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DISCLOSURE OR NON-DISCLOSURE OF HIV STATUS AMONG TUNISIAN PEOPLE LIVING WITH HIV: ISSUES AND CONSEQUENCES

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Abstract

The disclosure of HIV status remains a salient issue due to its direct impact on prevention. While the issue has been the focus of extensive research in Northern countries and sub-Saharan Africa, it has received less attention in the Middle East and North Africa (MENA) despite the rapid and ongoing spread of the epidemic in this region. This study examines how Tunisians living with HIV have chosen to manage information about their sero-status and the consequences of their choice on their daily lives. For this purpose, we adopted a mixed method approach, combining semi-structured interviews- with 23 HIV-positive individuals receiving care at the Hedi Chaker hospital in Sfax – and an archival analysis of their social and medical records. These individuals have opted for a limited and selective release of this information, either by keeping it secrecy or by sharing it with one person. The finding demonstrates the complexity of these choices, given the multiple issues involved: personal, moral, altruistic issues, aimed at avoiding stigma and protecting others. Protecting others have here two meanings: saving one's face (Goffman 1973) or one's psychological and physical well-being. The consequence of living with the secret refers to its dual functions in the respondent's present lives. On the one hand, it serves a protective and integrative role by concealing information that could have destructive effects on oneself and others (Simmel 1950; Goffman 1973). On the other hand, it fulfils a structuring role by influencing and shaping their life decisions.

Keywords: HIV/AIDS, Tunisia, Stigma, Coping Strategies, Secrecy.

INTRODUCTION

Since its emergence in the early 1980s, the acquired immunodeficiency syndrome (AIDS) has been a source of fear and moral judgment due to its lethal nature and stereotypes linking it with ''deviant behaviors ".

At that time, the disease was a medical enigma due to ignorance about its cause, apart from its prevalence among particular social groups, notably homosexuals and drug users. The fatal nature of the disease, coupled with its predominance among these already stigmatized and marginalized social groups, led to the resurgence of traditional interpretations of disease.

Guilt and Punishment, Deviation and Sanction (Thiaudière 2002: 3). These interpretations formed the basis for prejudice and discrimination towards sick people (Alonzo and Reynolds, 1995). Despite the significant change in the face of the AIDS[1] and the profile[2] of those affected, due to advancements in aetiology and therapy over the years, these interpretations endure and continue to fuel stigmatising views towards patients. If they have lost influence in Northern countries (Pierret, 2006), these interpretations persist in Southern countries, such as Arab-Muslim countries, where they are supported by moralising religious discourse. (Akbari and Safari 2020;Gachanja and al. 2024; Hutahaean and al.,2025).

In his famous book 'Stigma: Notes on the Management of a Spoiled Identity (1963)', Goffman defines stigma as a social process that discredits individuals and deprives them of full social acceptance due to their socially undesirable differences. These differences may relate to bodily appearance, personality traits, or ethnic and religious affiliation. However, the presence of an undesirable difference does not immediately lead to stigmatisation, as stigma tends to emerge during face-to-face interactions and depends on various factors, such as the visibility of that difference (Goffman, 1975).

Here, Goffman distinguishes between the 'discredited' and the 'discreditable'. The former is someone whose difference is already visible and known. The latter is someone whose difference is invisible and unknown. According to Goffman, the visibility of the difference determines how individuals are coping with stigma. For the former, the challenge is to manage the tensions risen by their difference.

For the latter, the challenge is to know how to control the information about their difference: ''To display or not to display; to tell or not to tell; to let on or not to let on; to lie or not to lie; and in each case, to whom, how, when, and where' (Goffman, 1975: 14; 57).

For people diagnosed as HIV-positive, the diagnosis marks the acquisition of a new identity, which consists of being at risk of developing AIDS, a deadly and highly stigmatizing disease. HIV seropositivity is typically asymptomatic, making it invisible. The advent of highly active antiretroviral therapy (HAART) has reinforced this invisibility by delaying disease progression and improving individuals' physical health. Although the invisibility of the seropositivity protect HIV-positive individuals from stigma, it nevertheless places them at the risk of stigma or discrditable to paraphrase Goffman.

