	Senior high School	-	UM	IDI

No	Code	Sex	HIV	Age	Job	Educ	HIV History	Marital Status	Type
5	Arman	Male	(-)	38	Business	Senior high School	-	UM	IDI
6	Aisyah	Female	(+)	34	Employee	Senior high School	Ex	UM	IDI
7	Nurul	Female	(+)	30	Housewife	Bachelor's degree	Ex	Married	IDI
8	Dewi	Female	(-)	26	Housewife	Senior high School	-	Married	IDI
9	Anti	Female	(-)	43	Housewife	Senior high School	-	Married	IDI
10	Melati	Female	(-)	31	Employee	Bachelor's degree	-	Married	IDI
11	Hasan	Male	(+)	45	Business	Bachelor's degree	Drugs	Married	FGD
12	Joko	Male	(+)	37	Driver	Junior High School	Free sex	Married	FGD
13	Rahmat	Male	(+)	35	Business	Senior high School	Free sex	Married	FGD
14	Yusuf	Male	(+)	39	Business	Senior high School	Free sex	Married	FGD
15	Ilham	Male	(+)	38	Laborer	Junior High School	Tattoo	Married	FGD
16	Dani	Male	(+)	32	Employee	Bachelor's degree	Free sex	Married	FGD
17	Fitri	Female	(+)	39	Housewife	Senior high School	Husband	Married	FGD
18	Lina	Female	(+)	31	Housewife	Senior high School	Husband	Married	FGD
19	Maya	Female	(+)	38	Business	Senior high School	Ex	Married	FGD
20	Sari	Female	(+)	29	Construction	Junior High School	Husband	Married	FGD
21	Indah	Female	(+)	24	Unemployed	Senior high School	Ex	UM	FGD
22	Wulan	Female	(+)	32	Business	Senior high School	Husband	Married	FGD
23	Nisa	Female	(+)	26	Business	Bachelor's degree	Ex	Married	FGD
24	Ayu	Female	(+)	35	Housewife	Senior high School	Husband	Married	FGD
Non-Disclosure									
25	Andi	Male	(+)	35	Employee	Bachelor's degree	Free sex	UM	IDI

No	Code	Sex	HIV	Age	Job	Educ	HIV History	Marital Status	Type
26	Rudi	Male	(+)	28	Employee	Bachelor's degree	Free sex	Married	IDI
27	Devi	Female	(+)	24	Housewife	Senior high School	Ex	UM	IDI
28	Putri	Female	(+)	25	Employee	Bachelor's degree	Ex	UM	IDI
Institutions									
29	Amri	Makassar drugs Victim's Organization							FGD
30	Lestari	Women HIV Positive Association (IPPI)							FGD
31	Rangga	Muslim Teenager Forum of South Sulawesi							FGD
32	Maspur	Peer Support Group Care Foundation (YPKDS)							FGD
33	Aksar	Celebes Foundation							FGD
34	Mami	HIV care for sex workers (KRA AIDS)							FGD
35	Mawar	AIDS key population (YKP2N)							FGD
36	Ahmad	Muslim Religion Leaders							IDI
37	Farsa	Nahdatul Ulama							IDI
38	Masnah	Provincial Health Office							IDI
39	Rachman	YPKDS							IDI

Across participants' narratives, stigma manifested through avoidance behaviors, moral judgments, fear of exposure, negative labeling, and institutional discrimination. These experiences were deeply shaped by the sociocultural context of Muslim communities in South Sulawesi, where HIV-related stigma intertwined with assumptions about morality, sexual behavior, and religious identity.

Overall, participants' experiences clustered into five primaries, interrelated thematic domains: (1) Stigma Related to HIV Status; (2) Healthcare Provider Stigma; (3) Stigma Related to Condom Use; (4) Serodiscordancy and Disclosure Dynamics; and (5) Community and Religious Actors in Shaping Stigma Narratives.

Stigma Related to HIV Status — Moralization, Avoidance, and Social Exclusion

Participants' narratives showed that HIV-related stigma operated not merely as a reaction to a health condition but as a moral and social framework through which individuals were judged. Across the dataset, HIV was consistently interpreted as a marker of personal behavior and moral standing, linking the condition to ideas of sin, social deviance, and violation of religious norms. This moral framing was not only reinforced by others but also became internalized by participants, shaping how they anticipated and navigated everyday social interactions. Importantly, stigma functioned as a pre-condition of disclosure, rather than simply its consequence. Participants carefully evaluated the risks of disclosure based on prevailing community understanding of HIV, indicating that stigma shaped disclosure decisions from the outset. Patterns across the different data sources further illustrated how stigma operated at multiple levels. In focus group discussions, stigma emerged as a shared social narrative that was collectively reproduced and reinforced through community discourse. In contrast, in-depth interviews revealed how these same narratives were experienced personally, shaping fear, hesitation, and strategies of self-protection.

Avoidance, Rumors, and Social Withdrawal

Avoidance emerged as a recurring form of stigma that developed through social processes rather than as an immediate response. Following disclosure, knowledge of an individual's HIV status often extended beyond the initial interaction and spread through wider social networks. As this occurred, responses towards individuals living with HIV were shaped not only by direct relationships but also by collective interpretations circulating within the community. . Disclosure therefore became more than an interpersonal event; its consequences were influenced by how others interpreted and shared that knowledge. Losing control over who knew one's HIV status marked a critical turning point in this process, as disclosure to a trusted individual could rapidly extend to a much wider social circle, altering multiple relationships simultaneously. This process was particularly evident in Aisyah's account:

> "I once disclosed my HIV to a friend. She was like a sister to me, so I decided to trust her with my diagnosis. After that, she stopped answering my calls and never came to my house again. She spread rumors about my HIV status, and eventually my other friends no longer wanted to see me. I felt deeply disappointed and confused because I had trusted her, yet suddenly many people knew about my condition without my consent." (Aisyah, Female, 34, Living with HIV)

Information shared with a trusted friend quickly extended beyond that relationship, shaping how a wider social network responded to the participant. As knowledge of her HIV status spread, avoidance became a collective rather than an individual response, affecting multiple relationships simultaneously. Avoidance was not always expressed through direct rejection. More often, it emerged through subtle yet persistent changes in everyday interactions:

> "They never said anything directly, but I could feel the difference. Before, we talked normally and spent time together, but after they learned about my HIV status, they became more distant. They spoke to me less, and I could sense that they no longer felt as comfortable around me as they had before." (Maya, Female, 38, Living with HIV)

Although the intensity of these experiences differed, both accounts described a similar process in which disclosure reshaped social relationships beyond the initial disclosure itself. Participants rarely reported direct confrontation. Instead, distancing emerged gradually through reduced interaction, diminished trust, and subtle changes in everyday communication. These responses were further shaped by persistent misconceptions and moralized understandings of HIV:

> "People are afraid to sit near people living with HIV. They think HIV can spread through clothes or simply by being nearby. I heard people say that HIV is a disgusting disease, so they don't want to be close to us. Hearing those comments made me feel different from everyone else." (Ali, Male, 27, Living with HIV)

In participants' accounts, physical distancing was rarely driven solely by fear of infection. Instead, concerns about HIV transmission were closely intertwined with moral judgments, making social exclusion appear justified rather than discriminatory. Misunderstandings about transmission further reinforced this distancing, while describing HIV as a "disgusting" disease added a moral dimension that positioned individuals living with HIV as socially undesirable. These perceptions were embedded in everyday interactions and created an environment in which disclosure carried considerable social risk. Consequently, expectations of being judged or avoided were shaped not only in personal experience but also in widely shared beliefs within the community. Awareness of these perceptions did not emerge only after disclosure. In several instances, participants actively explored how others viewed HIV before deciding whether to disclose:

> "Do you mean, outside of our HIV community? I once asked one of my friends what she thought about HIV because I wanted to understand her views. She said, 'oh my

> God, it's a disgusting disease, a sexually transmitted disease. You can get it from clothes or even by sitting next to someone who has it.' After hearing that, I decided not to tell her about my HIV status." (Andi, Male, 35, Living with HIV)

