

HIV KNOWLEDGE ATTITUDE AND RISKY BEHAVIOR AMONG ARAB MALE TOURISTS IN
THAILAND

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จุฬาลงกรณ์มหาวิทยาลัย
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บทคัดย่อและแฟ้มข้อมูลฉบับเต็มของวิทยานิพนธ์ตั้งแต่ปีการศึกษา 2554 ที่ให้บริการในคลังปัญญาจุฬาฯ (CUIR)

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ความรู้ทัศนคติและพฤติกรรมเสี่ยงต่อการติดเชื้อเอชไอวีในกลุ่มนักท่องเที่ยวชายชาวอาหรับที่
ท่องเที่ยวในประเทศไทย

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เฟาซี มุฟตา เอ อิลามัวรี : ความรู้ทัศนคติและพฤติกรรมเสี่ยงต่อการติดเชื้อเอชไอวีในกลุ่มนักท่องเที่ยวชายชาวอาหรับที่ท่องเที่ยวในประเทศไทย (HIV KNOWLEDGE ATTITUDE AND RISKY BEHAVIOR AMONG ARAB MALE TOURISTS IN THAILAND) อ.ที่ปรึกษาวิทยานิพนธ์หลัก: นพ. อเลซซิโอ พันซ่า, 69 หน้า.

ความรู้ทัศนคติและพฤติกรรมเสี่ยงต่อการติดเชื้อเอชไอวีในกลุ่มนักท่องเที่ยวชายชาวอาหรับที่ท่องเที่ยวในประเทศไทย

ภูมิหลัง:ภาคการท่องเที่ยวมีความสัมพันธ์กับความถี่ของการมีเพศสัมพันธ์ที่ไม่ได้ป้องกัน, ยาเสพติดและการใช้แอลกอฮอล์

วิธีการศึกษา:เป็นการศึกษาภาคตัดขวางเพื่อกำหนดความรู้เรื่อง HIV/AIDS,ทัศนคติและพฤติกรรมเสี่ยงของนักท่องเที่ยวชายชาวอาหรับในประเทศไทยและพบปัจจัยที่สัมพันธ์ต่อพฤติกรรมเสี่ยงของนักท่องเที่ยวชาวอาหรับต่อ HIV/AIDSในประเทศไทย การศึกษาได้ดำเนินการในสถานที่ท่องเที่ยวของชาวอาหรับในกรุงเทพ(มาบุญครองช้อปปิ้งเซนเตอร์และสุขุมวิท ซอย 3/1" นานา"และในสถานที่ท่องเที่ยวของชาวอาหรับในพัทยา(ห้องอาหารและสถานบันเทิง)

ผลการศึกษา:ค่าความรู้เฉลี่ยของผู้ถูกศึกษาเท่ากับ 6.8 จาก คะแนน 10(SD=2),(372 or96%)ของผู้เข้าร่วมการศึกษาเกี่ยวกับ HIV/AIDS,(149หรือ 39%)ของผู้ถูกศึกษามีความรู้ระดับสูง ,(120 หรือ 31%)ของผู้เข้าร่วมศึกษามีความรู้ระดับกลาง(103 หรือ 27%)

สรุป:มีการเพิ่มความต้องการความรู้และ ความรู้ต่อHIV/AIDSและพฤติกรรมเสี่ยง (โดยเฉพาะอย่างยิ่งการมีเพศสัมพันธ์แบบป้องกันและการดื่มแอลกอฮอล์)ระหว่างนักท่องเที่ยวชายชาวอาหรับ อย่างเร่งด่วน

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Background: The tourism sector is associated with sex frequent unprotected, drug and alcohol use.

Methods: The study was cross-section used to determine HIV / AIDS knowledge, attitude and risky behavior of Arab Male tourists in Thailand and to find factors associated with risky behavior of Arab Male tourists on HIV / AIDS in Thailand. The study was conducted in Arab touristic area in Bangkok (MBK mall center and Sukhumvit Soi 3/1 'Nana' and Arab touristic area Pattaya (Restaurants and Massage centers) –

Result: The mean knowledge score for the respondents was 6.8 out of possible 10 points (SD=2.0), (372 or 96%) of the participants head about HIV/AIDS, (149 or 39%) of them were at high level of knowledge, (120 or 31%) of them were at moderate level and (103 or 27%)

Conclusion: There is an urgent need for increased awareness about HIV/AIDS knowledge and risky behaviors (especially protect sex and drinking alcohol) among Arab male tourists

Field of Study: Public Health

Student's Signature

Academic Year: 2015

Advisor's Signature

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LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
CDC	Center of Disease Control
FGD	Focus group discussion
GARP	Global AIDS Response Progress Reporting
GDP	gross domestic product
HIV	Human Immunodeficiency Virus
IDU	injecting drug use
MENA	Middle East and North Africa
MSM	Men Who Have Sex With Men
NAP	National AIDS Program
PLHIV	People live with HIV
STDs	sexually transmitted diseases
STI	Sexually Transmitted Infections
SWs	Sex workers
UNAIDS	United Nations Programme on HIV/AIDS
UNGASS report	Special Session of the General Assembly
WHO	World Health Organization

CHAPTER I

INTRODUCTION

1.1 Background and significance of problem

HIV / AIDS global crisis requires urgent and committed attention, HIV has created a serious crisis which has a deep impact on communities and their development, causing the breakdown of the family bonds, left more than 9 millions of children orphaned "AIDS " worldwide)(Nations, 2001).

The HIV/AIDS crisis continues to increasing in the numbers of infected people, without Radical medical solutions. As a consequence, Education is the centrality of prevention and mitigation of the crisis through is being recognized in countries and among agencies. Educational interventions across a range of settings should provide the knowledge and encourage the development of attitudes and skills that can limit the spread and impact of the epidemic(Team, 2002).

Globally situation and trends, almost 75 million people have been infected with the HIV virus, an estimated 0.8% of adults, with nearly 1 in every 20 adults living with HIV and accounting for 71% of PLHIV worldwide(WHO, 2012).

1.1.1 HIV and Tourism sector

The tourism sector is associated with sex frequent unprotected, drug and alcohol use, all those factors linked to an increasing the risk of HIV transmission. To ensure that stopped the spread of the epidemic and new cases of infection we have to formulating an effective response for the tourism sector presents a number of challenges and calls for creativity and commitment to working in partnership in an effort to

minimize the situations where the risk of HIV transmission exists and continuo(Gary Abbott & Panos, 1992).

1.1.2 Thailand and Sex Tourism

Thailand, “The Land of Smiles” HIV prevalence among MSM is still high, especially among those living in large urban areas and international tourist destinations (e.g., Bangkok, Chiang Mai, Phuket, Pattaya).

Sex tourism is probably one of Thailand’s visible attributes beside the natural views, the weather and very mysterious place mixed with Urbanization ,historical places , religion and architecture, in generally the most friendly and Tolerant people who often turn a blind eye to major faux pas by foreigners, used for luring foreign tourists(Bauer & McKercher, 2003),when people think of sex tourism Thailand would be one of the first countries that pop out into people’s mind and Arab tourists being one of them(T. A. o. Thailand, 2002)

1.1.3 Sexual activity in Thailand among Arab Male Tourists

Thousands of Arab tourists and adventurers among those who visit Thailand each year, some of them may be at an increased risk of infection(T. A. o. Thailand, 2002), lack of information about risk and preventive measures and the fact that travel and tourism may enhance the probability of having sex with casual partners increase the risk of contracting sexually transmitted infections, some of those tourists in face unprotected sexual intercourse during international travel, and they have high risky rate to infection HIV / AIDS because of their sexual activity probably caused by the reduction of barriers abroad(Glasgow, 2013).

Conversely, some cultural practices exacerbate the spread of HIV including child marriage, bans on condom use , Cultural and social factors exacerbate the transmission of HIV (children, 2013; G. R. Mumtaz et al., 2014)

To date, there are almost no studies that have been published on determining the knowledge and attitude and risky behavior of Arab Male tourists on HIV/AIDS especially in Thailand. This study aims to determine the knowledge, attitude and risky behavior of Arab tourists on HIV/AIDS in Thailand.

1.2 Objectives of the study:



1.2.1 General objective:

- To investigate the characteristics of Arab Male tourists in Thailand.
- To find associations between these characteristics and the with risky behavior of Arab Male tourists in Thailand

1.2.2 Specific objective:

- To describe the socio-demographic, knowledge, attitudes and risky behavior characteristics (having sexual intercourse, condom use and multi sexual partners) of Arab Male Tourists in Thailand.
- To look association between socio-demographic level of knowledge attitudes and risky behaviors (having sexual intercourse, condom use and multi sexual partners) among Arab Male Tourists in Thailand

1.3 Research questions:

- What are the socio-demographic characteristics of Arab Male Tourists in Thailand?

- What are the level of knowledge attitudes and risky behaviors (having sexual intercourse, condom use and multi sexual partners) among Arab Male Tourists in Thailand?
- What is the association influenced risky behaviors of Arab Male Tourists that put them at risk for HIV infection in Thailand?