Once announced, the information about one's HIV status enters the intimate space that Goffman (1973) called 'the territories of the self'. It stays there unless the person decides to disclose it or to share it with a selected individual. Deciding between these three choices options is a hard task because they both have advantages and risks. While the concealment of such information may protect the person from stigma, it also deprives them of emotional support and leaves them to deal alone from the psychological effects of the disease.

On the other side, disclosing this information could aid gaining various sorts of assistance (emotional, practical, or financial), and avoid the psychological distress resulting from keeping the secret, but it could also expose to stigmatization and social rejection. This is why people are usually considering the advantages and disadvantages before making such a decision (Black and al., 2002). Whatever decision and the logic behind, it implies a way of controlling one's self territory and managing the disease.

Since the beginning of the epidemic, disclosing HIV status has been a public health concern due to its direct impact on prevention. Early research on the topic has primarily focused on understanding the reasons why people living with HIV (PLHIV) choose to disclose or not their serological status, as well as the consequences of their choice on their well-being and their preventive and therapeutic adherence (Pollak, 1986).

Although the topic has generated a substantial body of literature in the northern countries and sub-Saharan Africa (Perlson, 2021, Amir Khanian and al. 2024) it is still under-explored in Arab-Muslim countries, which are one of the contexts where knowledge about HIV/AIDS is very limited. (Abu Raddad et al., 2010.) Reports from these countries indicate significant stigmatization of people living with HIV, blamed for engaging in behaviors prohibited by religious texts, such as premarital sex, homosexuality, and prostitution. (Badahdah 2010; Akbari and Safari 2020; Hamidi and al 2024).

In Tunisia, which is an Arab-Muslim country, stigma, including that from healthcare professionals, is one of the main challenges faced by people living with HIV[3] (PNS 2021–2025; Hariz and al., 2024). Besides its harmful effects on human well-being, stigma poses significant public health issues by discouraging high-risk groups – men who have sex with men (MSM), injecting drug users (IDU), and sex workers (SW) from engaging with preventative and testing programs (National AIDS Plan 2015–2018: 35; Ferchichi and al., 2023).

Tunisia does not differ greatly from other Arab Muslim countries in terms of the dynamics of the epidemic, characterised by its low prevalence and concentration in at-risk populations. (PSN 2021–2025:10) However, behind this low prevalence lie alarming signs. According to the latest estimations of the Tunisian authorities (PSN 2021–2025: 21), the country today has around 5,000 people living with HIV/AIDS (PLWHA), a number that has steadily increased over the past decade due to the rise of the new infections. Furthermore, an important proportion of the people at risk are unaware of their HIV status (PSN 2018–2022: 39, 54)

The national AIDS agency has launched education campaigns to enhance the public knowledge of the disease and reducing stigma, but the effectiveness of these campaigns is unknown due to the absence of published follow-up.

The continued use of camouflage and concealment strategies by people living with HIV, as seen in the image below, may indicate the limits of these campaigns.

Despite the critical importance of HIV disclosure given the epidemic dynamics in Tunisia, there is a lack of research studies addressing this issue. We lack data on how Tunisian PLHIV manage information about their serostatus.

Do they share it or keep it secret? This article aims to provide some answers to these questions, using the example of 23 HIV-positive Tunisians interviewed for our PhD thesis. More specifically, we will examine the issues behind to the way these people chose to manage information about their serological status, and the consequences on their day-to-day lives.

Photos from the television program "Het Nahkiew" (Let's Talk), broadcast on a private Tunisian television channel.

METHODS AND MATERIALS

Semi-structured interviews and archived medical and social records.

The study was conducted over eight months, between 2017 and 2018, to understanding what it means to live with HIV by asking people living with the virus about the challenges they face on their daily life and how they manage it.

It uses a mixed method combining semi-structured interviews with 23 HIV-positive persons receiving care in the University Hospital of Hedi Chaker in Sfax, and an in-depth examination of their archived medical and social records. We opted semi-directive interviews method for two reasons. The first has to do with the kind of data we were looking to gather, which included perceptions, emotions, only accessible through an interactive, face-to-face encounter with the respondent.

