



# Prevalence of Stigma and Discrimination Amongst Men Who have Sex with Men (MSM) and Transgender Women (Waria) in Bali, Indonesia

Ni Wayan Septarini, Huijun Chih, Jacqueline Hendriks, Bruce Maycock & Sharyn Burns

To cite this article: Ni Wayan Septarini, Huijun Chih, Jacqueline Hendriks, Bruce Maycock & Sharyn Burns (2023): Prevalence of Stigma and Discrimination Amongst Men Who have Sex with Men (MSM) and Transgender Women (Waria) in Bali, Indonesia, Journal of Homosexuality, DOI: [10.1080/00918369.2023.2174470](https://doi.org/10.1080/00918369.2023.2174470)

To link to this article: <https://doi.org/10.1080/00918369.2023.2174470>

 View supplementary material [↗](#)

 Published online: 24 Feb 2023.

 Submit your article to this journal [↗](#)


 Article views: 16

 View related articles [↗](#)

 View Crossmark data [↗](#)



# Prevalence of Stigma and Discrimination Amongst Men Who have Sex with Men (MSM) and Transgender Women (Waria) in Bali, Indonesia

Ni Wayan Septarini, MD, MPH<sup>a,b</sup>, HuiJun Chih, PhD<sup>b</sup>, Jacqueline Hendriks, PhD <sup>b,c</sup>, Bruce Maycock, PhD<sup>d</sup>, and Sharyn Burns, PhD, MPH, PostGradDipHltProm, BEd, DipTch HPE<sup>b,c</sup>

<sup>a</sup>Department of Community and Preventive Medicine, Faculty of Medicine, Udayana University, Bali, Indonesia; <sup>b</sup>Curtin School of Population Health, Curtin University, Perth, Western Australia, Australia; <sup>c</sup>Collaboration for Evidence, Research and Impact in Public Health, Curtin University, Perth, Australia; <sup>d</sup>European Centre for Environmental and Human Health, College of Medicine and Health, University of Exeter, Devon, The United Kingdom

## ABSTRACT



Men who have sex with men (MSM) and transgender women (waria) in Indonesia experience stigma and discrimination. The prevalence of stigma and discrimination experienced by 416 MSM and waria living in Bali, Indonesia and associations with socio-demographic characteristics are described. High levels of stigma were reported by 50.5% of MSM and 62.7% of waria. Discrimination was reported by 35.5% of MSM and 72.4% of waria. Family rejection, or no family awareness of MSM status, equated to higher levels of stigma compared to those where MSM status was accepted. Homosexual and bisexual waria reported lower odds of experiencing stigma compared to heterosexual waria. MSM who were not single were twice as likely to experience discrimination compared to single participants. Non-Hindu MSM were nearly three times as likely to experience discrimination compared to Hindu participants. Waria who were studying were less likely to experience discrimination compared to those who reported regular employment jobs. Specific policy and practice to reduce experiences of stigma and/or discrimination specific to MSM and waria are needed.


## KEYWORDS

Discrimination; MSM; stigma; transgender women; waria; developing country; mixed methods

## Introduction

Globally marginalized populations, including Men who have Sex with Men (MSM) and transgender people, continue to experience human rights abuses such as stigma and discrimination (Lyons et al., 2019; Mitchell et al., 2019; Padilla et al., 2008; Preston et al., 2004; Stahlman et al., 2015; Thompson et al., 2013; White Hughto et al., 2015). Stigma is associated with negative or unfair beliefs and is a complex concept that refers to prejudice (Preston et al., 2007b), while discrimination refers to an enacted form of stigma or unfair treatment;

**CONTACT** Ni Wayan Septarini  [septarini@unud.ac.id](mailto:septarini@unud.ac.id); [15304247@student.curtin.edu.au](mailto:15304247@student.curtin.edu.au)  Department of Community and Preventive Medicine, Faculty of Medicine, Udayana University, Bali, Indonesia.

 Supplemental data for this article can be accessed online at <https://doi.org/10.1080/00918369.2023.2174470>

© 2023 Taylor & Francis Group, LLC

or mistreatment of an individual, group or population (Centers for Disease Control and Prevention, 2016; Preston et al., 2007b). Challenges faced by MSM and transgender people often differ between and within regions and countries and may include: living in hidden subcultures (Hassan et al., 2018); lack of confidentiality; fear of being not accepted by family (Putra et al., 2019; Victoryna et al., 2019); and difficulty in accessing health services (Kim et al., 2018; Mitchell et al., 2019). Studies exploring stigma and discrimination among marginalized populations have been conducted globally (Boya et al., 2019; Brown et al., 2016; Diehl et al., 2017; Oldenburg et al., 2014). Low and middle income countries in the Asia and Pacific region have employed different methodologies to reach marginalized populations, and address cultural environments (Septarini et al., 2021a).

Stigma is a known barrier to the provision of health services, health promotion and treatment for marginalized populations, leading to sub-optimal health-seeking behaviors (Lyons et al., 2019). Stigma and discrimination can negatively impact and act as barriers to MSM and transgender health and wellbeing at structural/societal, interpersonal and individual levels (Centers for Disease Control and Prevention, 2016; White Hughto et al., 2015). A study conducted in Eswatini reported multiple forms of stigma to be associated with high risk sexual behaviors. Participants reported increased odds of feeling excluded and gossiped about by family members, when these family members were aware of their status as same sex attracted or gender diverse individuals (Lyons et al., 2019). A national study in Cambodia found nearly 40% of transgender women had experienced sexual abuse and nearly 25% had lost their job due to their gender presentation (Mun et al., 2016). Increased stigma was associated with disclosed sexual orientation and forced condom-less sexual intercourse in Vietnam (Oldenburg et al., 2014).

Bali is one province in Indonesia which has attempted to assimilate historical cultural practices whilst also embracing other cultures. The indigenous Balinese community practises a patriarchal system, which means girls (women, daughters) usually marry and leave the family home while boys (men, sons) bring their wife into the household (Howe, 2006). Balinese men are commonly perceived as the dominant gender in Balinese culture and they enjoy privileged rights and inheritances (Ndun et al., 2018). Therefore, cultural expectations support Balinese men to marry a female and have a family (inheritors). However, there has been limited attempts to acknowledge diverse gender and sexual identities by Balinese religious societies (UNDP & USAID, 2014).

A 2007 review around gender and sexuality regulation in Indonesia discussed an era of reinforcing stigma by declaring homosexuality to be “deviant, unnatural and foreign” (Blackwood, 2007). Studies around stigma and discrimination in Indonesia have mainly focused on Human Immunodeficiency Virus (HIV) positive individuals (Desyani et al., 2019; Mitchell et al., 2019;

Putra et al., 2019; Victoryna et al., 2019). Overall, there is a lack of research focusing on stigma and discrimination experienced by MSM or transgender individuals especially in Bali.

It is important to delineate that the term sex relates to the physical body and is typically assigned to an individual at birth based upon genitals and chromosomes. Male or female are the most common sexes, but an individual's sex may also be indeterminant. Gender identity is a person's individual sense of self in relation to being masculine or feminine. Whilst gender identity will often align with sex (cisgender), some individuals may have a different sense of self and may consider themselves to be transgender, gender diverse or non-binary. Furthermore, an individual's gender identity (the term they use to describe themselves personally or publicly) may differ from their gender expression (how they present themselves in public). Finally, sexuality is another label used to describe who a person is romantically or sexually attracted to. Possible identity labels include heterosexual, homosexual, gay, lesbian, bisexual, pansexual and asexual (Diamond, 2002; Shively & De Cecco, 1977).

The MSM community may include those who identify as homosexual/gay, alongside men who engage in sexual activities with men without self-identifying as homosexual (e.g., male sex workers, bisexual men, and heterosexual men who have other partners). Within Indonesia, transgender women are referred to a *waria*. This is a local term in Indonesia to describe people who form same-sex relationships, and those who exhibit non-binary gender identities (World Health Organization, 2016). A study in Jakarta involving 302 MSM and waria found most waria were routinely exposed to stigma, discrimination, and violence (Safika et al., 2014).