Gauging others' attitudes became part of a deliberate strategy for navigating disclosure. Rather than disclosing spontaneously, participants assessed the social environment in advance, using indirect questioning to anticipate how others might respond. Negative reactions were interpreted as signs of potential stigma, often leading participants to withhold disclosure. In this way, stigma influenced disclosure not only after negative experiences had occurred but also beforehand, shaping decisions long before any information was shared. Careful consideration of when, where, and to whom disclosure occurred further illustrates this process:

> "Then I realized that we cannot just tell anyone. We have to think carefully about when, where, and with whom we disclose our status. Once people know, we can no longer control what happens next, and that can hurt us" (Putri, Female, 25, Living with HIV)

Experiences of stigma affected participants even before they revealed their HIV status. Several participants described modifying their plans, delaying disclosure, or abandoning it altogether after observing how HIV was discussed within their communities. As a result, decisions about disclosure were often shaped more by anticipated than by experienced stigma. For participants who had not disclosed their HIV status, avoidance served a different purpose. Rather than resulting from stigma, it became a strategy for preventing it:

> "I don't want to disclose my HIV status. I worry that people may look down on me or avoid me. Sometimes I even lie when people ask about my condition because I am afraid that if they find out, they will leave me and tell other people." (Devi, Female, 24, Living with HIV)
>
> "From what I have seen, once people know, everything changes. Even close relationships. That's why I think it is safer to keep my HIV status to myself so I can continue living normally with other people" (Rudi, Male, 28, Living with HIV)

In these situations, non-disclosure was deliberately maintained as a protective strategy. Participants described managing conversations, withholding information, and even offering alternative explanations to avoid revealing their HIV status. Decisions to withhold disclosure were informed by observations of how others had been treated, highlighting the central role of anticipated stigma. Here, behavior avoidance was not imposed by others but adopted by participants themselves to maintain their existing social relationships. "I choose carefully which friends I can talk about HIV. It's very risky to talk about HIV with other people. You know, the scariest part of living with HIV is not the virus itself but the stigma and the way people look at you because of your HIV status." (Yusuf, Male, 39, Living with HIV)

A more detailed account further illustrates how HIV-related stigma was understood within a broader social hierarchy:

> "No, it's easier to say I am gay than to say that I am living with HIV. People have very negative views of HIV as an infectious disease . It sounds ironic, but that is the reality in this community. In my view, being gay is seen as more acceptable than living with HIV. If you compare them, people living with HIV are placed at the very bottom—below transgender people, below gay people, and even below sex workers. People see us as individuals who have committed serious sins. But who hasn't made mistakes? I made mistakes in the past. I went to sex workers a few times, and at that time I didn't

> even know that I should use condoms. I was shocked when I found out my HIV status. From that moment, I felt as though I no longer had any value in the eyes of others ” (Rizal, Male, 33, Living with HIV)
>
> By comparing HIV with other already-stigmatized identities, Rizal illustrated the uniquely severe moral burden attached to HIV within his community. This comparison suggests that HIV was perceived as carrying a greater moral burden than other marginalized identities, intensifying both the fear of disclosure and participants' negative self-perceptions. Focus group discussions revealed another dimension, in which distancing was linked to responsibility and concern for others:“What I regret is that my partner was healthy before, and now she became infected because of me. Sometimes I feel deeply guilty when I think about it. I keep asking myself why it happened and whether I could have prevented it. Because of that, I try to keep my distance, especially when I am not feeling well, because I am afraid of making things worse”
>
> (Joko, Male, 37, Living with HIV)
>
> “I do not want others to experience what I have. It is enough that I am like this. Sometimes I choose to keep my distance from people around me because I don’t want to put them at risk.” (Indah, Female, 24, Living with HIV)

In these accounts, avoidance reflected not only anticipated stigma but also a sense of responsibility. Participants viewed themselves as potential sources of harm, leading to self-imposed restrictions on social interaction. These accounts suggest that avoidance was shaped by both social and internal processes, in which stigma and perceived responsibility intersected.

Comparing individual interviews and focus group discussions provided additional insight into how stigma operated across different contexts. Individual interviews primarily captured personal experiences of disclosure, rejection, and decisions regarding whom to trust, whereas focus group discussions highlighted the broader social narratives that shaped those experiences, including expectations of blame, rejection, and responsibility. Together, these data sources showed that disclosure decisions were influenced not only by personal experience but also by widely shared community beliefs. Avoidance, rumor circulation, and social withdrawal emerged as interconnected processes that reinforced one another, with enacted stigma increasing expectations of future rejection and anticipated stigma encouraging selective disclosure, concealment, and self-imposed distancing. Consequently, stigma functioned not simply as a consequence of disclosure but as a social condition that shaped whether, when, and how disclosure occurred.

Family Stigmatization and Emotional Hurt

> Within families, stigma often unfolded in subtle ways while carrying profound emotional and relational consequences. Disclosure was commonly motivated by expectations of trust and support; however, family responses were frequently shaped by fear, limited understanding of HIV, and concerns about family reputation. Rather than leading to acceptance, disclosure often introduced new tensions that reshaped participants' positions within their family relationships. “Since they found out my HIV status, they have tried to limit my visits. Maybe they are afraid that my HIV status will bring shame to them. . I felt sorry for myself… because she would not let me visit her house (Anti, Female, 43, Living with HIV)

Rather than explicit exclusion, participation in family life became conditional. Being “allowed” or “restricted” reflected a shift in how family members negotiated proximity, with maintaining distance becoming a way of managing perceived social risk.

This response placed participants in an uncertain position, as acceptance was no longer stable but depended on how others interpreted their presence. The impact of stigma extended beyond the individual to other family relationships, particularly those involving children. Concerns about HIV transmission, often rooted in misunderstanding, reshaped how children were treated within the extended family:"My sister-in-law found out about my HIV status. After that, she told her children not to play with my child. I felt very hurt because the one living with HIV, not my child. But they are still afraid, and I don't think they really understood how HIV is transmitted. Sometimes I feel guilty as a mother because my child is affected because of my condition." (Ayu, Female, 35, Living with HIV)

The exclusion of the participant's child illustrates how HIV-related fears extended beyond the person living with HIV. By treating the child as a potential source of risk despite the absence of any realistic route of transmission family members- reproduced stigma through association rather than direct experience "My brother told me to just die; he said that living as his brother is an embarrassing moment for him. He didn't want to eat, sit, and sleep with me… separate his clothes, his glass, and his plate from me. At that time, I felt very hurt and shocked because he is my own family, but he treated me like I was dangerous" (Fajar, Male, 27, Living with HIV)

The separation of eating utensils, clothing, and sleeping spaces made stigma visible in everyday family life. . These practices reflected not only fear of HIV transmission but also moral rejection. Compared with the more subtle forms of stigma described by female participants, this account illustrates how family stigma could vary in its expression, ranging from indirect distancing to overt exclusion. Concerns about family reactions were closely linked to decisions about HIV disclosure. Several participants described hesitating to disclose their HIV status because of anticipated consequences, particularly those affecting marital stability and acceptance within the extended family: "My wife worried that if I disclose my status to my mother-in-law, who does not understand HIV well, she will be angry or force us to divorce. I thought that stigma is the biggest problem for disclosing HIV status." (Ali, Male, 27, Living with HIV)

Concerns about how in-laws might respond became an important consideration in deciding whether to disclose. In this case, disclosure was delayed not because of an actual negative reaction, but because participants anticipated that it could threaten marital stability. These concerns were further reinforced by observations of how others had been treated within the community:

"Many couples worry about disclosing their HIV status to their families. . They are afraid that their families will distance themselves from them. I have seen many friends in our HIV community being rejected or divorced by their wives. The worst cases are when fathers are no longer allowed to see their children. Some wives also disclose their husbands' HIV status to others. All of this makes me afraid to disclose my own HIV status. Having our HIV status revealed without our consent is the most sensitive issue in a relationship." (Rudi, Male, 38, Living with HIV)

Experiences shared within peer groups shaped how participants anticipated family reactions. Observing rejection, divorce, and loss of contact with children contributed to a broader understanding that disclosure could have significant social and relational consequences. These collective narratives influenced disclosure decisions, indicating that they were shaped not only by personal experience but also by shared knowledge within the HIV community. Family reputation emerged as a central concern in responses to HIV. In some cases, the

consequences extended beyond the individual, affecting the social standing of other family members:

> "My family was afraid because they thought my HIV status would affect our reputation. But I never expected the consequences to be like this. Even my father was affected, although he had done nothing wrong. He was the head of the neighborhood and also an imam at the mosque. Because of my HIV status, he was removed from his position as head of the neighborhood. It was very difficult for me to see that happen." (Rizal, Male, 33, Living with HIV)

The consequences extended beyond the participant himself, affecting his father's social standing and illustrating how HIV became attached to family reputation rather than remaining an individual matter. His account also highlights how moral interpretations shaped both external responses and self-understanding, particularly in contexts where HIV was strongly associated with perceived wrongdoing.

