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Between Stigma and Survival: The Role of Digital Backstage and Selective Disclosure in MSM Health Navigation in Palu, Indonesia

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ABSTRACT

Introduction: In this study, we aimed to explore how Men Who Have Sex with Men (MSM) in post-disaster Palu, Indonesia, manage their sexual identities under religious conservatism, patriarchal norms, and heightened moral surveillance following the 2018 earthquake. Within this religiously conservative and disaster-affected context, our objective was to understand how MSM employ impression-management strategies to navigate visibility, stigma, and safety, and to analyze their implications for mental health, healthcare-seeking behavior, and overall well-being. This study addresses gaps in the literature by situating MSM experiences within Indonesia's sociocultural and religious frameworks, thereby contributing to regional and cross-cultural analyses of LGBTQ+ identity negotiation in Southeast Asia.

Methods: This qualitative phenomenological study employed in-depth interviews, photo-elicitation, and digital ethnographic observation over six months in Palu. A total of twenty-five MSM participants aged 18–40 were purposively recruited to ensure diversity of experience and social background. Sampling continued until thematic saturation was reached, meaning no new themes emerged during ongoing analysis. Data collection included semi-structured interviews and analysis of interactions on online platforms (e.g., Telegram, BlueD, and Instagram). Visual materials contributed to the coding framework by illustrating non-verbal expressions of impression management, later integrated into thematic synthesis. Ethical approval was obtained from the Institutional Review Board (IRB) of the Faculty of Public Health, Universitas Muhammadiyah Palu, following the British Psychological Society (BPS) and American Anthropological Association (AAA) ethical codes. Participants provided verbal and written informed consent, and all identifying details were anonymized.

Results: The primary outcome of the study was an understanding of how MSM in Palu adaptively navigate identity, stigma, and safety through impression management. Key findings revealed that MSM maintain dual personas—performing heteronormativity in public (front-stage) while expressing their authentic identities within digital backstage spaces. Selective disclosure of sexual orientation was governed by contextual trust, relational safety, and fear of institutional stigma. Digital platforms functioned as crucial psychosocial and health-navigation spaces, enabling solidarity and access to information. However, overreliance on digital interactions sometimes intensified isolation and reproduced inequalities linked to digital literacy and class. While these adaptive strategies ensure survival under moral surveillance, they inadvertently reinforce structural stigma by normalizing concealment and restricting public visibility.

Conclusion: In conclusion, this study contributes to understanding how Men Who Have Sex with Men (MSM) in Palu construct survival and well-being through impression management under conditions of religious-patriarchal stigma and disaster-induced moral tightening. It illustrates that dual personas, selective disclosure, and digital backstage practices function both as protection and as mechanisms that perpetuate invisibility. These findings inform the design of culturally sensitive, confidentiality-centered health interventions, emphasizing peer navigation, digital outreach, and faith-inclusive stigma reduction. Future studies should investigate the long-term mental health impacts of sustained concealment and digital dependency, advancing inclusive policies and provider training across Indonesia's public health systems and the broader Southeast Asian region.

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INTRODUCTION

In the sociocultural fabric of post-disaster Palu, Indonesia, Men Who Have Sex with Men (MSM) are subjected to intense religious, cultural, and patriarchal pressures that constrain visibility and expression. These pressures have intensified since the 2018 earthquake, which triggered moral surveillance and deepened local religious conservatism. Within this environment, MSM must strategically manage daily interactions to preserve both personal safety and social acceptability. The dominant religious-patriarchal order enforces heteronormative behaviors and moral conformity, reinforcing stigmatization through social expectations, local governance, and institutional health policies. The implications of such stigma extend deeply into mental health, self-concept, and healthcare-seeking behaviors, severely restricting MSM's access to essential health and community services.

Erving Goffman's (1959) impression-management theory provides a crucial analytical framework for understanding how individuals in stigmatized contexts control social perceptions through performance. This perspective is particularly relevant in non-Western societies where heteronormativity and religious morality shape public life. In such environments, MSM frequently engage in performative alignment with social expectations to evade discrimination. As Goffman posits, individuals maintain "front-stage" personas in public to mask stigmatized identities, while expressing their "back-stage" selves in trusted or private spaces. This dynamic is especially visible among MSM in Southeast Asia, who modify their self-presentation based on audience, social risk, and setting to balance authenticity with survival (1).