Many MSM who live in Bali come from other part of Indonesia, including from Java. For example, young males from East Java often migrate to Bali for employment opportunities (Alcano, 2016). Engaging in male sex work is also common. These individuals will usually visit family during Ramadhan (Islamic holy month) or during low tourist seasons (Alcano, 2016). Most family/village members do not know about their work in Bali, but when their jobs are revealed, the resultant social stigma both from the family or villagers means they often choose to remain permanently located within Bali (Alcano, 2016). Experience of stigma and discrimination faced by MSM and waria living in Bali, may be different for individuals who were born locally, in comparison to a migrant. This phenomenon is not well understood and is worthy of examination.

This paper describes socio-demographic characteristics of two different cohorts: MSM and waria in Bali, Indonesia, and their stigma and discrimination experiences. The associations between socio-demographic characteristics and stigma and discrimination experiences were assessed for each group.

## Materials and methods

### *Study design, participants, and procedure*

The findings described in this paper are drawn from a large community-engaged research study exploring attitudes, behaviors, and experiences of MSM and waria in Bali, Indonesia.

The sample size calculation was based on an estimation of the MSM population in Bali (14,000 adults (Bali AIDS Commission, 2014)); to obtain 95% confidence level, 5% precision (margin of error), 374 respondents were required (Septarini et al., 2021).

The quantitative cross-sectional survey was conducted from July to September 2020 using the Qualtrics online platform. Survey participants were recruited conveniently using a research partner-driven sampling technique (i.e., ten partners from non-government organizations (NGOs) were involved in this research project). Research partners recruited participants via the internet, short message services, social media campaigns and snowballing (Septarini et al., 2021).

The survey link directed participants to the information sheet and consent prior to the survey. Surveys were self-completed by participants, with the exception of those with low literacy levels ( $n = 47$ ) who were supported by the research partners who read the information sheet, consent, and survey aloud. The voluntary and anonymous nature of the survey was highlighted. The methodology is described in detail elsewhere (Septarini et al., 2021).

### *Sociodemographic characteristics measurements*

The survey was initially written in English and subsequently translated and administered in Bahasa Indonesia. The ten research partners, in addition to four Indonesian public health experts, reviewed the survey for face and content validity (Septarini et al., 2021b).

Demographic characteristics such as age, gender, sexual identity, marital status, education level, employment status, place of birth, religion, current living areas, and HIV+ status were collected. A detailed description of the characteristics and variables have been described elsewhere (Septarini et al., 2021b).

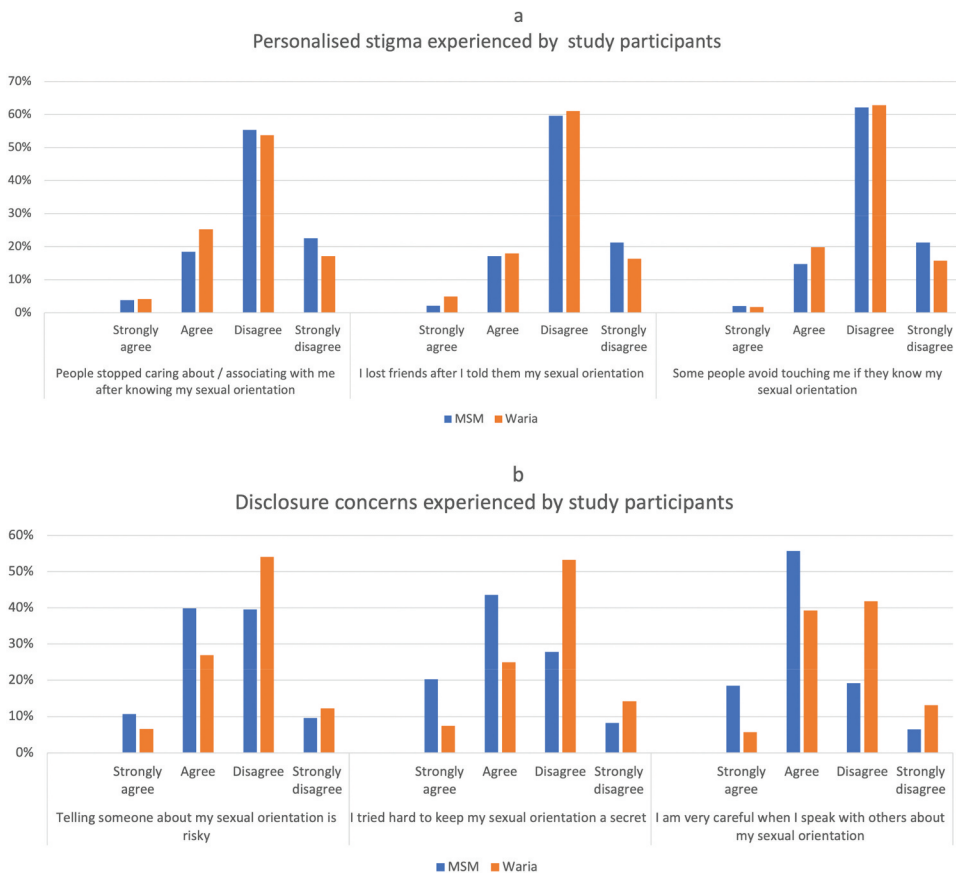
### *Stigma measurement*

The previously validated 12-item short version of the HIV Stigma Scale was used to measure stigma (perceived stigma) (Cronbach  $\alpha > 0.7$ ; Reinius et al., 2017). This 12-item stigma scale was adapted by replacing “HIV status” with “sexual orientation.” This scale includes four sub-domains of perceived stigma: “personalized stigma,” “disclosure concerns,” “concerns about public

attitudes,” and “negative self-image” (Reinius et al., 2017). Figure 1(a–d) describes the four sub-domains. Responses included a Likert scale ranging from strongly agree (1) to strongly disagree (4) (score: 12–48). A previous study summarized the total score for each sub-domain, then grouped the scores into 3 categories (scores 3–5: “lower stigma,” scores 6–9: “fairly high stigma,” and scores 10–12: “higher stigma”; Zeluf-Andersson et al., 2019). However, after analyzing the distribution of the data, due to a large number of low expected frequencies across the three levels of stigma across all four sub-domains (Supplementary Tables S1 and S2), Therefore, stigma was then recoded to “lower stigma” (score ≤ median) and “higher stigma” (score > median). Logistic regression using the enter selection method was used to estimate the association between various characteristics and stigma. Stigma experienced by study participants. Continued.

**Discrimination measurement**

Experienced discrimination (enacted stigma) was assessed using nine validated questions from a national study conducted in Cambodia (Mun et al.,



**Figure 1.** Stigma experienced by study participants.

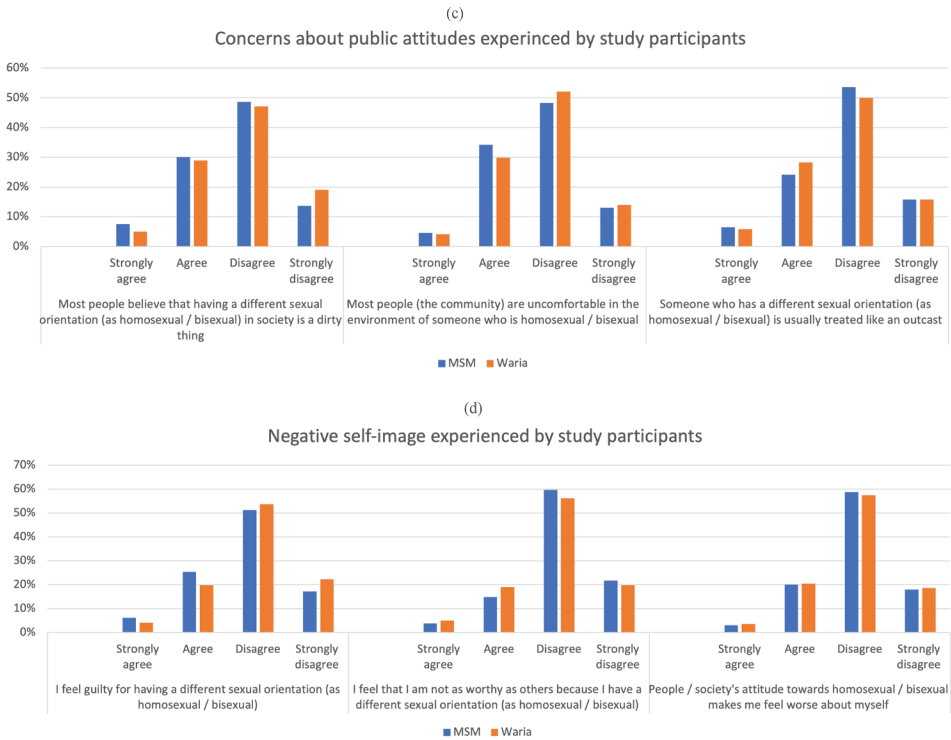


Figure 1. Continued.