> "Sometimes I feel more hurt when it comes from family, because they are the ones who should understand and support me. But when they act differently, it makes me feel like I am alone." (Nurul, Female, 30, Living with HIV)
>
> In response, participants described adjusting their behavior to manage the emotional impact of stigma and reduce further distress:
>
> "I try to limit myself, not because I don't want to be close to them, but because I don't want to feel hurt again. Sometimes it is easier to keep a distance than to face that situation." (Hasan, Female, 45, Living with HIV)

Distancing in this context was not only imposed by others but also enacted by participants as a way to cope with changing family dynamics. Family stigma affected not only how participants were treated by relatives but also how they adjusted their own behavior to avoid further emotional harm. Differences across participants and data sources revealed distinct ways in which family stigma was experienced and understood.

Although experiences varied across individuals, women's accounts more often emphasized gradual restrictions within family relationships, including limitations on family visits, concerns about their children's treatment, and feelings of emotional isolation following disclosure. These experiences were frequently described as subtle changes in everyday interactions that altered participants' sense of belonging within the family. In contrast, male participants more often described overt forms of rejection, concerns about marital disruption, and the impact of HIV-related stigma on family reputation and social standing. Taken together, family stigma was described through both indirect restrictions on participation in family life and more explicit forms of rejection that affected relationships, parenting, marriage, and family reputation.

Individual interviews primarily captured emotional consequences following disclosure, including feelings of rejection, disappointment, guilt, and isolation. Participants described changes in everyday family interactions and the emotional burden of losing expected sources of support. In contrast, focus group discussions emphasized broader concerns regarding marital stability, family reputation, and the social consequences of disclosure. Together, these findings indicate that family stigma influenced not only how participants were treated after disclosure, but also how they evaluated the risks of disclosure itself, often contributing to delayed, selective, or avoided disclosure within family settings.

Healthcare Provider Stigma — Discrimination in Clinical Settings

Experiences within healthcare settings indicate that stigma was not confined to social or family environments but also emerged in clinical encounters. Interactions with healthcare

providers were contexts in which participants expected professional care and confidentiality; however, these expectations were not always met. Instead, provider responses were sometimes shaped by fear, discomfort, and moral judgment, influencing both the quality of care and participants approached to disclosure in clinical settings. One form of stigma was expressed through subtle yet meaningful changes in provider behavior during clinical interactions. These changes were not always explicitly stated but were perceived through tone of voice, body language, and responsiveness: judgment behavior.

> "I went to the hospital to collect my ARV medication. When I entered the doctor's room, I told him that I had come to collect my medication, but he simply wrote the prescription without looking at me. He did not say anything or even smile. I kept wondering whether he treated me that way because of my HIV status. After that experience, I asked my sister to collect my ARV for me because I no longer wanted to see that doctor."(Joko, Male, 37, Living with HIV)
>
> "Several months ago, I was in prison and visited the prison health clinic because I wanted to consult about my condition. No healthcare worker was willing to see me. I heard them talking about HIV. At that moment, I realized they were avoiding me because of my HIV status." (Hasan, Male, 45, Living with HIV)

Although these experiences differed in form, both participants described interactions in which healthcare providers became less willing to engage once the participant's HIV status was known or suspected. The resulting stigma was communicated not only through explicit avoidance but also through reduced communication, emotional distance, and unwillingness to provide consultation. These responses altered participants' perceptions of healthcare environments and, in some cases, discouraged future engagement with healthcare services. In some cases, differences in provider responses were interpreted in relation to perceived levels of risk associated with specific types of care:

> "When I went to the dentist, she asked my wife to see another dentist. She said she could not treat my wife's dental problem. I am the one living with HIV, but she treated my wife as though she also had HIV. Sometimes I think healthcare workers should understand this better, but I don't know… maybe they think the risk is higher during dental treatment. However, when I go to the health center to collect my medication, I do not notice any difference in how I am treated. It was only this dentist who treated my wife and me differently.
>
> (Rizal, Male, 33, Living with HIV)

The participant's wife was also affected despite not living with HIV herself. Treatment decisions appeared to be shaped by assumptions regarding transmission risk rather than by the clinical condition being treated. The contrast between dental services and routine medication services suggests that stigma was not experienced uniformly across healthcare settings but was influenced by how healthcare workers interpreted occupational risk. Rather than being confined to the person living with HIV, stigma extended through association, affecting family members even when they were not seeking HIV-related care. Decisions about where to seek care were also influenced by concerns about visibility and unintended disclosure:

> "We live in Takalar (a rural area), but I chose to receive treatment in Makassar (a city) because of the stigma here. I worry that if I go to the local hospital, people might find out about my HIV status. Even though Makassar is about an hour away from my home, I prefer to receive treatment there." (Fajar, Male, 27, Living with HIV)

Seeking treatment outside the local area reflects participants' efforts to manage the social risks associated with accessing HIV services. Healthcare settings were not perceived as neutral spaces; instead, they were embedded within social environments where being seen could lead to unwanted disclosure. These findings indicate that stigma influenced not only interpersonal interactions but also patterns of healthcare utilization. Clinical encounters also revealed how HIV disclosure could shape the course of treatment. In some cases, participants disclosed their HIV status as part of responsible clinical care, yet interpreted the response as being influenced by that disclosure:

> "My wife took me to the hospital emergency room. I told the nurse that I am B20- they call us that term, it's kind of like a secret code for them and for us, because I didn't want to put her (nurse) at risk, especially if she needed to take my blood using a syringe. Surprisingly, she only gave me paracetamol and told me to come back the next day. At that time, I was actually very weak, so I called a peer support worker from YPKDS and told them what had happened. After they communicated with the hospital, another nurse finally gave me an IV. I felt angry because I thought she treated me that way after she knew my HIV status." (Yusuf, Male, 39, Living with HIV)

Disclosure in this situation was intended to support appropriate clinical care, yet it introduced uncertainty about whether treatment decisions were influenced by the participant's HIV status. The use of coded language ("B20") suggests an attempt to manage disclosure carefully, reflecting an awareness that revealing HIV status could affect how care was provided. This highlights how disclosure within healthcare settings was not always straightforward, as it involved both clinical necessity and perceived social risk. Viewed collectively, disclosure and healthcare access were closely interconnected. Participants did not simply decide whether to disclose their HIV status; they also evaluated where disclosure would occur, who would receive the information, and how that information might affect the care they received. Traveling to distant facilities, using coded language, and carefully selecting opportunities for disclosure reflected ongoing efforts to balance clinical needs with concerns about stigma. Disclosure within healthcare settings therefore emerged as a negotiated process rather than a routine administrative requirement. Expectations of stigma were also shaped by prior interactions, including those involving individuals with medical knowledge:

> "My cousin was a nurse… when she asked about my HIV status, I lied. Her response was, 'it's good, you are safe; it would be very shameful if you had it.' What I find ironic is that there are posters in the HIV counseling room saying, don't avoid people living with HIV, yet they still had negative views about people living with HIV. That made me feel confused about what to expect from them." (Devi, Female, 24, Living with HIV)

Unlike family and community stigma, discussions of healthcare-related stigma were largely absent from focus group discussions. Experiences of healthcare stigma were primarily described in individual interviews, indicating that these encounters were reported mainly as personal experiences rather than as collectively discussed community concerns. A recurring pattern emerged across participants, revealing variation in how healthcare stigma was experienced. Some participants described direct experiences of altered treatment, avoidance, or exclusion following disclosure of their HIV status. Others described anticipated stigma shaped by prior interactions with healthcare workers, even before disclosure. While experienced stigma influenced future healthcare-seeking behavior, anticipated stigma contributed to caution, concealment, and uncertainty regarding disclosure within clinical settings. Together, these narratives indicate that

healthcare settings functioned not only as sites of treatment but also as spaces where stigma and disclosure were continuously negotiated.

