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Phytochemical Test of Several Organic Fermentation Solutions

Azah Istikharoh[1*], Ardiana Priharwanti[2], Jaya Maulana[3]
Public Health Study Program, Faculty of Health Sciences, University of Pekalongan, Indonesia
Corresponding Author: Azah Istikharoh : azahistikharoh15@gmail.com

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ABSTRACT

Pemalang Regency has shown an increasing trend in HIV/AIDS cases, with 10 cases recorded among Men Who Have Sex with Men (MSM), indicating this group as a key population vulnerable to HIV transmission. This study aims to analyze the background of deviant sexual behavior among people living with HIV within the MSM group at the Petarukan Subdistrict Health Center, Pemalang Regency. A qualitative study with a phenomenological approach was conducted, involving purposively selected informants who were MSM living with HIV and had engaged in risky sexual behavior. Data were collected through in-depth interviews, observation, and documentation, and analyzed using thematic analysis based on the Miles and Huberman model (1994). The findings indicate that deviant sexual behavior is shaped by the interaction of psychological, social, economic, and structural factors. Psychological factors play a dominant role, including lack of family support, internalized stigma related to sexual orientation and HIV status, and limited access to safe spaces. These conditions lead informants to engage in concealed and poorly controlled sexual practices. Additionally, knowledge of HIV and safe sex has not been fully translated into healthy attitudes and behaviors. Limited access to inclusive healthcare services and insufficient structural support further hinder behavioral change toward safer sexual practices.

INTRODUCTION

Human Immunodeficiency Virus (HIV) remains one of the most complex global public health challenges, particularly in developing countries such as Indonesia. According to the World Health Organization (2023), approximately 39.9 million people worldwide are living with HIV, including 1.4 million children. In the same year, 1.3 million new HIV infections were reported, representing a 39% decrease compared to 2010, while HIV-related deaths reached 630,000, declining by 51% since 2010. Despite these achievements, the global HIV response has not yet reached the 95–95–95 targets, as only 86% of people living with HIV are aware of their status, 77% are receiving antiretroviral therapy, and 72% have achieved viral suppression. Since the beginning of the epidemic, an estimated 88 million people have been infected with HIV and 42 million have died, indicating that the elimination of HIV by 2030 still requires intensive and targeted efforts.

In Indonesia, HIV continues to show a concerning upward trend, particularly among Men Who Have Sex with Men (MSM), locally referred to as Lelaki Seks dengan Lelaki (LSL). Data from the Indonesian Ministry of Health indicate that MSM constitute one of the populations with the highest HIV prevalence, largely driven by persistent risky sexual behaviors. UNAIDS (2023) reports that MSM have a 22–26 times higher risk of acquiring HIV compared to the heterosexual population. National surveillance data recorded 35,415 new HIV cases and 12,481 new AIDS cases between January and September 2024, with approximately 71% occurring among men and nearly 90% affecting young and productive age groups. The primary modes of transmission remain unsafe sexual practices and the use of non-sterile needles. These figures demonstrate that HIV transmission in Indonesia is strongly associated with sexual behavior patterns that cannot be fully explained through biomedical or epidemiological data alone.

Deviant sexual behavior often associated with the MSM population is influenced by a complex interaction of psychological, social, cultural, economic, and structural factors. Previous studies have identified psychosocial backgrounds such as childhood trauma, experiences of sexual abuse, social pressure, and suppressed sexual identity as significant contributors to the formation of risky and deviant sexual behaviors among MSM (Wijayanti et al., 2020). External factors, including social stigma, discrimination, marginalization, and lack of family support, further intensify feelings of isolation and vulnerability. This social alienation often drives individuals to seek intimacy, validation, and emotional connection through unsafe sexual practices (I. K. Putra & Hidayah, 2021).

Moreover, socio-cultural contexts that have not fully accepted sexual minorities create additional barriers for MSM in accessing inclusive and stigma-free healthcare services. Fear of discrimination and negative judgment from healthcare providers discourages many MSM from seeking sexual health counseling, HIV testing, and preventive services. As a result, levels of sexual health education and consistent condom use remain low, further increasing the

risk of HIV transmission and reinforcing patterns of deviant sexual behavior (D. Rahmawati & Sari, 2022).