2016). Questions focused on experiences related to participants' sexual identity. The nine questions asked about past experiences related to employment, health services, home and school (see, Figure 2). Responses included 'yes', 'no,' and "do not know." The variable was categorized into "ever experienced discrimination" and "never experienced discrimination." To be categorized as

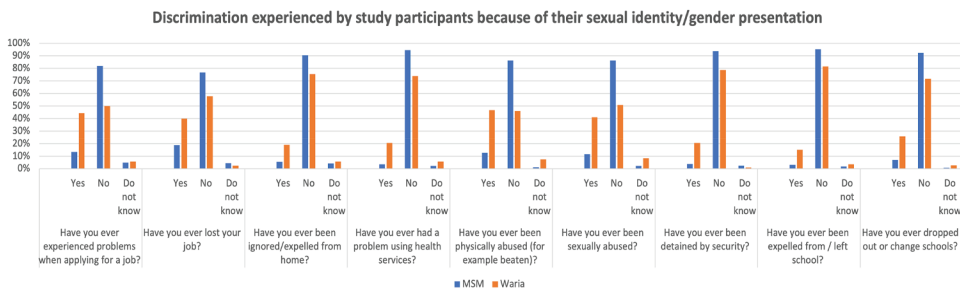


Figure 2. Discrimination experienced by study participants because of their sexual identity/gender presentation.

“ever experienced discrimination” a participant needed to respond “yes” to at least one of the nine questions.

### **Data analysis**

Data were analyzed using SPSS v.26. Descriptive statistics in the form of mean, standard deviation, and range were calculated for continuous variables, and frequency and percentage for categorical socio-demographic variables. Data were reported separately for the MSM and waria cohorts. Frequency and percentage were also reported for each response item of the stigma and discrimination questions, independently for the two cohorts. Stigma was categorized as “lower stigma” and “higher stigma” (Reinius et al., 2017) whilst discrimination was categorized as “ever experienced discrimination” and “never experienced discrimination” (Mun et al., 2016). Subsequently, the distributions of socio-demographic characteristics and stigma experience (low/high), as well as discrimination experience (ever/never), were presented using frequency and percentage. Binary logistic regression models were performed to assess associations between socio-demographic variables with stigma and discrimination experiences whilst adjusting for age, sexual identity, education level, marital status, employment status, place of birth, religion, residential district, and HIV status. Separate logistic regression models were performed for the MSM and waria cohorts. Statistical significance was set at  $p < .05$ .

## **Results**

### **Sociodemographic characteristics of participants**

Responses were received from 416 MSM (70.4%) and waria (29.6%) individuals living in Bali, Indonesia. The mean age of MSM participants was 32.0 (SD = 7.5) years. Common characteristics of MSM participants included: identified as homosexual or tend to be homosexual (67.9%); had graduated from senior high school (58.4%); were single (67.6%); had a regular/full time job (54.6%); were Islamic (54.9%); were from Bali (39.6%); currently resided in an urban area (88.4%); HIV-negative (68.2%); and almost three quarters of participants reported their family were unaware of their MSM identity (72.9%; Table 1).

Waria participants were mostly aged 26–40 years (69.1%); identified as homosexual or tend to be homosexual (79.7%); had graduated from senior high school (38.2%); were single (75.6%); had a regular/full time job (52.8%); were Islamic (59.3%); were from Java (43.1%); currently resided in an urban area (81.3%); HIV-negative (57.4%); and over half reported that their family was accepting of their waria identity (57.9%; Table 1).



**Table 1.** Characteristics of the study participants (N = 416).

Characteristics	MSM n (%)	Waria n (%)
<b>Total participants</b>	293 (70.4)	123 (29.6)
<b>Age (in years)</b>		
Mean (SD)	32.0 (7.5)	34.5 (8.2)
Min-Max	18–59	19–55
<b>Age groups</b>		
18–25	55 (18.8)	14 (11.4)
26–40	201 (68.6)	85 (69.1)
41–60	37 (12.6)	24 (19.5)
<b>Sexual identity</b>		
Heterosexual/tend to be heterosexual	46 (15.7)	21 (17.1)
Homosexual/tend to be homosexual	199 (67.9)	98 (79.7)
Bisexual	48 (16.4)	4 (3.3)
<b>Education level</b>		
No or elementary school	13 (4.4)	34 (27.6)
Junior high school	37 (2.6)	34 (27.6)
Senior high school	171 (58.4)	47 (38.2)
Diploma or higher	72 (34.6)	8 (6.5)
<b>Marital status</b>		
Single (not married, widow)	198 (67.6)	93 (75.6)
Married	30 (10.2)	3 (2.4)
Living with a partner	65 (22.2)	27 (22.0)
<b>Daily activities</b>		
Regular/full time job	160 (54.6)	65 (52.8)
School/college	47 (16.0)	8 (6.5)
No job/ no school	48 (16.4)	20 (16.3)
Home duties/others	38 (13.0)	30 (24.4)
<b>Religion</b>		
Hindu	91 (31.1)	35 (28.5)
Islam	161 (54.9)	73 (59.3)
Others	41 (14.0)	15 (12.2)
<b>Place of born</b>		
Bali	116 (39.6)	46 (37.4)
Java	111 (37.9)	53 (43.1)
Others	66 (22.5)	24 (19.5)
<b>Current living area</b>		
Urban	259 (88.4)	100 (81.3)
Rural	34 (11.6)	23 (18.7)
<b>HIV status</b>		
Positive	93 (31.8)	52 (42.6)
Negative	190 (65.1)	63 (51.6)
Do not know/ have never tested for HIV	9 (3.1)	7 (5.7)
<b>Family attitudes on sexual identity status</b>		
All accept	41 (14.1)	70 (57.9)
Some accept/reject	38 (13.1)	32 (26.4)
Family does not know	212 (72.9)	19 (15.7)

### **Stigma experienced by MSM and waria**

Figure 1 describes the frequency of the 12 stigma items by four sub-domains (“personalized stigma,” “disclosure concern,” “concerns about public attitudes,” and “negative self-image”) as experienced by the MSM and waria participants, separately.

The majority of participants in the MSM group disagreed or strongly disagreed with the following statements from the “personalized stigma” domain: *people stop caring about/associating with me after knowing my sexual orientation* (77.8%); *I lost friends after I told them about my sexual orientation*

(80.8%); *some people avoid touching me if they know my sexual orientation* (83.3%). Similarly, they disagreed/strongly disagreed with the following statements from the “concerns about public attitudes” domain: *most people believe that having a different sexual orientation in society is a dirty thing* (62.3%); *most people are uncomfortable in the environment of someone who is homosexual/bisexual* (61.3%); *someone who has a different sexual orientation is usually treated like an outcast* (69.4%); as well as the “negative self-image” domain: *I feel guilty for having a different sexual orientation* (68.4%); *I feel that I am not as worthy as others because I have a different sexual orientation* (81.4%); and *people/society’s attitude toward homosexual/bisexual makes me feel worse about myself* (76.8%). Despite this, in relation to the “disclosure concern” domain, 20% of MSM participants strongly agreed that they had tried to keep their sexual identity a secret and 18.5% strongly agreed that they were very careful when they spoke with others about their sexual orientation.