Stigma Related to Condom Use — Symbolism, Moral Judgment, and Negotiation within Couples

Participants did not begin by describing condoms as a method of protection. Instead, they spoke about what condoms mean in their social environment, and those meanings appeared immediately, even before any discussion about use took place. The association was neither tentative nor contested; rather, it was direct and familiar, as if it did not need further explanation.

> "For me, condoms are always associated with sex workers, unfaithful husbands, or sexual disease. When people see condoms, they don't think about health first; they think about those kinds of behaviors. That's why people feel uncomfortable even talking about them. Even if you just mention a condom, people already have a negative perception, so it's difficult to start the conversation." (Budi, Male, 45, Partner without HIV)

The association moves quickly from object to judgment. Condoms are not introduced as something to be considered, but as something already understood within a shared moral frame. Conversations about protection often do not begin, not because of lack of knowledge, but because the meaning attached to condoms already carries social consequences. A similar pattern appeared when participants spoke in group settings. Condoms were not framed as individual choices, but as objects that already carried shared meanings:

> "People closely associate condoms with HIV, sex workers, and 'bad women.' They will think that I am one of them. So even if I only want to protect myself, people will not see it that way; they will see me as that kind of woman" (Putri, Female, 25, Living with HIV)
>
> Unlike individual interviews, in which participants described their own experiences and dilemmas, these group discussions reflected assumptions that were widely accepted as common knowledge. The association between condoms and moral judgment required little explanation, suggesting that stigma was collectively reinforced and circulated within the social environment. The strength of these shared meanings became particularly evident when condoms were encountered in everyday situations: "My neighbor visited my mother when she was sick, and saw several boxes of condoms in my husband's bag. She screamed as though she had seen a lion, saying 'Allahu akbar, why do you have those forbidden things?' She really overreacted. She believed that having condoms was bad behavior. You know, people think that if you have condoms, you are not a good Muslim. So, it's not just about the condoms, it's about what they think of you as a person." (Fitri, Female, 39, Living with HIV)

The reaction leaves no room for negotiation or explanation. Meaning was assigned immediately and became difficult to reverse. The presence of condoms shifted from being a private matter to becoming a public statement, with interpretations shaped by others rather than by the individual. Women described experiencing this process more directly, particularly in situations where condom use could be interpreted as reflecting their own behavior:

> "I never buy condoms by myself. Maybe it is easier if the buyer is a man, but for women, people will judge you as a bad girl. Even I would probably think the same if I saw a woman buying condoms. I would assume she was a sex worker. So, it's difficult for women to be open about it, even if they know it is important."
>
> (Nisa, Female, 26, living with HIV)

> "Sure, having or buying condoms will invite rumors, especially for a divorced woman. People will judge you as a bad girl. They will not think that you are trying to protect yourself; instead, they will judge your behavior. So sometimes it's better to avoid that situation."
> (Dewi, Female, 26, Partner without HIV)

Judgment extended beyond external reactions and shaped how participants anticipated being perceived and regulated their own behavior. Even when protection was recognized as necessary, initiating condom use became difficult because it was closely tied to how one might be viewed by others. Within intimate relationships, these meanings continued to influence how condom use was negotiated. In some situations, attempts to introduce condoms shifted away from prevention and instead became questions about the relationship itself:

> "She asked me to use a condom, she said, 'aren't you worried that you will become infected because of me?' Then I told her, would you allow me to find another woman just so I could have sex without a condom? It's about us. I don't care about the facilitator's suggestion. If I don't use a condom, who will be infected? Me or her? I don't care anymore. For me, it's about the relationship, not about the condom."
> (Arman, Male, 38, Partner without HIV)

The shift in this exchange narrowed the topics that could be discussed regarding protection. Condom use was no longer approached as a practical strategy for reducing HIV risk but instead became closely tied to how the relationship itself was interpreted. Raising the issue could be perceived as a sign of doubt or emotional distance, making it difficult to redirect the conversation toward health concerns. Once the discussion shifted in this direction, returning the conversation toward prevention became increasingly difficult. In other situations, attempts to negotiate condom use continued but gradually lost their effectiveness:

> "We never use a condom because he refused to use one, even though I asked him many times. I was worried that he might become infected, especially because I already knew my HIV status, but he did not take it seriously. I tried to explain, but I could not force him. In the end, I simply followed what he wanted, even though I knew there was a risk. I just did not want to make the situation worse between us." (Nurul, Female, 30, Living with HIV)
>
> "I asked him to use a condom, but he said he had his own way to avoid pregnancy, so he did not want to use one. I tried to convince him, but I could not force him, and I did not want to argue because I was afraid it would create conflict between us. So, I agreed, even though I was not comfortable with that decision. It is not that I do not understand the risk, but it is difficult to persuade him."
> (Aisyah, Female, 34, Living with HIV)

Both accounts describe repeated attempts to introduce condom use, followed by consistent refusal. The challenge did not lie in explaining the risk itself but in how those explanations were received by their partners. Each attempt carried the possibility of disagreement, and over time, participants found it increasingly difficult to continue insisting on condom use. Avoiding relationship conflict became a more immediate priority than continuing the negotiation, gradually shaping the outcome. Awareness of HIV risk was clearly present, however, negotiation remained constrained by concerns about conflict, relationship stability, and maintaining intimacy. The limitation therefore lay not in participants' knowledge, but in the extent to which that knowledge could be translated into practice within their relationships.

Across these accounts, difficulties surrounding condom use were closely connected to communication about HIV within intimate relationships. Condom negotiation was not only shaped by perceptions of HIV risk but also by concerns about trust, relationship stability, and how discussions about protection might be interpreted by a partner. Consequently, conversations about condom use often became indirect negotiations about disclosure, responsibility, and the future of the relationship rather than discussions focused solely on prevention. This constraint becomes more pronounced when HIV status has not been disclosed:

> "He doesn't know my HIV status, so it's impossible to insist that he use a condom. If I insist, he will start asking questions. Disclosure? Yes, I will tell him, but not now. The best thing I can do is maintain my CD4 count and take my ARV regularly. For now, I just try to manage the situation without making him suspicious." (Devi, Female, 24, Living with HIV)

Condom use could not be separated from HIV disclosure in this situation. Requesting condom use was not merely a preventive behavior but also an action that could disrupt the balance of the relationship by raising suspicion. The request itself became meaningful, not because of the condom, but because of what it might reveal. In this context, silence was not simply the absence of communication but an active strategy for maintaining the relationship while managing HIV-related risk in less visible ways. As a result, opportunities to negotiate condom use were strongly influenced by whether HIV disclosure was anticipated, postponed, or deliberately avoided.

> "He didn't want to use it; he said that we will die even if we use a condom. It cannot protect us from death. So, for him, using a condom or not is the same." (Nurul, Female, 30 Living with HIV)
>
> "It reduces our pleasure. I mean, it interrupts intimate moments, we have never used a condom before, so using a condom is not part of our routine. It's not something we are used to, so it feels uncomfortable." (Sari, Female, 29, Living with HIV)

Risk is not dismissed in these accounts, but it is not treated as something that must always be actively managed. References to fate, comfort, and habit shift the focus away from prevention and toward what feels more familiar in everyday life. In this context, condom use is not directly refused, but gradually left aside, as it does not easily fit with how intimacy is experienced. Differences across participants and data sources revealed multiple ways in which condom-related stigma was experienced and negotiated. Women's accounts more frequently emphasized social judgment, disclosure concerns, and difficulties negotiating condom use, whereas male participants more often framed condom use in relation to trust, intimacy, and relationship meaning. Individual interviews primarily captured the interpersonal challenges of discussing condom use within intimate relationships, including concerns about trust, conflict, and disclosure. In contrast, focus group discussions highlighted broader social meanings attached to condoms, including associations with immorality, promiscuity, and social judgment. Across both contexts, condom use was rarely discussed as a purely biomedical prevention strategy. Instead, it was embedded within social expectations, relationship dynamics, and disclosure processes that shaped whether condom negotiation was possible or avoided altogether.