Local masculinity scripts and religious moral frameworks profoundly shape impression-management strategies in Indonesia. Masculinity is culturally equated with piety, family leadership, and social respectability, positioning deviation from heteronormativity as moral failure. Consequently, MSM often adopt hyper-masculine or heteronormative performances in public—deepening their voice, concealing gestures, or engaging in heterosexual rituals—to maintain social legitimacy. While such performances ensure sociocultural survival, they generate psychological strain and identity fragmentation (2). Religious frameworks, particularly dominant Islamic interpretations, reinforce this stigmatization by constructing homosexuality as sinful, deviant, and socially contaminating, sustaining systemic exclusion and internalized stigma (3,4).

This societal marginalization has tangible and compounding health consequences. MSM frequently avoid healthcare facilities due to anticipated discrimination, gossip, or moral condemnation, resulting in delayed diagnosis and untreated HIV or sexual health conditions. Fear of exposure or moral judgment discourages transparent communication with health providers, leading to self-censorship and medical avoidance. As a result, health-seeking behaviors are governed by complex calculations of risk, trust, and confidentiality. Empirical studies indicate that internalized stigma and structural discrimination correlate strongly with anxiety, depression, and suicidal ideation among MSM populations in Indonesia and other ASEAN contexts (5,6). Addressing MSM health disparities therefore requires confronting not only medical barriers but also the cultural and institutional architectures of stigma.

This challenge is exacerbated in post-disaster contexts, where crises often reinvigorate moral boundaries and collective anxiety. In Palu, following the 2018 earthquake, religious leaders and community institutions intensified moral surveillance, associating social disorder with perceived moral decay. MSM were stigmatized as symbols of immorality or divine punishment, becoming scapegoats for wider social distress. Post-disaster reconstruction thus reinforced conservative ideology and expanded surveillance systems that policed behavior and sexuality. Research from Indonesia and other disaster-prone societies shows that moral tightening during recovery phases amplifies gender hierarchies and social exclusion, particularly for non-conforming groups (7,8).

Gender norms in Indonesia provide a critical lens for understanding MSM identity formation and the psychological costs of conformity. Dominant masculine ideals emphasize emotional restraint, physical strength, religious devotion, and heterosexual virility as indicators of male respectability. MSM often experience cognitive and emotional dissonance between these expectations and their lived identities. To manage this tension, many switch personas across settings, overperform masculinity, or engage in heteronormative rites such as marriage or fatherhood (9,10). These negotiations illustrate not only the constraints of conformity but also the creative agency of marginalized men in constructing survivable identities within restrictive sociocultural systems.

The pervasive influence of Islamic discourse and religious institutions further complicates MSM visibility and acceptance in Indonesia. Clerics, local preachers, and religious councils play central roles in shaping moral opinion, with sermons, fatwas, and media statements often reinforcing anti-LGBTQ+ narratives. Consequently, MSM

are publicly constructed as threats to social morality and religious order, their identities routinely denied or condemned (11,12). This religious framing translates into policy and service delivery, where healthcare systems frequently omit MSM-specific needs or enforce moral gatekeeping in clinical encounters. Moreover, religious doctrine and community pressure often dissuade MSM from participating in public health or psychological programs, deepening isolation and reducing service uptake (13).

These intersecting pressures—religious condemnation, masculine conformity, institutional neglect, and post-disaster surveillance—create a layered environment of social precarity and identity regulation. The cumulative psychological toll manifests as chronic anxiety, depressive symptoms, and self-concealment, reinforcing health inequities. Internalized stigma correlates strongly with avoidance of formal health services, especially where confidentiality is uncertain. Yet, emerging community-based and peer-led interventions in Indonesia demonstrate adaptive pathways of resilience, including peer education, discreet health outreach, and digital support systems that improve mental health and care access (13–15). These findings underscore the potential of community-driven strategies to counteract stigma within moral and institutional constraints.

Despite these advancements, empirical research remains limited on how MSM in provincial or post-disaster settings such as Palu negotiate identity, stigma, and healthcare access. Existing literature tends to focus on metropolitan areas and often overlooks the role of local cultural scripts and digital mediation in shaping survival strategies. This study therefore examines how Men Who Have Sex with Men (MSM) in Palu navigate religious-patriarchal stigma through impression-management strategies, focusing on how they balance visibility, safety, and self-expression. It asks: How do MSM negotiate identity performance and disclosure within conservative religious frameworks, and what role do digital spaces play in enabling survival and community connection?