For waria participants, 67.5% disagreed/strongly disagreed that they had tried to keep their sexual identity a secret. They also disagreed/strongly disagreed that they were very careful about speaking to others about their sexual orientation (54.9%). Moreover, waria participants disagreed/strongly disagreed with the following statements from the “personalized stigma” domain: *people stop caring about/associating with me after knowing my sexual orientation* (70.8%); *I lost friends after I told about them my sexual orientation* (77.3%); *some people avoid touching me if they know my sexual orientation* (78.5%); as well as the “concerns about public attitudes” domain: *most people believe that having a different sexual orientation in society is a dirty thing* (66.1%); *most people are uncomfortable in the environment of someone who is homosexual/bisexual* (66.1%); *someone who has a different sexual orientation is usually treated like an outcast* (65.8%); and the “negative self-image” domain: *I feel guilty for having a different sexual orientation* (76.0%); *I feel that I am not as worthy as others because I have a different sexual orientation* (76.0%); and *people/society’s attitude toward homosexual/bisexual makes me feel worse about myself* (76.1%).

### **Discrimination amongst MSM and waria**

Figure 2 presents the response of MSM and waria participants toward each of the nine discrimination items. Over their lifetime, 13% of MSM participants had experienced problems when applying for a job and 19% had lost their job due to their sexual identity/gender presentation.

Over 40% of waria participants had experienced problems when applying for a job and nearly 40% of them had lost their job due to their sexual identity/gender presentation. Waria participants also reported *being ignored/expelled from home* (18.9%); *a problem using health services* (20.5%); *being physically*

*abused (46.7%); being sexually abused (41.0%); being expelled from school/left school (15.1%); and dropping out of school or changing schools (25.7%).*

### **Associations between characteristics and stigma and discrimination experienced by MSM and waria**

Table 2 presents the prevalence of stigma and discrimination experienced by MSM and waria participants. When considered collectively, around half of all participants reported lower levels of stigma (53.9%) and had never experienced discrimination (53.6%). Separate analyses for each group indicated that for MSM participants, 50.5% reported lower levels of stigma and 64.5% reported no previous experience of discrimination. For waria participants, 62.7% reported lower levels of stigma and 27.6% had never experienced discrimination.

Table 3 presents the association between various characteristics of MSM participants, and their experiences of stigma and discrimination. Among MSM participants, the odds of experiencing high levels of stigma were lower amongst non-Hindu MSM (aOR = 0.53, 95%CI = [-0.31, 0.91]). MSM for whom some of their family reject their MSM status were four times more likely to experience high levels of stigma (aOR = 4.13, 95%CI = [1.49, 11.42]), and MSM whose family members did not know their MSM status were also almost five times more likely to feel high levels of stigma (aOR = 4.94, 95%CI = [2.16, 11.33]) compared to those for whose family had accepted their MSM status. Age groups, sexual identity, educational level, marital status, employment status, place of birth, current living area, and HIV status were not significantly associated with stigma amongst the MSM cohort.

However, experience of discrimination amongst MSM was significantly associated with marital status and religion. MSM who were married or living with a partner were twice as likely to experience discrimination compared to single participants (aOR = 2.04, 95%CI = [1.21, 3.45]). MSM participants with a religion other than Hindu were nearly three times as likely as Hindu MSM participants to experience discrimination (aOR = 2.82, 95%CI = [1.56, 5.09]). After adjustment for the same covariates, age groups, sexual identity, place of

**Table 2.** Prevalence of stigma and discrimination amongst the study participants.

Characteristics, n (%)	MSM 293 (70.4)	Waria 123 (29.6)	Total 416 (100)
<b>Stigma</b>			
Lower stigma	143 (50.5)	69 (62.7)	212 (53.9)
Higher stigma	140 (49.5)	41 (37.3)	181 (46.1)
<b>Discrimination</b>			
Never experienced	189 (64.5)	34 (27.6)	223 (53.6)
Ever experienced	104 (35.5)	89 (72.4)	193 (46.4)

**Table 3.** Associations between characteristics and stigma and discrimination experienced by MSM, presented with adjusted\* odds ratio (aOR) and 95% confidence interval (95% CI) of aOR.

Characteristics	Stigma		Discrimination					
	Lower stigma (score ≤ median)	Higher stigma (score > median)	Stigma (aOR, 95% CI)	p-value	Never experienced discrimination	Ever experienced discrimination	Discrimination (aOR, 95% CI)	p-value
<b>Age groups</b>								
18–25	20 (14.0)	34 (24.3)	1		36 (19.0)	19 (18.3)	1	
26–40	107 (74.8)	87 (62.1)	0.55 (0.29, 1.04)	.064	126 (66.7)	75 (71.1)	1.16 (0.58, 2.32)	0.68
41–60	16 (11.2)	19 (13.6)	0.85 (0.34, 2.14)	.725	27 (14.3)	10 (9.6)	0.79 (0.28, 2.25)	0.665
<b>Sexual identity</b>								
Heterosexual/tend to be heterosexual	24 (16.8)	20 (14.3)	1		32 (16.9)	14 (13.5)	1	
Homosexual/homosexual	101 (70.6)	90 (64.3)	1.40 (0.68, 2.92)	.362	122 (64.6)	77 (74.0)	1.59 (0.77, 3.29)	0.214
Bisexual	18 (12.6)	30 (21.4)	1.56 (0.65, 3.74)	.321	35 (18.5)	13 (12.5)	0.99 (0.39, 2.52)	0.979
<b>Education level</b>								
No or elementary school	8 (5.6)	5 (3.6)	1		7 (3.7)	6 (5.8)	1	
Junior high school	15 (10.5)	21 (15.0)	1.40 (0.35, 5.61)	.637	19 (10.1)	18 (17.3)	1.65 (0.42, 6.53)	0.476
Senior high school	81 (56.6)	86 (61.4)	0.92 (0.26, 3.22)	.893	108 (57.1)	63 (60.6)	1.12 (0.32, 3.91)	0.854
Diploma or higher	39 (27.3)	28 (20.0)	0.60 (0.16, 2.28)	.454	55 (29.1)	17 (16.3)	0.64 (0.17, 2.46)	0.518
<b>Marital status</b>								
Single (not married, widow)	93 (65.0)	97 (69.3)	1		138 (73.0)	60 (57.7)	1	
Married/ living with a partner	50 (35.0)	43 (30.7)	0.98 (0.55, 1.74)	.953	51 (27.0)	44 (42.3)	2.04 (1.21, 3.45)	<b>0.008</b>
<b>Daily activities/Employment status</b>								
Regular/full time job	77 (53.8)	75 (53.6)	1		108 (57.1)	52 (50.0)	1	
School/college	21 (14.7)	25 (17.9)	0.95 (0.45, 2.04)	.905	30 (15.9)	17 (16.3)	1.41 (0.66, 3.00)	0.369
No job/ no school/home duties	45 (31.5)	40 (28.6)	0.92 (0.51, 1.66)	.795	51 (27.0)	35 (33.7)	1.46 (0.81, 2.66)	0.209
<b>Place of born</b>								
Bali	49 (34.3)	65 (46.4)	1		86 (45.5)	30 (28.8)	1	
Java	61 (42.7)	42 (30.0)	0.86 (0.35, 2.10)	.746	66 (34.9)	45 (43.3)	0.79 (0.31, 1.99)	0.612
Others	33 (23.1)	33 (23.6)	1.18 (0.47, 2.96)	.718	37 (19.6)	29 (27.9)	0.89 (0.34, 2.33)	.821
<b>Religion</b>								
Hinduism	35 (24.5)	54 (38.6)	1		72 (38.1)	19 (18.3)	1	
Others	108 (75.5)	86 (61.4)	0.53 (0.31, 0.91)	<b>.020</b>	117 (61.9)	85 (81.7)	2.82 (1.56, 5.09)	<b>.001</b>

(Continued)

Table 3. (Continued).