Serodiscordancy and Disclosure — Ongoing Negotiation, Fear, and Silence

Stigma within serodiscordant relationships shaped disclosure as a dynamic process over time. Participants did not view disclosure as a single decision that could be completed; rather, they described it as something that had to be continually reconsidered in relation to possible reactions, relational consequences, and social risks. Disclosure was therefore managed, delayed, or avoided depending on how safe a situation was perceived to be. In individual interviews, participants often

described first observing how others talked about HIV before deciding whether disclosure was possible. “I asked my friends because I wanted to see their response. They said, ‘Oh my God’, it’s a disgusting disease, a sexually transmitted disease. It can be transmitted by clothes, and even if you sit beside someone living with HIV, you will get it.’ Then I thought, ‘okay, I will not disclose my HIV status.” (Putri, Female, 25, Living with HIV)

> “I love her, but I cannot predict her response if I reveal my HIV status… I am worried that she will reject me and spread rumors… even though we have been together for six years, I am still not ready.” (Andi, Male, 35, Living with HIV)

Although these accounts occur in different social contexts, both participants based their disclosure decisions on anticipated reactions rather than direct experiences of rejection. Observing stigmatizing attitudes or imagining potential consequences was sufficient to discourage disclosure. In both cases, disclosure was evaluated not only in terms of honesty or openness but also in relation to the potential loss of social support, friendship, and intimate relationships.

> “I plan to marry her; I may disclose my HIV status after we get married. … I don’t want to lose her… maybe if our relationship is more secure, she will stay.” (Andi, Male, 35, Living with HIV)
>
> “My friend asked me about my husband’s status… I said ‘No, my husband has dengue fever.’ I tried to convince her because I did not want people to know my husband’s status…” (Anti, Female, 43, Partner without HIV)

Disclosure was not always rejected outright. Instead, participants described actively managing when, how, and under what circumstances information would be shared. Some delayed disclosure until a relationship was perceived as more secure, while others substituted alternative explanations to avoid revealing HIV status. These findings suggest that disclosure functioned as a strategic process rather than a single decision.

> “Since I moved and got married to him, I have not had close friends… I don’t have the courage to talk about HIV… he is very sensitive and always gets angry if I talk to someone.” (Melati, Female, 31, Partner without HIV)
>
> “No, it’s a sensitive issue, I don’t know how to explain it clearly to them. I don’t feel capable of doing that. so I never want to talk about HIV.” (Putri, Female, 25, Living with HIV)

These accounts highlight how disclosure depended not only on participants’ willingness to disclose but also on the availability of supportive communication within relationships. Limited social networks, fear of conflict, and difficulties explaining HIV reduced opportunities for disclosure. In these situations, silence reflected both practical communication barriers and concerns about stigma. In group discussions, disclosure was described less as a personal dilemma and more as a shared expectation about how others behave.

> “I never talk about HIV with others. People will avoid or stay away from you if they know your HIV status,so be careful.” (Ilham, Male, 38, Living with HIV)
>
> “It’s very dangerous to talk about HIV with people. The scariest thing is not the virus but the stigma. People will treat you differently.” (Wulan, Female, 32, Living with HIV)

Participants spoke in general terms, referring to what “people” do rather than what they personally experienced. These statements point to widely shared assumptions about stigma and rejection. Disclosure was perceived as risky not because of a single event but because these expectations circulated and were continually reinforced within the community. Individual hesitation therefore aligned with these shared understandings, making non-disclosure appear to be a reasonable

response. Serodiscordant relationships remained sites of ongoing tension, particularly in relation to HIV transmission. Concerns about HIV transmission remained present even when the relationship had continued over time.

> "Having an HIV-negative partner always makes you anxious. You always think, is she safe?" (Ali, Male, 33, Living with HIV)
>
> "Honestly, I am worried that I may get HIV. I always pray. Please don't let him infect me." (Dewi, Female, 26, Partner without HIV)

While individual interviews focused on disclosure decisions within specific relationships, focus group discussions reflected broader shared expectations regarding stigma and rejection. Participants frequently spoke about what "people" might do if HIV status became known, suggesting that anticipated stigma was reinforced collectively rather than emerging solely from personal experience. These shared expectations aligned with individual concerns about transmission, responsibility, and future relationships, contributing to the ongoing uncertainty surrounding disclosure. Differences across participants and data sources revealed multiple ways in which disclosure was negotiated within serodiscordant relationships. Women's accounts more frequently emphasized communication barriers, disclosure constraints, and efforts to maintain relationship stability, whereas male participants more often described fears of rejection, social consequences, and responsibility toward their HIV-negative partners. Individual interviews primarily captured personal disclosure decisions, including delay, concealment, selective disclosure, and strategic communication. In contrast, focus group discussions reflected shared expectations regarding stigma, rejection, and social consequences, often framing non-disclosure as a reasonable protective response. Across both contexts, disclosure was rarely described as a single event. Instead, it emerged as an ongoing process shaped by anticipated stigma, relationship dynamics, communication constraints, and concerns about relational stability.

Community and religious actors in shaping stigma narratives

Participants highlighted that HIV-related stigma was deeply embedded in social, religious, and moral frameworks. Both community members and institutional stakeholders noted that effective messaging needed to consider these contextual factors to promote understanding and reduce discrimination.

Religious Leaders as Key Messengers

Participants described religious leaders as occupying a unique position in community life, where they influence not only religious practices but also the interpretation and discussion of health issues. Across stakeholder accounts, HIV was often viewed as a topic that community members encountered through moral and religious frameworks before they encountered biomedical information. As a result, participants consistently identified religious leaders as important actors in shaping public understanding of HIV and reducing stigma. One stakeholder explained that HIV-related information delivered through religious forums could help challenge stigma because religious leaders are trusted sources of guidance within the community.

> "Providing HIV material for the Khutbah… maybe it will be good for reducing stigma. However, the HIV- related content should be easy to understand."
> (Masnah, 43, Provincial Health Office)

This account highlights that the issue was not simply the availability of HIV information, but also how that information was communicated and by whom. HIV-related messages delivered through religious settings were expected to challenge existing moral interpretations of HIV. For this reason, participants emphasized the need for messages that could be understood and accepted within everyday community life rather than relying solely on technical explanations. A representative

from a Muslim organization similarly argued that religious leaders could play a broader role beyond information dissemination alone.

> "If you have a session, maybe it's better to invite an Ustaz or ustazah to provide testimony or advise as a keynote speaker. The problem among people living with HIV, especially those in serodiscordant relationship, is that they often feel trapped. Partners without HIV may feel that they have no choices and experience hopelessness, especially women."
>
> (Mami, HIV care for sex workers/ KRA AIDS)

Rather than describing stigma solely as misinformation, this participant connected stigma to emotional responses such as hopelessness, fear, and self-blame. The account suggests that HIV-related challenges were often interpreted through religious understandings of patience, responsibility, and coping. In this context, religious leaders were viewed not only as educators but also as sources of emotional and moral support for couples navigating disclosure and HIV prevention within their relationships. The same participant further emphasized that increasing HIV knowledge among religious leaders could create wider effects within the community.

> "Involving ustas or ustazah in your event will increase their knowledge about HIV. it means working or living with friends who are HIV positive will not infect you automatically. It will be widely shared within the community, then uztas and uztazah will spread this information to people in our community." (Farsah, Nahdatul Ulama Organization)

Across stakeholder accounts, religious leaders were described as occupying a strategic position between biomedical knowledge and community belief systems. Participants consistently viewed them as trusted authorities capable of influencing how HIV was interpreted, discussed, and responded to within everyday social life. Their role extended beyond information delivery to shaping attitudes toward disclosure, prevention, and relationships affected by HIV

Community and Youth Engagement

Participants and stakeholders consistently described stigma as an issue that could not be addressed through healthcare services alone. Many argued that HIV-related initiatives had historically focused on people living with HIV while giving limited attention to broader community actors who influence everyday attitudes toward HIV. A representative from a youth organization challenged assumptions that community and religious groups were unwilling to engage with HIV-related activities.

