KNOWLEDGE AND ATTITUDE LEVELS TOWARD HIV/AIDS AMONG ARAB MALE TOURISTS IN THAILAND

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ABSTRACT:

Background: Thailand tourism sector encourages tourists from all over the world. Hence, the numbers of Arab tourists are large enough to visit this country each year. In the Middle East and the North Africa (MENA) regions considered the lowest level of the prevalence of the HIV/AIDS. This might affect their Knowledge regarding the disease. Many reasons lead to the low prevalence of HIV in the region; and the main reason has been credited to the conservative cultural values of traditional Arab society. This study assessed the HIV knowledge and attitude levels among Arab male tourists who visiting Bangkok and Pattaya.

Methods: A cross-sectional study was used to describe the socio-demographic, knowledge, attitudes, and association between socio-demographic and level of HIV knowledge attitudes among Arab male tourists in Thailand. A convenience sampling using electronic survey was conducted with the Arab male tourists aged 18 years old and above visiting Thailand not more than 6 months.

Results: There were 384 participants, the majority of participants were aged between 30-44 years. All of them were male; and the majority of participants 251 (65%) came to Thailand in 2016 for vacation. Most of them preferred to go to the islands, beaches and enjoy the night life in bars. Most of the participants heard about HIV/AIDS; and majority of them had high HIV knowledge level and negative attitude towards HIV/AIDS.

Conclusion: The study found high level of HIV transmission knowledge and some negative HIV/AIDS attitudes among Arab male tourists. Education and HIV prevention programs are recommended for tourists and tourism workers. These findings could aid the development of appropriate international awareness-raising messages to help reduce the gaps in knowledge and misconceptions on HIV/AIDS among tourists.

Keywords: HIV/AIDS, Knowledge, Attitude, Arab male tourists, Thailand

DOI: 10.14456/jhr.2016.64 *Received: June 2016; Accepted: August 2016*

INTRODUCTION

Thailand is a tourist country and visited by thousands of Arab tourists and others for recreation each year [1]. The tourists arrival from these countries have more than doubled since the late 1990s, with a large proportion of visitors coming from oil-rich Arab countries with highly conservative traditional cultures [2]. At end of 2014 according to the Ministry of Tourism and Sports, Thailand, the Middle East tourists arrived to Thailand by country of residence and nationality at Suvarnabhumi International Airport about 506,713 tourists, approximately 2.30% much more than previous years [1]. There were male more than female tourists coming to Thailand. This happened because women life in the Middle East is very different from the west women; one example is that women must have permission to travel out of their countries, or they have to travel with men. Some of them may be at an increased risk of infection, lack of information about risk and preventive measures; and the fact that travel and tourism may enhance the probability of having risky sexual behaviors. This may increase the risk of contracting sexually transmitted infections. Some of these tourists may

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Cite this article as: Elamouri F, Panza A. Knowledge and attitude levels toward HIV/AIDS among Arab male tourists in Thailand. J Health Res. 2016; 30(Suppl.1): S27-33. DOI: 10.14456/jhr.2016.64

face unprotected sexual intercourse during international travel; and they may have high risk of HIV/AIDS infection because of their sexual activity probably caused by the reduction of barriers abroad [3].

In the Middle East and the North Africa (MENA) regions considered the lowest level of the prevalence of the HIV/AIDS comparing to the other regions; by the end of 2008, the prevalence of adult was estimated about 0.2% [4]. The lack of credible database, however, limits practitioners' understanding of the HIV situation. Many reasons lead to the low prevalence of HIV in the region; and the main reason has been credited to the conservative cultural values of traditional Arab society [5]. Almost the universal male circumcision has played a protective role in slowing and limiting HIV transmission in (MENA) in comparison with other regions. There is compelling evidence that male circumcision reduces the risk of heterosexually acquired HIV infection in men by approximately 60% [6]. To date, no published study has investigated HIV knowledge and attitude levels among Arab tourists in Thailand or elsewhere. In this study we described HIV knowledge and attitude levels among Arab male tourists who visiting Bangkok and Pattaya.