Characteristics	Stigma		Discrimination				<i>p</i> -value
	Lower stigma (score ≤ median)	Higher stigma (score > median)	Stigma (aOR, 95% CI)	<i>p</i> -value	Never experienced discrimination	Ever experienced discrimination	
<b>Current living area</b>							
Urban	128 (89.5)	122 (87.1)	1		161 (85.2)	98 (94.2)	1
Rural	15 (10.5)	18 (12.9)	0.79 (0.34, 1.81)	.578	28 (14.8)	6 (5.8)	0.53 (0.20, 1.39)
<b>HIV status</b>							
Positive	52 (36.6)	39 (27.9)	1		61 (32.3)	32 (31.1)	1
Negative /Do not know	90 (63.4)	101 (72.1)	1.30 (0.76, 2.24)	.343	128 (67.7)	71 (68.9)	1.44 (0.82, 2.56)
<b>Family attitudes on sexual identity status</b>							
All accept	32 (22.5)	8 (5.8)	1		24 (12.8)	17 (16.5)	1
Some accept/reject	18 (12.7)	19 (13.7)	4.13 (1.49, 11.42)	<b>.006</b>	20 (10.6)	18 (17.5)	1.49 (0.57, 3.92)
Family does not know	92 (64.8)	112 (80.6)	4.94 (2.16, 11.33)	<b>&lt;0.001</b>	144 (76.6)	68 (66.0)	0.84 (0.39, 1.80)

1. \*adjusted for age, sexual identity, education level, marital status, employment status, place of birth, religion, current living area, and HIV status.

**Table 4.** Associations between characteristics and stigma and discrimination experienced by transgender, presented with adjusted\* odds ratio (aOR) and 95% confidence interval (95% CI) of aOR.

Characteristics	Stigma			Discrimination				
	Lower stigma (score ≤ median)	Higher stigma (score > median)	Stigma (aOR, 95% CI)	p-value	Never experienced discrimination	Ever experienced discrimination	Discrimination (aOR, 95% CI)	p-value
<b>Age groups</b>								
18–25	7 (10.1)	6 (14.6)	1		4 (11.8)	10 (11.2)	1	
26–40	44 (63.8)	31 (75.6)	0.62 (0.18, 2.14)	.454	19 (55.9)	66 (74.2)	0.79 (0.14, 4.41)	.784
41–60	18 (26.1)	4 (9.8)	0.31 (0.06, 1.48)	.142	11 (32.4)	13 (14.6)	0.56 (0.08, 4.19)	.574
<b>Sexual identity</b>								
Heterosexual/tend to be heterosexual	5 (7.2)	12 (29.3)	1		4 (11.8)	17 (19.1)	1	
Homosexual/tend to be homosexual	61 (88.4)	28 (68.3)	0.19 (0.06, 0.59)	<b>.004</b>	27 (79.4)	71 (79.8)	0.75 (0.15, 3.74)	.723
Bisexual	3 (4.3)	1 (2.4)	0.14 (0.01, 1.68)	.121	3 (8.8)	1 (1.1)	0.02 (0.00, 0.80)	<b>.038</b>
<b>Education level</b>								
No or elementary school	16 (23.2)	11 (26.8)	1		9 (26.5)	25 (28.1)	1	
Junior high school	17 (24.6)	14 (34.1)	1.42 (0.41, 4.89)	.578	10 (29.4)	24 (27.0)	0.93 (0.25, 3.49)	.911
Senior high school	31 (44.9)	13 (31.7)	0.72 (0.20, 2.57)	.616	14 (41.2)	33 (37.1)	1.42 (0.39, 5.16)	.593
Diploma or higher	5 (7.2)	3 (7.3)	1.10 (0.15, 7.82)	.926	1 (2.9)	7 (7.9)	28.60 (1.24, 657.43)	.036
<b>Marital status</b>								
Single (not married, widow)	53 (76.8)	28 (68.3)	1		25 (73.5)	68 (76.4)	1	
Married/living with a partner	1 (23.2)	1 (31.7)	0.98 (0.34, 2.75)	.961	9 (26.5)	21 (23.6)	0.70 (0.21, 2.40)	.575
<b>Employment status</b>								
Regular/full time job	35 (50.7)	26 (63.4)	1		15 (44.1)	50 (56.2)	1	
School/college	4 (5.8)	3 (7.3)	0.60 (0.10, 3.51)	.563	4 (11.8)	4 (4.5)	0.13 (0.02, 0.89)	<b>.038</b>
No job/ no school/home duties	30 (43.5)	12 (29.3)	0.48 (0.17, 1.32)	.155	15 (44.1)	35 (39.3)	0.39 (0.13, 1.15)	.089
<b>Place of birth</b>								
Bali	25 (36.2)	19 (46.3)	1		21 (61.8)	25 (28.1)	1	
Java	31 (44.9)	14 (34.1)	0.40 (0.14, 1.12)	.081	12 (35.3)	41 (46.1)	0.27 (0.02, 4.24)	.35
Others	8 (18.8)	13 (19.5)	0.44 (0.13, 1.53)	.194	1 (2.9)	23 (25.8)	1.85 (0.06, 52.33)	.718

(Continued)

Table 4. (Continued).

Characteristics	Stigma			Discrimination				
	Lower stigma (score ≤ median)	Higher stigma (score > median)	Stigma (aOR, 95% CI)	p-value	Never experienced discrimination	Ever experienced discrimination	Discrimination (aOR, 95% CI)	p-value
<b>Religion</b>								
Hinduism	21 (30.4)	12 (29.3)	1		19 (55.9)	16 (18.0)	1	
Others	48 (69.6)	29 (70.7)	2.70 (0.51, 14.26)	.244	15 (44.1)	73 (82.0)	21.77 (1.34, 353.81) <sup>#</sup>	.030
<b>Current living area</b>								
Urban	55 (79.7)	33 (80.5)	1		23 (67.6)	77 (86.5)	1	
Rural	14 (20.3)	8 (19.5)	0.99 (0.24, 4.00)	.986	11 (32.4)	12 (13.5)	0.48 (0.10, 2.29)	.357
<b>HIV status</b>								
Positive	28 (40.6)	18 (45.0)	1		13 (38.2)	39 (44.3)	1	
Negative/ Do not know	41 (59.4)	22 (55.0)	0.65 (0.27, 1.57)	.34	21 (61.8)	49 (55.7)	0.88 (0.28, 2.72)	.819
<b>Family attitudes on sexual identity status</b>								
All accept	44 (64.7)	19 (46.3)	1		22 (66.7)	48 (54.5)	1	
Some accept/reject	14 (20.6)	15 (36.6)	1.95 (0.70, 5.48)	.204	3 (9.1)	29 (33.0)	4.48 (0.87, 23.00)	.073
Family does not know	10 (14.7)	7 (17.1)	1.79 (0.49, 6.53)	.375	8 (24.2)	11 (12.5)	0.603 (0.15, 2.42)	.476

a \*adjusted for age, sexual identity, education level, marital status, employment status, place of birth, religion, current living area, and HIV status.

b # prediction was too imprecise to illustrate the relationship.

birth, educational level, employment status, current living area, and HIV status were not statistically associated with discrimination.

Table 4 presents the association between various characteristics and experiences of stigma and discrimination amongst waria participants. Compared to participants identifying as heterosexual/tend to be heterosexual, waria participants who self-identified as homosexual/tend to be homosexual had lower odds of experiencing high levels of stigma (aOR = 0.19, 95%CI = [0.06, 0.58]). No other variables were found to be significantly associated with stigma experienced by waria.

In relation to discrimination, there were statistically significant associations for sexual identity and daily activities/employment status. Bisexual waria participants, compared to heterosexual waria participants, had slightly lower odds of experiencing discrimination (aOR = 0.02, 95%CI = [0.00, 0.80]). Waria participants who were students/went to school/college were less likely to experience discrimination compared to those who had regular or full-time jobs (aOR = 0.13, 95%CI = [0.02, 0.89]). Other variables including age group, marital status, place of birth, current living area, and HIV status were not significantly associated with discrimination amongst waria participants.

## Discussion

In Indonesia, for over a decade, groups have advocated against stigma and discrimination among gender and sexual diverse people (Ridwan & Wu, 2018). In Indonesia same sex relations are not criminalized (except in the Aceh Province which has adopted Sharia law), and this provides opportunity for popular gay and waria entertainers to perform on television. The same sex attracted and gender diverse community is largely accepted, especially in urban areas. However, some movements (specific religion activists and some politicians) reject the existence of gender and sexual diverse people stating “LGBT is a disease, not a human right” (Mollman, 2016).

