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The Intention of Men Who Have Sex With Men to Participate in Voluntary Counseling and HIV Testing and Access Free Condoms in Indonesia

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Abstract

This study aimed to identify factors that influenced the intention of men who have sex with men (MSM) to participate in voluntary counseling and HIV testing (VCT) and in accessing free condoms. A qualitative inquiry using one-on-one in-depth interviews was conducted with MSM participants who were recruited using a purposive sampling technique. Data analysis was guided by a framework analysis for qualitative data by Ritchie and Spencer, and the Theory of Planned Behavior (TPB) framework was used to analyze the data. The findings were grouped into three themes—namely, (a) attitude encompassing knowledge about HIV/AIDS and HIV/AIDS services and the belief about the positive outcomes of the services; (b) subjective norms including support from MSM peers and family members and motivation to comply with the support; and (c) perceived behavioral control, which is associated with resource availability and having confidence and positive intention to participate in VCT and willingness to access free condoms. Findings indicated that personal, community, and structural factors were predictors to intention to accessing services. Interventions targeting large numbers of MSM population and further studies to understand what needs to be done by nongovernmental organizations and governmental institutions to halt the spread of HIV infections among MSM populations and increase their intention to use HIV/AIDS services are also recommended.

Keywords

intention, VCT, free condom provision, MSM, Yogyakarta, Indonesia

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Introduction

The spread of HIV infection among men who have sex with men (MSM) populations across countries and settings has widely been documented in various studies (MSMGF, 2013; Mumtaz, Hilmi, McFarland, Kaplan, & Akala, 2011; UNAIDS, 2015). The 2017 Joint United Nations Programme on HIV and AIDS (UNAIDS) report identified that globally gay men and other MSM accounted for 12 % of new HIV infection in 2016 (UNAIDS, 2017). Within the Asia and Pacific region, Indonesia was at the leading position of new HIV infection among MSM in 2016, followed by Australia, Mongolia, Vietnam, and Thailand (UNAIDS, 2017).

In Indonesia, the number of new HIV cases among an estimated three million MSM population is reported to have significantly risen over the past 5 years, from 1,040 cases in 2011 to 1,514 cases in 2012, 3,287 cases in 2013, 3858 cases in 2014, 4,241 cases in 2015, and 13,063 in

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2016 (Kementrian Kesehatan RI, 2017). The Indonesian government has a strong commitment to fighting HIV/AIDS through policies and programs and to supporting HIV/AIDS programs including prevention, care, treatment and support, knowledge and behavior change, and impact alleviation (Indonesian National AIDS Commission, 2014; WHO, 2010). MSM, as one of the highly susceptible groups, has become the target of HIV/AIDS programs held by the Indonesian government in collaboration with nongovernmental organizations (NGOs) (Indonesian National AIDS Commission, 2014; Kementrian Kesehatan RI, 2017; WHO, 2010).

Voluntary counseling and testing (VCT) and free condom provision, implemented by an NGO in Yogyakarta and led by MSM peers in collaboration with the local government, are the examples of the HIV/AIDS services specifically targeting MSM population (Kementrian Kesehatan RI, 2017; WHO, 2010). The VCT services are provided trimonthly and free condoms are accessible at any time. The aim of these MSM peer–led services is twofold: (a) to reduce risky sexual behaviors and HIV transmission through increasing risk perceptions and knowledge of HIV/AIDS among MSM populations, and (b) to increase accessibility of VCT services and HIV/AIDS-related information and condoms.

As far as is known, there have been no studies conducted to identify predictors of intention to participate in HIV interventions among MSM in the Indonesian context. This study aimed to identify factors that influence the intention of MSM in Yogyakarta to participate in VCT and access free condoms services provided by an NGO in Yogyakarta.

Methods

Study Area

With a population density of 13,340 people per km^2 and a total population of 636,660 people, the Special Region of Yogyakarta is a province located in South Java Island in Indonesia comprising 1 municipality, 4 districts, 78 subdistricts, and 438 villages (BPS D. I. Yogyakarta, 2016a, 2016b). It has 2 government hospitals and 18 private hospitals, and 18 public health centers and 9 subpublic health centers (BPS D. I. Yogyakarta, 2016c). Yogyakarta city, where this study was held, comprises 14 subdistricts and 45 villages (BPS D. I. Yogyakarta, 2016a, 2016b).