The second reason relates to the sensitive topic of AIDS, which deals with intimacy and sexuality. We felt that semi-structured interviews would be the most appropriate method for addressing this topic, as they offer great flexibility in terms of pace and time, thereby enabling us to establish a reassuring connection with the person and gain their trust. Furthermore, it also allows respondents to skip questions they do not wish to answer, or, conversely, to elaborate on their answers, which provide important clues for deeper understanding of their illness experience.

The analysis of archived social and medical records sheds another light on the materials collected through interviews. By consulting medical records, we can access biological and clinical information about our respondents and learn more about their socioeconomic backgrounds. This will allow us to strengthen the rigor of our research and gain a deeper understanding of the medical and social context influencing their illness experience.

Sample Selection Criteria

Given the exploratory nature of the study, we did not set any criteria in advance for the recruitment of informants. Nevertheless, the low presence of people living with HIV in civil society, coupled with the difficulty of reaching them, has necessitated the utilization of healthcare institutions to find our informants. We were conscious that going through the hospital would keep us from having a diverse population (because all the respondents are under treatment and benefit from clinical follow-up). Despite these constraints, we ensured to respect the principle of heterogeneity by selecting informants with diverse profiles as much as possible.

We were aware that conducting the interviews at the hospital setting might lead participants to frame their responses to fit the perceived expectations of the caregivers. To reduce this bias, we emphasized our independence from the hospital to respondents by showing them proof of our status as researchers. We have the impression that thanks to the neutrality and anonymity they provided, the interviewees allowed the respondents to briefly breaking the silence that held them captive and share their experiences, sometimes with great intensity

Survey Process

To recruit informants, we demanded for help from the social worker, who facilitated our contact with the concerned individuals. We planned one-on-one meetings to persuade them to take part in the study. During these meetings, which lasted around 15 minutes each, we sought to emphasize the study's purely academic and scientific purposes. Thirty-two people asked to participate in the study, nine of whom declined. Each participant who agreed to participate signed an informed consent form, in compliance with the Medical Ethics Committee's requirement. We have recorded each interview with the interviewee's consent, transcribed it into their language, and then translated it into French.

Sample Description

The mean age of the study population was 44 years, and they had been living with HIV for an average of nine years. The vast majority of them came from southern regions like Kasserine, Gabes, Kebili and Gafsa. More than half (13 out of 23) were married, including three who got married after becoming infected. Most of the others are single males. Married people have a relatively long experience of living with HIV (8–19 years).

According to data, sexual intercourse appears to be the predominant mode of transmission among the population studied, regardless of the type of contact (heterosexual or homosexual), its status (extramarital or intra-marital) or the setting in which it took place (in Tunisia or abroad). Men carried out almost all of these sexual encounters during their single life, whether in Tunisia or abroad.

The following table details the key characteristics of the population studied

Tableau 1: the key characteristics of the sample

	Characteristics	Number of respondents
Sex	Men	**12**
	Women	11
Age	>40	**14**
	25-40	8
	<25	1
Marital status	Married	**13**
	Single	6
	Widows	3
	Divorced	1
Educational level	Primary	**15**
	Illiterate	3
	Higher education	2
	Secondary education	2
	Pre-secondary education	1
Professional status	Housewife	8
	Independent work	5
	Day Laborer	5
	Employee	3
	Unemployed	1
	Retired	1
Mode of transmission	Heterosexual intercourse.	**17**
	Ignorance of contamination method	4
	homosexual intercourse	1
	injection drug use	1
Residency	Outside Sfax	**13**
	Sfax and its suburbs	10

DATA ANALYSIS METHOD

Thematic analysis method

Interviews analyzed using the thematic analysis method, which involves identifying themes, and sub-themes that emerge from the data gathered, as well as the trend within each. The procedure consists of the following steps: reviewing the recorded statements; extracting the most significant ones, and coding those that are similar. Similar codes divided into sub-themes and then combined to form substantial themes, offering a complete view of the phenomenon in question.