1.4 Hypotheses

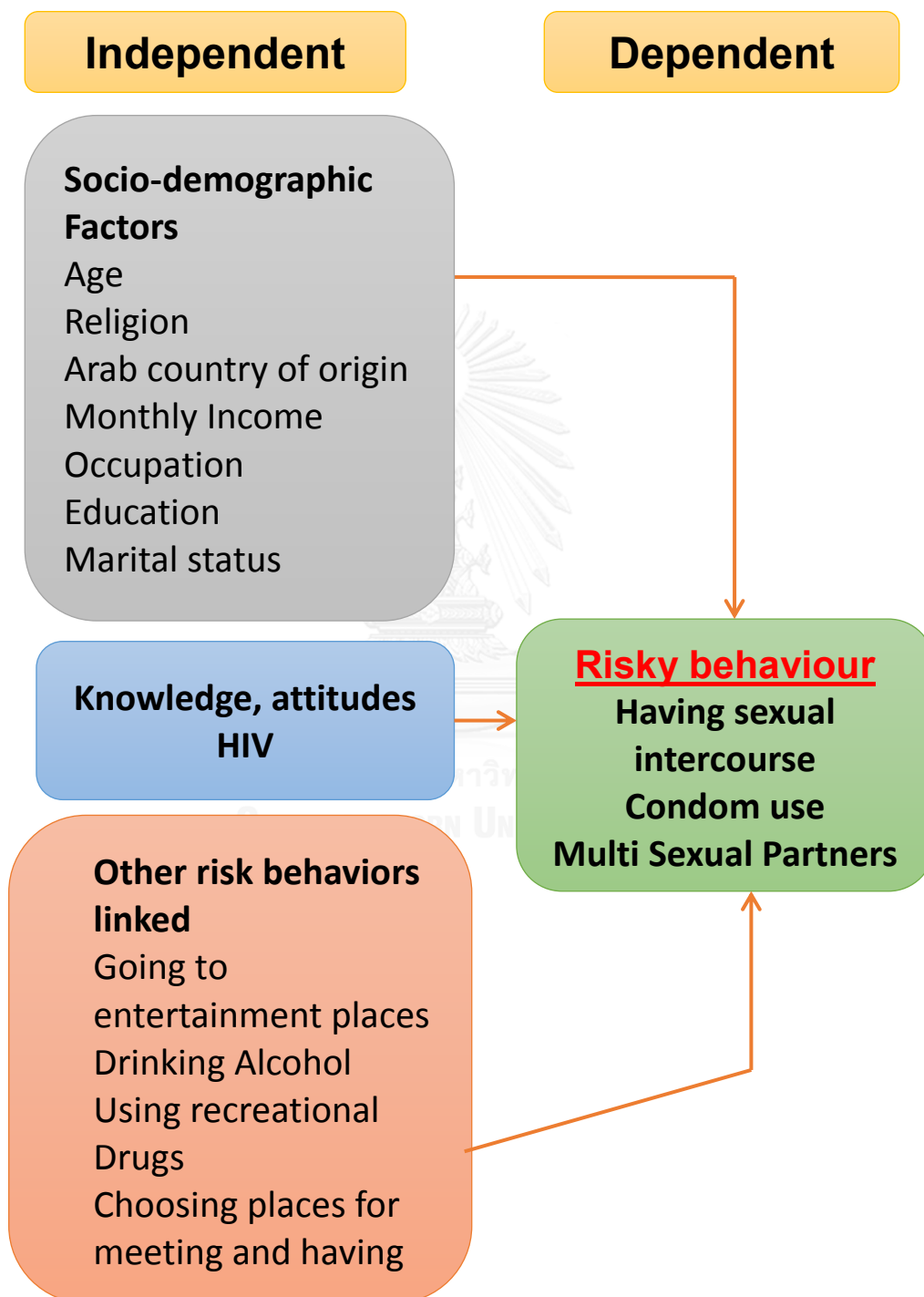
Null Hypothesis 1

There will be no association between various socio-demographic characteristics and level of knowledge, attitudes and risky behavior (having sexual intercourse, condom use and multi sexual partners) among Arab Male Tourists in Thailand.

Alternative Hypothesis 1

There will be association between various socio-demographic characteristics and level of knowledge, attitudes and risky behavior (having sexual intercourse, condom use and multi sexual partners) among Arab Male Tourists in Thailand.

1.5 Conceptual framework



1.6 Operational Definition not consistent

- **Age:**

Refers self-reported of year of life the respondents have when filling in the questionnaire

- **Religion**

Refers to a system of beliefs held to by the visitor, classified as Muslim, Christian, Jewish, others.

- **Arab country of origin**

The countries are (United Arab Emirate –Bahrain — Qatar – Oman – Kuwait - Saudi Arabia –Yemen – Syria – Lebanon – Palestine – Jordan – Iraq - Egypt – Libya – Tunisia – Algeria – Morocco)

- **Monthly Income:**

Refers amount of the money earned by the person monthly whatever source, a wage or salary, Salary security or anything at all and other forms of revenue.

- **Occupation:**

Refers usual and main type of work classified as student /researcher, government employee, company employee, part time, self-owned business or unemployed

- **Education:**

Refers to level of schooling completed which be participate; primary level –middle school , higher school - college or undergraduate , graduate or more

- **Marital status**

Refers to participate current marital status classified as Single, Married, Divorced, Widowed.

- **HIV Knowledge:**

Refers the information that Arab Male Tourists have about HIV, the infection, cause, how it is transmitted and can be prevented.

- **HIV Attitude:**

Subjective feelings, opinion, thoughts, beliefs and behavior tendencies towards ideas, objects or concepts related to HIV/AIDS.

- **Going to entertainment places:**

Refers to places where tourists going and enjoy and have pleasure for example (Bars, island and beaches, message centers, Tea and coffee shop, restaurants and shopping malls) throughout the period of the participant in Thailand

- **Drinking Alcohol:**

Refers the reported drink of alcohol and getting drunk throughout the period of the participant in Thailand

- **Drugs use:**

Refers the reported use of any kind of recreational drug (methamphetamines – Heroin – cocaine and hashish) throughout the period of the participant in Thailand

- **Choosing Places to have sex**

Refers to places where tourists have sex with sexual partner (room in hotel, short term Hotel, At Club, public toilet or others places.

- **Places to meet sex partner**

Refers to places where tourists meet sexual partners (parks, Street, Internet, Disco, bar, Restaurant, shopping mall, massage center or others

- **Sexual intercourse**

Refers the tourist's sexual intercourse (that the penis was entered in the vagina or anus). With or without condom.

- **Condom use**

Refers the tourist's condom use when having sexual intercourse with or without condom.

- **Number of sexual Partner:**

This refers to the number of sexual partners in Thailand; it also includes the nature of relationship in terms of boyfriend/girlfriend, sex workers (SWs), one-night stand, casual, and regular.



CHAPTER II

LITERATURE REVIEW

2.1 Prevalence and transmission of HIV

AIDS (acquired immunodeficiency syndrome) as a chronic disease, caused by the human immunodeficiency virus (HIV), damaging the immune system, HIV interferes with the body's ability to fight the body that cause disease. (WHO2013)

About 35 Million in the world wide PLHIV, approximately 3.2 million children (less than 15 years old) most of those children live In Africa and most of them infected by mothers have HIV positive during the pregnancy, so far about 2.1 million newly infected with HIV (WHO 2013), about 19 million of the 35 million PLHIV today do not know that they infected (UNAIDS 2013).

The majority of PLWHIV they live in Low and Middle-income countries , sub-Saharan Africa region is the most affected 71% of all PLHIV in the world live in this region (WHO2013) , HIV the most Sexual transmitted infection in the world leading to Killer , about 39 Million person died since 1981 and 1.5 million persons died of AIDS-related causes (WHO 2013)

HIV prevalence do not affect the PLHIV of individuals , No but even impacts house wares , communities and economic growth of the nations , Many of the most affected countries of HIV also suffer from other communicable diseases, food insecurity, and other serious problems.

In spite of these challenges, there are successes and promising indicators, many global efforts there are mounted to address the epidemic, especial in the last decade. Awareness and Prevention has helped to reduce HIV prevalence rate but growing

prevalence of communities and new HIV infections are speculated to be on the decline. Moreover, the number of PLHIV receiving treatment in resource-poor countries has dramatically increased in the last decade. (WHO 2013)

Globally 12.9 million PLHIV were receiving antiretroviral therapy (ART) , of which 11.7 million were receiving ART in low- and middle-income countries, since 2010 a 5.6 million increase in the number of people receiving ART , However, almost 22 million other PLHIV, or 3 of 5 people living with HIV(Akala & Semini, 2010).

2.2 HIV prevalence of MENA region

In the Middle East and North Africa (MENA) region, the lowest level of the prevalence of the HIV/AIDS if we compare other regions, By the end of 2008, the prevalence of adult was estimated about 0.2 %(Alkaiyat & Weiss, 2013). Some 400,000-530,000 were considered to be PLHIV (UNAIDS, 2010), about 75,000 new infections having occurred in 2009. The lack of credible database, however, limits practitioners' understanding of the HIV situation.

Many reasons lead the low prevalence of HIV in the region and the main reason has been credited to the conservative cultural values of traditional Arab society(SETAYESH, AND, ROUDI-FAHIMI, & FEKI, june 2014). Almost the universal male circumcision has played a protective role in slowing and limiting HIV transmission in Middle East and North Africa (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%(WHO, 2014). WHO/UNAIDS recommendations emphasize that male circumcision should be considered an efficacious intervention for HIV prevention in countries and regions with

heterosexual epidemics, high HIV and low male circumcision prevalence (Kalichman, Eaton, & Pinkerton, 2007)

2.3 Transmission in key populations at higher risk of HIV exposure

In the Middle East and North Africa, the estimated number of people acquiring HIV rose by more than 50 %.

- 2001: 21 000 [16 000–30 000]
- 2012: 32 000 [22 000–47 000]

Engage in high-risk behaviors and are mostly not aware of their status (97 % in Saudi Arabia), an estimated 17,000 adults and children died of AIDS in 2012. (society, 2014)

Despite the customs, traditions and religion in the region HIV is therefore not absent from Middle East and North Africa (MENA) countries, in general towards the epidemics in developing countries at higher risk of HIV exposure including injecting drug users, men who have sex with men, and to a lesser extent female sex workers, with heterogeneity between countries on the relative importance of each of these high-risk groups. (Abu-Raddad et al., 2010)

In Middle East and North Africa (MENA) region, most HIV infections are occurring in Male and in urban areas - was reported HIV cases has been increasing in many countries. In some countries of the region, the proportion of women Live with HIV is also growing as HIV spreads from (mostly males) IDUs and the clients of commercial female sex workers/traffickers to their wives, In Morocco, (33 %) of women diagnosed with AIDS were married. (Abu-Raddad et al., 2010)

Table 1 Estimates of HIV Prevalence among Key Populations in Selected MENA Countries

Prevalence Rate	Men Who Have Sex With Men	People Who Inject Drugs	Female Sex Workers
1.0% to 4.9%	Lebanon, Morocco Tunisia, Sudan	Bahrain/Oman /Saudi Arabia	Algeria, Iran, Morocco, Sudan, Tunisia, Yemen
5.0% to 9.9%	Egypt	Egypt/ Tunisia	Somalia
10.0% or higher		Libya Morocco	Djibouti South Sudan

Sources: UNAIDS, Middle East and North Africa Regional Report on AIDS, 2011 (Geneva: UNAIDS, 2011); and 2012 UNGASS Country Reports for Sudan and Yemen

2.4 HIV/AIDS concerning Thailand Tourism sector

“The psychology of tourist behavior is poorly understood, but what researchers are discovering is worrying: many tourists associate foreign travel with freedom - from traditional social and family obligations and the norms which shape sexual conventions at home”.(G Abbott, 1992).

Sex tourism it has become one of the most attractive type of tourism in this modern world. More and more people are going for sex tourism and they do not feel shy or embarrassing to admit they travel for sex experiences.

HIV infection is strongly associated with population mobility (UNAIDS, 1998),while it also appears to contribute to HIV prevalence by increasing sexual risk behaviors(UNAIDS, 1998), In addition, condom use may lag behind partnership levels if mobile populations have reduced access to HIV information, health services and means of prevention such as condoms (UNAIDS, 2001),Increased sexual mixing while abroad brings with it an associated risk of acquiring a sexually transmitted infection, including HIV infection (Rogstad, 2004).

When tourism and sex are sold together some major cities such as Bangkok Positioned within East-West flows of tourism, more than 300 bars and clubs, that there are as many as 200,000 employed in the city's adult entertainment sector (Mercer et al., 2007).

Sex tourism can bring a lot of money and job opportunities to people directly or indirectly however, due to the rapid growing of this industry; sex tourism have brought lots of serious consequences and damages, here dark side from this industry, STD and HIV/AIDS, in Thailand, female sex workers who living with HIV 2.69% in 2010, and in same year male sex workers who living with HIV 16.00%(N. Thailand, 2014).