Several studies conducted throughout Indonesia demonstrate a high prevalence of stigma around sexual identity and HIV (Desyani et al., 2019; Victoryna et al., 2019; Waluyo et al., 2021) especially among female sex workers and MSM (Wirawan, 2019). Experience of stigma varied between sub-domains for MSM participants in this study. MSM participants reported high levels of stigma related to disclosure with 63.9% of MSM participants reporting they kept their sexual orientation a secret and 74.3% indicating they were careful when speaking to others about their sexual orientation. Studies in Myanmar and China suggest hidden MSM often do not disclose their same-sex behavior but engage in identity practice negotiation, by never admitting that they are MSM, as a strategy to avoid stigma and discrimination from their families and communities (Steward et al., 2013; Veronese et al., 2019). The need to hide their identity may exacerbate barriers for MSM around their



sexual health seeking behaviors (Veronese et al., 2019). However, a study across 28 countries with high levels of stigma found concealment of sexual orientation partially protects individuals against discrimination and victimization even though this concealment may compromise their life satisfaction (Pachankis & Bränström, 2018).

As most MSM participants in this study did not disclose their MSM status to their family (72.9%), it may be that as a hidden population, their sexual identity was not recognized publicly, hence these participants may have been less likely to experience discrimination. An Indonesian study conducted in Bandung found of the 13% of young MSM who disclosed their MSM status to their families, one-third experienced stigma and discrimination (Johnston et al., 2021). Another study found adolescent MSM were pressured to hide their sexual identity to avoid rejection and hostility (Harrison, 2003). A qualitative study conducted in China found MSM to fear stigma, however as most had not disclosed their status, they had not personally experienced discrimination. Participants also reported cultural pressures including the expectation that sons will marry (Steward et al., 2013). In the current study almost three quarters (72.4%) of waria participants, who are less able to hide their identity than MSM participants, reported to have experienced at least one type of discrimination. Islamic beliefs in Indonesia suggest being transgender or waria is a deviation from human nature (Afif, 2019). Others have reported similar findings. Altman et al. (2012) reported the prejudice and discrimination experienced by waria is undoubtedly far greater than that encountered by other MSM in many societies. Moreover, female transgender participants in a Thai study reported experiences of employment discrimination and faced difficulties when applying for a job (Ojanen et al., 2019). Another study revealed the more people are aware of an individual's status as transgender women, the greater probability of violence and discrimination (Lombardi et al., 2002). Currently there are no published studies focusing on waria acceptance in Balinese society.

This study found factors significantly associated with overall stigma amongst MSM participants included religion, and family disclosure or acceptance. Non-Hindu MSM were significantly more likely to report lower levels of stigma compared to Hindu participants. This may be because these participants were more likely to be born outside Bali, whereas Hindu participants who are native to Bali may feel more stigma as they are living in their own community. This is consistent with the concept that stigma is universal, but experiences are local (Murthy, 2002). Local people may experience perceived stigma, be more concerned about disclosing their sexual identity, be more concerned about local people's attitude toward them, and therefore, have more negative self-image compared to those who have not grown up in the community. The United States-based Pew Research Institute which polled 38,426 participants across 34 countries in 2019 found that 9% of Indonesians agreed

that homosexuality should be accepted by society, compared to only 3% in 2013 (as cited in Adjie, 2020). Rural gay men in Pennsylvania, US found exposure to stigma was predominant in the areas in which these gay men lived (Preston et al., 2007a).

Family attitudes toward MSM status of participants were strongly associated with stigma for MSM. MSM who reported partial acceptance from family members reported higher levels of stigma compared to those individuals where all family members had accepted their MSM status. In the Eswanti study, same sex and gender diverse participants were more likely to feel excluded and gossiped about by family members, when family were aware of their sexual attraction or gender identity. However, it was not reported if participants' family had accepted their sexuality or gender status (Lyons et al., 2019). These findings confer with those of this study suggesting MSM may hide their identity from family to avoid discrimination.

Participants who were married and/or living with a partner were more likely to experience discrimination compared to those MSM who were single, not married or widowed. In Indonesia, it is perceived that a man should get married to a woman and be a responsible and dutiful husband (Boellstorff, 2005). Being married is one way to hide sexual orientation from family and communities, to preserve family and keep the family free from ridicule. Due to the cross-sectional nature of this study, and the focus on lifetime experience of discrimination, it was not known if discrimination or marriage occurred first. Similarly, in China marriage is considered an important part of fulfilling social and family expectations and is used as a strategy of MSM to avoid societal discrimination (Steward et al., 2013). In India, MSM were likely to marry females in order to follow societal norms and to have children (Solomon et al., 2010). Moreover, in Asian countries, religion and traditional beliefs highlight that lack of a female relationship mirrors some sort of "problem" with the person, either physical or psychological, with suggestions of "abnormality" associated with being single/unmarried (Liu & Choi, 2006), therefore, marriage is a common strategy to overcome the "problem."

MSM participants who follow religions other than Hinduism were more likely to experience discrimination compared to Hindu participants. Intersectionality theory suggests an individual's identity is heterologous, meaning multiple variables are likely to influence identity (Atewologun, 2018). This theory offers theoretical explanations of the ways in which heterogeneous members of specific groups (such as MSM) might experience discrimination differently, not only depending on one social variable but multiple social variables such as their religion, ethnicity, and other social factors (Atewologun, 2018). For example, a Hindu, Balinese born MSM teenager may experience discrimination differently compared to a Muslim, non-Balinese born MSM adult due to a range of ecological factors.

Factors that significantly influenced stigma and discrimination amongst waria participants included sexual identity and employment status, education level, and religion. However, education level and religion were too imprecise to illustrate the relationship with discrimination (wide 95% confidence intervals). Waria participants who identified as bisexual were significantly less likely to experience discrimination compared to those who identified as heterosexual. In contrast, a qualitative study conducted in Timor Leste found *mane-for-te* (heterosexual identifying men) discussed hiding their sexual relationships with MSM and waria; sustaining their masculine identity with women; and having more evident relationships with women to prevent discrimination (Niven et al., 2018).

Despite the novel elements that this study identified, this work is not without some limitations. The study used research partners to administer the survey. While this was an important strategy of this community engaged project, participants from rural areas, and those not engaged with the partners' organizations may have been less likely to participate. A small proportion required the support of partners to complete the survey due to literacy issues which may have biased responses. This study focused on MSM and waria living in Bali and hence may not be generalizable to other provinces of Indonesia, or other countries.

## Conclusion

Despite varying levels of stigma and discrimination experienced by MSM in Bali, higher levels of stigma was associated with religion and familial support. Discrimination was significantly associated with marital status and religion. Amongst waria, sexual identity influenced stigma, while sexual identity and employment status were significant factors for discrimination. The community-engaged research focus of this project provides opportunity for the development of relevant strategies with the non-government organizations involved with this project. The findings highlight the need for specific strategies to engage families as familial support was found to be a significant factor in reducing stigma amongst MSM. Advocacy for legislation to reduce workplace discrimination is important as currently there is no anti-discrimination in workplaces law specific to LGBT people in Indonesia (Equaldex, 2022).

## Acknowledgments

The authors are grateful to all ten research partners, three Bali-based public health experts, research participants, and Australia Awards Scholarship for supporting this research.

## Disclosure statement

No potential conflict of interest was reported by the author(s).

## Funding

This paper is based on a research project that is funded through the Australia Awards Scholarship and administered through the doctoral program at the School of Public Health, Curtin University.

## ORCID

Jacqueline Hendriks  <http://orcid.org/0000-0002-1177-8980>

## Data availability statement

Derived supporting data of this study are available on request from the corresponding author. Access data set requests should be directed to Ni Wayan Septarini, [septarini@unud.ac.id](mailto:septarini@unud.ac.id).