At the regional level, Central Java Province is classified among the 11 provinces with the highest HIV burden in Indonesia. Although specific data on HIV prevalence among MSM in this province are limited, provincial health reports consistently identify MSM as a key population prioritized in HIV prevention and control programs. The increasing number of newly detected cases and the extensive MSM networks in urban and peri-urban areas suggest that Central Java follows a pattern similar to national trends, where MSM contribute a substantial proportion of new HIV infections.

At the local level, Pemalang Regency has experienced a steady increase in HIV/AIDS cases, with Petarukan Subdistrict identified as one of the areas contributing the highest number of cases alongside Pemalang and Randudongkal Subdistricts. Data from the Pemalang Regency Health Office indicate 143 new HIV/AIDS cases by the end of 2023, bringing the cumulative total since 1988 to approximately 706 cases. By mid-2025, an additional 80 new cases were reported, raising the cumulative estimate to over 740 cases. Within Petarukan Subdistrict, data show that at least 10 HIV cases occurred among the MSM group, positioning MSM as a key population with heightened vulnerability. Although the absolute number appears relatively small, it represents a critical warning signal given the high-risk sexual practices, low condom utilization, limited access to inclusive healthcare services, and persistent social stigma faced by this group.

Taken together, these global, national, regional, and local conditions indicate that HIV transmission among MSM, particularly those living with HIV, is closely linked to complex psychosocial and contextual factors. Deviant sexual behavior within this group cannot be sufficiently understood through medical or statistical approaches alone, but requires in-depth exploration of lived experiences, social pressures, and structural constraints. Therefore, this study aims to analyze the background of deviant sexual behavior among people living with HIV within the MSM group at the Petarukan Subdistrict Health Center, Pemalang Regency.

METHODS

This study employed a qualitative research design with a phenomenological approach to explore the underlying causes of deviant sexual behavior among people living with HIV within the Men Who Have Sex with Men (MSM) group. The phenomenological approach was selected to gain an in-depth understanding of participants' lived experiences and subjective meanings related to sexual behavior, identity, and HIV status, which cannot be adequately captured through quantitative measures alone (Creswell & Poth, 2021). The primary focus of the study was to examine psychological, social, and structural factors influencing deviant sexual behavior and to understand how these factors interact within the lived experiences of MSM living with HIV.

Participants were selected using purposive sampling based on criteria relevant to the research focus, emphasizing information-rich cases and experiential depth. The main informants consisted of MSM living with HIV, aged

18 years and above, who were willing to participate in in-depth interviews and had engaged in same-sex sexual relationships. Additional supporting informants included an HIV-negative MSM individual to provide insight into social and family dynamics, as well as a healthcare professional (doctor, nurse, or clinical psychologist) involved in HIV services to support data triangulation. This sampling strategy aligns with qualitative research principles that prioritize depth, relevance, and contextual understanding over representativeness (Patton, 2020).

Data were collected through in-depth interviews, observation, and documentation. The researcher served as the primary instrument of data collection, supported by interview guides containing open-ended questions to ensure consistency while allowing flexibility for participants to narrate their experiences freely. Field notes and observation sheets were used to capture non-verbal cues and contextual information during the data collection process. This combination of data collection techniques was intended to enrich data depth and enhance analytical rigor (Creswell & Poth, 2018).

Data analysis was conducted using thematic analysis guided by the Miles and Huberman interactive model, which consists of data reduction, data display, and conclusion drawing and verification (Miles & Huberman, 1994). Initially, raw data were reduced through coding and categorization to identify meaningful units related to the research focus. The reduced data were then organized into displays such as summaries and thematic matrices to facilitate pattern recognition and the identification of relationships between themes (Nowell et al., 2017). The final stage involved drawing and verifying conclusions by interpreting recurring patterns and themes, with ongoing validation to ensure analytical accuracy (Braun & Clarke, 2022).