The analysis pursued until saturation. The management of information about HIV status was a recurring theme in all interviews. Sub-themes included the reasons for revealing or keeping quiet about this information, the circumstances surrounding disclosure, and the experiences of disclosing HIV status.

THEORETICAL ANALYSIS FRAMEWORK

Sociology of illness experience

Data analysis showed the relevance of the experience of living with chronic illness as a theoretical framework for interpreting our research findings.

This interactionist-inspired analytical framework, recognized in sociology for over 40 years (Goffman, 1968; Strauss and Glaser, 1975), focuses on the viewpoints of individuals experiencing illness to understand the disruptions caused by their condition, along with the resources and strategies they use to manage these disruptions and keep their lives normal as possible.

Although HIV infection does not impose physical restrictions that prevent individuals from living normally, the stigma surrounding it can harm their social lives, exposing them to loneliness and marginalisation. Controlling this information then becomes a vital issue in retaining identity inscriptions and sustaining a normal life, as pre-infection life.

RESULTS

Overall, respondents opted for very limited and selective disclosure of information about their HIV status. Half of them (12 out of 23), who were mainly unmarried or widowed at the time, kept it strictly secret and did not share it with anyone. The others (n = 11), all married, shared it only with their spouses. Parents, siblings, friends, and co-workers excluded from the circle of secrecy.

REASONS OF DISCLOSURE OR NOT HIV STATUS

Dependency and fear of rejection

Fear of stigma is the main reason for respondents' choice to conceal their HIV status from their parents. Although everyone experiences it, the fear of stigma does not weigh equally on two groups of populations that differ in their marital status and degree of dependence on their families: singles and widows on the one hand, and married people on the other. For the former group, the fear of stigmatisation and rejection exacerbated by the significant losses they are likely to suffer due to their financial and moral dependence on their families. Single people still live with their parents and rely on them economically. Although widows enjoy autonomy and financial independence due to their husbands' pensions, they have maintained daily and consistent contact with their families, who provide them with moral and social support since the death of their spouses. Given the dependence on their families, non-disclosure of their serological status was a condition for singles and widows to keep their material security and moral support they needed at the time, and which most of them still need today, as they have not yet escaped this dependence.

By contrast, concerns about stigma and rejection by family members are less prevalent among married people. The main reason they chose to conceal their HIV status from family was to avoid causing them unnecessary distress. Some men's (n = 5) expressed the ideas that the disease is an intimate matter that gives one the right to keep it secret. The words of Zouheir, a 48-year-old married man, illustrate these ideas.

> *"I haven't talked about it with anyone, not my mother, or my father, or my brother. Only my wife knows. I see no reason for anyone else to know about something that concerns me alone.”*

From the perspective of the experience of illness, choosing the silence about HIV status is a strategic decision that enables to protect one’s identity and maintain a normal social life as before the onset of infection. Nevertheless, protecting oneself is also a protection of others. In fact, some single people have said they kept their HIV status a secret from their parents because they were afraid it would have a negative impact on their mental and physical well-being. Bear in mind that all the single people interviewed contracted HIV through sexual relations, and all come from the Southern Tunisia, which is particularly characterised by conservatism and a strong sense of community and patriarchy. (Sellami, 2015). A son having premarital sex, which is socially seen as sinful and illegal, breaches the idealised image of the ‘’disciplined child “and becomes a source of shame for his or her family. This is even more the case when he is female, a symbol of chastity and purity and perceived as a badge of honour for the family. (Sellami, 2017). Manel, an unmarried 26-year-old girl, illustrates all of these issues.

> *« [...]"It was the biggest mistake of my life, a mistake that has cost me dearly." I will spend the rest of my life under treatment, threatened by death, mental fatigue, and becoming a source of shame and dishonor for my family and loved ones. [...] ".*

Hiding HIV status from parents is so an attempt to retain the conventional image of the ‘disciplined’ child, save face for parents, and avoid disappointing them. This disappointment can have a detrimental effect on their psychological well-being and physical health, particularly if they are already dealing with a health condition. Yousra, a 24-year-old woman contaminated by her ex-boyfriend, illustrates this idea.