## References

- Adjie, M. (2020, June 28). Survey on acceptance in Indonesia gives hopes to LGBT community. The Jakarta Post. <https://www.thejakartapost.com/news/2020/06/28/survey-on-acceptance-in-indonesia-gives-hopes-to-lgbt-community.html>
- Afif, M. B. (2019). Islam and transgender (A study of Hadith about transgender). *International Journal of Nusantara Islam*, 7(2), 185–189. <https://journal.uinsgd.ac.id/index.php/ijni/article/view/6138/3384>
- Alcano, M. C. (2016). *Masculine identities and male sex work between east java and Bali: An ethnography of youth, bodies, and violence*. Springer.
- Altman, D., Aggleton, P., Williams, M., Kong, T., Reddy, V., Harrad, D., Reis, T., & Parker, R. (2012). Men who have sex with men: Stigma and discrimination. *The Lancet*, 380(9839), 439–445. [https://dx.doi.org/10.1016/S0140-6736\(12\)60920-9](https://dx.doi.org/10.1016/S0140-6736(12)60920-9)
- Atewologun, D. (2018). *Intersectionality theory and practice*. Oxford Research Encyclopedia of Business and Management.
- Bali AIDS Commission. (2014). *Estimation of key affected population in 2014 in Bali districts and Bali Province*.
- Blackwood, E. (2007). Regulation of sexuality in Indonesian discourse: Normative gender, criminal law and shifting strategies of control. *Culture, Health & Sexuality*, 9(3), 293–307. <https://doi.org/10.1080/13691050601120589>
- Boellstorff, T. (2005). Between religion and desire: Being Muslim and gay in Indonesia. *American Anthropologist*, 107(4), 575–585. <https://doi.org/10.1525/aa.2005.107.4.575>
- Boya, H., Yang, V. F., & Goldsen Karen, F. (2019). LGBT older adults at a crossroads in mainland China: The intersections of stigma, cultural values, and structural changes within a shifting context. *The International Journal of Aging & Human Development*, 88(4), 440–456. <https://doi.org/10.1177/0091415019837614>
- Brown, J., Low, W. Y., Tai, R., & Tong, W. T. (2016). Shame, internalized homonegativity, and religiosity: a comparison of the stigmatization associated with minority stress with gay men

- in Australia and Malaysia [article]. *International Journal of Sexual Health*, 28(1), 28–36. <https://doi.org/10.1080/19317611.2015.1068902>
- Centers for Disease Control and Prevention. (2016). Gay and bisexual men's health. *CDC*. Retrieved October 8, 2016 from <https://www.cdc.gov/msmhealth/stigma-and-discrimination.htm>
- Desyani, N. L. J., Waluyo, A., & Yona, S. (2019). The relationship between stigma, religiosity, and the quality of life of HIV-positive MSM in Medan, Indonesia. *Enfermeria Clinica*, 29, 510–514. <https://doi.org/10.1016/j.enfcli.2019.04.026>
- Diamond, M. (2002). Sex and gender are different: Sexual identity and gender identity are different. *Clinical Child Psychology and Psychiatry*, 7(3), 320–334. <https://doi.org/10.1177/1359104502007003002>
- Diehl, A., Vieira, D. L., Zaneti, M. M., Fanganiello, A., Sharan, P., Robles, R., & De Jesus Mari, J. (2017). Social stigma, legal and public health barriers faced by the third gender phenomena in Brazil, India and Mexico: Travestis, hijras and muxes. *International Journal of Social Psychiatry*, 63(5), 389–399. <https://doi.org/10.1177/0020764017706989>
- Equaldex. (2022). LGBT rights in Indonesia <https://www.equaldex.com/region/indonesia>
- Harrison, T. W. (2003). Adolescent homosexuality and concerns regarding disclosure. *The Journal of School Health*, 73(3), 107–112. <https://doi.org/10.1111/j.1746-1561.2003.tb03584.x>
- Hassan, N. R., Swartz, L., Kagee, A., De Wet, A., Lesch, A., Kafaar, Z., & Newman, P. A. (2018). “There is not a safe space where they can find themselves to be free”: (Un)safe spaces and the promotion of queer visibilities among township males who have sex with males (MSM) in Cape Town, South Africa. *Health & Place*, 49, 93–100. <https://doi.org/10.1016/j.healthplace.2017.11.010>
- Howe, L. (2006). *The changing world of Bali: Religion, society and tourism*. Routledge.
- Johnston, L. G., Soe, P., Widiastuti, A. S., Camellia, A., Putri, T. A., Rakhmat, F. F., Nurwandani, R. A., Prabhu, S. M., Sulaiman, N., & Pronyk, P. M. (2021). Alarmingly high HIV prevalence among adolescent and young men who have sex with men (MSM) in Urban Indonesia. *AIDS and Behavior*, 25(11), 3687–3694. <https://doi.org/10.1007/s10461-021-03347-0>
- Kim, H.-Y., Grosso, A., Ky-Zerbo, O., Lougue, M., Stahlman, S., Samadoulougou, C., Ouedraogo, G., Kouanda, S., Liestman, B., & Baral, S. (2018). Stigma as a barrier to health care utilization among female sex workers and men who have sex with men in Burkina Faso. *Annals of Epidemiology*, 28(1), 13–19. <https://doi.org/10.1016/j.annepidem.2017.11.009>
- Liu, J. X., & Choi, K. (2006). Experiences of social discrimination among men who have sex with men in Shanghai, China. *AIDS and Behavior*, 10(4 Suppl), S25–33. <https://doi.org/10.1007/s10461-006-9123-5>
- Lombardi, E. L., Wilchins, R. A., Priesing, D., & Malouf, D. (2002). Gender violence: Transgender experiences with violence and discrimination. *Journal of Homosexuality*, 42(1), 89–101. [https://doi.org/10.1300/J082v42n01\\_05](https://doi.org/10.1300/J082v42n01_05)
- Lyons, C., Stahlman, S., Holland, C., Ketende, S., Van Lith, L., Kochelani, D., Mavimbela, M., Sithole, B., Maloney, L., Maziya, S., & Baral, S. (2019). Stigma and outness about sexual behaviors among cisgender men who have sex with men and transgender women in Eswatini: A latent class analysis. *BMC Infectious Diseases*, 19(1), 211. <https://dx.doi.org/10.1186/s12879-019-3711-2>
- Mitchell, E., Lazuardi, E., Rowe, E., Anintya, I., Wirawan, D. N., Wisaksana, R., Subronto, Y. W., Prameswari, H. D., Kaldor, J., & Bell, S. (2019). Barriers and enablers to HIV care among waria (transgender women) in Indonesia: A qualitative study [Journal article]. *AIDS Education and Prevention*, 31(6), 538–552. <https://link.lis.curtin.edu.au/cgi-bin/ezproxy/ezpgateway.cgi?url=http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=cagh&AN=20203081497>