To ensure trustworthiness, several validation strategies were applied. Data triangulation was conducted by comparing information obtained from different informants and data sources. Member checking was implemented by returning preliminary findings to participants for confirmation and clarification, thereby enhancing credibility. Reflexivity was maintained throughout the research process by continuously identifying and minimizing potential researcher bias. Additionally, an audit trail documenting all stages of data collection and analysis was maintained to enhance transparency and dependability of the findings (Shenton, 2020).

RESULTS

Puskesmas Petarukan was selected as the research location due to the relatively high number of HIV cases, particularly among the MSM population. Data from the Pemalang Regency Health Office indicate an increase in HIV cases in Petarukan District, with most cases occurring among individuals aged 18–40 years.

Table 1. HIV Cases in Petarukan District, Pemalang Regency

Year	18–24 Years	25–30 Years	31–35 Years	36–40 Years	Total (18–40 Years)
2022	120 (20%)	180 (30%)	150 (25%)	90 (15%)	540 (90%)
2023	155 (22%)	212 (30%)	177 (25%)	113 (16%)	657 (93%)
2024	47 (25%)	56 (30%)	47 (25%)	28 (15%)	178 (95%)
2025	42 (27%)	47 (30%)	39 (25%)	24 (15%)	152 (97%)

Data collection was conducted between August 7 and September 18, 2025, through face-to-face and online interviews, accompanied by health center staff. The study involved eight informants consisting of three main informants (MSM living with HIV), three supporting informants (MSM without HIV), and two triangulation informants (healthcare workers).

Table 2. Characteristics of Research Participants

No	Initials	Age	Gender	Occupation	Residence	Status
1	EB	21	Male	Administrator	Petarukan District	MSM, HIV-positive (<1 year)
2	SP	28	Male	Photographer	Karangasem District	MSM, HIV-positive (>1 year)
3	BL	38	Male	Restaurant Staff	Petarukan District	MSM, HIV-positive (>1 year)
4	GS	24	Male	HIV Program Staff	Petarukan District	MSM, HIV-negative
5	AA	27	Male	HIV Program Staff	Petarukan District	MSM, HIV-negative
6	AD	32	Male	Entrepreneur	Petarukan District	MSM, HIV-negative
7	WY	42	Female	P2P Program Officer	Karangasem District	Healthcare worker
8	BS	46	Male	P2P Program Officer	Petarukan District	Healthcare worker

The participants consisted of individuals aged 21–46 years with varied occupational backgrounds. Three participants were MSM living with HIV, three were MSM without HIV, and two were healthcare workers involved in HIV services. The characteristics presented in the table describe the profile of informants involved in this study and serve as the basis for further presentation of findings.

The results of the analysis in this study were obtained through the processes of data reduction, data display, and thematic conclusion drawing. The analysis was conducted by linking field findings with the analytical framework, which includes internal factors, external factors, stigma and discrimination, as well as their impact on deviant sexual behavior and HIV status among the MSM (Men Who Have Sex with Men) group. The following are the main themes that emerged from the in-depth interviews with the informants.

1. Self-Identity and Awareness of HIV Status

The findings show that most participants became aware of their HIV status after engaging in prolonged risky sexual behaviors. HIV testing was generally conducted following recommendations from healthcare workers rather than personal awareness. Participants stated:

"I only took the test because the health worker suggested it,"

"I didn't feel sick, so I never thought I was at risk."

Emotional reactions after receiving an HIV-positive diagnosis included shock, fear, and psychological distress. Several participants expressed strong concerns about social consequences:

"I was really shocked and stressed,"

"What scared me the most was my family finding out,"

"I'm more afraid of people's judgment than the illness."

Some participants reported being mentally prepared due to their sexual history:

"I was already prepared because I knew I changed partners a lot."

Over time, participants described a gradual process of acceptance:

"At first I blamed myself,"

followed by

"Now I try to accept it and take my medication regularly."