The novelty of this research lies in its localization of Goffman's impression-management theory within an Indonesian post-disaster and religious-patriarchal context, revealing how MSM reconstruct identity and resilience under intensified moral surveillance. It aims to identify practical and ethical pathways for intervention by documenting lived strategies of concealment, selective disclosure, and digital adaptation, and by evaluating their implications for mental health and healthcare engagement. Through this lens, the study contributes a culturally grounded, regionally inclusive understanding of stigma, resilience, and health navigation—offering empirical insights for inclusive health policy, peer-led programming, and stigma reduction across Southeast Asian settings.

METHODOLOGY

This study adopts a qualitative phenomenological approach to examine how Men Who Have Sex with Men (MSM) in post-disaster Palu, Indonesia, negotiate stigma through impression-management and identity-performance strategies. The choice of phenomenology aligns with the research aim to capture lived experiences, emotional realities, and meaning-making processes within stigmatized and morally conservative contexts.

Research Design

Phenomenology emphasizes individuals' subjective experiences and the ways they interpret social and moral phenomena. This approach is particularly suitable for studying MSM populations, who continuously negotiate visibility, morality, and safety within restrictive sociocultural systems. Reflexivity was a central methodological pillar, with the lead researcher maintaining a reflexive journal to document positionality, interpretive challenges, and relational dynamics between researcher and participants (16). For clarity, reflexivity refers to the continual self-awareness and critical reflection on how the researcher's background, values, and assumptions shape data interpretation.

Research Setting and Participants

The study was conducted in Palu, Central Sulawesi, a provincial city characterized by religious conservatism and patriarchal social structures that intensified following the 2018 earthquake. Twenty-five self-identified MSM, aged 18–40, were recruited through purposive and snowball sampling to capture heterogeneity in socioeconomic background, occupation, and disclosure status. Sampling continued until data saturation was achieved, defined as the point when no new themes or perspectives emerged during iterative coding and analysis. Recruitment was facilitated

by local community-based organizations (CBOs) with established trust within MSM networks, ensuring ethical access and participant comfort.

Data Collection Techniques

In-Depth Interviews

Semi-structured interviews served as the primary data source, enabling participants to describe lived experiences in their own voices (17). The interview guide explored stigma, impression management, religious conformity, digital adaptation, and healthcare navigation. Interviews were conducted face-to-face or via encrypted digital platforms, each lasting 60–90 minutes, and were audio-recorded and transcribed verbatim with participants' consent.

Photo-Elicitation and Visual Prompts

Participants were encouraged to share, create, or interpret photographs representing their daily impression-management practices or spaces of self-expression. These visual materials were systematically integrated into the coding process, serving as analytic anchors that complemented textual data. Visual prompts helped reveal non-verbal cues of stigma navigation and digital backstage life, thereby enhancing the interpretive richness and triangulation of findings.

Digital Ethnography

Digital Ethnography Recognizing that MSM often perform backstage identity work in digital environments, the study incorporated digital ethnography through observation in Telegram groups, BlueD, Grindr, and private Instagram spaces (18). Observations focused on interaction styles, linguistic codes, anonymity strategies, and privacy practices, documenting how digital platforms mediate visibility, belonging, and self-protection. Detailed field notes captured patterns of risk negotiation and emotional expression in online interactions.

Ethical Considerations

Given the sensitive and stigmatized nature of MSM identities, stringent ethical measures were applied. Ethical approval was obtained from the Institutional Review Board (IRB) of the Faculty of Public Health, Universitas Muhammadiyah Palu, in accordance with the British Psychological Society (BPS) and American Anthropological Association (AAA) ethical codes. Verbal and written informed consent were obtained from all participants, who used pseudonyms throughout. Interviews were held in secure, neutral spaces or encrypted digital platforms to ensure privacy. The research team adhered to international guidelines on anonymity, confidentiality, and digital safety (18). Local NGO partners served as ethical liaisons, providing oversight and psychosocial support when needed.