Study Design, Recruitments, and Ethical Considerations

A qualitative study using in-depth one-on-one and face-to-face interviews was used to identify factors influencing MSM's access to VCT and free condoms provided by an NGO in Yogyakarta. A purposive sampling method was employed to recruit the study participants. This nonprobability sampling technique was used because the study was centered on a specific research objective and the population, which was MSM. As this population is hard to reach and the topic is sensitive to discuss, this technique was instrumental in recruiting participants through contacting the initial participant(s) followed by a snowballing technique. A key informant who was the coordinator of the HIV/AIDS program at an NGO targeting MSM population and known to the researchers was contacted to participate in this study. On his acceptance to participate, the program coordinator was asked to distribute to his MSM friends and colleagues the information sheet containing the contact details of the field researchers and detailed information about the current study. Additionally, the information sheet asked potential participants to disseminate the study information to other known MSM and for them to register their contact details in a confidential register (accessed only by researchers), which was made available at the HIV program office. Thirty-three registered potential participants were contacted and arrangements for interviews were made at this point when they met inclusion criteria including (a) individuals who voluntarily consented to the study, (b) individuals who were men who have sex with men, and (c) individuals who were 18 years old and/or above.

Out of 33 individuals, 24 including the key informant met the inclusion criteria and agreed to participate. Before commencing the interviews and before signing the consent form, participants were further informed about (a) reasons for their participation in the in research, (b) the purpose and the research ethics procedures, (c) the risk and benefits associated with this research, if at all, (d) the voluntary nature of their participation and their right to stop at any time without any consequences, and (e) their right to confidentiality and protection.

The interviews were conducted in July 2015 by the first three authors at a time and place recommended by the participants. The interview guide explored broad areas of interest including (a) participants' knowledge about the availability of MSM HIV/AIDS–related services in Yogyakarta, (b) participants' intention to access any of the available HIV/AIDS-related services, (c) factors that influenced decision to access the services, (d) accessibility and appropriateness of services for MSM, (d) barriers or enablers to accessing services including individual, community, and health service factors, and (e) whether they had done anything or had intention to address barriers to access, if any. After signing and returning a written informed consent, interview with each participant was conducted in Bahasa and recorded using a tape recorder, and it lasted between 40 and 90 min. The study was

approved by the Medicine Research Ethics Committee (information blinded for peer review), Yogyakarta, Indonesia (Ref. No.: 002-B/C.10/FK/UKDW/VI/2015).

Theoretical Framework

Because the study explored the intention of MSM to access the HIV services in Yogyakarta, the Theory of Planned Behavior (TPB; Ajzen, 1991) was used as the theoretical framework to analyze the data. This theory explains behavioral intention as a strong predictor of behaviors, and it is associated with three predetermining factors including attitudes, subjective norms, and perceived behavioral control (Ajzen, 1991, 2002). Attitudes are an individual's beliefs about the outcomes or attributes of performing a certain behavior (behavioral beliefs), weighted by evaluations of behavioral outcomes (Ajzen, 1991; Montaño & Kasprzyk, 2008). A person who strongly believes that the behavior will have positive outcomes will have positive attitudes toward the behavior and vice versa (Montaño & Kasprzyk, 2008). Subjective norms, determined by *normative beliefs*, are an individual's beliefs about whether most people approve or disapprove of performing the behavior. Such beliefs are weighted by the individual's motivation to comply with the expectations (Ajzen, 1991; Montaño & Kasprzyk, 2008). A person who believes that other people think he or she should perform a behavior and is motivated to meet the expectations of those people will hold a positive subjective norm (Ajzen, 1991; Montaño & Kasprzyk, 2008). The theory is also associated with perceived behavioral control over the performance of the behavior (Ajzen, 1991, 2002; Montaño & Kasprzyk, 2008). Perceived behavioral control is determined by *control beliefs* concerning factors outside individuals that may facilitate or hamper intention and behavioral performance and one's ability to perform the behavior (behavioral control or perceived power) (Ajzen, 1991, 2002; Montaño & Kasprzyk, 2008). This theory has been successfully applied in previous studies predicting several health behaviors including substance use (Morrison, Spencer, & Gillmore, 1998), exercise (Albarracin, Fishbein, & de Muchinik, 1997), drinking (Trafimow, 1996), and sun protection (Steen et al., 1998). It has also been used in predicting HIV/AIDS prevention behaviors and condom use (Albarracin, Johnson, Fishbein, & Muellerleile, 2001; Bogart et al., 2000; Bosompra, 2001).