Sex has become a key element in the tourist industry, the Thai economy earning around 7% of its gross domestic product (GDP) from international tourism revenue, The total contribution of travel and tourism to (GDP) in Thailand is projected to rise by 0.1% in 2014 from 2.4 trillion Thai Baht recorded in 2013, according to the World Travel & Tourism Council, the council prediction that the total contribution to GDP will rise by 6.4% per annum on average over the next decade to generate a total of 4.47 trillion baht, or 22.7% of GDP in 2020(Tourism, 2014).

HIV had impact on sex tourism, for both tourists and the host country, starting tourism becomes a risky business, The persons who have high sexual activities and new partner when traveling, and/or attract in high-risk sexual behaviors while abroad , are possible to have higher risk sexual more generally(Mercer et al., 2007; Nemoto, Yokota, Hanafusa, & Wada, 2002), and a more than the normal number of sexual partners at home(Bloor et al., 1998), Moreover, "the persons travelling especially for sex are more possible to attract in unprotected sex and have more partnerships while abroad than they normally happen at home" (Herold & van Kerkwijk, 1992),."This risk

is likely to be highest among men engaging in unprotected sex with local partners in countries where the prevalence of sexually transmitted infections is elevated"(Richens, 2006), particularly among 'sex tourists' (persons travelling for commercial sex) (Rogstad, 2004), the majority of whom are men and are of older age(Wright, 2003).

2.5 Sex tourism in Thailand

During Vietnam War (In 1960-1970) Sex tourism start publicly exposed in Thailand, Thai and USA governments signed a treaty allowing the American soldiers to come to Thailand for "Rest and Recreation(TaksinaNimmonratana, 2000).

The first law regulating prostitution in Thailand was passed in 1960 The Prostitution Suppression Act of 1960; The Prostitution Suppression Act substituted the Contagious Diseases Prevention Act 1908, which tried to control prostitution. The Act provided that convicted prostitutes should be reformed through medical treatment and a period not exceeding one year in an assistance center where they were to receive vocational training(Caye, Dek, Bangkok, UNICEF, & Asia, 1995).

In addition, while bringing women and girls into and/or taking them outside of Thailand for prostitution and sexual exploitation were criminalized, domestic prostitution was not, Substituted the Contagious Diseases Prevention Act 1908, the prostitution and brothels were allowed to conduct their business as long as they registered and paid and appropriate tax to the state, although law enforcement agencies such as the police were able to monitor activates of prostitution and brothels to some extent, they could not stop the expansion of prostitution, because a high number of prostitutes and brothels did not register(Obokata, 2006).

The Entertainment Places Act of 1966 that the act of Service Establishments was passed which made it possible for Thai women to render "special services." This

is done, for example, by establishing such places as massage parlor where client come and look at women, who are sitting separated by a glass wall, and can pick and choose who they want. The women come to the client's hotel room and 'massage' them, but, in reality do more than that. It is usually left for the man to decide what kind of "private service" he really wants, and because of that, they are able to participate in this industry without any legal action being taken against them, While the existence of prostitution is legally suppressed and demoralized, entertainment places (pimping) became formalized to protect owners and customers. This shift of emphasis made it impossible to enact anti-prostitution legislation, except in the case of street soliciting. It also drove women into entertainment places. Since having these two acts passed as legislation, it has become much more feasible for both women and entertainment establishments to render sexual services, under the guise that only "special services" will be performed. It has become a lot easier for business owners to operate their companies because the owners can employ prostitutes as special services girls' under the conditions of the labor code governing service establishments(Dave, 1999).

The Prevention and Suppression of Prostitution Act of 1996 a very strict law was enacted that makes it a serious crime to engage a prostitute if she is under age 18. The Act also helps the prostitute who is not over 18 year of age who shall receive protection and vocational development for a period not over 2 years “safeguarding the welfare of Thai women and children is a national priority for the Government of Thailand. Of particular concern to the Royal Thai Government is the exploitation of children for the purpose of commercial sex. Young girls and boys too often are lured or forced into working in brothels and other sexually oriented establishments by

profiteers." The 1996 law repealed the Prostitution Suppression Act of 1960 (section 3)(National laws on labour, 1996/2539).

Around the worldwide the sex tourism has become popular and attractive , the Pimps , male and female sex workers they believed it is a gainful business , ‘Sex tourism’ is a tour when tourists come from another country to purchase and engage the sexual services , is a an exotic way of entertainment for consumers. , provided by local women and men. This kind of tourism gets its popularity and affectivity in the Low and Middle-income countries with high level of poverty and unemployment(Nuttavuthisit, 2006).

The Male / Female sex worker can offers the client not only sex, but also, boy or girl can be a girlfriend or boyfriend for the client during his or her holiday, In Thailand, due to poverty (12.6%) (UNDP 2012) and unemployment in rural areas, Incapacity of parents to get enough money and the increasing number of homosexual tourists searching this services, young girls and boys become exploited in sexual direction, The working conditions of male / female sex workers are varied in bars, and massage parlors. In general, all these places are concentrated on entertainment places. In bars, the customer is allowed to watch the show, have a drink, and choose a girl for the night or couple of hours. The masseuses major in different kinds of massage, and, also, provide extra service (a massage with ‘happy ending’)(G. Mumtaz et al., 2011).

2.6 Arab Tourist in Thailand

Since 1980s, Thailand became an important focus for Arab tourists, the growing economic and touristic importance has occurred beside a general increase in Arab tourism to Thailand. A discernment of some features of this growth is necessary to understand the dynamics and present structure of the area compares tourist flows from

Arab countries to Thailand between 1998 and 2009. The tourist arrivals 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 (Butler, 1992). However, at end of 2014 according to The Ministry of Tourism and Sports, Thailand, the Middle East tourists who arrived at Suvarnabhumi International Airport about 506,713 tourists, its mean 2.30 % much more than previous year. (International Tourist Arrivals), male tourists more than female come to Thailand, this should happen because women life in Middle East is very different from the west women; one example is that women must have permission to travel out from their countries or travel with men, we estimate the number of male tourists 2008 according to The Ministry of Tourism and Sports, Thailand 246,205. (International Tourist Arrivals)

2.7 Female sex workers

Unprotected sex appears to be an important factor in the HIV epidemics throughout the Middle East and North Africa (MENA) region, HIV prevalence among commercial female sex workers was notably above the estimated adult national HIV prevalence in Algeria (9 % in 2004), and Morocco (2%–3 % since 2001) (Bozicevic, Riedner, & Calleja, 2013). In Egypt, 6.8 % of sex workers acknowledged condom use at least once in 12 months prior to the survey, as did 12 % of street boys and 13 % of street girls, who are also linked to commercial sex as well as sexual abuse (UNICEF) (Akmatov, Mikolajczyk, Labeeb, Dhaher, & Khan, 2008)

In the Palestine, the situation of sex workers is under-researched. Recent data collected in the West Bank and East Jerusalem, however, point towards the vast majority of them being coerced into the activity, despite knowing about HIV, most of

them (72 %) did not consider themselves vulnerable to HIV, nor did their clients (82 %). They therefore seldom used condoms (36 % using them often or sometimes). Seventy % of clients also reported having a wife or a girlfriend with whom they also did not use condoms.(Al Rifai, 2006)

2.8 HIV Knowledge

Knowledge of this region's epidemic is comparatively limited and is often perceived as a 'black hole' in terms of HIV/AIDS data(Mirzazadeh et al., 2014) . One study showed that only 4 of the 23 Arab countries assessed had effective HIV surveillance systems enabling them to track their epidemics.(Bozicevic et al., 2013)

A number of findings are worrisome. While, in Egypt , 84.4 % of married women reported knowledge about HIV, about 6.1 % of them had extensive knowing of HIV when they were asked more detailed questions about the disease(Akmatov et al., 2008).

In Jordan, school students reported wrong knowing on a number of suggested HIV transmission means such as casual interaction with infected people, sharing eating and drinks with them or using public toilets(Bhebhe, 2013), Many people in the region do not consider themselves at risk of HIV 60 In Jordan, 82 % of general population women reported not being at risk for HIV at all 61, In the Republic of Yemen, 95.1 % of secondary school students believed that young people are not susceptible to HIV infection(Organization, 2012).

In the Palestine, conducted a study investigating Palestinian university students' knowledge about HIV and their attitudes toward PLHIV. A total of 1,165 male and female students selected from four Palestinian universities in the West Bank/East Gaza

and Jerusalem participated in the study. although comprehensive knowledge was lacking(Husseini & Abu-Rmeileh, 2007).

A year later(Al Rifai, 2006),conducted a national study whereby a total of 1,047 single and married Gaza and West Bank/East Jerusalem females aged 15-49 years participated. The study diagnosed significant information gaps in most addressed issues. Comprehensive knowledge was clearly deficient. For example, almost 99 % reported having heard of HIV/AIDS, while only 38.7 % did not think that an unmarried adolescent could catch a sexually-transmitted disease (STD) without prior sexual activity and 12.2 % did not know if this could happen at all. Almost 9 % reported not having heard of STDs. In addition, almost 14 % had no idea of how to avoid HIV infection and more than a third (33 %) did not know that a healthy looking person could be living with HIV. As to means of HIV transmission, 95 % knew the risk of transmission through injectable drugs, 84 % knew about mother-infant transmission (pregnancy and delivery) compared to 50 % who knew about breastfeeding transmission. Conversely, having a meal with an HIV-infected person was considered a mean of transmission by 18.6 % in addition to 6.4 % who did not know if this is true or not. Likewise, more than a third (31.7 %) believed that a mosquito bite is a means of transmitting HIV(Al Rifai, 2006; El-Sayyed, Kabbash, & El-Gueniedy, 2008).

Condom knowledge is another protective behavior of which there is widespread ignorance and some diversity of opinions in the region. Condom knowledge to of HIV prevention. Parts of the populations in the Middle East and North Africa (MENA) region believe of condoms as a contraceptive method, but are not aware of its use for HIV(Husseini & Abu-Rmeileh, 2007).

Knowledge of condom use for HIV prevention in Palestine was found in 67 % of the surveyed Palestinian university students (Al Rifai, 2006), and 40.6 % of girls and women in the general population. This is compared to 33 % of women in the general population in Jordan (Roudi-Fahimi, 2003), and 60 % of women in the Egyptian general population and 49.3 % of Egyptian men having sex with men (Rashad, Osman, & Roudi-Fahimi, 2005).