Data Analysis Procedures

Data were analyzed using reflexive thematic analysis (Braun & Clarke, 2021), emphasizing the iterative co-construction of meaning between data and researcher interpretation. Transcripts and visual materials were imported into NVivo 14 for systematic coding. Inductive coding was followed by theme refinement through cross-case comparison and theoretical alignment. To ensure reliability, peer debriefing and intercoder verification were conducted, achieving an agreement rate of 0.82. Reflexive memos were used to track interpretive shifts and researcher assumptions, enhancing analytic transparency and credibility.

Community Involvement and Participatory Methods

To promote ethical integrity and participant agency, the study incorporated participatory research principles (19). Community representatives and local MSM advocates co-designed interview questions, validated data collection strategies, and contributed to the interpretation of emerging themes. This participatory process prevented extractive research dynamics, ensuring findings remained culturally grounded, contextually accurate, and empowering for the local community.

Methodological Adaptation and Cultural Framing

Recognizing the salience of local masculinity and moral codes, cultural frameworks were explicitly integrated to interpret how impression-management practices manifest within Palu's religious-patriarchal setting. Narrative, participatory, and adaptive techniques allowed for the co-creation of meaning and flexible modification of questions in response to participants' comfort levels (20,21). This approach ensured that data collection remained culturally sensitive, ethically attuned, and reflexively grounded.In sum, this multi-method, participatory, and culturally responsive design enabled a nuanced exploration of how MSM in Palu construct, perform, and negotiate their identities amid intersecting religious, moral, and social stigmas.

RESULTS

This chapter presents comprehensive findings from a qualitative analysis of 25 Men Who Have Sex with Men (MSM) in post-disaster Palu, Indonesia, exploring how they negotiate religious-patriarchal stigma through impression-management and identity-performance strategies. The analysis revealed three interrelated themes—dual persona navigation, selective disclosure practices, and health-service navigation—which together illustrate the layered survival mechanisms MSM employ to preserve safety, maintain social legitimacy, and access healthcare within a morally conservative and surveillance-intense environment.

Participant Demographic Profile

Participant Demographic Profile Participants were aged 22–40 years and represented a diverse cross-section of educational and occupational sectors, including university students, freelancers, civil servants, and private employees. The group included people living with HIV (PLHIV), caregivers to HIV-positive partners, and MSM with undisclosed or ambiguous HIV status. Openness varied substantially—some were fully open within digital peer networks, while others maintained strict concealment offline. Engagement with healthcare services was likewise diverse, influenced by perceived safety, clinic reputation, and moral climate within health facilities. This demographic variability was analytically significant, providing insight into how social class and disclosure intersect to shape stigma navigation.

Table 1. Demographic Overview of Core Informants

Code	Age	Occupation / Education	HIV Status	Disclosure Status
RHN	34	Company employee	Caregiver (partner)	Selective disclosure
IDM	39	Freelance worker	ODHA	Concealed
FHI	30	Journalist	ODHA	Open within peers
CKY	40	Office boy	ODHA	Concealed
GLG	25	Honorary staff (local govt)	Peer (HIV-affected)	Open to NGO only
RGL	27	Civil servant (ASN)	ODHA	Selectively disclosed
ARD	24	Post-grad student	ODHA	Fully open online
RLY	38	PPPK staff	Not disclosed	Fully concealed
FHM	22	Undergrad student	ODHA	Semi-open
AKB	26	Undergrad student	ODHA	Concealed

This table summarizes key socio-demographic characteristics of core informants whose narratives underpin the subsequent themes. It underscores the varied positionalities, occupational contexts, and disclosure patterns among participants—critical for understanding how stigma, religion, and social hierarchy intersect to shape MSM identity management and health-seeking behavior in Palu.

Theme 1: Dual Persona Performing Masculinity and Concealing Identity

Participants consistently adopted heteronormative behaviors—locally termed "bakancing"—to conform to dominant expectations of masculinity in public life. This front-stage performance involved suppressing feminine

expressions, deepening vocal tone, limiting physical expressiveness, and participating visibly in religious activities to project moral conformity. Such adaptive performances were crucial for maintaining safety, family acceptance, and professional stability (15). As RHN explained, "At home, I have to act like a real man—deepen my voice, control my gestures—so my parents don't suspect."