Data Analysis

The recorded data were transcribed verbatim into coding sheets and translated into English by the field researchers, all of whom are fluent in Bahasa and English. Data cross-checks for accuracy and clarity among the three authors were ensured during transcription and translation processes to maintain data reliability and validity. The data analysis was conducted using the five steps of the framework analysis by Ritchie and Spencer and included familiarization with the data, identifying a thematic framework, indexing the data, charting the data, and mapping and interpretation (Ritchie & Spencer, 1994). The application of this framework analysis ensured that data were managed in a consistent and structured way and contributed to transparency, rigor, and validity of data analysis process (Ritchie & Spencer, 1994; Srivastava & Thomson, 2009). Underpinned by TPB, the analysis of this article explored factors that influenced the intention of MSM to access VCT and free condom services.

Findings

Participants' Profile

Aged between 21 and 42 years, the 24 participants were from seven different provinces including Yogyakarta, West Java, West Nusa Tenggara, East Nusa Tenggara, Bali, South Sulawesi, and South Kalimantan. Fourteen participants were entrepreneurs or had their own businesses, three were staff at an NGO, and the rest were students at the local universities. The majority of participants (67%) were senior high school graduates, one had a bachelor degree, and the rest were university students. All the participants reported to have had a diagnosis of at least one of four sexually transmitted infections (STIs), including HIV, syphilis, gonorrhea, and chlamydia. Five participants were HIV positive.

The findings were thematically grouped into three categories including attitudes, subjective norms, and perceived behavioral control. These are further described in the following text.

Attitude Toward Attending VCT and Accessing Free Condom Services

The knowledge about the content and aim of the HIV/AIDS services (VCT and condom provision) targeting the MSM populations was strongly associated with the participants' intention to attend VCT and access free condoms. The increase in knowledge about these services and about HIV/AIDS issues obtained through seminars or workshops provided by the NGO seemed to have strengthened MSM's intention to access the available HIV/AIDS services:

> I have twice participated in HIV/AIDS seminars and been told about HIV/AIDS services I can access for free. I know the aims of the services are mainly to help us so that we do not get infected with HIV or other sexually transmitted infections. This encourages me to attend VCT, access the free condoms and consistently use [condoms]. Thanks to other colleagues and NGO that has made these [HIV/AIDS] services available for us. (R22: 21 years old)

> At the beginning I know about HIV infection and free HIV/AIDS services in an HIV/AIDS socialisation event for MSM held by the [Yogyakarta] AIDS Commission. They [AIDS Commission staff] explained about the content and aims of HIV/AIDS services. Having this information supports me to access the free condoms and voluntarily participate in counselling and HIV testing because I am aware that getting infected with HIV will have detrimental impacts on my health and social life. (R13: 25 years old)

The beliefs about the outcomes of attending VCT service or accessing and using condoms also had a positive influence on the participants' intention and behaviors. They included (a) economic benefit of free services, (b) health benefit of accessing and using condoms for protection from HIV and other STI transmission, and (c) benefits of early initiation of treatment through testing and early diagnosis of HIV and other STIs:

> I have a commitment to voluntarily undergoing HIV and other STIs testing because I believe that the sooner I know about my HIV or STIs status the faster I can access treatments. Treatment at early stage of infection can help prevent the infection progress. Besides, the counsellor always reminds me every time I attend VCT to have condom use sex so that I do not get infections. This also encourages me to access condoms. These [services] are free, I do not have to spend my money. (R10: 32 years old)

> I access the free condoms provided for us because I know using condoms can protect me from HIV and other STIs transmission. I also regularly get tested every time I attend VCT because I was advised by the counsellor and medical doctor I talked to that early treatment to infection is actually better for my health. (R4: 26 years old)