2.9 Attitudes toward HIV

Attitudes toward PLHIV are generally negative, discriminatory and stigmatization in the region. In Egypt for example, 99 % of women in the general people did not accept including caring for patients with an AIDS-related illness, buying from HIV-positive shopkeepers if they know them, do not allowing HIV-positive women to teach in the school, and being willing to unmask the infection of a family member (El-Sayyed et al., 2008). In Palestine (Al Rifai, 2006), the study revealed that a majority (67.3%) of the surveyed girls and women in the general population was reluctant to share a meal with HIV positive person. Almost 56 % disapproved the stay of HIV positive child at school with other children. A majority (60.3 %) would not disclose the HIV positive persons of a family member. Almost 63 % would not buying from HIV-positive shopkeepers if they know them, likewise, found that respondents had diverse attitudes toward PLHIV. Positive attitudes and support were manifested when the respondents viewed the patient as a victim as when contaminated blood transfusion is the route of transmission or when the wife gets the infection from her husband. Nonetheless, this was replaced with negative attitudes and lack of support in cases where the HIV-positive person gets the disease from injecting drugs or a sexual relationship outside marriage. This shows the strong influence of conservative cultural

values that pertain to sexual behavior in light of the predominant religious and socially-defined moral grounds. According to (Al Rifai, 2006), more than 26 % of women explained their differential treatment of AIDS victims on the basis of cause of infection being contaminated blood transfusion versus sexual relations outside marriage. Specifically among health care workers, high rates of negative attitude towards PLHIV were found. Doctors in Turkey were found to overestimate the risks of infection and to have negative attitudes towards HIV-positive patients, sometimes refusing them treatment or feeling angry for having to treat them if they were infected through risky behaviors (Duyan, Agalar, & Sayek, 2001). The same was found among nurses in both Egypt (Shouman & Fotouh, 1994) more than half of physicians in Kuwait would avoid contact with PLHIV (Fido & Al Kazemi, 2002).

However, there seems to be a rising trend of reducing discrimination and stigmatization toward PLHIV. In Morocco, 68 % of women in the general population declared that they would care for PLHIV (Laith J. Abu-Raddad, Iris Semini, & Tawil, 2010). In Jordan, the percentages of youth who believed that people living with HIV have the right to keep their illness a secret has increased from 18 % in 1994 to 29 % in 1999 and to 34.3 % in 2005 (Laith J. Abu-Raddad et al., 2010).

2.10 Risky behavior

Sexual and injecting drug use (IDU) risk behavior measures in the Middle East and North Africa (MENA) tend to be poor, partially due to limited surveillance efforts and partially due to the conservative nature of its societies and the stigma associated with sexual and IDU risk behaviors. Even when such risk behavior measures exist, they may not provide us with a precise or even accurate assessment of the risk of exposure to human immunodeficiency virus (HIV). Sexual risk behavior, and to some extent

injecting drug use, is a complex phenomenon that cannot be directly observed. Only indirect data are available on sexual activity and these data are typically collected from questionnaires, interviews, focus group discussions, and other qualitative methods (Obasi et al., 1999).

The indirect nature of evidence, the private and sensitive nature of sexual behavior, the informational limitations of egocentric sexual behavior data, and the nonrandom biases in sexual behavior reporting, including social desirability and memory, can introduce elements of bias and uncertainty in available measures (Renzetti & Lee, 1993).

A cross-sectional survey among randomly selected first-year, gender-segregated Arab students at the national university in Al Ain in 2005 was conducted using an adaptation of an anonymous self-administered World Health Organization questionnaire. Knowledge and attitudes were scored. Response was 89%; 119 males and 148 females. Knowledge scores about HIV/AIDS were low for 75%, moderate for 24%, high for <1%. Although 90% knew main routes of infection, there were misconceptions about transmission, and only 31% knew there is no vaccine and 34% no cure. Religion was stated as a reason to avoid extramarital relationships by 91% and sexually transmitted diseases (STDs) by 38%; 94% favored premarital testing. Attitudes toward people living with HIV (PLHIV) were neither friendly nor tolerant, including 97% who felt all people entering UAE should be tested, and 53% that PLH should be forced to live apart and only 27% who felt children with HIV should be allowed to attend school. Ninety-six percent stated that young people should be taught how to protect themselves and 57% that teaching at school was insufficient. Main information sources were books/media; preferred sources were media, schools, and

health professionals. Males scored higher on knowledge and were more susceptible to fear of STDs, society, and family; females showed greater compassion and interest in premarital testing and education to protect themselves(Gańczak et al., 2007).

The Study conducted in Kuwait a focus group discussion held among female and male University students in Kuwait City in 2014 as part of the GARP reporting process, suggests that as much as 10-20% of young men had their first sexual experience before the age of 15. No information is available for young women regarding sex before the age of 15. Reportedly, the first sexual contacts of young males often take place abroad with sex workers. Furthermore, boys report that first sexual contacts although not necessarily penetrative sex -- may occur between boys, especially in public schools where there is segregation of sexes. First sexual contacts between boys and girls in Kuwait are often limited to oral and/or anal sex in order to preserve the girls' virginity, but this will usually be after 15 years of age, high-risk sexual behaviors with multiple partners, mainly unprotected sex with foreign sex workers, particularly during trips abroad to some countries. These behaviors were reportedly quite common for young Kuwaiti males. In addition, respondents mentioned the presence of commercial sex in Kuwait as well. This highlights the importance of conducting a systematic survey among young people and adults regarding multiple sexual partnerships, many high-risk sexual behaviors with multiple partners, mainly foreign sex workers abroad. These behaviors were reportedly quite common for young Kuwaiti males. In addition, respondents mentioned the presence of commercial sex in Kuwait as well. Respondents indicated that condom use depended on the location and nationality of the sex worker, as well as her "overall appearance". Overall, respondents said no condoms were used in about one-quarter (25%) of these sex contacts. Condoms

were more likely to be used with women perceived to be “higher risk”, especially Asian or East European women, while condoms would be less used with those women perceived to be “lower risk”, especially women from the region. These FGD findings highlight the importance of conducting a systematic survey among young people and adults regarding condom use during high-risk sex(UNAIDS, 2014a).

Study conducted in 2010-2011In UAE; a HIV/AIDS KAP study among university students at 3 Universities in UAE (2/3 Emiratis, 1/3 foreign students), approximately 10% of respondents reported having had sexual experiences without marriage. Of those (10%) who had had sex without being married, only 50% reported having used a condom last time they had sex outside marriage. Almost 40% of them (these 10%) reported having had sex with multiple partners and 7% (so effectively less than 1%) reported having had sex with sex workers. While this does not show what proportion had sex before the age of 15, it does show that a small proportion of young people in UAE admit they become sexually active before marriage, and engage in high-risk sex with multiple partners; although scores on specific key questions were relatively poor. Emirati respondents had less knowledge than other nationalities. Female Emirati respondents were least knowledgeable about HIV and AIDS. Key results regarding "Accurate knowledge" on prevention of HIV, Sex with only one uninfected partner: 37%, Consistent condom use 36% , Healthy-looking person can have HIV 73% (UNAIDS, 2014b).

CHAPTER III

METHODOLOGY

3.1 Research Design

The study was cross-section used to determine HIV / AIDS knowledge, attitude and risky behavior of Arab Male tourists in Thailand and to find factors associated with risky behavior of Arab Male tourists on HIV / AIDS in Thailand

3.2 Study Area

The study was conducted in Arab touristic area in Bangkok (MBK mall center and Sukhumvit Soi 3/1 ‘Nana’ and Arab touristic area Pattaya (Restaurants, pubs and massage centers) – Thailand.

3.3 Inclusion criteria

- i) Arab Male Tourists visiting Thailand for minimum 3 days and maximum 6 months.
- ii) Able to read and write Arabic or English.

3.4 Exclusion criteria

- i) Respondents who refuse to participate in study
- ii) Didn’t have time to answer the questionnaire.

3.5 Study population

The target population for this research was Arab Male Tourists 18 years old and above as calculated from their last birthday.

3.6 Sample Size calculation

The sample size are calculated by using Wayne W., D. (1995). *Biostatistics: A Foundation of Analysis in the Health Sciences* (6th ed.). John Wiley&Sons, Inc., 180.

Ngamjarus C., Chongsuvivatwong V. (2014). *n4Studies: Sample size and power calculations for android*. The Royal Golden Jubilee Ph.D. Program - The Thailand Research Fund&Prince of Songkla University.

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

The output of the sample size calculation from n4Studies:

n = Minimum number of sample size

N = total population of Arab Male Visitors to Thailand = 246,205

Z score 95% = 1.96

d = Acceptable error = 0.05

P = People at risk (0.5)

Sample size = 383

$$N = \frac{246,205 \times 1.96^2 \times 0.5 \times (1-0.5)}{(246,205-1)(0.05)^2 + (1.96)^2 \times 0.5 \times (1-0.5)} = 384$$

3.7 Sampling Technique

Convenience sampling The Arab Male Tourists approached by after going through restaurants, pubs and massage centers.

3.8 Data collection process

Due to strict security measures at Suvarnabhumi Airport, we were not able to gain access beyond customs and conducted our interviews in the departures check-in area as we planned in thesis proposal. So we changed the site of data collection to Bangkok and Pattaya in restaurants, pubs and massage centers. We found the Arab Male tourists

in the shopping malls, restaurant and massage centers. Before handing out the questionnaires, the subjects were screened for eligibility by asking duration of stay and age. The researcher recruited Arab Males until the sample size of 384 was reached. In this stage of data collection was not very easy special our topic quite sensitive and controversial and it was needed to be highlighted in the field of the studies, to reached to the sample size its cost us time, money and social talking to can build the trust between the researcher, assistants and target population. The researcher and assistants introduce the research to the participants and asked them to sign the consent form and give to them the questionnaire and let them answer by themselves then we were nearby to explain any question they may ask and wait until they finish, after the participant finish answer the questionnaire we provided leaflet of right answer of HIV/AIDS knowledge to participants.

3.9 Measurement tools

We collected through electronic self-administration anonymous questionnaire, used 8 notebook (iPad Pro 9.7 inch display) internet connected, installed the electronic questionnaire to be ready using by participants and all individual answers sent to researcher's email in Excel sheet in Arabic and English language. The electronic questionnaire is increasingly replacing paper-and-pencil questionnaires in face-to-face surveys and 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 have also been used to collect data when the information requested is of a private or sensitive nature. Electronic questionnaire assisted 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 (Group, 2007).

All the questions had multiple options, which we found posed no significant problem for the respondent. Of course, open-ended responses were not possible. To insure complete answering the questionnaire by participants, we designed the questionnaire so that the participants can not skip any questions only if given to them the choice to skip.

(ANNEX I) the questionnaire adapted from previous literature review (Van Griensven et al., 2001), a self-administered questionnaire. The questionnaire has 47 questions and five sections and we used electronic survey.

The first section was comprise of socio-demographic characteristics of the respondents and the second and third part as have questions that address the HIV knowledge forth section attitudes regarding HIV/AIDS, fifth section risky behavior and last one about sexual experience.

Section I: Socio demographic factors

There are 7 questions asked about general information which consist of age, religion, monthly income, occupation, level of education, marital status

Section II: Travel experience

There are 7 questions asked about reason coming to Thailand, country origin, the length of staying in Thailand, with whom stay and come to Thailand and the Entertainment places in Thailand.