In contrast, digital spaces functioned as the "backstage"—private, semi-anonymous domains where participants could reclaim authenticity and emotional expression. Applications such as Telegram, BlueD, and Instagram's "locked stories" were frequently described as safe zones for intimacy, belonging, and identity experimentation (22). ARD shared, "Through these apps, I can be myself without fear of insults or rejection. There, I speak freely and love freely." These digital environments buffered participants from physical-world stigma, offering both psychological relief and social connectivity. Yet, as several noted, access and safety in these digital backstages depended on digital literacy and cautious self-curation.

Fluid identity-switching across physical and digital contexts emerged as a defining feature of the dual persona. Participants described constant behavioral calibration—modifying speech, dress, and gestures depending on context: family gatherings, mosque visits, or workplace interactions. CKY admitted, "At the office, I present masculine, but online I send rainbow emojis to close friends. Two different worlds, and I must play both." This reflection highlights the dual consciousness MSM must sustain, balancing safety with authenticity—a process that ensures social respectability but also produces emotional exhaustion and self-alienation.

Theme 2: Selective Disclosure Managing Trust and Consequences

Disclosure was described as a calculated, risk-laden act, governed by relational trust, social proximity, and anticipated repercussions. Most participants engaged in selective disclosure, confiding only in trusted peers or MSM-friendly health workers (22). IDM stated, "I only tell those I know will keep my secret. One wrong word and I could lose my job, my family, everything." This underscores how disclosure functions as emotional labor, shaped by fear of exposure, job insecurity, and moral judgment.

Health-service interactions were among the most delicate arenas of disclosure. Participants deliberately avoided clinics affiliated with religious organizations or those known for staff moralizing behaviors. FHI recalled, "I skipped the closest clinic because the nurse once preached to a friend. I'd rather travel further than risk humiliation." Instead, MSM relied on peer-recommended, confidentiality-assured clinics, demonstrating the centrality of informal health networks in facilitating safe access. This finding aligns with regional evidence of stigma avoidance behaviors among marginalized sexual minorities.

Participants frequently employed coded language, symbolic references, and euphemisms to conceal relational or identity details. These linguistic strategies minimized interrogation, allowing participants to navigate heteronormative spaces without confrontation. RGL noted, "When I introduce my partner, I just say he's my housemate. It's easier that way—no questions asked." Such discursive tactics illustrate how impression management operates linguistically, safeguarding privacy while maintaining access to workplace, family, and healthcare spaces.

The outcomes of disclosure varied markedly. Those with affirming families or MSM-supportive peers experienced improved self-esteem, emotional relief, and proactive health engagement (23). Conversely, participants unable to disclose safely described deep isolation, chronic anxiety, and withdrawal from health services. CKY expressed, "I can't tell anyone. Not even my doctor. I feel sick, but I'm more afraid of being exposed than of the illness itself."

Theme 3: Health-Service Navigation Between Fear and Resilience

Fear of stigma and social exposure profoundly shaped participants' healthcare engagement. Many avoided neighborhood clinics where staff recognition could trigger gossip or moral scrutiny (15). CKY explained, "The nurse at the nearby clinic is my neighbor. If she sees me getting tested, rumors will spread. I'd rather stay sick than face that."

Digital peer-support networks emerged as vital navigation infrastructures in this stigmatizing environment. Participants used Telegram groups, WhatsApp chats, and anonymous blogs to exchange clinic reviews, HIV testing advice, and ART management strategies. ARD explained, "In the Telegram group, we share which doctors are safe,

what times are best to go. It feels like a hidden support system." These virtual collectives functioned as community intelligence systems, simultaneously mitigating isolation and enabling informed health choices.

Administrative and structural barriers further entrenched avoidance behaviors. Mandatory identification checks, name recording, and address verification created perceived risks of exposure. These bureaucratic demands discouraged healthcare-seeking, even when medical needs were urgent. RLY lamented, "Even the receptionist wants to know everything—name, ID, address. What if they recognize me? What if they tell someone?" This illustrates how procedural formality becomes a mechanism of exclusion under moral surveillance.

Despite systemic constraints, some participants reframed health adherence as moral responsibility and self-affirmation. They reported strict adherence to ART schedules, participation in discreet workshops, and promotion of safe-sex practices as both self-care and reputational performance(23,24). FHI explained, "Even if I hide who I am, I still take my meds on time. It's the only control I have over my health." This demonstrates how health behavior becomes an act of agency—integrating self-preservation, resistance, and moral negotiation within a stigmatizing public sphere.