> "Personally, I disagree with the rumors about Muslim organizations. The stigma exists because they have never been involved in HIV strategies. We are very welcome to participate if you invite us." (Rangga, Muslim Teenager Forum)

This account shifts responsibility away from communities themselves and toward the absence of engagement. Rather than describing stigma as a consequence of community resistance, the participant suggested that community organizations had often been positioned outside HIV-related programs. Their limited involvement reduced opportunities for dialogue, allowing misconceptions to persist and reinforcing social distance between HIV programs and community networks.

Several stakeholders also emphasized the importance of peer support and facilitated discussion as mechanisms for reducing stigma.

> "Providing small group discussion facilitated by a doctor, or a counselor may be one solution. People can discuss their concern, ask questions, and receive feedback from health professionals" (Amri, Makassar Drugs Victims' Organization)

The value of these discussions was described as extending beyond information sharing. Participants frequently referred to fears, uncertainty, and practical concerns that were difficult to address through one-way education alone. Small-group discussions were viewed as spaces where individuals could ask questions, share experiences, and discuss challenges that might otherwise remain hidden. Other stakeholders highlighted limitations in existing HIV support systems, particularly their focus on people living with HIV rather than couples as a unit.

> "Honestly, our focus is on people living with HIV. We have not directly involved partner without HIV in our intervention. Nevertheless, it is a good idea to include HIV-negative partners in our activities."
> (Rachman, YPKDS)

This account is particularly important because it acknowledges a gap that emerged repeatedly throughout the study. While disclosure, prevention, and stigma affected both partners, support programs remained center primarily on people living with HIV. Stakeholders recognised that HIV-negative partners also required information, emotional support, and opportunities to discuss their own experiences. This concern was echoed by participants living with HIV.

> "A solution for serodiscordant couples is to involve partner of people living with HIV in group meetings, and, if needed, their family members, such as mother and fathers. They also have access to information because it seems unfair that only people living with HIV can participate in these groups." (Rahmat, Male, 35, Living with HIV)

The account broadens the focus of stigma beyond the individual. Participants described disclosure and HIV prevention as issues that affected relationships and families, not only people living with HIV. Family members and partners often became involved in decisions about disclosure, treatment, and prevention, yet were frequently excluded from support activities designed to address these challenges. Several participants further argued that support programs should draw more heavily on the experiences of people who had already navigated similar situations..

> "We should involve both couples. Maybe it's better if we invite seroconcordant couples to share their experience." (Lestari, Women HIV Positive Association (IPPI)
> "Involving us, who has experience as a serodiscordant couple in a group meeting, so that we can share our experiences." (Sari, Female, 29, Living with HIV)
> Unlike expert-led education, these accounts emphasized the value of experiential knowledge. Participants who had navigated disclosure, treatment, HIV prevention, and long-term relationships were viewed as credible sources of practical guidance. Their experiences provided examples of how HIV-related challenges could be managed within everyday life, offering forms of reassurance that formal information alone might not provide. A similar idea emerged among participants, who suggested that support should also be tailored to individual circumstances of disclosure. "I think grouping women who have not yet disclosed their HIV status to their partners would provide a better opportunity to share experiences and support one another, so that we can gain the confidence to disclose our status." (Devi, Female, 24, Partner without HIV)

Several participants explicitly connected community engagement with disclosure support. Rather than viewing disclosure as an individual responsibility, they described it as a process that often-required encouragement, shared experiences, and supportive social environments. Community-based groups were viewed not only as sources of information but also as mechanisms for reducing the fears and uncertainties that frequently delayed disclosure. Together, these accounts suggest

that disclosure was understood as a social process requiring preparation and collective support rather than as a purely individual decision.

Across stakeholder groups, participants emphaszised complementary pathways for reducing stigma. Youth organizations focused on inclusion within HIV initiatives, service providers highlighted the importance of dialogue and structured support whereas people living with HIV emphasized involving partners, families, and individuals with lived experience. Despite these differences, all groups described stigma reduction as a collective responsibility that extended beyond healthcare services and required broader community participation.

This synthesis highlights an important distinction across contexts. While stigma and disclosure were often experienced as personal challenges within relationships and everyday interactions, proposed responses were framed as collective responsibilities involving community organizations, religious leaders, families, and peers. Taken together, these findings suggest that reducing stigma involved not only increasing HIV knowledge but also creating supportive social environments that could facilitate disclosure, strengthen relationships, and reduce isolation.

Discussion

This study demonstrates that HIV-related stigma shaped disclosure experiences across multiple, interconnected social contexts, including family relationships, intimate partnerships, religious beliefs, community interactions, and healthcare encounters. Rather than emerging solely after HIV status was disclosed, stigma often influenced whether disclosure was perceived as safe, desirable, or even possible before it occurred. Participants continuously assessed the potential social, relational, and moral consequences before deciding whether, when, and to whom, their HIV status should be disclosed. These findings highlight disclosure as a socially embedded process that extends beyond simply revealing HIV status and is closely linked to concerns about social belonging, family relationships, and community acceptance

A striking feature of the findings was the extent to which HIV continued to be interpreted through moral and religious meanings rather than through biomedical understandings of disease. Across different social settings, participants described environments in which HIV was associated with moral failure, socially unacceptable behavior, and violations of religious expectations. Such interpretations appeared to extend beyond concerns about HIV transmission and shaped how people living with HIV were perceived within their communities. In this context, HIV was often understood not only as a health condition but also as a reflection of personal character and social worth. Similar moral constructions of HIV have been documented in Indonesia, where HIV is frequently associated with personal responsibility, moral failure, and socially unacceptable behavior [5,6]. Consistent with Parker and Aggleton's conceptualization of stigma as a social process linked to power and social control [27], the present findings suggest that these moral interpretations continue to influence not only experiences of HIV-related stigma but also disclosure decision-making among heterosexual couples

These observations are consistent with previous studies showing that HIV-related stigma is frequently sustained through moral judgments that assign blame and responsibility to people living with HIV. While previous studies have primarily focused on the role of moral judgment in producing HIV-related stigma, the present findings suggest that these moral narratives also influenced disclosure decisions before disclosure took place. Furthermore, the findings suggest that anticipated stigma functioned as an important mechanism linking social perceptions of HIV with disclosure behavior. Participants frequently evaluated community attitudes, family responses, and everyday conversations about HIV as indicators of potential future reactions. Consequently, disclosure decisions were often shaped by expectations of stigma rather than direct experiences of

discrimination. This observation is consistent with previous research demonstrating that anticipated stigma can influence disclosure practices, healthcare engagement, and treatment adherence even in the absence of enacted stigma [11,28].

Participants' concerns were rarely limited to personal rejection. Disclosure was often considered within a broader social framework that included family relationships, community acceptance, and social reputation. In this sense, disclosure involved navigating multiple forms of potential loss simultaneously. Decisions about disclosure were shaped not only by concerns about revealing HIV status but also by concerns about how disclosure might alter existing social relationships and personal identities. This broader social context helps explain why many participants described disclosure as a gradual and carefully negotiated process rather than a single decision made at a particular point in time [29].

The influence of these moral interpretations became particularly visible within family relationships. Families occupied a complex position in participants' experiences of HIV disclosure. On one hand, family members were often viewed as the primary source of emotional support, practical assistance, and acceptance. On the other hand, they were also among those whose reactions often had the greatest influence on participants' disclosure decisions. As a result, disclosure decisions were frequently shaped by hopes for support and fears of disappointment, rejection, or changes in family relationships. Similar dynamics have been documented in Indonesia, where family responses often shape disclosure experiences, treatment engagement, and social well-being among people living with HIV. Studies by Fauk et al. and Mahamboro et al. have shown that concerns regarding family acceptance, social reputation, and moral judgment frequently influence how individuals navigate disclosure and their broader social relationships. Comparable patterns have also been reported in other collectivist settings where family relationships play a central role in post-disclosure adjustment [5,6].