METHODS

A cross-sectional study was used to describe the socio-demographic, knowledge, attitudes, and association between socio-demographic and level of HIV knowledge attitudes among Arab male tourists in Thailand. A convenience sampling using electronic survey was conducted with the Arab male tourists aged 18 years old and above as calculated from their last birthday and visiting Thailand not more than 6 months. Inclusion criteria were Arab male tourists visiting Thailand for minimum 3 days and maximum 6 months, and able to read and write Arabic or English. Exclusion criteria were respondents who refuse to participate in study and who didn't have time to answer the questionnaire.

Data collection

The research method used in this study involved an electronic survey. We conducted it from April to May 2016 during Songkran festival; this might have an effect on increasing an attention to travel to Thailand.

We found the Arab male tourists in the pubs, restaurants and massage parlors. The participants were screened for eligibility by asking about duration of stay and age before handing out the questionnaires.

The researcher introduced the research to the participants and asked them to sign the consent form. Questionnaires were given to participants. The researcher let participants answer the questions by themselves, but sat nearby to explain any questions they might ask.

The researcher waited until participant finish, then provided leaflet of right answers of HIV/AIDS knowledge to participants.

The sample size is calculated by using Daneil in 1995 [7] and Ngamjarus et al. [8].

$$n = \frac{Np(1-p)z^2_{1-\frac{\alpha}{2}}}{d^2(N-1) + p(1-p)z^2_{1-\frac{\alpha}{2}}}$$

Measurement tools

We collected information through electronic self-administration anonymous questionnaire using 8 notebook (iPad Pro 9.7 inch display) internet connected, installed the electronic questionnaire to be ready using by participants. All individual answers sent to researcher's email in Excel sheet in Arabic and English language. The electronic questionnaire is increasingly replaced with paper-and-pencil questionnaires; and it is perceived as a practical way to reduce data entry costs, while increasing the accuracy of the data through programmed consistency checks and automated skip patterns. Electronic questionnaire assists self-interviewing, by minimizing the respondent's interaction with the researcher, reduces the respondent's predilection to modify or change answers. It has become the method of choice in the United States for surveys that collect information about sensitive behaviors [9]. The questionnaire had 4 sections including 33 questions; the first section comprised of socio-demographic characteristics of the respondents; the second section comprised of travel experiences; and the third and the fourth sections comprised of questions that address the HIV knowledge and attitudes regarding HIV/AIDS.

Data analysis

Data were analyzed using SPSS 22.0 version (the University licensed). Regarding knowledge and attitude, scores were computed by taking the sum. Descriptive statistics included frequency, percentage, mean, standard deviation. Descriptive statistics presented frequency and percentage for categorical data, means and standard deviation, normal distribution and with median.

Table 1 Frequency and percentage distribution of respondents by Socio-demographic characteristics and travel experience (n=384)

Socio-demographic characteristics		n= 384	%
Age (years)	18-29	113	29.4
	30-44	177	46.1
	45-59	94	24.5
Religion	Muslim	344	89.6
	Christin	38	9.9
	Jewish	2	0.5
Nationality	Emirati	95	24.7
	Saudi	39	10.2
	Omani	37	9.6
	Bahraini	35	9.1
	Egyptian	34	8.9
	Kuwaiti	30	7.8
	Lebanese	27	7.0
	Qatari	24	6.3
	Iraqis	22	5.7
	Others*	41	10.7
Education level	High school or less	203	52.9
	College or postgraduate	181	47.1
Occupation	Self-owned business	158	41.1
	Company employee	148	38.5
	Student	42	10.9
	Government employee	36	9.4
Monthly income	I don't earn any money	29	7.6
	200-500 USD	22	5.7
	600-1,000 USD	134	34.9
	1,100-3,500	199	51.8
Marital status	Married	194	50.5
	Single	127	33.1
	Divorced	63	16.4
Reason come to Thailand	Vacation	251	65.4
	Business	75	19.5
	Medical tourism	57	14.8
	Education	1	0.3
Duration stay in Thai	Less than 1 week	38	9.9
	1-2 weeks	277	72.1
	Weeks – 1 moth	68	17.7
	More than 1 month	1	0.3
Come to Thailand with	Alone	166	43.2
	With my friends	140	36.5
	With family	54	14.1
	With my wife	23	6.0
	With relatives	1	0.3
Stay in Thailand with	Alone	277	59.1
	With my friends	95	24.7
	With family	38	9.9
	With my wife	24	6.3
Been before to Thailand	Yes	223	58.1
	No	161	41.9
Frequency come to Thailand (times)	1-2	153	39.8
	3 or more	70	16.4
	Missing	161	41.7