DISCUSSION

The findings of this study offer critical insights into the multidimensional identity negotiation strategies employed by Men Who Have Sex with Men (MSM) in Palu, Indonesia, a context where religious-patriarchal norms and post-disaster conservatism profoundly shape visibility, health, and survival. This chapter extends the interpretation through both theoretical and applied perspectives, focusing on four interconnected analytical strands: the structural implications of digital backstage reliance, the contextual adaptation of peer navigation under religious stigma, the strategic engagement of religious discourse in anti-stigma efforts, and the ambivalent role of impression management as both resistance and reproduction of stigma. Together, these strands build a layered understanding of agency, vulnerability, and survival, illustrating how MSM navigate constraints while crafting micro-level acts of autonomy within restrictive systems.

In the first analytical dimension, this study underscores the growing dependence on digital backstage spaces—including Telegram, BlueD, WhatsApp, and Instagram "locked stories"—as critical arenas for identity performance, emotional release, and peer support among MSM. These virtual spaces operate as counter publics where alternative selves are enacted beyond the moral surveillance of family, religion, and community. As Ortiz (2019) and Hansman & Drenten (2023) suggest, the affordances of digital media help mitigate psychological distress and sustain collective resilience through anonymity and mutual validation (25,26). Within these networks, MSM exchange health information, coordinate testing, and forge intimacy, building solidarity amidst marginalization. However, this digital refuge is double-edged. Limited internet access and digital literacy can intensify exclusion, particularly for working-class or rural MSM, reproducing structural inequities and intra-community hierarchies. Consequently, while digital backstage environments are indispensable for psychological survival, they cannot fully substitute embodied community spaces and affective solidarity, a pattern mirrored in studies from Malaysia, Thailand, and the Philippines where digital reliance similarly stratifies queer resilience.

The second analytical strand reimagines peer navigation programs—central to HIV prevention and care—within socio-religious systems governed by moral conservatism. In such contexts, conventional biomedical discourse often clashes with religious norms, diminishing program reach and legitimacy. As Toumaras (2025) emphasizes, adaptation requires training peer navigators to embed health advocacy within culturally resonant moral frameworks (27). Framing HIV testing, ART adherence, and safe-sex behavior through discourses of familial responsibility, spiritual wellness, and communal harmony fosters acceptance without moral confrontation. In Palu, involving **trusted figures—religious teachers, elders, or progressive clerics—**can humanize MSM health needs and mitigate backlash. As Polischuk & Kirillina (2024) argue, these intermediaries act as moral translators, legitimizing public health within local ethics (28). When paired with encrypted digital outreach, such hybrid peer navigation can bridge both material and ideological barriers, promoting health equity through culturally grounded solidarity.

The third domain concerns the integration of religious discourse into anti-stigma and health advocacy. While religion is often regarded as a mechanism of sexual repression, emerging scholarship (Nguyen et al. 2024) shows that faith-based values can also serve emancipatory and inclusive purposes (29). By invoking Qur'anic principles of compassion, mercy, and justice, anti-stigma efforts can reframe MSM inclusion as consistent with moral and

communal care, rather than deviance. In religiously conservative Palu, where clerical authority shapes public morality, strategic engagement with progressive imams, ulama, and Islamic educators can transform public narratives. Such alliances lend theological legitimacy to MSM health interventions and reduce doctrinal resistance. However, it is essential to acknowledge potential sociopolitical risks, including doctrinal backlash, selective co-optation, or symbolic inclusion without substantive change. These cautions ensure a balanced and ethically reflexive approach that leverages religion as a resource for empathy while guarding against its misuse in moral governance.

The final analytical dimension interrogates the ambivalent role of impression-management strategies. Goffman's dramaturgical framework is especially illuminating in contexts of religious surveillance and heteronormative policing, where performance becomes a mechanism of safety and belonging. MSM in Palu enact **multiple front-stage personas—masculine speech, religious participation, and heterosexual facades—**to deflect scrutiny and ensure survival. While these acts represent adaptive resilience, they are also psychologically draining, requiring continuous vigilance, code-switching, and compartmentalization of identity. However, as Chan & Wu-Ouyang (2025) note, the normalization of concealment implies that authenticity itself is perilous (30). Similarly, Nguyen et al. (2025) warn of a feedback loop wherein invisibility reinforces stigma, sustaining the very oppression it seeks to avoid (31). Thus, impression management emerges as a paradoxical form of agency—simultaneously protective and complicit, reflecting the structural ambivalence of survival within moral regimes.