The emotional impact of stigma was often linked not only to negative reactions themselves, but to the perceived loss of relationships that participants valued deeply. Experiences of distancing, reduced contact, and altered family interactions appeared particularly painful because they occurred within relationships expected to provide care and protection. In this sense, family stigma carried a different emotional weight from stigma encountered in broader community settings. The distress described by participants was not simply a response to negative attitudes towards HIV, but also reflected the weakening of social bonds that formed an important part of their everyday lives. This interpretation is consistent with evidence demonstrating that HIV-related stigma can negatively affect psychological well-being, social connectedness, and quality of life through disruptions in valued interpersonal relationships [30].

These findings also highlight how disclosure decisions were embedded within broader family systems rather than being made solely at the individual level. Participants often considered how disclosure might affect spouses, children, parents, and other relatives before deciding whether to share their HIV status. Concerns about family reputation, social standing, and the possibility that stigma might extend to loved ones frequently shaped participants' disclosure strategies. Similar dynamics have been reported in collectivist societies, where individual decisions are closely connected to family relationships and social obligations. In such contexts, disclosure may have implications not only for the person living with HIV but also for those perceived to be associated with them. These findings are consistent with the concept of courtesy stigma, whereby stigma extends beyond the individual living with HIV to affect family members and others who perceived to be associated with them [31]. Emerging evidence on secondary stigma further

suggests that family members and intimate partners may experience social judgment and discrimination because of their association with people living with HIV [21].

Family stigma was not always expressed through direct rejection. In many cases, it emerged through subtle changes in everyday interactions, including emotional distancing, altered communication patterns, and reduced involvement in family activities. These forms of stigma may be less visible than overt discrimination; however, they can have equally profound consequences for emotional well-being and social belonging. Such findings suggest that efforts to support disclosure should pay greater attention to the quality of family relationships and the social environments in which disclosure occurs, rather than focusing exclusively on individuals making disclosure decisions. Similar patterns of subtle or indirect stigma have been documented in qualitative research, which demonstrates that social exclusion may occur through everyday relational practices rather than overt acts of discrimination alone [32].

The influence of stigma was not confined to family and community relationships. Participants' accounts also draw attention to the role of healthcare settings as important spaces where disclosure decisions continued to be negotiated. While healthcare services are often positioned as sources of support, information, and treatment, the present findings suggest that interactions with healthcare providers may also become a source of uncertainty. In some cases, concerns about how healthcare workers might respond to an individual's HIV status shaped decisions about when, where, and to whom disclosure occurred within clinical settings. Studies conducted in Indonesia have shown that healthcare-related stigma remains a persistent challenge for people living with HIV despite ongoing efforts to strengthen HIV services. Research involving both healthcare providers and people living with HIV has documented concerns regarding confidentiality, discriminatory attitudes, and differential treatment within clinical settings [6, 33]. Similar concerns have also been reported internationally, where disclosure decisions are often shaped by anticipated judgment and uncertainty about healthcare workers' responses [11].

Stigma within healthcare settings was not limited to direct experiences of discriminatory treatment. For some participants, previous encounters with healthcare workers, observations of how people living with HIV were treated, or stories shared by others contributed to expectations of negative judgment. These findings suggest that healthcare-related stigma may operate not only through direct discrimination but also through anticipated reactions that influence healthcare engagement and disclosure practices [28].

The findings further point to important differences between healthcare contexts. Participants generally described HIV-specific services as supportive environments where disclosure was expected and accepted. In contrast, uncertainty was more commonly associated with healthcare settings where HIV was not the primary focus of care. This distinction suggests that stigma was shaped not only by attitudes towards HIV itself but also by how healthcare workers understood and responded to perceived risks of transmission. Research conducted in both high- and low-resource settings has shown that misconceptions regarding occupational exposure and the risk of HIV transmission continue to influence interactions between healthcare providers and people living with HIV [33]. The present findings extend this literature by suggesting that healthcare stigma was not experienced uniformly across services but varied with how healthcare workers interpreted transmission risk in specific clinical contexts. While previous studies have largely examined healthcare stigma as a general phenomenon, the present findings demonstrate important differences across healthcare contexts. Participants distinguished between HIV-focused services, where disclosure was often expected and supported, and non-HIV healthcare settings, where uncertainty and concerns about stigma remained more pronounced.

A growing body of evidence indicates that fears regarding occupational exposure and misconceptions about HIV transmission remain key contributors to healthcare-related stigma. Fear of HIV transmission, inadequate understanding of transmission pathways, and persistent stereotypes about people living with HIV have been identified as important drivers of stigma within healthcare settings. These findings suggest that reducing healthcare-related stigma requires more than improving HIV knowledge alone; it also requires addressing institutional practices, professional norms, and risk perceptions that continue to shape interactions between healthcare workers and people living with HIV [34].

The findings concerning condom use provide further insight into how disclosure was negotiated within intimate relationships. Rather than functioning solely as a preventive health measure, condom use often carried broader social and relational significance. Discussions about condom use frequently became entangled with questions of trust, fidelity, responsibility, and HIV status. In this context, decisions about condom use were rarely independent of decisions about disclosure. Instead, both became part of an ongoing process through which partners navigated uncertainty, vulnerability, and the potential consequences of revealing HIV status. Previous research among serodiscordant couples has similarly shown that HIV prevention practices are closely intertwined with relationship dynamics, trust, and communication between partners [7, 35].

Participants often described difficulties discussing condom use before HIV status had been disclosed. Requests to use condoms could raise suspicions, prompt questions about the need for protection, or create concerns about relationship stability. As a result, some participants found themselves negotiating HIV prevention without being able to speak openly about HIV status. This finding highlights how stigma may indirectly affect prevention practices by limiting opportunities for open communication within intimate relationships. Evidence from qualitative studies suggests that concerns regarding stigma and relationship disruption may complicate discussions about condom use and HIV prevention, particularly before HIV status is disclosed [29].

These dynamics were especially evident within serodiscordant relationships, where concerns about HIV transmission, partner wellbeing, and relationship continuity intersected. Existing literature has identified HIV status disclosure as an important step in strengthening prevention and supporting relationship adjustment among serodiscordant couples. Most previous studies have examined condom use within serodiscordant relationships primarily as a prevention strategy. The present findings extend this literature by demonstrating that condom negotiation and HIV status disclosure were often inseparable processes.

Discussions about condom use frequently became discussions about trust, risk, and HIV status, highlighting how stigma could indirectly influence prevention practices through its effects on communication and disclosure. This interpretation is consistent with qualitative research suggesting that disclosure and prevention behaviors are often negotiated simultaneously within intimate partnerships rather than occurring as separate processes [34]. The findings also point to the importance of looking beyond individual behavior when considering responses to HIV-related stigma and disclosure challenges. Across the different contexts explored in this study, stigma was sustained through social relationships, community attitudes, and shared beliefs rather than through the isolated actions of particular individuals. Participants frequently described stigma emerging through everyday interactions and social expectations. This suggests that efforts to support disclosure and reduce stigma may be most effective when they engage with the broader social environments in which people living with HIV navigate their daily lives. Research examining HIV-related stigma across diverse settings has similarly demonstrated that stigma is often

produced and maintained through social processes embedded within families, communities, and cultural norms rather than through individual prejudice alone [24].

Participants rarely described stigma reduction as the responsibility of healthcare services alone. Instead, they frequently emphasized the role of families, communities, peer networks, and religious leaders in shaping how HIV was understood and discussed. These observations highlight the social nature of stigma. Just as stigma was experienced through relationships and social interactions, participants also viewed supportive relationships and community engagement as important resources for challenging stigma and facilitating disclosure. Evidence from community-based HIV programs suggests that peer support, community engagement, and opportunities for meaningful social contact can strengthen social connectedness while reducing stigma toward people living with HIV [29].