Section III: HIV knowledge

There are 11 true/false questions ask about HIV Knowledge which adapted question from previous studies (Van Griensven et al., 2001). Total score of knowledge

is 11 points that mean if correct answer will be scored 1 point, on the other hand, incorrect answer and don't know will be scored 0 point. The range of score is 0-11 points. After that, the total score of students' knowledge will be classified into 3 levels according to bloom's cut off point.

Low	0-5 points (<59%)
Moderate	6-8 points (60-80%)
High	9-11 points (100-80%)

Section IV: Attitude regarding HIV/AIDS

There are 8 questions was used to access attitude on the HIV/AIDS. The questions was modified from previous research's questionnaire(Kendi, 2012) which the statement of questions comprise of both positive and negative statements. The scale of variable is divided using five categories Likert's scale consist of strongly agree, agree, neutral, disagree and strongly disagree.

Table 2 Attitude scores for positive and negative statements

Positive Statement		Negative Statement	
choice	score	choice	score
Strongly agree	5	Strongly agree	1
Agree	4	Agree	2
Neutral	3	Neutral	3
Disagree	2	Disagree	4
Strongly disagree	1	Strongly disagree	5

The score from each item summed up to classify the level of attitude. The range of score is 8-40 points. The total score of students' attitude classified into 3 levels:

Negative Attitude	0-23 points (<59%)
Neutral attitude	24-31 points (60-80%)
Positive Attitude	32-40 points (100-80%)

Section V: Alcohol consumption and drug use_risky behavior

There are 6 questions will be used to access risky behavior ask about drinking alcohol, take illicit drug, smoke Marijuana during visit Thailand . The questions modified from previous research's questionnaire(Van Griensven et al., 2001)

Section VI: Sexual experience

There are 8 questions used to know the sexual experience, ask about the sexual orientation, have sexual contact or/and oral sex, sexual intercourse, condom used, sex venues, and number of sexual partners during visit Thailand, The questions modified from previous research's questionnaire (Van Griensven et al., 2001)

3.10 Questionnaire validity and reliability

Validity:

The questioner has been validated from previous studies(Van Griensven et al., 2001), for Section IV: risky behavior and Section V: Sexual experience For neither question nor previously validated the help of the 3 experts from public health field sought as following;

1. Alessio Panza, M.D, M.Com.H, DTMH
College of Public Health Sciences, Chulalongkorn University
2. Prof. Baderedden Alnagar , Ph.D
National Center of Disease Control – Libya
3. Dr. Hussen Benothman, MD
National Center of Disease Control – Libya

Reliability:

Crombackfor internal consistency

To ensure the reliability of questionnaire, questionnaires pre-tested among 30 Arab Male tourists who will not be included in the study in the MBK center Bangkok of

Thailand, The data which are collected from the pretesting for the knowledge and attitude part used to analyze to estimate internal consistency by using Cronbach's alpha for scale reliability the score was 0.240 probably due to only eight questions used to measure the construct of attitude.

The questionnaire translated from English as Source Language to Arabic language as target language, by one translator the Head of STI department and head of NAP CDC Libya expert in HIV/STI have Fluent of the English- and Arabic.

The Arabic translation back-translated into English by the member in NAP CDC Libya also expert in HIV/STI and fluent in English and Arabic, and not aware of the original English version of the questionnaire.

Discrepancies between the translation and back translation discussed by the two translators and they came to an agreed translation without involvement of third translator as a mediator.

3.11 Data analysis

Descriptive statistics present frequency and percentage for categorical data means and standard deviation normal distribution and with median.

Bitivariate analysis, (odds ratio) OR and 95% CI were used for data analysis used to measure the association between categorical dependent and categorical independent variables separately, the p value <0.05 consider as statistically significant.

In multiple logistic regressions, the dependent variables which are classified into dichotomous outcome (Having sexual intercourse, condom use and number of sexual partner) in relation to all independent variables

This model is used to isolate the relationship between the independent variable and the dependent variable from the effects of one or more other variables (called covariates or

confounders). The independent variables with p value ≤ 0.2 included into model. Other independent variables with p value > 0.2 but have significant association in previous studies also retained in the model. The positive association calculated by odds ratio with 95% confidence interval.

3.12 Expected Benefit & Application

The study provides a measure of the knowledge, attitudes and risky behavior among Arab Male Tourists in Thailand. These findings provide a better understanding of the problem to public health professionals including the Ministry of Tourism, Tourist Guides and NGOs. This study provides basic information required (knowledge of high and attitude to assess the risks and the factors influencing them) for the implementation of prevention programs of HIV / AIDS in communities. HIV, to increase the practice of sexual behaviors and further studies aimed at the socio-cultural context in this field study, the result from this research can be a data base about the knowledge, attitudes and risky behavior among Arab to planning capacity building to the tourism in Thailand and Arab countries.

3.13 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.

CHAPTER IV

RESULTS

This chapter presents and describe the findings from the data analysis of the survey. The variables are described as simple percentages, means, and standard deviations as appropriate depending on the nature of the variables, its start with the demographic data followed by the responses for each section of the questionnaire. The level of knowledge, attitude and risky behavior were then presented followed by the results OR and 95% CI were used for data analysis to see whether there is any association between socio demographic characteristics and risky behavior. Lastly correlation was used to see the relationship between socio-demographic characteristics and (sexual intercourse, condom use and number of sexual partner), HIV/AIDS knowledge, attitude (sexual intercourse, condom use, and number of sexual partner), alcohol drinking and drug use and (sexual intercourse, condom use, and number of sexual partner)

I. Socio-demographic characteristics

This study was conducted in Bangkok and Pattaya. Three hundred eighty-four participants (384) completed the electronic survey. Table (3) shows the socio-demographic characteristics of the Arab Male Tourists in Thailand, (113 or 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 (95 or 25%) were coming from Emirate, A few countries were represented by less than 15 participants from (Libya 14 or 4%, Algeria (10 or 3%), Tunisia 9 or 1%, Jordan 4 or 1 %, Morocco 3 or 0.8%, Palestinian 1 or 0.3%). The majority of the participants (203 or 53%) were High

school, the majority of the participants (158 or 41%) were self-owned business, the average monthly income of the majority (199 or 52%) were between 1,100-3,500 USD, more than half of the participants (194 or 50%) were married. Detailed Socio-demographic characteristic details are showing in table (3).

Table 3 Frequency and percentage distribution of respondents by Socio-demographic characteristics (n=384)

Socio-demographic characteristics		n= 384	%
Age	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

II.Traveling experience

Table (4) shows the traveling experience of respondents to Thailand. The majority of participants (251 or 65%) came to Thailand for vacation, most of participants (277 or 72%) were visiting Thailand for 1-2 weeks. The majority of participants (166 or 43%) were visit Thailand alone and more than half of the participants (277 or 59%) staying alone. The majority of participants (233 or 58%) have ever been to Thailand before. The majority of participants (153 or 40) were visited Thailand more than one time. The majority of participants (225-59%) prefer to go to the islands and beaches in Thailand. Detailed traveling experience details are showing in table

Table 4 Frequency and percentage distribution of respondents shows Traveling experience (n=384)

Traveling experience		n= 384	%
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	1-2 times	153	39.8
	3 or more	70	16.4
	Missing	161	41.7
	Islands and beaches	225	58.6

Favorites places for pleasure	Bars	182	47.4
	Massage centers	120	31.3
	Restaurants	64	16.7
	Shopping malls	47	12.2
	Coffee shops	9	2.3

III. 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 (5) shows that (372 or 96%) of the participants head about HIV/AIDS, (103 or 27%) of respondents were at low level of knowledge, (120 or 31%) of them were at moderate level and (149 or 39%) of them were at high level.

Table 5 Frequency and percentage 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			

I. Participants' knowledge about HIV/AIDS

Participants answered a total (10) close ended, multiple choices questions about HIV/AIDS and mode of transmission. Each correct response was given one mark with a total of 10 marks.

Response for the knowledge part of the questionnaire was summarized in table (6). (357 or 96%) of the participants knew that a person can get HIV through unprotected sex with an infected person. The question with the least number of correct answer were (129 or 35%) for question regarding HIV transmission by Kissing on the cheek and (202 or 55%) for question regarding to people Live with the HIV look sick. Detailed Knowledge on HIV/AIDS details are showing in table (6).

Table 6 Participants' knowledge about HIV/AIDS (n= 372)

Item		Correct N (%)	Incorrect N (%)	Missing N (%)	Total N
1	HIV/AIDS transmission by shaking hands/touching a person infected with HIV/AIDS	317 (85.2)	55 (14.8)	12(3.1)	384
2	A person can get HIV through unprotected sexual intercourse with an infected person	357 (96.0)	15 (4.0)	12(3.1)	384
3	A person can get HIV through sharing needles and razorblades.	344 (93.0)	26 (7.0)	14(3.6)	384
4	A person can get HIV from mosquitoes or other insect bites	289 (78.1)	81 (21.9)	14(3.6)	384
5	A baby can get HIV from the mother during pregnancy	246 (66.3)	125(33.7)	13(3.4)	384
6	A baby can get HIV from the mother during delivery	208 (56.2)	162(43.8)	14(3.6)	384
7	A baby can get HIV from the mother via breast feeding	214 (57.8)	156(42.2)	14(3.6)	384
8	HIV transmission by Kissing on the cheek	129 (34.8)	242(65.2)	13(3.4)	384
9	People Live with the HIV look sick	202 (54.6)	168(45.4)	14(3.6)	384
10	AIDS patients can be treated	252 (67.7)	120(32.3)	12(3.1)	384

II. Attitudes towards HIV/AIDS

Eight items measured the respondents' attitudes towards HIV/AIDS. For the attitude questions on the questionnaire, the five point Likert-like scale ranging from strongly agree to strongly disagree was used. In the analysis of the attitude questions, strongly agree and agree responses were grouped together and strongly disagree and disagree responses were grouped together. Their total scores measured the respondents' attitudes towards HIV/AIDS. It should be noted that items 1 and 8 looked at HIV/AIDS education and the others looked at HIV/AIDS in relation to stigma, discrimination and transmission.

Table 7 Frequency and percentage distribution of respondents showing the attitude towards HIV/AIDS (n=384)

In table (7) describes the frequency and percentage of participants' attitude towards each question together with the mean and standard deviation. There are (360 or 93%) of the participants agree to "get education about HIV/AIDS" and mean score (2.87). There are (282 or 73%) of the participants disagree to "afraid get HIV/AIDS because they are sure that not the person who are going to get HIV/AIDS" and mean score (2.87). Detailed attitude toward to HIV/AIDS details are showing in table (7).