> *"Impossible, I can't inform her (my mother)." She suffers from hypertension and has already had two heart attacks. If she learns about my illness, and how I got it, she could end up in the worst situation. I am afraid of losing my mother, because I've already lost my father.*

Reasons for sharing the secret

Much research on HIV status disclosure has focused on spouses and sexual partners, given the significant risk of virus transmission in this population. It is not surprising therefore, that most of this research conducted in sub-Saharan Africa, where the epidemic is widespread and sexual transmission is predominant (Iwelunmor and al., 2015; Hassan and al., 2022). In contrast, countries with low prevalence rates, such as West and North Africa, have received very little attention. (Coutherut & Desclaux, 2014 (Karbasi et al., 2023).The literature from sub-Saharan Africa shows a varying rate of serostatus disclosure between partners, depending on the quality of the relationship and gender:

Disclosure is more likely in a stable relationship than in transitory ones (Iwelunmor and al., 2015; Pierret, 2006: 57; Twimukye et al., 2024. Love and fidelity, which characterize long-term relationships, encourage disclosure, while the emotional ‘neutrality’ that characterizes short-term relationships promote secrecy. This same literature states that women are more reluctant than men to disclose their HIV status due to gender inequality. Their socioeconomic dependence on their husbands exacerbates their fear of abandonment, leading them to prefer keeping their HIV status secret (Coutherut & Desclaux, 2014).

Our research does not provide data to validate these finding in the Tunisian context, since all the married women interviewed contracted HIV from their husband. Nevertheless, the study revealed a high disclosure rate among men (3/5), mainly for preventive reasons. These men first reported that the medical personnel had strongly recommended that they inform their spouses testing purpose. They then expressed their moral obligation to do so by the principles of marital faithfulness and cohabitation.

While these men considered it their moral responsibility to talk their wives about their HIV status, this was not the case concerning how they contracted the virus. In fact, most have chosen to stay silent about the circumstances of their infection, to avoid revealing a shameful past. Remember here that all these men contracted the virus through unprotected sex intercourse during their single lives. When their wives ask them about the origin of the infection, they tend to adopt covering strategies that attribute the infection to fewer stigmatizing causes. They often cite fate or a possible infection at the hairdresser. These strategies help to mitigate the ‘moralizing’ nature of the illness and allow them to present themselves as ‘victims’, which leads them to expect pity and compassion from their partners.

CONSEQUENCES OF KEEPING SECRECY

Controlling secrecy

Many young singles mention strategies they utilise to avoid unintentionally disclosing of the secret. These strategies include controlling the storage of drugs and all documents that might suggest their HIV status (a doctor’s prescription, for example). A recurring practice among these young people is to keep the pillbox locked in the back of the armoire and to burn it in a fire when finished. When it comes to taking their medication, they themselves lock themselves in a safe place, like the bathroom. Implementing these strategies demands constant vigilance, which makes them challenging. This is why they place particular and urgent importance on marriage as a radical solution to gain a certain autonomy, which will alleviate life and disease management. For example, when they will be in the marital home, they do not have to worry about a family member accidentally finding the pillbox and revealing the secret. Marriage is here a distancing strategy aimed not only at protecting secrecy, but also at ensuring the conditions necessary to maintain it. In fact, through marriage, these young people attempt to reorganize a private space, as opposed to the family home, to guarantee treatment compliance, which is crucial for their survival and the maintenance of the secret. However, the question of marriage gives rise to a dilemma about the future partner’s serological profile, as expressed in the following questions: Is it possible to find someone willing to marry an HIV-positive person? What guarantee is there that he will respond positively without disclosing the secret? Except for three men who rejected the idea of marrying an HIV-positive woman, the other (6/9), all women, decided to marry someone with the same serological status.These young women first expressed their pessimism about the possibility of finding someone who would accept to marry them despite their HIV-positive status, then shared their concern about the risk that this person would disclose the secret entrusted to them. Devaluing attitudes toward non-virgin women is another factor that explains these young women’s doubts about the possibility to meet someone who accept them despite their illness. Yossra, a 24-year-old single woman, expresses all these ideas well.