The prominence of religious leaders in participants' accounts is especially significant in Muslim communities. Religious leaders were often described as influential figures capable of shaping community attitudes and providing guidance on sensitive issues. This finding suggests that faith-based actors may occupy a unique position between community values and public health messaging. Rather than functioning solely as sources of religious authority, they may also play an important role in challenging misconceptions about HIV, promoting compassion, and creating social environments that are more supportive of disclosure and care-seeking. Previous studies in Indonesia have shown that HIV is frequently interpreted through moral and religious frameworks that influence perceptions of responsibility, blame, and social acceptance. Halimatusa'diyah's work highlights how moral and religious narratives can shape experiences of stigma and social recognition among people living with HIV. Within this context, religious leaders may play an important role in reinforcing or challenging stigma-related beliefs and community responses to HIV [16, 23].

The findings further suggest that disclosure is unlikely to be improved through information-based interventions alone. While increasing HIV knowledge remains important, knowledge does not automatically eliminate stigma or reduce fears of rejection. Participants' experiences indicate that disclosure decisions were shaped by concerns about relationships, social acceptance, and belonging as much as by knowledge of HIV itself. This may help explain why stigma persisted even in contexts where awareness of HIV was relatively high. Addressing disclosure-related challenges therefore requires attention not only to what people know about HIV, but also to the social meanings attached to the condition and the ways in which those meanings are reproduced within communities. Evidence from recent intervention studies indicates that stigma reduction efforts are most effective when educational strategies are combined with opportunities for social contact, community engagement, and structural support [36].

An interesting pattern emerged across the two data sources. Individual interviews primarily highlighted the emotional and relational consequences of stigma and disclosure, including concerns about rejection, relationship disruption, and social isolation. In contrast, focus group discussions more often emphasized shared social norms, community expectations, and collective concerns regarding family reputation and social acceptance. Together, these perspectives illustrate how disclosure was shaped not only by personal experiences but also by broader social environments in which HIV was understood and discussed.

Across the different contexts explored in this study, HIV-related stigma and disclosure emerged as deeply social processes rather than purely individual experiences. The challenges described by participants were embedded within networks of family relationships, healthcare interactions, intimate partnerships, and community expectations. At the same time, these social

environments were identified as potential sources of support, acceptance, and change. This highlights the importance of stigma-reduction strategies that go beyond the individual level and engage families, communities, healthcare providers, and religious actors in creating conditions that support disclosure while reducing the social costs associated with it.

The findings challenge approaches that frame HIV disclosure primarily as an individual choice or a matter of personal readiness. Participants' experiences suggest that disclosure was shaped by a broader social landscape in which moral judgments, family relationships, healthcare interactions, and concerns about relationship stability were closely intertwined. Decisions about disclosure were therefore rarely based on HIV status alone. Rather, they reflected ongoing efforts to balance the potential benefits of openness against the possibility of social, emotional, and relational consequences. This interpretation supports a growing body of literature arguing that disclosure should be understood as a socially situated process influenced by interpersonal relationships, community contexts, and broader social structures rather than as a discrete individual behavior [27,29].

Evidence from this study further suggests that stigma continues to influence the lives of people living with HIV in ways that extend beyond direct experiences of discrimination. Stigma was frequently embedded in everyday interactions, shaping how participants anticipated future responses from others and, in turn, how they approached disclosure. Understanding disclosure through this broader lens may help explain why disclosure remains challenging even in settings where HIV treatment is increasingly available and public awareness has improved. These findings reinforce the need for HIV responses that address not only knowledge gaps but also the social and moral environments that continue to shape both disclosure decisions and disclosure experiences.

Strengths and Limitations

Several limitations should be considered when interpreting the findings of this study. First, the study was conducted within Muslim communities in Indonesia, and participants were recruited from specific social and cultural contexts. Experiences of stigma and disclosure may differ in other religious, cultural, or geographic settings. The findings should therefore be interpreted as contextually situated rather than representative of all people living with HIV in Indonesia.

Second, as with all qualitative research, the findings reflect participants' perspectives and experiences at a particular point in time. Participants may have recalled events differently or chosen to emphasize certain experiences over others. However, the use of both in-depth interviews and focus group discussions enabled the exploration of stigma and disclosure from multiple perspectives and helped identify recurring patterns across individual and collective accounts.

Third, discussions about HIV, stigma, and disclosure involve highly personal and potentially sensitive experiences. Although efforts were made to create a supportive environment for data collection, some participants may have been reluctant to discuss particularly difficult experiences or to framed their responses in ways they considered socially acceptable. As a result, certain experiences may remain underrepresented.

Despite these limitations, the study has several important strengths. The use of methodological triangulation through individual interviews and focus group discussions provided a richer understanding of how stigma and disclosure were experienced, negotiated, and interpreted across different social contexts. The inclusion of people living with HIV, healthcare stakeholders, and community representatives also enabled the exploration of stigma from multiple perspectives. Furthermore, by examining disclosure within the context of Muslim communities, the study contributes contextually grounded evidence to a growing body of literature on HIV-related stigma

and disclosure in settings where social relationships, family obligations, and religious values play an important role in everyday life.

Conclusion

This study highlights how HIV-related stigma shaped disclosure experiences among couples living in Muslim communities in Indonesia. Stigma was not limited to overt experiences of discrimination following disclosure but also influenced disclosure decisions before HIV status was revealed. Moral interpretations of HIV, concerns about family relationships, fears of social exclusion, healthcare interactions, and challenges within serodiscordant relationships all contributed to how participants assessed the risks and consequences of disclosure. These findings suggest that disclosure is best understood as a social and relational process rather than solely an individual decision.

The findings have important implications for HIV policy and practice. Efforts to support disclosure should move beyond individual counseling approaches and incorporate family- and couple-centered strategies that strengthen communication, address fears of stigma, and support disclosure within intimate relationships. HIV services may also benefit from integrating disclosure support into routine care, particularly for individuals navigating serodiscordant relationships and concerns about condom negotiation. In addition, stigma-reduction initiatives should extend beyond healthcare settings and involve families, peer networks, community organizations, and religious leaders who play an important role in shaping attitudes towards HIV within Muslim communities. Creating supportive environments for disclosure may be as important as improving HIV knowledge itself. Interventions that combine disclosure support, community engagement, peer-support programs, and faith-based participation may help reduce the social risks associated with disclosure while strengthening support for people living with HIV and their partners.

Family-inclusive approaches, community dialogue initiatives, and stigma-reduction training for healthcare providers may further contribute to environments in which disclosure is safer, more supported, and less likely to result in social or relational harm. Such efforts have the potential to improve wellbeing, strengthen relationship stability, and support sustained engagement in HIV care among people living with HIV and their partners.

Acknowledgements

We sincerely thank all participants for sharing their experiences and trust. We also acknowledge the Peer Support Group Care Foundation (YPKDS) in South Sulawesi for facilitating participant recruitment and community engagement. We are grateful to the field team for their assistance during data collection.

Authors' contributions

ESR conceptualized the study, led data collection, conducted the primary analysis, and drafted the manuscript. SB contributed to coding review, interpretation of findings, and refinement of themes. MK and CT contributed to interpretation of findings and provided insights into thematic development. MNQ contributed to interpretation of findings, particularly regarding legal, normative, and sociocultural dimensions of HIV stigma and disclosure, and critically revised the manuscript. MM contributed to English language editing, manuscript preparation, and critical review of the manuscript. ESR and SB served as co-corresponding authors and share equal responsibility for the overall integrity of the study.

Funding

This study received no external funding.

Availability of data and materials

The qualitative datasets generated and analysed during the current study are not publicly available due to ethical and confidentiality restrictions, as they contain sensitive information that could compromise participant privacy. Data are available from the corresponding author upon reasonable request and with appropriate ethical approval.

Declarations

Ethics approval and consent to participate

Ethical approval for this study was obtained from the Institutional Review Board of the Faculty of Public Health, Mahidol University (Certificate of Approval No. MUPH 2018-177). All participants were provided with detailed information about the study and gave written informed consent prior to participation. Confidentiality and anonymity were ensured throughout data collection, transcription, and analysis. This study was conducted in accordance with the ethical principles of the Declaration of Helsinki.

Transparency statement: The data analyzed in this study were derived from a broader qualitative project; findings addressing different research questions have been reported elsewhere.

Consent for publication

Not applicable.

Competing interests

The authors declare that they have no competing interests.

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