However, it seemed that accessing free condoms did not guarantee consistent condom use behavior among the participants. Participants' discontent of condom use during sexual intercourse particularly for partners on a receptive role and the reduction of sexual pleasure when using condoms were expressed as the main reasons for their inconsistent condom use:

> I do not really enjoy it [sexual intercourse] once using condom, the sexual sensation is not the same as without condom, that is why sometimes I simply do not want to use it. (R19: 32 years old)

> I often feel uncomfortable if my partner uses condom, so sometimes we [he and his partner] use [condom] sometimes we do not. (R11: 22 years old)

Coupled with the influence of sexual partners' pressure to avoid condom use, not availing condoms easily at the time of sexual contact was a determinant of inconsistencies in using condoms:

> I use condom inconsistently because sometimes I just do not have it or my steady partner suggests to not use it. (R8: 23 years old)

> Some of my [sex] partners do not like condom use sex, so I often do not use condoms when having sex with them… . I do not always have condoms available in my room or bring them with me in my pocket. (R21: 26 years old)

Participants' low level of knowledge about the health benefits of VCT and condom services and low risk perceptions about HIV and other STIs were also associated with low intention to access the available services. These were reflected in such statements as follows:

> I know I have already got HIV infection, so I think what for I should attend the VCT… . I hardly access or use condoms… . I have casual partners but we do not talk about HIV or STIs. (R3: 22 years old)

> I know about VCT and free condom provision. I remember I once attended VCT but that was two years ago. I also accessed the free condoms a few times. I do not regularly access these services … maybe because I feel like I do not really need to attend the VCT and access condoms every time, I am feeling healthy. (R5: 42 years old)

Subjective Norm Regarding Participating in VCT and Accessing and Using Condoms

Social support among MSM peers seemed to play a pivotal role in increasing participants' intention to participate in the HIV/AIDS services. The majority of the participants including those handling MSM-specific HIV/AIDS program and the recipients of the program reported that they encouraged each other to consistently participate in VCT and accessing condoms. The main reasons were to have as many MSM as was possible involved in the program. This would increase their awareness of the peril of HIV infection, thus increasing MSM protective sexual behaviors, with subsequent reduction in HIV transmission among these populations:

> I am responsible for the HIV/AIDS program provided for MSM population so I always try to support and encourage others to participate in the program or access the free services. VCT and condom provision are provided to help MSM, to make them aware of HIV and other STIs so that they can protect themselves from the infections or increase safe sexual behaviour. (R15: 37 years old)

> I am interested in the HIV/AIDS program provided by an NGO here [Yogyakarta] and become a volunteer assigned to reach as many as possible MSM to access HIV/AIDS-related services including information, VCT and condoms. It is because I think if the number of MSM who know about

> HIV/AIDS through these services increases then condom use promotion as a way to prevent HIV transmission can be effective. (R24: 24 years old)

> I feel massive supports and encouragements from other colleagues particularly the staff and volunteers who implement HIV/AIDS program. They always encourage me to access free condoms or attend VCT. (R16: 23 years old)

Support from family members was also noted to be additional factor that amplified participants' intention to access available HIV/AIDS services. Two of the participants commented that their relatives who knew about their HIV and STI status and sexual orientation encouraged them to attend regular medical checkups, to adhere to medications, and to have protected sexual behaviors:

> My sister is the only one in my family who knows that I am IV positive, and because I am handling HIV/AIDS program for MSM and interacting with other MSM almost every day, I guess she also knows that I am a gay… . The good thing is that she always encourages me to attend VCT and have condoms available in my pocket. (R14: 25 years old)

> I feel that I get support from my oldest sister and her husband. I told them about the free services provided for us by one of the NGOs in Jogja [nickname for Yogyakarta] so they often remind me to access those services. (R20: 27 years old)

Furthermore, individual motivation to comply with the support and encouragement from MSM peers and family members seemed to be a supporting factor for participants' intention to attend VCT and access free condoms. The main reasons to comply with these expectations were that they wanted to avoid HIV and other STIs transmission and to live a healthy life:

> My close friends always support me to participate in the HIV program such as VCT and condoms provision and because of their support I once decided to undergo HIV testing and luckily I am negative. Since then I am committed to always attending VCT and using condoms because I want to protect myself from HIV or STIs transmission. (R13: 25 years old)