Table 1 Frequency and percentage distribution of respondents by Socio-demographic characteristics and travel experience (n=384) (cont.)

Socio-demographic characteristics		n= 384	%
Favorites places for pleasure	Islands and beaches	225	58.6
	Bars	182	47.4
	Massage centers	120	31.3
	Restaurants	64	16.7
	Shopping malls	47	12.2
	Coffee shops	9	2.3

* Other nationality are (Algerians, Tunisians, Moroccans, Libyans, Jordanians and Palestinians)

Table 2 Distribution of respondents showing level of knowledge about HIV/AIDS (n=384)

Level of knowledge on HIV/AIDS		n= 384	%
Have you ever heard of HIV	No	12	4.4
	Yes	372	95.6
HIV knowledge (score) (372)	Low (0-5 points)	103	26.8
	Moderate (6-8 points)	120	31.3
	High (9-10 points)	149	38.8
	Total	372	96.9
	Missing	12	3.1
	Total	384	100.0
Mean = 6.8, Median= 7.0, Std. Deviation= 2.0, Minimum= 1.0, Maximum= 10.0			

Ethical consideration

Ethical application of the study has been approved by the Ethical Committee at the Ethics Review Committee for Research Involving Human Research Subjects, Health Science Group Chulalongkorn University. Bangkok, Thailand under number (COA No: 057/2016). An information letter was given to the participants to make sure they were well informed about the study and that this study was anonymous and voluntary.

RESULTS

In total 384 participants passed the screening questions and completed the electronic survey in order to be our sample in this study.

Table 1 shows the socio-demographic characteristics of the Arab male tourists in Thailand, 46% of the participants were aged between 30-44 years; and all the participants were male. The majority of participants 90% were Muslim. The majority (25%) came from Emirate. A few countries were represented by less than 15 participants from Libya (4%), Algeria (3%), Tunisia (1%), Jordan (1%), Morocco (0.8%), and Palestinian (0.3%). The majority of the participants (53%) obtained high school. The majority of the participants (41%) were self-owned business; and the average monthly income of the majority (52%) was between 1,100-3,500 USD. More than half of the participants (50%) were married.

The majority of participants (65%) came to Thailand for vacation. Most of participants (72%) visited Thailand for 1-2 weeks. The majority of participants (43%) visited Thailand alone; and more than half of the participants (59%) stayed alone. The majority of participants (58%) had ever been to Thailand before. The majority of participants (40%) had visited Thailand more than one time. Most of participants (59%) preferred to go to the islands and beaches in Thailand. Detailed traveling experience details are shown in Table 1.

Level of knowledge on HIV/AIDS

The mean knowledge score for the respondents was 6.8 out of possible 10 points (SD=2.0). Table 2 shows that 96% of the participants heard about HIV/AIDS, 27% of respondents were at low level of knowledge; 31% of those were at moderate level and 39% of those were at high level. Response to the knowledge part of the questionnaire, 96% of the participants knew that a person can get HIV through unprotected sex with an infected person. The questions with the least number of correct answers were 35% for question regarding HIV transmission by Kissing on the cheek and 55% for question regarding to people live with the HIV looking sick.