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 8 Attitude level towards HIV/AIDS (n=384)

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

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 \pm 5.58	

III. Alcohol drinking and drug use risky behavior of participants

In this section, pattern of drinking alcohol during visiting Thailand of respondents in the study was. The majority of respondents (238 or 62%) were drinking alcohol, more than 99% of the respondents who had no history of using illegal drugs and 98% of them never using injection drugs, about 30.5% of the respondents had history of smoking Marijuana. Detailed alcohol drinking and drug use Risky Behavior details are showing in table (9)

Table 9 frequency and percentage distribution of respondents showing Risky Behavior of Arab Male Tourists in Thailand (n=384)

Items	n= 384	%
Drinking alcohol during visit Thailand		
Yes	238	62.0
No	146	38.0
Got drunk (n=238)		
Yes	62	26.05
No	176	73.9
Used any kind of illegal drugs		
Yes	1	0.3
No	383	99.7
Missing		
Smoking Marijuana		
Yes	117	30.5
No	267	69.5
Used injecting drugs		
Yes	6	1.6
No	378	98.4
Shared needles (n=6)		
Yes	4	66.7
No	2	33.3

IV. Sexual Behavior of Participants

Table (10) the sexual behavior of participants, The majority of the respondents (321 or 84%) were attracted to Girls, The majority of the respondents (213 or 55%), had oral sex during visit Thailand and (213 or 55%), of them had ever had sexual intercourse during visit Thailand, during this sexual intercourse there (120 or 52%), of the respondents did not use condom, The majority (142 or 37%) of the respondents those had sexual intercourse had sex with one night stand partner. The majority (171 or 74%) of respondent had sex in their room in the hotel, the majority of the respondents (183 or 79%) had more than one sexual partner and the majority of respondents (103 or 44%), and they met their sexual partner in the bars. Detailed sexual behavior of participants details are showing in table (10).

Table 10 frequency and percentage distribution of respondents showing sexual behavior

	n= 384	%
Sexual orientation		
Girls only	321	83.6
Boys only	33	8.6
both	30	7.8
Having oral sex during visit Thailand		
Yes	213	55.5
No	171	44.5
Having sexual intercourse during visit Thailand		
Yes	231	60.2
No	153	39.8
Condom use among (n=231) say yes in this occasion		
Yes	111	48.1
No	120	51.9
Sexual partner (multiple Answer) (n=231)		
Casual one night stand	142	37.0
Sex worker	74	19.3
Girl friend	9	2.3
Casual partner	9	2.3
Boy friend	4	1.0
Places having sex (n=231)		
My room in hotel	171	74.0
Short term hotel	59	25.5
At night club	1	0.4
Number of sexual partner (n=231)		
1 partner	48	20.7
2 or more	183	79.3
Mean = 1.79 SD = 0.40 Minimum = 1 Maximum = 2		
Places you met your sexual partner (multiple Answer) (n=231)		
Bars	103	44.6
Internet	69	29.8
Massage center	40	17.3
Street	37	16.0
Restaurants	17	7.3
Shopping malls	10	4.3

Bivariate analysis

I. Association between socio-demographic characteristics and sexual intercourse

Table (11) showing, the association between socio-demographic characteristics and sexual intercourse. The variables are; age, religion, nationality, education level, occupation, income, marital status, were categorized to find out the associations with having sex using Chi-square (or) Fisher's exact test as necessary.

As showing in same table we mentioned above, Age group (30-44 years) were 2.1 times more likely to having sexual intercourse than other age group at (p-value 0.002, OR= 2.19, 95% CI= 1.32-3.61), (Saudis, Omanis, Bahrainis and others) were more like to having sexual intercourse (p-value=0.009, OR 2.81 95% CI= 1.28-6.13) , (p-value = 0.005, OR=3.12, 95% CI=1.41-6.90), (p-value = 0.027, OR= 2.49, 95% CI= 1.10-5.60) and (p-value = 0.001, OR= 3.78, 95% CI= 1.74-8.17) respectively. Moreover, the divorced respondents were 0.29 times more likely to have sexual intercourse at (p-value = 0.002, OR=0.29, 95% CI= 0.13-0.62). Other remaining characteristics were not significant association with have sexual intercourse.

Table 11 Association between Socio-demographic characteristics and having sexual intercourse (n=384)

Variable	Having sex		Total	Odds ratio (95% CI)	P. Value
	Yes	No			
Age					
18-29	80(70.8)	33(29.2)	113(100.0)	1.00	
30-44	93(52.5)	84(47.5)	177(100.0)	2.19 (1.32-3.61)	.002
45-59	58(61.7)	36(38.3)	94(100.0)	1.50 (0.84-2.69)	.168
Religion					
Muslim	202(58.7)	142(41.3)	344(100.0)	1.00	
Christin	27(71.1)	11(28.9)	38(100.0)	0.58 (0.27-1.20)	.145
Jewish	2(100.0)	0(0.0)	2(100.0)	0.99 (0.0-.)	.999

Nationality					
Emirati	71(74.7)	24(25.3)	95(100.0)	1.00	
Kuwaiti	19(63.3)	11(36.7)	30(100.0)	1.71(0.71-4.10)	.228
Saudi	20(51.3)	19(48.7)	39(100.0)	2.81(1.28-6.13)	.009
Omani	18(48.6)	19(51.4)	37(100.0)	3.12(1.41-6.90)	.005
Bahraini	19(54.3)	16(45.7)	35(100.0)	2.49(1.10-5.60)	.027
Qatari	14(58.3)	10(41.7)	24(100.0)	2.11(0.83-5.37)	.116
Lebanese	20(74.1)	7(25.9)	27(100.0)	1.03(0.39-2.75)	.944
Iraqis	13(59.1)	9(40.9)	22(100.0)	2.04(0.77-5.39)	.147
Egyptian	19(55.9)	15(44.1)	34(100.0)	2.33(1.02-5.30)	.043
Others	18 (43.9)	23 (56.1)	41 (100.0)	3.78(1.74-8.17)	.001

Table 12 Association between Socio-demographic characteristics and having sexual intercourse (n=384)

Variable	Having sex		Total	Odds ratio (95% CI)	P. Value
	Yes	No			
Education level					
High school or less	119 (58.6)	84 (41.4)	203(100.0)	1.00	
College or Postgraduate	112(61.9)	69(38.1)	181(100.0)	0.87(0.57-1.31)	.515
Occupation					
Student	26(61.9)	16(38.1)	42(100.0)	1.00	
Government employee	21(60.0)	15(41.7)	36(100.0)	1.16(0.46-2.88)	.748
Company employee	83(56.1)	65(43.9)	148(100.0)	1.27(1.27-0.63)	.501
Self-owned business	101(63.9)	57(36.1)	158(100.0)	0.91(0.45-1.85)	.809
Income					
I don't earn any money	16(55.2)	13(44.8)	29(100.0)	1.00	
200-500 USD	14(63.6)	8(36.4)	22(100.0)	0.70(0.22-2.19)	.544
600-1,000 USD	87(64.9)	47(35.1)	134(100.0)	0.66(0.29-1.50)	.325
1,100-3,500	114(57.3)	85(47.7)	199(100.0)	0.91(0.41-2.01)	.830
Marital status					
Single	77(60.6)	50(39.4)	127(100.0)	1.00	
Married	101(52.1)	93(47.9)	194(100.0)	1.41(0.90-2.23)	.132
Divorced	53(84.1)	10(15.9)	63(100.0)	0.29(0.13-0.62)	.002

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

II. Association between HIV/AIDS knowledge, attitude sexual intercourse

The table (13) showed, HIV/AIDS were not significant association with have sexual intercourse. There significant association between positive attitude level and having sex at (p-value= 0.005, OR= 3.61 and 95% CI = 1.48-8.83).

Table 13 Association between HIV knowledge, attitude and having sexual intercourse (n=372)

Item	Having sex		Total	Odds ratio (95% CI)	P. Value
	Yes	No			
HIV/AIDS Knowledge					
Low	61 (59.2)	42 (40.8)	103 (100.0)	1.00	
Moderate	86 (71.7)	34 (28.3)	120 (100.0)	0.57(0.32- 1.00)	.052
High	77 (51.7)	72 (48.3)	149 (100.0)	1.35(0.81- 2.25)	.237
Attitude level					
Negative	114(63.0)	67(37.0)	181(100.0)	1.00	.018
Moderate	109(61.2)	69(38.8)	178(100.0)	1.07(0.70- 1.65)	.733
Positive	8(32.0)	17(68.0)	25(10.00)	3.61(1.48- 8.83)	.005

III. Association between alcohol drinking and drug use and sexual intercourse

The table (14) showing, there significant association between alcohol drinking and sexual intercourse at (p-value <0.001, OR= 0.08, 95% CI = 0.05-0.13), getting drunk, were significant association with having sexual intercourse at (p-value=0.003, OR= 20.33, 95% CI= 2.73-15.02), smoking Marijuana, were significant association with having sexual intercourse at (p-value = <0.001, OR= 27.85, 95% CI= 11.01-70.45).

Table 14 Association between alcohol drinking and drug use risky behavior and having sexual intercourse (n=384)

Variable	Having sex		Total	Odds ratio (95% CI)	P. Value
	Yes	No			
Drinking alcohol during visit Thailand					
No	38(26.0)	108(74.0)	146(100.0)	1.00	
Yes	193(81.1)	45(18.9)	238(100.0)	0.08(0.05-0.13)	<.001
Got drunk (n=238)					
No	61(98.4)	1(1.6)	62(100.0)	1.00	
Yes	132(75.0)	44(25.0)	176(100.0)	20.33(2.73-151.02)	.003
Smoking Marijuana					
No	112(95.7)	5(4.3)	117(100.0)	1.00	
Yes	119(119)	148(55.4)	267(100.0)	27.85(11.01-70.45)	<.001
Used injecting drugs					
No	5(83.3)	1(16.7)	6(100.0)	1.00	
Yes	226(59.8)	152(40.2)	378(100.0)	3.36(0.38-29.06)	.270

IV. Association between socio-demographic characteristics and condom use

The table (15) showing, the age group (30-44 years) were significant association at (p-value 0.20, OR= 0.48, 95% CI = 0.26-0.89), as well as age group (45-59) had significant association at (p-value .006, OR=0.38, 95% CI= 0.19-0.76), there are significant association between nationality and using condom, (Kuwaitis) at (p-value 0.002, OR = 0.17, 95% CI = 0.05-0.53), (Omanis) at (p-value 0.03, OR= 0.30, 95% CI = 0.10-0.88), (Bahrainis) at (p-value 0.046, OR= 0.34, 95% CI = 0.12-0.98), (Qataris) at (p-value 0.031, OR= 0.26, 95% CI = 0.08-0.88), other nationalities was significant association at (p-value 0.030, OR= 0.30, 95% CI = 0.10-0.88), there was significant association between marital status and drinking alcohol, Divorced respondents were more likely to drinking alcohol at (p-value 0.005, OR= 0.34, 95% CI = 0.16-0.73).

Other remaining characteristics were not significant association with have sexual intercourse.