Participants stated that their HIV status did not change their sexual orientation, although it affected their sexual awareness:

"My orientation is still the same,"

"Sometimes desire still takes over even though I know my status."

2. Sexual History and Sexual Relationship Patterns

The results indicate that same-sex attraction generally began during adolescence and developed gradually. Participants described early feelings of difference:

"Since junior high school, I felt more attracted to male friends,"

"At first, it was just admiration, not sexual."

Several participants reported traumatic sexual experiences that influenced their sexual behavior:

"I was sexually abused when I was young,"

"After that, I felt afraid of being close to women."

Initial same-sex sexual experiences occurred during late adolescence or early adulthood and were often initiated by peers or curiosity:

"It started because a friend invited me,"

"I was just curious at first."

Most participants reported non-exclusive sexual relationships and frequent partner changes:

"Changing partners is normal in my circle,"

"It's rare to be faithful to one person."

Economic factors also appeared in participants' narratives:

"I did it because I needed money,"

"At first it was forced, then it became normal."

Sexual activities were commonly conducted in secrecy due to social stigma:
"Everything had to be done secretly,"
"I was afraid of being found out."

3. Condom Use and Safe Sex Practices

The findings indicate that participants generally had adequate knowledge about condom use and safe sex. However, this knowledge was not consistently reflected in their actual sexual practices. Most participants reported inconsistent condom use, especially before knowing their HIV status. As stated by participants:

"Most of the time I didn't use condoms,"
"Sometimes the partner asked not to use one."

Decisions regarding condom use were often influenced by mutual agreement and sexual desire:

"When both want it, we usually just take it off,"
"It feels different when using a condom."

After being diagnosed with HIV, some participants reported increased awareness of safe sex concepts, including ARV treatment and U=U. However, several participants believed condom use was unnecessary when viral load was undetectable:

"If the viral load is undetectable, the risk is zero,"
"WHO already recommends that."

Others reported consistent condom use with casual or unknown partners:

"If it's a new partner, I usually use condoms," a
"When changing partners, it's safer to use condoms."

Healthcare workers confirmed that most patients understood the risks but struggled to change behavior:

"They know the risks, but they are already comfortable with their habits,"
"We keep reminding them gradually, without forcing."

4. Commercial Sex and Substance Use

The results show that some participants were involved in commercial sex and substance use, both of which contributed to risky sexual behavior. Economic pressure was frequently cited as the initial reason for engaging in paid sex:

"It started because I needed money,"
"At that time, my financial situation was difficult."

Participants described an initial sense of coercion that later became normalized:

"At first it was forced, then it became normal,"
"After doing it often, it just feels ordinary."

Some participants also reported paying for sex to meet immediate sexual needs:

"If I wanted it quickly, I looked for paid sex."

Sexual encounters in commercial contexts were described as brief and emotionally detached, often involving partners with unknown health status:

"Usually I don't know the partner's status."

Condom use in these encounters was inconsistent and sometimes dependent on clients' requests:

"If the client asked not to use a condom, sometimes I agreed."

Substance use, including alcohol and drugs, was reported as a factor that reduced inhibition and increased sexual risk-taking:

"After drinking, I become more confident,"

"Using substances makes me less shy,"

"When I'm under the influence, self-control decreases."

Healthcare workers supported these findings, stating:

"Those who use substances and engage in paid sex usually have higher risk,"

and emphasized the need for non-judgmental approaches:

"If we forbid them directly, they tend to withdraw."

5. Psychological Factors: Trauma, Regret, and Sexual Pleasure

The findings indicate that psychological factors play an important role in shaping risky sexual behavior among MSM living with HIV. Informants reported past traumatic experiences related to family rejection and unwanted sexual encounters.

"I was humiliated when they found out I liked the same sex."

"At that time I wasn't ready, but it already happened."

These experiences influenced informants to prefer temporary and non-committed sexual relationships.

"It's easier to look for something temporary than to be emotionally attached."

After sexual encounters, many informants described feelings of regret and fear, particularly after knowing their HIV status.

"After it's over, I keep thinking about it."