Attitudes towards HIV/AIDS

In Table 3 describes the frequency and percentage of participants' attitude towards each question together with the mean and standard

Table 3 Distribution of respondents showing the attitude towards HIV/AIDS (n=384)

Items of attitude towards HIV/AIDS (n=384)	Agree		Neutral		Disagree		Mean	S.D
	N	%	N	%	N	%		
Necessary to get education on HIV/AIDS	360	93.8	0	0.0	24	6.3	2.87	0.48
AIDS patients should be kept separately from their families and community	196	51.0	0	0.0	188	49.0	1.97	1.00
HIV/AIDS is somehow punishment from god	219	57.0	0	0.0	165	43.0	1.85	0.99
We should not tell other if one has HIV/AIDS	233	60.7	1	0.3	150	39.1	2.21	0.97
I am not afraid get HIV/AIDS because I am sure that I am not the person who is going to get HIV/AIDS	100	26.0	2	0.5	282	73.4	2.47	0.87
Generally, having sex without condom a few times will not infect a person with HIV	140	36.5	3	0.8	241	62.8	2.26	0.96
I know the difference between risky sexual behavior and safer sex.	282	73.4	1	0.3	101	26.3	2.47	0.88
My partner cannot infect me with HIV/AIDS because I trust him / her.	126	32.8	1	0.3	257	66.9	2.34	0.93

Table 4 Attitude level towards HIV/AIDS (n=384)

Items	n=384	%
Negative attitude (8-23)	181	47.1
Neutral attitude (24-31)	178	46.4
Positive attitude (32-40)	25	6.5
Mean 24.20∓5.58		

deviation. There were 360 (93%) of the participants agree to "get education about HIV/AIDS" with the mean score of 2.87. There were 282 (73%) of the participants disagree to "afraid get HIV/AIDS because they are sure that they are not the person who are going to get HIV/AIDS" with the mean score of 2.87.

Table 4 shows level of attitude towards HIV/AIDS. The score is ranging from 8-40. The mean score recorded at 24.20 and SD was 5.58. Majority of the respondents (47%) had negative attitude towards HIV/AIDS, while 46% had moderate attitude, only 6.5% had positive attitude.

DISCUSSION

In this study, almost 96% of respondents had ever heard about HIV/AIDS. The mean knowledge score for the respondents was 6.8 out of possible 10 points (SD=2.0) on the correct modes of transmission of HIV/AIDS. However, HIV knowledge gaps about transmission and curability put Arab male tourists at risk of contracting HIV. Misconceptions were presented. For example, 22% of participants responded mosquitoes transmit HIV; 65% of them though HIV transmitted by kissing on the cheek; and 45% of them living with sick HIV people. The fact that most of participants did not know the basics of HIV transmission; moreover, AIDS patients cannot be treated indicated inadequate teaching. With limited knowledge, it was probably lower among persons with less education. As UNAIDS Middle East and North Africa in regional report on AIDS 2011, it reported that the region has limited HIV knowledge, high levels of risk behavior, and false perceptions of low risk activities [8]. Knowledge of this region's epidemic is comparatively limited and is often perceived as a 'black hole' in terms of HIV/AIDS data [10]. In same ways a study among Arab university students in UAE toward HIV/AIDS knowledge, attitudes, and educational needs find 90% knew main routes of infection; there were misconceptions about transmission; and only 31% knew there is no vaccine and 34% knew there was no cure against HIV/AIDS [11].

In our study the participants showed low 27% knowledge level of overall knowledge scores on HIV/AIDS, moderate 31% and high 39% knowledge level. Differences in scores between different nationalities could be attributed to differences in beliefs, cultures, religions and schooling. All of which can have significant impact over the knowledge, attitudes and behaviors towards the disease.

After intensive literature review, we found not possible to compare HIV knowledge among Arab

male tourists; because there was no published literature. However, comparisons should be treated with caution as different assessment tools and population, and sample used.

In our finding the attitudes towards HIV/AIDS were mostly 47% negative and 46% moderate with the exceptions of some specific questions. There were significant between positive attitudes and having sexual intercourse; the study also showed a correlation between a positive attitude towards HIV/AIDS and a number of sexual partner. According to study among Egyptian industrial and tourist workers towards HIV/AIDS shows both groups had negative attitudes towards patients living with HIV/AIDS concerning their right to confidentiality and to work [12]. Another study assessing knowledge and attitudes toward HIV/AIDS among university students in the United Arab Emirates found that 85% of students expressed negative attitudes towards people living with HIV [13].