Taken together, these insights reveal the double bind of existence in which MSM operate—balancing expression and concealment, solidarity and safety, digital freedom and embodied risk. Supportive interventions must therefore address both micro-level performances and macro-level power structures that compel them. Effective programs should be intersectional, locally anchored, and structurally aware, engaging faith leaders, digital platform designers, healthcare providers, and legal advocates in coordinated stigma reduction. Policy reform must emphasize confidentiality protections, non-discrimination clauses, and inclusive sexuality education to create psychologically and socially enabling environments. These measures will ensure that health promotion for MSM is not only biomedical but also cultural, ethical, and rights-based.

Future research should further examine MSM identity negotiation across hybrid boundaries—digital and physical, sacred and secular, local and transnational. Longitudinal inquiry could illuminate how impression-management strategies evolve alongside shifting political climates, religious discourses, and digital cultures. Moreover, participatory and community-led research approaches are urgently needed to ensure that interventions are co-created with MSM participants rather than imposed upon them. Such participatory ethics will strengthen contextual validity, ownership, and empowerment, advancing a decolonized and inclusive model of sexual health research in Indonesia and the wider ASEAN region.

CONCLUSION

This study examines how Men Who Have Sex with Men (MSM) in post-disaster Palu, Indonesia, navigate religious-patriarchal stigma through impression-management strategies. Drawing from in-depth interviews, visual elicitation, and digital ethnography, it reveals the interconnected dynamics between identity negotiation, stigma, and healthcare-seeking within a deeply moralized socio-religious environment. MSM participants adopt dual personas—performing heteronormativity in public (front-stage) while expressing authentic identities in private and digital spaces (backstage). This adaptive strategy ensures safety and social acceptability, yet produces chronic psychological tension and emotional fatigue. Selective disclosure, governed by trust and perceived risk, shapes healthcare behavior, where fear of exposure or moral condemnation often leads to delayed treatment or avoidance of care.

Digital platforms function as critical safe zones for connection, mutual care, and health information exchange, particularly in a context where physical spaces are morally policed. However, digital reliance can exacerbate social fragmentation, privileging those with access and literacy while excluding rural or lower-income MSM. Impression management—though essential for survival—also reproduces structural invisibility, reinforcing norms that mark non-heteronormative identities as socially dangerous or shameful.

The findings highlight the urgent need for culturally grounded, intersectional interventions that combine peer navigation, secure digital outreach, inclusive religious engagement, and confidentiality-centered health policies. These initiatives should address both the personal coping mechanisms and the structural systems—religious, bureaucratic, and digital—that perpetuate stigma and exclusion.

By centering MSM narratives and lived experiences, this study underscores the importance of participatory, reflexive, and ethically attuned research approaches to reduce stigma, promote mental health, and expand equitable access to healthcare and social protection in religiously conservative and post-disaster societies. The study ultimately advocates for inclusive policy reform and context-sensitive community strategies that uphold human dignity and social justice for sexual minorities in Indonesia and across Southeast Asia.

AUTHOR'S CONTRIBUTION STATEMENT

All authors made substantial contributions to this work. FS led the study conception, participant recruitment, data collection, and initial drafting of the manuscript. NR and IMT contributed to methodological refinement, analytic interpretation, and critical manuscript revision. AS provided conceptual guidance, supervised the research process, and ensured overall alignment with ethical and scholarly standards. All authors reviewed and approved the final version of the manuscript.

CONFLICTS OF INTEREST

The authors declare that there are no conflicts of interest related to the design, conduct, analysis, or reporting of this study.

DECLARATION OF GENERATIVE AI AND AI-ASSISTED TECHNOLOGIES IN THE WRITING PROCESS

ChatGPT was used solely to support clarity, structure, and language refinement during manuscript drafting. All AI-assisted suggestions were reviewed, verified, and revised by the authors to ensure conceptual accuracy and originality. The authors assume full responsibility for the final content of the manuscript.

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