"I'm scared, but it happens again."

Despite this regret, sexual pleasure remained a strong reinforcing factor, providing emotional relief and a sense of acceptance.

"When it happens, I feel accepted."

"When I'm stressed, I look for an outlet."

Health workers also noted unresolved psychological issues among informants.

"Many of them have not made peace with themselves."

6. Sexual Environment and Access to "Safe Spaces"

The results show that the sexual environment and access to perceived "safe spaces" strongly influence informants' sexual behavior. Safe spaces were described as places where informants could express their sexual identity without fear of stigma.

"In that place, I feel like I can be myself." (I2)

Due to limited safe spaces in the wider social environment, informants sought closed or private locations.

"Outside, I'm afraid of being exposed, so I look for places with fewer people." (I1)

These environments were characterized by permissive norms toward casual and multiple sexual partners.

"*Everyone there already knows, so no one judges.*" (I3)

In such settings, concern for sexual health risks tended to decrease.

"*As long as I'm safe from people's talk, I sometimes forget about health.*" (I4)

Access to these spaces was closely linked to social networks within the MSM community.

"*It's always the same places, and the people know each other.*" (I2)

Some informants remained in these environments despite the risks because they lacked alternative social spaces.

"*If I leave that environment, I feel completely alone.*" (I1)

7. Stigma, Discrimination, and Social Pressure

The findings show that stigma, discrimination, and social pressure strongly influenced informants' sexual behavior. Informants experienced stigma related to both their sexual identity as MSM and their HIV status.

"*Since I was young, I kept hearing that MSM is wrong, so I kept it to myself.*" (I1)

Social pressure led informants to hide their identity, limiting emotional support from family and increasing reliance on peer acceptance.

"*At home I can't talk about it, only with friends I feel accepted.*" (I3)

Discrimination was reported in the form of social rejection and avoidance.

"*Once they found out, people kept their distance.*" (I2)

After being diagnosed with HIV, informants described increased pressure and fear of judgment.

"*If people know I have HIV, it feels heavier than being known as MSM.*" (I4)

Some informants felt hesitant to disclose their identity in healthcare settings.

"*I'm afraid if I'm honest, I'll be treated differently.*" (I1)

Social pressure also affected emotional coping and sexual decision-making.

"*Sometimes I just want to feel accepted, even if the way is wrong.*" (I3)

"*When I'm under pressure, I don't think about risk.*" (I2)

Internalized stigma was expressed by some informants.

"*Sometimes I feel like I deserve this*." (I4)

8. Knowledge, Attitudes, and Self-Control toward Sexual Behavior

The results indicate a gap between knowledge, attitudes, and self-control related to sexual behavior. Most informants were aware of HIV transmission risks.

"*I know HIV comes from sex without condoms, especially changing partners.*" (I1)

However, some informants reported limited understanding of reinfection and long-term risks.

"*I used to think that once you have HIV, it's all the same.*" (I3)

Knowledge of safe sex did not always translate into practice.

"*In theory I know, but in practice it's difficult.*" (I2)

Attitudes toward condom use varied, particularly with trusted partners.

"*If I already know the partner, it feels safe.*" (I4)

"*I know it's important, but sometimes it's uncomfortable.*" (I1)

Self-control was described as weak in emotionally challenging situations.

"When I need attention, my self-control becomes weak." (I3)

"At that moment I knew the risk, but I didn't think it through." (I2)

Some informants reported temporary behavioral changes after knowing their HIV status.

"At first I was careful, but over time I went back again." (I4)

Low self-worth also influenced protective behavior.

"Sometimes it feels like it's already too late." (I1)

Based on in-depth interviews, observations, and document review, the findings indicate that risky sexual behavior among MSM living with HIV was shaped by the interaction of supporting and inhibiting factors. These factors influenced how sexual behaviors were initiated, maintained, or restrained, as reflected in informants' narratives and lived experiences.

1. Supporting Factors

The findings indicate that risky sexual behavior among MSM living with HIV was supported by multiple interacting factors. A dominant factor was the need for affection, attention, and social acceptance, particularly among informants who experienced emotional distance or rejection from family.