In a conservative society, sex and HIV/AIDS is associated with taboos and the belief that HIV can only be transmitted though forbidden sexual relationships which further contributes to the stigmatization of people living with the disease. Although the overall stigma score was quite high, the stigmatizing attitudes of respondents, also represent a challenge as almost half (51%) of the respondents show stigmatizing and discriminative actions. This reflected when they agreed that HIV/AIDS patients should be kept separately from their families and community. About (57%) of them say HIV/AIDS is somehow punishment from god; and about 39% of the respondents agreed that disclosing HIV status to others if one has HIV/AIDS.

A survey on the knowledge and attitudes among the students of Al-Azhar University to HIV/AIDS, the Gaza Strip-Palestine, only one third of the study respondents were willingness to be in close touch with people living with HIV or even communication with them. Less than 50% thought that it was their right to be engaged in a public or governmental job, stigma and discriminatory attitudes toward HIV/AIDS persons is high. Only 48% of the students thought it was right to employ people living with HIV (PLHIV); and 35.5% refused to work in the same place with PLHIV [14]. Stigma and discrimination can be an earnest barrier for the HIV/AIDS action and response. These make participants less likely to get information on HIV/AIDS, have test or treat for HIV. Overall knowledge on HIV/AIDS and stigmatizing attitudes towards people living with HIV/AIDS continue to exist among Arab male tourists in Thailand.

CONCLUSION

The results showed that knowledge on HIV/AIDS and stigmatizing attitudes towards people living with HIV/AIDS continue to exist among Arab male tourists in Thailand. The study found high level of HIV transmission knowledge and some negative HIV/AIDS attitudes among Arab male tourists. The study confirmed that willingness to get educated and consequently comprehensive HIV prevention programs are recommended for tourists and tourism workers. Results of this study will aid the development of appropriate international awareness raising messages to help reduce the gaps in knowledge and misconceptions on HIV/AIDS among tourists.

STRENGTH AND LIMITATIONS

To the author knowledge and after intensive literature review, this was the first study investigating alcohol drinking and sexual risk behavior among Arab male tourists in Thailand. Due to the use of convenience sampling technique to select participants to the study, the results could not be generalized to all Arab male tourists visiting Thailand. Generalization was only possible with random sampling of the participants; which in this case it was a very difficult procedure for this type of population; also time and budgets were limited.

RECOMMENDATIONS

Overall knowledge on HIV/AIDS and stigmatizing attitudes towards people living with HIV/AIDS continue to exist among Arab male tourists in Thailand. Anti-stigma strategies and policies in Arab countries need urgent attention; and they have to be directed to reduce negative attitudes towards people living with HIV. Limited awareness on HIV/AIDS, lack of sufficient information on HIV/AIDS among Arab male tourists and the reluctance of public health policy in the airports makers were important issues to carry out on the HIV awareness programs [15].

Due to negative attitudes in this study, we recommend origin countries' government program implementers should sustain their Information-Education-Communication: IEC interventions. Erroneous beliefs the AIDS patients should be kept

separately from their families; and community and misconceptions are obstacles in fighting against stigmatization and discrimination; as well as tend to encourage the spread of the HIV disease. They believe that HIV/AIDS is somehow punishment from god. We recommend the use of religious leaders in communication and education efforts. This is a key strategy for disseminating accurate information about HIV/AIDS to the most (reticent- this word means silent or reluctant- you may want to choose another word here) people.

Information on HIV/AIDS, safe sex, using condom and the effects of illicit drugs should be available at different travel destinations; and it could be placed on social media and forums used by tourists.

ACKNOWLEDGMENTS

The author would like to thank the dean of College of Public Health Sciences, Chulalongkorn University, Prof. Sathirakorn Pongpanich and Assoc. Prof. Ratana Somrongthong for their advice and their kind cooperation during data collection period. Special thanks extend to Mr. Johann Konrad Rohrmose, Dr. Somchai Teetipsatit and Dr. Jeng Suwannee for their immense help and invaluable support.

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