Table 15 Association between socio-demographic and using condom (n=231)

Variable	Condom use		Total	Odds ratio (95% CI)	P. Value
	Yes	No			
Age					
18-29	28 (35.0)	52 (65.0)	80 (100.00)	1.00	
30-44	49 (52.7)	44 (47.3)	93 (100.00)	0.48(0.26- 0.89)	.020
45-59	34 (58.6)	24 (41.4)	58 (100.00)	0.38(0.19- 0.76)	.006
Religion					
Muslim	96 (47.5)	106 (52.5)	202 (100.00)	1.00	
Christin	14 (51.9)	13 (48.1)	27 (100.00)	0.84(0.37- 1.87)	.673
Jewish	1 (50.0)	1 (50.0)	2 (100.00)	0.90(0.05- 14.67)	.944
Nationality (231)					
Emirati	23 (32.4)	48 (67.6)	71 (100.00)	1.00	
Kuwaiti	14 (73.7)	5 (26.3)	19 (100.00)	0.17(0.05- 0.53)	.002
Saudi	9 (45.0)	11 (55.0)	20 (100.00)	0.58(0.21- 1.61)	.300
Omani	11 (61.1)	7 (38.9)	18 (100.00)	0.30(0.10- 0.88)	.030
Bahraini	11 (57.9)	8 (42.1)	19 (100.00)	0.34(0.12- 0.98)	.046
Qatari	9 (64.3)	5 (35.7)	14 (100.00)	0.26(0.08- 0.88)	.031
Lebanese	10 (50.0)	10 (50.0)	20 (100.00)	0.47(0.17- 1.31)	.152
Iraqis	5 (38.5)	8 (61.5)	13 (100.00)	0.76(0.22- 2.60)	.670
Egyptian	8 (42.1)	11 (57.9)	19 (100.00)	0.65(0.23- 1.85)	.431
Others	11 (61.1)	7 (38.9)	18 (100.0)	0.30(0.10- 0.88)	.030
Education level (231)					
High school or less	51(42.9)	68 (57.1)	119(100.0)	1.00	
College or Postgraduate	60(53.6)	52(46.4)	112(100.0)	0.65(0.38- 1.09)	.104

Table (15) Association between socio-demographic and using condom (n=231)

Variable	Condom use		Total	Odds ratio (95% CI)	P. Value
	Yes	No			
Occupation (231)					
Student	14 (53.8)	12 (46.2)	26 (100.0)	1.00	
Government employee	10 (47.6)	11 (52.4)	21 (100.0)	1.28(0.40-4.06)	.671
Company employee	42 (50.6)	41 (49.4)	83 (100.0)	1.13(0.47-2.75)	.773
Self-owned business	45 (44.6)	56 (55.4)	101 (100.0)	1.45(0.61-3.44)	.398
Income (231)					
I don't earn any money	6(37.5)	10(62.5)	16(100.0)	1.00	
200-500 USD	6(42.9)	8(57.1)	14(100.0)	0.80(0.18-3.46)	.765
600-1,000 USD	47(54.0)	40(46.0)	87(100.0)	0.51(0.17-1.52)	.230
1,100-3,500	52(45.6)	62(54.4)	114(100.0)	0.71-(0.24-2.10)	.542
Marital status (231)					
Single	37(48.1)	40(51.9)	77(100.0)	1.00	
Married	53 (52.5)	48 (74.5)	101 (100.0)	0.83(0.46-1.51)	.559
Divorced	21 (39.6)	32 (60.4)	53 (100.0)	1.41(0.69-2.86)	.343

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

V. Association between HIV knowledge and condom use

The table (16) showing, there significant association between moderate HIV knowledge and condom use at p-value 0.14, and OR= 0.42, 95% CI = 0.21-0.83, and High HIV knowledge at p-value .005, OR=0.36, 95% CI= 0.18-0.73

Table 16 Association between HIV knowledge, attitude and condom use (n=231)

Variable	Condom use		Total	Odds ratio (95% CI)	P. Value
	Yes	No			
HIV Knowledge					
Low	20(32.8)	41(67.2)	61 (100.0)	1.00	
Moderate	46(53.5)	40(46.5)	86 (100.0)	0.42(0.21-0.83)	.014
High	44(57.1)	33(42.9)	77 (100.0)	0.36(0.18-0.73)	.005
Missing	-	-	7 (100.0)		
Attitude level					
Negative	51(44.7)	63(55.53)	114(100.0)	1.00	
Moderate	55(50.5)	54(49.5)	109(100.0)	0.79(0.46-1.34)	.393
Positive	5(62.5)	3(37.5)	8(100.0)	0.48(0.11-2.13)	.338

VI. Association between alcohol drinking and drug use and condom use

As showing here in table (17), there are no clear association between alcohol drinking, drug use and condom use.

Table 17 Association between alcohol drinking, drug use and condom (n=231)

Variable	Condom use		Total	Odds ratio (95% CI)	P. Value
	Yes	No			
Drinking alcohol during visit Thailand					
Yes	88 (45.6)	105(54.4)	193(100.0)	1.00	
No	23 (60.5)	15 (39.5)	38 (100.0)	0.54(0.26-1.11)	.095
Got drunk (193)					
Yes	22 (36.1)	39 (63.9)	61 (100.0)	1.00	
No	66 (50.0)	66 (50.0)	132 (100.0)	0.56(0.30-1.05)	.072
Smoking Marijuana					
Yes	47 (42.0)	65 (58.0)	112 (100.0)	1.00	
No	64 (53.8)	55 (46.2)	119 (100.0)	0.62(0.36-1.04)	.073

VII. Association socio-demographic characteristics and number of sexual partner

As showing in table (18). There significant association between nationality (Bahrainis) and number of sexual partner, at p-value 0.010, and OR= 0.42, 95% CI = 0.21-0.83. Other remaining characteristics were not significant association with have sexual intercourse.

Table 18 Association between Socio-demographic characteristics and number of sexual partner (n= 231)

Variable		No of Partner		Total	Odds ratio (95% CI)	P. Value
		1Partner	2 or more			
Age	18-29	17(21.3)	63(78.8)	80(100.0)	1.00	
	30-44	17(18.3)	76(81.7)	93(100.0)	1.20(0.56 -2.55)	.624
	45-59	14(24.1)	44(75.9)	58(100.0)	0.84(0.37 -1.89)	.688
Religion	Muslim	43(21.3)	159(78.7)	202(100.0)	1.00	
	Christin	4(148.8)	23(85.2)	27(100.0)	1.55(.510 -4.73)	.437
	Jewish	1(50.0)	1(50.0)	2(100.0)	0.27(0.17 -4.41)	.359
Nationality	Emirati	10(14.1)	61(85.9)	71(100.0)	1.00	
	Kuwaiti	6(31.6)	13(68.4)	19(100.0)	0.35(0.11 -1.15)	.084
	Saudi	5(25.0)	15(75.0)	20(100.0)	0.49(0.14 -1.65)	.252
	Omani	6(33.3)	12(66.7)	18(100.0)	0.32(0.10 -1.07)	.065
	Bahraini	8(42.1)	11(57.9)	19 (100.0)	0.22(0.07 -0.69)	.010
	Qatari	3(21.4)	11(78.6)	14(100.0)	0.61(0.14 -2.54)	.489
	Lebanese	5(25.0)	15(75.0)	20(100.0)	0.49(0.14 -1.65)	.252
	Iraqis	0 (0.0)	13(100.0)	13(100.0)	-	-
	Egyptian	3(15.8)	16(84.2)	19(100.0)	0.87(0.21 -3.55)	.851
	Others	2(11.1)	16(88.9)	18(100.0)	1.31(0.26 -6.59)	.742

Education level	High school or less	22(18.5)	97(81.5)	119(100.0)	1.00	
	College or Postgraduate	26(23.2)	86(76.8)	112(100.0)	0.75(0.39 -1.41)	.377
Occupation	Student	10(38.5)	16(61.5)	26(100.0)	1.00	
	Government employee	7(33.3)	14(66.7)	21(100.0)	1.25(0.37 -4.16)	.716
	Company employee	21(25.3)	62(74.7)	83(100.0)	1.84(0.72 -4.68)	.198
	Self-owned business	10(9.9)	19(90.1)	101(100.0)	5.68(2.04 -15.85)	.001
Income	I don't earn any money	5 (31.3)	11 (68.8)	16 (100.0)	1.00	
	200-500 USD	5 (35.7)	9 (64.3)	14 (100.0)	0.81(0.17 -3.74)	0.796
	600-1,000 USD	15(17.2)	72 (82.8)	87 (100.0)	2.18(0.66 -7.20)	.201
	1,100-3,500 USD	23(20.2)	91 (79.8)	114(100.0)	1.79(0.56 -5.69)	.318
Marital status	Single	12(15.8)	65(84.4)	77(100.0)	1.00	
	Married	28(27.7)	73(72.3)	101(100.0)	0.48(0.22 -1.02)	.057
	Divorced	8(15.1)	45(84.9)	53(100.0)	1.03(0.39 -2.74)	.939

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

VIII. HIV knowledge and number of sexual partner

As showing in table (19). There significant association between high HIV/AIDS knowledge and number of sexual partner, at p-value 0.037, and OR= 0.36, 95% CI = 0.14-0.94. Other remaining characteristics were not significant association with have sexual intercourse

Table 19 Association between HIV knowledge and number of sexual partner (n=231)

Variable	No of Partner		Total	Odds ratio (95% CI)	P. Value
	1 Partner	2or more			
HIV knowledge					
Low	7(11.5)	54(88.5)	61(100.0)	1.00	
Moderate	21(24.4)	65(75.6)	86(100.0)	0.40(0.15-1.01)	.054
High	20(26.0)	57(74.0)	77(100.0)	0.36(0.14-0.94)	.037
Missing	-	-	7 (100.0)		
Attitude level					
Negative	121(66.9)	60(33.1)	181(100.0)	1.00	
Moderate	108(60.7)	70(39.3)	178(100.0)	1.30(0.84-2.01)	.224
Positive	9(36.0)	16(64.0)	25(100.0)	3.5(1.49-8.58)	.004

IX. Association alcohol drinking and drug use and number of sexual partner (n=231)

As showing in table (20), there are no clear association between alcohol drinking and drug use and number sexual partner.

Table 20 Association between alcohol drinking, drug use and number of sexual partner (n=231)

Variable	No of Partner		Total	Odds ratio (95% CI)	P. Value
	1 Partner	2 or more			
Drinking alcohol during visit Thailand					
Yes	42 (21.8)	151(78.2)	193(100.0)	1.00	
No	6 (15.8)	32(84.2)	38 (100.0)	1.48(0.58- 3.78)	.409
Did you got drunk					
Yes	8 (13.1)	53(86.9)	61 (100.0)	1.00	
No	34 (25.8)	98(74.2)	132(100.0)	0.43(0.18- 1.00)	.052
Did you smoking Marijuana					
Yes	21 (18.8)	91(81.3)	112(100.0)	1.00	
No	27 (22.7)	92(77.3)	119(100.0)	0.78(0.41- 1.49)	.461
Did you used injecting drugs					
Yes	1 (20.0)	4 (80.0)	5 (100.0)	1.00	
No	47 (20.8)	179(79.2)	226(100.0)	0.95(0.10- 8.72)	.952



Multivariate analysis

Binary logistic regressions done for the variables who had p-value <0.005. Multivariate analysis model was constructed using the variables which had (p<0.2) from binary logistic regression. These variables with (p<0.2) included (Age, Marital Status, Attitude level toward HIV/AIDS, Drinking alcohol during visit Thailand and smoking Marijuana).