- Mollman, S. (2016). "LGBT is a disease, not a human right": A growing movement in Indonesia rejects gay rights. *Quartz*. Retrieved December 14, 2016 from <https://qz.com/617445/lgbt-is-a-disease-not-a-human-right-a-growing-movement-in-indonesia-rejects-gay-rights/>
- Mun, P., Tuot, S., Chhim, S., Chhoun, P., Ly, C., Pal, K., Ngim, C., & Yi, S. (2016). *Integrated biological and behavioral survey among transgender women in Cambodia*. NCHADS and HIV/AIDS Flagship Project 2016.
- Murthy, R. S. (2002). Stigma is universal but experiences are local. *World Psychiatry*, 1(1), 28. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1489817/>
- Ndun, H. C., Suttor, S., & Widhiyaastuti, I. G. A. A. D. (2018). Does customary law discriminate Balinese women's inheritance rights? *Udayana Journal of Law and Culture*, 2(1), 97–114. <https://doi.org/10.24843/UJLC.2018.v02.i01.p05>
- Niven, H., Jose, H., Rawstorne, P., & Nathan, S. (2018). 'They love us just the way they love a woman': Gender identity, power and transactional sex between men who have sex with men and transgender women in Timor-Leste. *Culture, Health & Sexuality*, 20(8), 858–872. <https://doi.org/10.1080/13691058.2017.1388928>
- Ojanen, T. T., Burford, J., Juntrasook, A., Kongsup, A., Assatarakul, T., & Chaiyajit, N. (2019). Intersections of LGBTI exclusion and discrimination in Thailand: The role of socio-economic status [article]. *Sexuality Research and Social Policy*, 16(4), 529–542. <https://doi.org/10.1007/s13178-018-0361-x>
- Oldenburg, C. E., Biello, K. B., Colby, D., Closson, E. F., Thi, M., Thi, N., Nguyen, N. A., & Mimiaga, M. J. (2014). Stigma related to sex work among men who engage in transactional sex with men in Ho Chi Minh City, Vietnam. *International Journal of Public Health*, 59(5), 833–840. <https://dx.doi.org/10.1007/s00038-014-0562-x>
- Pachankis, J. E., & Bränström, R. (2018). Hidden from happiness: Structural stigma, sexual orientation concealment, and life satisfaction across 28 countries. *Journal of Consulting and Clinical Psychology*, 86(5), 403. <https://doi.org/10.1037/ccp0000299>
- Padilla, M., Castellanos, D., Guilamo-Ramos, V., Reyes, A. M., Sánchez Marte, L. E., & Soriano, M. A. (2008). Stigma, social inequality, and HIV risk disclosure among dominican male sex workers. *Social Science & Medicine*, 67(3), 380–388. <https://doi.org/10.1016/j.socscimed.2008.03.014>
- Preston, D. B., D'Augelli, A. R., Kassab, C. D., Cain, R. E., Schulze, F. W., & Starks, M. T. (2004). The influence of stigma on the sexual risk behavior of rural men who have sex with men. *AIDS Education and Prevention*, 16(4), 291–303. <https://www.proquest.com/scholarly-journals/influence-stigma-on-sexual-risk-behavior-rural/docview/198063799/se-2>
- Preston, D. B., D'augelli, A. R., Kassab, C. D., & Starks, M. T. (2007a). The relationship of stigma to the sexual risk behavior of rural men who have sex with men. *AIDS Education & Prevention*, 19(3), 218–230.
- Preston, D. B., D'Augelli, A. R., Kassab, C. D., & Starks, M. T. (2007b). The relationship of stigma to the sexual risk behavior of rural men who have sex with men. *AIDS Education and Prevention*, 19(3), 218–230. <https://search.proquest.com/docview/20296866?accountid=10382>
- Putra, I. N. A. M., Waluyo, A., & Yona, S. (2019). The correlation between stigma and family acceptance with religiosity of PLWH MSM in Medan, Indonesia. *Asian/Pacific Island Nursing Journal*, 4(3), 123. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6753846/pdf/apinj-04-123.pdf>
- Reinius, M., Wettergren, L., Wiklander, M., Svedhem, V., Ekström, A. M., & Eriksson, L. E. (2017). Development of a 12-item short version of the HIV stigma scale. *Health and Quality of Life Outcomes*, 15(1), 115. <https://hqlo.biomedcentral.com/track/pdf/10.1186/s12955-017-0691-z>



- Ridwan, R., & Wu, J. (2018). 'Being young and LGBT, what could be worse?' Analysis of youth LGBT activism in Indonesia: Challenges and ways forward. *Gender and Development*, 26(1), 121–138. <https://doi.org/10.1080/13552074.2018.1429103>
- Safika, I., Johnson, T. P., Cho, Y. I., & Praptoraharjo, I. (2014). Condom Use Among Men Who Have Sex With Men and Male-to-Female Transgenders in Jakarta, Indonesia. *American Journal of Men's Health*, 8(4), 278–288. <https://doi.org/10.1177/1557988313508430>
- Septarini, N. W., Burns, S., & Maycock, B. (2021). THE CABE PROJECT: Developing a model to conceptualise the sexual attitudes, behaviours, and experiences of men who have sex with men and Waria in Bali, Indonesia: Protocol for a mixed-methods design within a community-engaged research study. *Research Methods in Medicine & Health Sciences*, 3(1), 2–10. <https://doi.org/10.1177/26320843211061294>
- Septarini, N. W., Hendriks, J., Maycock, B., & Burns, S. (2021a). Methodologies of stigma-related research amongst men who have sex with men (MSM) and transgender people in Asia and the Pacific Low/Middle Income Countries (LMICs): A scoping review. *Frontiers in Reproductive Health*, 73. <https://doi.org/10.3389/frph.2021.688568>
- Septarini, N. W., Hendriks, J., Maycock, B., & Burns, S. (2021b). Psychological distress and happiness of men who have sex with men and transgender people during the coronavirus disease-19 pandemic: Is there a need for public health policy intervention? *Frontiers in Public Health*, 1350. <https://doi.org/10.3389/fpubh.2021.647548>
- Shively, M. G., & De Cecco, J. P. (1977). Components of sexual identity. *Journal of Homosexuality*, 3(1), 41–48. [https://doi.org/10.1300/J082v03n01\\_04](https://doi.org/10.1300/J082v03n01_04)
- Solomon, S. S., Mehta, S. H., Latimore, A., Srikrishnan, A. K., & Celentano, D. D. (2010). The impact of HIV and high-risk behaviours on the wives of married men who have sex with men and injection drug users: Implications for HIV prevention. *Journal of the International AIDS Society*, 13(2), S7. <https://doi.org/10.1186/1758-2652-13-S2-S7>
- Stahlman, S., Bechtold, K., Sweitzer, S., Mothopeng, T., Taruberekera, N., Nkonyana, J., & Baral, S. (2015). Sexual identity stigma and social support among men who have sex with men in Lesotho: A qualitative analysis. *Reproductive Health Matters*, 23(46), 127–135. <https://doi.org/10.1016/j.rhm.2015.11.017>
- Steward, W. T., Miège, P., & Choi, K.-H. (2013). Charting a moral life: The influence of stigma and filial duties on marital decisions among Chinese men who have sex with men. *PLoS One*, 8(8), e71778. <https://doi.org/10.1371/journal.pone.0071778>
- Thompson, L. H., Khan, S., du Plessis, E., Lazarus, L., Reza-Paul, S., Hafeez Ur Rahman, S., Pasha, A., & Lorway, R. (2013). Beyond internalised stigma: Daily moralities and subjectivity among self-identified kothis in Karnataka, South India [Article]. *Culture, Health & Sexuality*, 15(10), 1237–1251. <https://doi.org/10.1080/13691058.2013.818714>
- UNDP & USAID. (2014). *Being LGBT in Asia: Indonesia country report*. <https://www.aidsdatahub.org/resource/being-lgbt-asia-indonesia-country-report>
- Veronese, V., Clouse, E., Wirtz, A. L., Thu, K. H., Naing, S., Baral, S. D., Stoové, M., & Beyrer, C. (2019). "We are not gays . . . don't tell me those things": Engaging 'hidden' men who have sex with men and transgender women in HIV prevention in Myanmar. *BMC Public Health*, 19(1), 1–12. <https://doi.org/10.1186/s12889-018-6351-3>
- Victoryna, F., Yona, S., & Waluyo, A. (2019). The relationship between stigma, family acceptance, peer support and stress level among HIV-positive men who have sex with men (MSM) in Medan, North Sumatera, Indonesia. *Enfermeria Clinica*, 29, 219–222. <https://doi.org/10.1016/j.enfcli.2019.04.026>
- Waluyo, A., Mansyur, M., Earnshaw, V. A., Steffen, A., Herawati, T., Maria, R., & Culbert, G. J. (2021). Exploring HIV stigma among future healthcare providers in Indonesia. *AIDS Care*, 1–10. <https://doi.org/10.1080/09540121.2021.1897777>

- White Hughto, J. M., Reisner, S. L., & Pachankis, J. E. (2015). Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions. *Social Science & Medicine (1982)*, *147*, 222–231. <https://doi.org/10.1016/j.socscimed.2015.11.010>
- Wirawan, D. N. (2019). Stigma and discrimination: Barrier for ending AIDS by 2030 and achieving the 90- 90-90 targets by 2020. *Public Heal Prev Med Arch*, *7*(1), 1–2. [https://web.archive.org/web/20200321145637id\\_/https://phpmajournal.org/index.php/phpma/article/viewFile/206/pdf](https://web.archive.org/web/20200321145637id_/https://phpmajournal.org/index.php/phpma/article/viewFile/206/pdf)
- World Health Organization. (2016). FAQ on health and sexual diversity - an introduction to key concepts. World Health Organization. <https://www.who.int/gender-equity-rights/news/20170329-health-and-sexual-diversity-faq.pdf>
- Zeluf-Andersson, G., Eriksson, L. E., Schönnesson, L. N., Höijer, J., Månehall, P., & Ekström, A. M. (2019). Beyond viral suppression: The quality of life of people living with HIV in Sweden. *AIDS Care*, *31*(4), 403–412. <https://doi.org/10.1080/09540121.2018.1545990>