> I want to do what my sister and friends suggest because I want to live a healthy life, and I think regularly undergoing VCT and consistently using condoms can help me achieve it. (R18: 24 years old)

In contrast, lack of support from MSM peers and family members could also be a possible explanation of the low intention of the general MSM populations and participants to access the available HIV/AIDS services:

> The HIV/AIDS program we provide has reached approximately 2500 MSM but I am sure that there are still thousands of MSM in this province [Yogyakarta] who do not have access to HIV/AIDS-related services. It could be that they might not have heard of this program or are less informed about health services they can make use of. (R10: 32 years old, a staff of the NGO that provides HIV/AIDS services)

> My parents, brothers and sisters never tell me to undergo HIV testing or access free condoms. I think it is because they do not know anything about HIV/AIDS disease and HIV/AIDS-related services. So, it depends on me, and I rarely access such services. (R6: 26 years old)

Because not as many MSM were connected to existing gay communities and social networks, they also missed information and accessibility to already limited HIV/AIDS-specific services to MSM in the city center of Yogyakarta:

> I think many MSM who are not connected to MSM community and network in the city centre of Yogyakarta are unaware of this [HIV/AIDS] program. Or they might have heard about these services but do not know how to access them. I think this is because they do not have much support from other MSM who can inform them about available HIV/AIDS services such as VCT and free condom provision, and how to access these services. (R15: 37 years old, a staff of the NGO that provides HIV/AIDS services)

> I was not involved in gay community here [Yogyakarta], just stayed at home and did my own activities. So I did not know much about the [HIV/AIDS] services. But recently a friend of mine introduced me to the community and other [MSM] colleagues told me about the services I can use for free. (R6: 26 years old)

Perceived Behavioral Control

The availability of resources including time and finances to facilitate travel to the VCT service facilities and the proximity of these facilities were also factors supportive of participants' intention to attend VCT and access free condoms. These were expressed by the majority of the study participants as highlighted in the following quotes:

> The clinic where VCT service is provided is close to the place where I live, it takes me only a few minutes to get there. So I always want to attend VCT in every three months… . I also regularly access condoms. Mostly, I just stop by at the office [the NGO office] on my way back home [from work]. (R9: 27 years old)

> I am self-employed so I can manage my own schedule and time to attend VCT or access condoms. Besides, the cost of the transport to the points of services is not that much, it is affordable. (R23: 28 years old)

> I am busy with my work but I can still manage to access the services. Besides, the VCT is once per three months and also the office of the NGO where free condoms are available is nearby so I can go there anytime; I can also take as many condoms as I want so that I do not have to access them every week. (R17: 28 years old)

Familiarity, confidence, and ease of access to the HIV/AIDS services seemed to be enablers of participants' intention to participate. The confident feeling was indicated to be a result of the previous experiences of accessing these services and of the knowledge of whom to interact with during the VCT or when accessing condoms:

> I feel confident to access the services because it does not take a big effort to attend VCT or access condoms. Everybody can just go to the clinic and do the counselling or HIV testing, or go to the office and ask for condoms. (R4: 26 years old)

> I am confident to attend VCT or access condoms because I am familiar with these services and know the counsellors and staff who distribute free condoms. (R7: 27 years old)

Competency and staff willingness to provide and support easy access to services seemed to play a part in enhancing participants' intention to participate:

> I and other staff are the ones who promote the [HIV/AIDS] program and try to get as many as MSM to participate or make use of this program, so I am confident to do these [VCT and access condoms]. Besides, I should also show to the others that accessing these services is easy and they can do it for sake of their health. (R14: 25 years old)

> Every time I want to do the VCT or access condoms I always ask one or two of my [MSM] colleagues to accompany me. I just want to make them familiar with the services and to show them how to access the services. (R15: 37 years old)

However, the issue of confidentiality of the results of HIV and other STI testing was reported to be a hindrance to participations' intention to access the HIV/AIDS services. A few participants commented that at times they were reluctant to attend VCT due to the fear of disclosure to other people of results of HIV and other STI testing. It was the NGO's protocol that results of the tests were first sent to the coordinator of the HIV/AIDS program or staff coordinating the VCT, and they were responsible for counselling each patient of the tests outcomes:

> I often do not want to undergo VCT, I feel uncomfortable and unconfident because I am worried if the program coordinator or other staff [who are also MSM] intentionally or unintentionally expose the results to the others. (R1: 22 years old)

> One of the reasons I do not have intention to access the [HIV/AIDS] services particularly the HIV and STIs testing is because I do not want other people to know about the result. I am afraid if the result is positive and they [coordinator or staff who handle the HIV/AIDS program] disclose it to the others. It could be a problem for me since many of us know each other. (R2: 25 years old)

Discussion

It should be acknowledged that HIV among MSM is a significant public health problem in Indonesia and globally. Several factors including positive attitudes and the intention to access HIV services are necessary enablers of service utilization and, thus, protection of populations from HIV infection. Consistent with previous studies (Bandawe & Foster, 1996; Basen-Engquist & Parcel, 1992; Bogart et al., 2000; Bosompra, 2001; Fauk & Mwanri, 2014b; Mwanri, Fauk, Kustanti, Ambarwati, & Merry, 2018; Reitman et al., 1996), this study confirms that attitudes such as knowing the content and benefits of HIV/AIDS services were enablers associated with the participants' intention to use the available HIV/AIDS services. The study participants were aware that attending VCT and using condoms would help prevent contracting HIV and other STIs or encourage treatment at the earliest after the diagnosis. Although participants seemed to have good knowledge about the importance and the need to use condoms consistently and good knowledge about HIV/AIDS and its consequences, they still used condoms inconsistently, with stated reasons including discomfort during sexual intercourse when using condoms, a reduction in sexual pleasure when using condoms, and the influence of regular partners to not use condoms. Similar findings have been reported elsewhere (Malebranche, Fields, Bryant, & Harper, 2009; Ross, 1992; Wheeler, 2006; Williams, Wyatt, Resell, Peterson, & Asuan-O'Brien, Fauk et al., 2018; Fauk & Mwanri, 2004, 2015) indicating that knowledge about HIV/AIDS and the protective benefits of condoms do not necessarily translate into individuals' consistent intention to use condoms. However, supportive of previous studies (Adih & Alexander, 1999; Albarracin et al., 2001; Bandawe & Foster, 1996; Ross, 1992), the current study informs that attitudes such as individual beliefs about the positive outcomes or attributes of accessing health services had positive influence on participants' intention to attend and access HIV/AIDS program. Mwanri et al. (2018) claim that limited knowledge or limited information about the existence of the available services and their benefits can hinder access to HIV/AIDS services. The current study observed a similar finding with one of the reasons stated as that many MSM in the province were not reached and may thus not access the HIV/AIDS program.

In supporting previous authors (Adih & Alexander, 1999; Bandawe & Foster, 1996; Bosompra, 2001; Doswell, Braxter, Cha, & Kim, 2011; Fauk & Mwanri, 2014a), this study affirms that subjective norms, such as social support from friends and family members, were strongly associated with participants' intention to access available HIV/AIDS services. The role of MSM friends in introducing the available HIV/AIDS-related services and their benefits and the encouragement from family members and MSM friends were the reasons reported to support the participants' intention to attend VCT and to use condoms. Likewise, consistent with previous findings (Albarracin et al., 1997; Albarracin et al., 2001; Bandawe & Foster, 1996; Bosompra, 2001), the strong motivation of MSM participants to comply with the support or expectations from friends and family members was a strength to their intention to access the available free HIV/AIDS program. Such strong motivation was also underpinned by the participants' intention to avoid HIV and other STI transmission and to live a healthy life.