> *"[...] "Everything changed after I became a lady. A girl who has lost her virginity may only marry the man with whom she had sex […, but where do you find that person (*Someone who agrees to marry an HIV-positive woman)*? Do you think we are in a romantic movie? We are in Tunisia! And specifically, in Gabes* (a city in the southeast of Tunisia). *It is very difficult to find someone who is willing to marry a woman who is not a virgin. So how do you expect me to believe that there are men willing to marry an HIV-positive woman? Impossible! [...] "*

For these young women, serological constraints become a source of emotional distress as it shatters the dreams they had built up since childhood about the profile of their future partner. However, the dual importance of marriage in managing and reorganizing their present and future lives with HIV will force them to make further sacrifices in the hope of increasing their chances of getting married, as demonstrated by Lobna, a 26-year-old woman.

> *"For us girls, it's extremely difficult [...] when we reach a certain age, we have to get married otherwise you'll be the laughingstock of neighbours. [...]The other day, the social worker suggested I marry a 40-year-old Libyan man. Despite the big age difference between him and me, I said "OK, normal".*

Widows and divorcees have decided not to remarry for two main reasons. The first reason is similar to that cited by single people: the pessimism of finding someone who agrees to commit them despite their HIV status. The second reason related to the little importance they have ascribed to the question of marriage in the reorganizing of their life with HIV. The marginal importance that these widows have given to marriage may be due to the fact they have found something to invest in for their new phase of life, which matches with the announcement of their seropositivity and the loss of their husbands. All declared having children who now become the center of their lives and the element from which they derive meaning, both for the present and for the future of their lives. They want to devote the rest of their lives to helping and supporting them, in the hope of leaving them in better conditions. Farida, a 42-year-old widow, expresses this idea well.

> *"I now feel that my children are the air I breathe, and the most important thing for me is that they are happy and healthy." I no longer worry about my private life. »*

For singles people who are waiting to meet their future partner can be problematic. The longer the time, the more problems multiply and become more complex. At first, these singles may face with questions about the reasons for their delay in finding a life partner, but repeated rejection of marriage proposals can arise concern and expose them to questions from their loved ones.In such situations, cover-up strategies are the first refuge to avoid revealing their stigmatized identity. These strategies involve invoking fake reasons to justify their refusal of marriage proposals. Siwar, a 35-year-old single woman contaminated by her ex-boyfriend, gives us a good example. Before meeting her husband, who is also HIV-positive, she received many marriage proposals, which she all rejected. She admitted that she had always looked for the slightest flaw in these men (and sometimes even invented one), to justify these repeated rejections to her parents.

> *"For example, a man came to ask for my hand in marriage from my parents, and as usual, I refused." He asked me to drop out of university as soon as we got married and that was the point, I used to justify to my family my refusal to marry him. I told them I wanted to finish my studies.*

Widows and divorced women were also subject to these conditions. They asked why not considered remarrying after the death of their husbands. The strategy of concealment was also a way for them to manage these situations and protect the secrecy surrounding their HIV status, as Latifa’s words make this clear.

> *"Ooh, almost everyone, mostly from my family's side" but every time, I tell them that I won't remarry as long as my daughter lives with me. I don't want my daughter living under the same roof as a strange man (the non-biological father). I tell them about several cases of widowed or divorced women who remarried, and whose new husband behaved badly toward their daughter or sexually assaulted her.*