"When there's no closeness with family, I look for attention outside." (I2)

Sexual relationships were perceived as a way to feel valued and accepted.

"Through sex, at least I feel wanted." (I2)

A permissive social environment within MSM peer networks also supported risky behavior. Informants described partner switching and condomless sex as normalized within their social circles.

"In our circle, changing partners is normal." (I4)

Economic pressure emerged as another supporting factor, especially among informants involved in transactional sex.

"When I really need money, I have no choice." (I3)

In such situations, health considerations were often secondary to financial needs. Easy access to digital media and dating applications further facilitated risky behavior by enabling quick and anonymous partner seeking.

"Through apps, it's easy to find partners." (I1)

2. Inhibiting Factors

Inhibiting factors referred to conditions that reduced or restrained risky sexual behavior. Increased health awareness after HIV diagnosis was frequently described as a turning point.

"After knowing I have HIV, I think more carefully." (I2)

This awareness encouraged some informants to limit partners and use condoms more consistently. Support from healthcare providers and NGOs also played an important role.

"When I have regular counseling, I remember the risks." (I4)

Health-related trauma, such as physical decline or treatment fatigue, contributed to reduced sexual activity.

"When my body feels weak, I don't think about sex." (I1)

Moral responsibility toward partners also emerged as an inhibiting factor. *"I'm afraid of transmitting it to others."* (I3)

DISCUSSION

The results of this study indicate that deviant sexual behavior among people living with HIV within the Men Who Have Sex with Men (MSM) group in the working area of the Petarukan Community Health Center is a multidimensional phenomenon that cannot be explained by a single factor. Such behavior is formed through a complex interaction of individual, psychological, social, economic, and structural factors. These findings emphasize that risky sexual behavior cannot be understood partially, but must be viewed within the context of individuals' lived experiences, the social pressures they face, and limitations in access to social support and inclusive healthcare services.

From the perspective of sexual identity and self-awareness, this study found that most informants had become aware of their attraction to the same sex during adolescence. However, the process of identity formation occurred under strong social pressure due to the dominance of heteronormative norms within families and society. This pressure encouraged informants to conceal their sexual identity and engage in sexual life in secrecy. Such conditions resulted in limited access to safe spaces for identity expression and adequate sexual health education.

These findings are consistent with the study by (Wijayanti et al., 2020), which stated that social rejection of minority sexual orientations can influence the formation of unhealthy sexual behaviors and increase health risks. Early experiences of same-sex sexual relationships among informants generally occurred without sufficient knowledge of safe sex practices and HIV transmission risks. These sexual encounters were exploratory in nature and influenced by curiosity, emotional impulses, and the process of identity exploration. Limited access to inclusive sexual health literacy for sexual minority groups further increased vulnerability to risky sexual behavior.

This finding aligns with (Rahmawati dan Sari, 2022), who emphasized that limited access to comprehensive sexual health information increases the risk of unsafe sexual behavior among MSM groups. In terms of sexual relationship patterns, the majority of informants did not have a steady partner and tended to change partners frequently. This pattern was driven not only by biological needs but also by psychological needs for acceptance, emotional attachment, and self-validation.

Sexual relationships were perceived as a means of coping with feelings of loneliness and social isolation resulting from a lack of family and social support. These findings support the study by Putra and Hidayah (2021), which stated that social isolation and minimal emotional support contribute to unsafe sexual practices among MSM living with HIV. This study also found that unprotected sexual practices continued among some informants despite their awareness of their HIV-positive status. This phenomenon indicates a gap between knowledge and behavior.

Knowledge about HIV risks had not been fully internalized into consistent attitudes and self-control. Some informants perceived condom use as a barrier to comfort and emotional intimacy in sexual relationships. This condition is consistent with the findings of Nugroho and Prasetyo (2020), who identified negative perceptions of condoms as a major barrier to safe sex behavior among key populations. The involvement of some informants in commercial sex practices reflects economic pressure and limited access to decent employment opportunities. Under such conditions, the body becomes an economic resource to meet daily living needs.