Factors including availability of resources (time and monetary) to travel, proximity to the point of health services, ability, confidence, and familiarity with the services were also identified in the current study as the influencers of participants' intention to access the available program. It is also worth noting that the ability and confidence of the participants to perform such behaviors were supported by factors such as familiarity with HIV/AIDS services, including the content of VCT and procedures to access free condoms, trust, and positive interactions with staff or counsellors. Familiarity and trust are known to be synergistically complementary in encouraging confidence, and both have an influence in minimizing the complexities of social issues (Luhmann, 1979, 1988, 1995). Past experiences, knowledge, and trust (e.g., due to issues around confidentiality of HIV/STI test results) in this study have been noted to assist people in making decisions. On the other hand, the current study suggests that lack of trust in confidentiality of HIV/STIs test results discouraged participants' intention to access the available HIV/AIDS services. This may also indicate existence of poor levels of cultural competency of health-care providers, which have been reported elsewhere (Logie et al., 2017; Smith & Mathews, 2007; Tellez, Ramos, Umland, Palley, & Skipper, 1999) as structural barriers to HIV testing and prevention services. Moreover, the positive associations between perceived behavioral control (control beliefs and perceived power) and intention have been reported as facilitators or influencers of condom-using behavior intention among various groups (Albarracin et al., 2001; Jemmott, Jemmott, & Hacker, 1992; Reinecke, Schmidt, & Ajzen, 1996).

Although our analysis for this article focused on behavioral intention to accessing HIV/AIDS services by individual MSM, the findings of this study indicate several structural factors as facilitators of access to the services. They include availability of HIV services, free access to HIV testing and condoms, and affordability of travel costs and proximity to health service facilities. These show that structural factors reported in previous studies as barriers to HIV service accessibility, including cost of transport, health insurance coverage, and inadequate infrastructural resources of health facilities (Freed, Hansberry, & Arrieta, 2013; Levy et al., 2014; Mimiaga et al., 2009; Ravenell, Whitaker, & Johnson, 2008), were not the case in the current study. Interestingly, social barriers such as HIV stigma and discrimination due to MSM sexual orientation reported in previous studies (Dillon & Basu, 2014; Kraft, Beeker, Stokes, & Peterson, 2000; Radcliffe et al., 2010) and known significant structural barriers to HIV testing and prevention services among MSM were not detected in the current study. None of the study participants reported being stigmatized and discriminated against by health-care providers or people in the communities where he lived due to being a gay. This is a significant finding as an indication of acceptance MSM by the Yogyakarta community and health sector. As stigma and discrimination are significant barriers to accessing health services (Mwanri et al., 2018), tolerance and a nonjudgmental approach toward MSM, which seem to be the case in this study, could be an important factor (Tribun Jogja, 2016, February 25; Wardhana, 2016, November 28) to enhance positive health and well-being outcomes of MSM in the Yogyakarta city.

The results of the current study should be interpreted with caution due to several limitations. First, participants in this study were recruited from the city center of Yogyakarta, which is deemed to have potentially good opportunities to access HIV/AIDS program, services, and information, compared to other settings in Indonesia. Therefore, the study results might not be transferable to other MSM populations from other settings where availability of services is poorer. Second, the study participants had been involved in HIV/AIDS-related program, which may have increased their knowledge and information about HIV/AIDS. This might have resulted in undersampling of MSM from other parts of Yogyakarta who were less exposed to HIV/AIDS programs, services, and information and an incomplete overview of determinants associated with intention to access to HIV/AIDS-related services, including VCT and free condoms. Third, the use of TPB could also be a study limitation as it focused on the identification of individual-level explanatory factors and did not address in detail the diverse structural factors that influence intention to access health services. Future studies covering a large range of MSM populations from different settings and diverse structural factors are recommended.

Conclusions

The current study has used the TPB to analyze the intention of MSM to access HIV/AIDS services. The components of positive attitudes included MSM's perceptions or knowledge about HIV infection, the content and aim of HIV/AIDS services, and the benefits of attending VCT and accessing condoms. Meanwhile, the components of negative attitudes included the low perceptions or knowledge about HIV/AIDS and the benefits of VCT services and condom use. These positive and negative attitudes influenced their decision to participate in HIV/AIDS services.

The positive subjective norm reflected one's beliefs (social support or pressure) about expectations and approval and influenced one's decision to access the available services. Perceived behavioral control reflected resource (time and finances) and structural barriers including distance and health facility barriers hindering accessibility. While these findings inform serious issues related to factors that influence the intention of MSM population in Yogyakarta to access the available HIV/AIDS services, further studies are recommended to improve our understanding of what needs to be done by NGOs and governmental institutions to halt the spread of HIV infection among MSM population and to increase the intention of all MSM populations to use HIV/AIDS services.

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