DISCUSSION

This article investigates the practice of disclosing HIV status among Tunisians living with HIV. It discusses the reasons behind their decisions to disclose or not disclose their status and the consequences these decisions have on their daily lives. The finding supported the trend observed in the international literature revealing a continual reluctance among people living with HIV to disclose their status. The reasons for this reluctance are extremely complex and involve a maze of personal, moral, and ethical issues. The fear of stigma remains the main reason that leads people living with HIV to practice control over information related to their infection and to act in a way that restricts and selects the dissemination of this information. In addition to these personal concerns, there are also moral ones driven by the intention to protect others from the possible harm resulting from their learning of their HIV status. Secrecy seems thus to play three interconnected functions: protection, integration, and the establishing of social order, by cancelling information potentially detrimental to the self, others, and the social system. Simmel (1950) first examined the protective and integrative function of secrecy and then by Goffman (1996), who were among the first sociologists to study secrecy as a control and self-assertion strategy. For Goffman, secrecy is a means of preserving self-information and protecting public face, defined as 'the positive social value a person effectively claims for himself by the line others assume he has taken during a particular contact' (Goffman, 1974). Simmel evoked this protective function of secrecy as part of his reflection on the characteristics of the new modern industrial society. He showed how the social conditions of strong personal differentiation, created by this new type of society, favoured the emergence of secrecy as a means for individuals to protect the things they value (ideas, objects, activities).

Perhaps the main contribution of this study is its contextualization of the fear of stigma. We have established that although all respondents share a common fear of rejection, its intensity varies depending on the individuals' positions and living conditions. For instance, we have shown that this fear is more acute among single and widows because of the significant losses they may incur due to their moral and material reliance on their families. The study's findings also support the idea that keeping secrets can have a negative impact on individual's well-being, as has been widely documented in studies on the disclosure of HIV status worldwide.

Although secrecy may protect against stigma and the psychological distress associated with it, it can nonetheless become a major source of emotional suffering. In fact, the decision to hide HIV+ status not only deprives the individual of access to the moral support that could help them cope with the emotional burden of the diagnosis, it also generates ongoing stress. The stress stems from the fear of unintentional disclosure of the information about their illness, and from the continual work required to control this information and prevent its disclosure. Such work demands constant vigilance, which is a source of stress and chronic anxiety. The relevance of our research lies in highlighting the unequal burden of this work, which depends on individuals' settings and living conditions. Living with this secret is tough for young single people because they live with their families, which makes it hard to keep the secret hidden, as Constance R. S. Mackworth-Young et al., 2021, also shown among young Zambian women.

CONCLUSION

The findings of this study, in concordance with other research around the world, show that people living with HIV continue to face challenges in disclosing their status due to the pervasive stigmatized nature of the disease, despite the advancements in science and treatment. Our findings challenge the international HIV guidelines, which promote HIV-positive status disclosure due to its critical role in prevention, treatment compliance, and quality of life enhancement (WHO 2013). We posit that this pro-disclosure should be relativized, by considering people's contexts and living conditions. In contexts where HIV/AIDS is highly stigmatized, concealing one's sero-status is a wise decision, as it facilitates the preservation of personal identity and the maintenance of social integration. The national actor in charge of the fight against AIDS in Tunisia should develop strategies aimed at reducing the stigma associated with HIV/AIDS. These strategies should make an atmosphere favorable to disclosure, which will promote individuals' social and psychological well-being, and preventative efforts. This initiative will be consistent with the democratic society that Tunisia aspire to establish for over a decade now. A democratic society, which should defend the rights of minorities. This study has demonstrated the psychological cost of concealing one's HIV status. However, it provided no data regarding its impact for treatment protocol. It is unknown if respondents discontinued or interrupted their medication to avoid exposing their HIV-positive status, so defying the treatment regimen prescribed by their doctor. A study addressing this question might be valuable in the Tunisian setting. Nearly all of the participants in this study are from the southern part of the country, known for its conservatism. It would be important to conduct a study in the north of the country to compare the finding of this one.

Footnotes

1) The isolation of the causative agent of AIDS and the identification of its modes of transmission in 1983 revealed the widespread nature of the disease. This means that anyone can contract the disease, which is not specific to particular individuals or groups.
2) In particular, the transition of AIDS from a deadly disease to a long-term chronic illness, thanks to highly active antiretroviral treatments marketed since 1996.
3) https://menarosa.org/fr/stigmatisation-et-discrimination-dans-les-etablissements-de-soins-de-sante-en-egypte-et-en-tunisie/

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