These findings indicate that deviant sexual behavior is not solely related to individual or moral aspects, but is also influenced by structural factors such as poverty and social inequality. Research by Sari and Lestari (2021) emphasized that economic pressure is an important determinant in commercial sex practices among MSM and contributes to increased HIV transmission risk. In addition, the use of alcohol and illicit substances before or during sexual activity further exacerbated risky sexual behavior.

Informants revealed that substance use reduced self-control and rational decision-making abilities, thereby increasing the likelihood of engaging in unprotected sexual intercourse. This finding is consistent with the study by Prabowo and Handayani (2022), which demonstrated a significant relationship between substance use and risky sexual behavior among individuals living with HIV. Unsafe sexual environments and limited access to "safe spaces" also influenced informants' sexual behavior. Sexual activity was often conducted in hidden and inappropriate locations with minimal health protection and supervision.

This condition reflects the low availability of safe spaces that are friendly to MSM groups. According to Kurniawan (2020), the absence of safe spaces reinforces risky sexual practices because individuals lack alternative environments that support healthier sexual behavior. Stigma and discrimination experienced by informants, both in society and within healthcare services, emerged as dominant factors reinforcing the cycle of deviant sexual behavior. Stigma caused informants to hesitate in accessing healthcare services regularly and openly, thereby hindering HIV prevention and control efforts. These findings strengthen the study by Handayani and Setyawan (2021), which stated that stigma toward people living with HIV and MSM directly affects low utilization of healthcare services and increases subsequent health risks.

From the perspective of knowledge, attitudes, and self-control, this study shows that increasing knowledge alone is insufficient to encourage sustainable behavioral change. Permissive attitudes toward risky sexual behavior and weak self-control represent major challenges in prevention efforts. This indicates that health interventions must be conducted comprehensively, not only through education but also through psychosocial support and individual capacity building. These findings are consistent with the study by Wibowo and Santoso (2023), which emphasized the importance of a holistic approach to sexual behavior change among MSM living with HIV.

Overall, this discussion confirms that deviant sexual behavior among people living with HIV within the MSM group is the result of a complex interaction of psychological, social, economic, and structural factors. Therefore, HIV prevention and control efforts among MSM need to be implemented comprehensively through a biopsychosocial approach, strengthening inclusive and non-discriminatory healthcare services, and systematic efforts to reduce stigma at the community level.

CONCLUSIONS

This qualitative phenomenological study concludes that deviant sexual behavior among people living with HIV within the MSM group in the working area of Petarukan Community Health Center, Pemalang Regency, is shaped by a complex and interrelated set of factors. The findings identified eight main themes reflecting the background and dynamics of risky sexual behavior, including sexual identity and HIV status acceptance, sexual history and relationship patterns, inconsistent condom use, psychological factors, unsafe sexual environments, stigma and discrimination, gaps between knowledge and self-control, and the role of healthcare and social support. Risky sexual behavior is reinforced by supporting factors such as the need for affection and social acceptance, family rejection, economic pressure, peer environment, and substance use. Conversely, inhibiting factors include increased health awareness after HIV diagnosis, experiences of illness, and support from healthcare providers and NGOs through counseling and psychosocial assistance. These inhibiting factors have the potential to encourage safer sexual behavior when provided consistently and sustainably.

Based on the findings, health service providers are encouraged to strengthen inclusive, stigma-free, and confidential services for MSM living with HIV, particularly in counseling, psychosocial support, and mental health care, while collaborating closely with NGOs and community organizations. Individuals in the MSM group with HIV are advised to increase self-awareness and actively utilize available health and psychosocial support services to promote safer and more responsible sexual decision-making. Families and the social environment are expected to reduce stigma and provide emotional support to create a more supportive atmosphere that facilitates positive behavioral change. Furthermore, the government and related institutions should use these findings as a reference for developing HIV prevention policies and programs that are more sensitive to the needs of key populations and focused on stigma reduction.

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