I. Association between Independent variables and having sexual intercourse

The multivariate analysis showed a highly significant statistical for alcohol consumption (OR=13.01; 95%CI =7.10-23.84), p<0.01. Smoking marijuana (OR=31.13; 95%CI =11.13-88.13), p<0.001.

Table 21 Multivariate Analysis of the independent variables with having Sexual intercourse.

Variable	OR	(95% CI)	P. Value
Age			
18-29		1.00	
30-44	1.12	(0.52-2.38)	.766
45-59	1.04	(0.43-2.52)	.918
Marital status			
Single		1.00	
Married	0.70	(0.38-1.28)	.545
Divorced	1.24	(0.39-3.98)	.143
Attitude level			
Negative		1.00	
Moderate	0.704	(0.38-1.28)	.252
Positive	1.24	(0.39-3.98)	.707
Drinking alcohol during visit Thailand			
No		1.00	
Yes	13.01	(7.10-23.84)	<.001
Smoking Marijuana			
No		1.00	
Yes	31.32	(11.13-88.13)	<.001

II. Association between Independent variables and Condom use

The multivariate analysis showed There significant association between age group 45-59 years old and condom use (OR=0.48; 95%CI =0.30-1.08), p-value = 0.049, There significant association between moderate level of HIV knowledge and condom use (OR=0.46; 95%CI =0.23-0.92), p-value = 0.028 and There significant association between high level of HIV knowledge and condom use (OR=0.43; 95%CI =0.21-0.88), p-value = 0.022. As showing in the table (22)

Table 22 Multivariate Analysis of the independent variables with Condom use.

Variable	Odds ratio	(95% CI)	P. Value
Age			
18-29		1.00	
30-44	0.57	(0.30-1.08)	.087
45-59	0.48	(0.32-0.99)	.049
HIV knowledge			
Low		1.00	
Moderate	0.46	(0.23-0.92)	.028
High	0.43	(0.21-0.88)	.022

III. Association between Independent variables and Number of sexual partner

The multivariate analysis showed there are no a significant statistical association between number of sexual partner and Knowledge and attitude level toward HIV.

Table 23 Multivariate Analysis of the independent variables with Number of sexual partner.

Variable	OR	(95% CI)	P. Value
HIV knowledge			
Low		1.00	
Moderate	0.42	(0.16-1.08)	.074
High	0.41	(0.15-1.11)	.080
Attitude level			
Negative		1.00	
Moderate	0.67	(0.33-1.34)	.267
Positive	0.80	(0.14-4.46)	.801



CHAPTER V

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

This study was conducted to describe independent variable such as socio-demographic characteristics, Knowledge on HIV/AIDS, attitude towards HIV/AIDS, risky behaviors, and to find out the associations of these independent variables with dependent variable (have ever had sexual intercourse, used condom and number of sexual partner during visited Thailand) among Arab male tourists in Thailand. The data was collected using electronic self-administrated questionnaire. The main questions explored in this study concerned socio-demographic characteristics that related to risk behaviors, HIV knowledge and HIV related high risk behaviors. Analysis of each variable and OR and 95% CI were used for data analysis. In this section, the findings will be discussed in the context of research questions and objectives.

(i) Socio-demographic characteristics and risky sexual behaviors

The majority (84%) of participants mentioned they were attracted to girls, 9% of them were attracted to boys only and 8% of them they were attracted to both girls and boys., It was unexpected to find that an important minority (17%) of the participants shared their same-sex sexual orientation due to the homosexuality among Arab people is strongly influenced by the prevailing laws, cultural traditions and religious mores of their countries of origin that discourage the disclosing of such orientation. Countries such as United Arab Emirates, Saudi Arabia and Kuwait, criminalize same-sex sexuality. Previous studies on homosexuality and legislation in Muslim and Arab countries are few and far between; moreover, what exists can largely be found only in

universities' unpublished academic records (Ferchichi, 2011). So further study related to sexual orientation among Arab tourists need to understand the situation in deep.

In our study, most (60%) of the respondents had sexual experience during their visiting Thailand. Among these respondents with sexual activity the majority (52%) was in the age of 30 to 44 years, in our finding this age was significantly associated with having sexual intercourse in Thailand. Previous study (Manieri, Svensson, & Stafström, 2013) among tourist Swedish men buying sex in Thailand mean age in the sample was 44 years, similar to our finding,. Almost half (49%) of those tourists had Intention to have sex on their trip. a finding that is marginally lower than in our sample.

Our results also shows that 50 % of respondents were married and about 33% single and 16% were divorced. This study showed that marital status also influences sexual activity with different prevalence according to different marital status. In particular More than 84% of divorces participants has sexual intercourse during visiting Thailand, this difference was statistically significant. Sexual activity among Arab divorced may be explained by their culture barrier and the religious reasons. Short term sexual relationships are quite common among divorced, and afterwards men seek a sexual relationship that is linked to an emotionally close relationship (Lawson & Thompson, 1996) Several studies found that there was more sexual activity at present among recently divorced. Recent research has found that divorced single individuals consist of a large group that is at risk for sexual transmitted infections and HIV. this is due to they demonstrate minimal protective behavior, are not targeted for prevention education and have a greater number of sex partners than among the currently married(Rich, 2001). Many widowed and divorced people are dating again and they may be less likely to protect themselves (Centers for Disease Control and Prevention, 2015).

Although there was a variety of nationality, majority of our respondents were Emiratis. The same proportion of Arab tourist to Thailand as reported by the department of tourism operation center(TAT, 2014)

Less than half (48%) of sexual active respondents using condom with sexual partner during visiting Thailand, previous study among Japanese male tourists in Thailand (Yokota, 2006) asked about recent condom use with sexual partner and found that 87% of the men reporting consistent use. Another comparable study among Swedish men buying sex in Thailand (Manieri et al., 2013) reported that 72% of them consist condom use with sexual partner. Based on our findings, seem to failure consistent use condoms during sexual intercourse, at substantial risk of infection or pregnancy during visited Thailand. Use condoms slightly less often when purchasing sex than the average Western male and Japanese male tourists, however, consider that the present study did not ask with whom use condom.

The results, that indicate that the unwillingness to use condoms when having sex with a sexual partner, indicate that the assessed population level transmission risk of HIV might be related to use of condoms, this relation between sex abroad and risky behavior emphasizes the importance of initiatives to promote safe sex on holidays and ensure that condoms and contraceptives are easily available throughout tourist package start from air flight to show some short video related to safe sex.

In our results shows, about 80% of participants had more than two partners during visiting Thailand. Most of them (43%) individuals arrive in Thailand alone and the majority (59%) stay alone even if they came with wife, friends and family. In a survey of 150 people in the departure lounges of Tenerife among UK travelers, 35% reported that they had sex with someone other than their regular partner while on holiday.

(Hamlyn, Peer, & Easterbrook, 2007) In a further study on the sexual behavior of young among (16–35 years) tourists in Ibiza, 56% reported having sex with at least one person on holiday, and with more than one partner in 26% of men. (Bellis, Hughes, Thomson, & Bennett, 2004)

Based on our study, related to multi sexual partner Arab male tourist slightly had higher sexual partner during visiting Thailand than the average UK travelers and tourists in Ibiza, however, having sex, having unprotected sex, and having sex with more than one person abroad were all positively associated with having higher numbers of partners as risk factors and Multiple sexual partners are believed to be one of the predisposing risk factors to HIV and STIs, potentially best placed to transmit STIs on their return.

The sexual activity of many people extends to multiple partners and relationships within which the level of commitment and sexual fidelity is low. In our study we found 37% of participants had sex with local or non-local one-night stand partner and more than 19% of participants are have sex with sex workers in Thailand, since in parts of northern Thailand, in particular, sex work is socially accepted and sex work is intrinsic to the fabric of gender relations and socio-economic hierarchies. Sex workers are frequently rural-urban migrants – particularly from north and northeastern Thailand, and the money they earn brings buying power to families in poor villages.

In our study we found Arab tourist finds their sexual partner through different venues. More than 47% of participants are prefer go to the bars as favorite place for pleasure during they stay in Thailand, since most the Arab countries the bars are not very socially acceptable or legally allowed. So we found about 45% of sexual active participants met their sexual partner in bars, and the other way to find sexual partners is by using internet. The internet is playing an increasing role in the sex lives of some tourists, compared to

the bars, the Internet provides a discreet and more anonymous way to meet people. According to our findings about 30% of the participants are used the internet to meet sexual partners and they think its easy way to find sexual partner and no need to be in public places to find their partner. After intensive search we found not possible to compare use of social media as a venue for finding partner in Arab countries because there is no published literature. In particular MSM. Importance of this role to finding sexual among male tourist in Denver (Colorado) to examine risk behaviors they found men who used the Internet prior to travel were also more likely to report a new sexual partner (38.5%) than men who did not (Benotsch et al., 2011).

(ii) HIV knowledge and attitude and risky behavior

In this study, almost 96% of respondents have 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 in about transmission and curability put Arab male tourist at risk of contracting HIV. Misconceptions are present. For example 22% of participants say mosquitoes transmit HIV, 65% of them though HIV transmitted by kissing on the cheek and 45% of the though people live with HIV look sick. The fact that most of participants did not know the basics of HIV transmission and that AIDS patients cannot be treated indicated inadequate teaching. With limited knowledge, it is probably lower among persons with less education.

In our study the participants show 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 which can have significant impact over the

knowledge, attitudes and behaviors towards the disease.

After intensive search we found not possible to compare HIV knowledge among Arab male tourists because there is no published literature. However, comparisons should be treated with caution as different assessment tools and population sample were used.

In our finding the attitudes towards HIV/AIDS were mostly 47% negative and 46% moderate with the exceptions of some specific questions. There are significant between positive attitudes and having sexual intercourse, the study also shows a correlation between a positive attitude towards HIV/AIDS and a number of sexual partner.

In a conservative society, sex and HIV/AIDS is associated with taboos and the belief that HIV can only be transmitted through 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, its reflected when they agreed that HIV/AIDS patients should be kept separately from their families and community and 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. Stigma and discrimination can be an earnest barrier for the HIV/AIDS action and response and 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.

(iii) Alcohol drinking and drug use risky behavior

Alcohol consumption and using drugs consistently as an important contributory factor to reducing inhibitions and increasing risk-taking behavior. In our study we found that

62% of participants are drink alcohol, more than 30% of them had ever smoked Marjuana when visited Thailand. Our finding is consistent with a study among Japanese Tourists in Bangkok, Thailand (Nemoto et al., 2002), find that about 34% had used marijuana, and indicated that who travelled abroad more likely to use alcohol and Marjuana during holidays.

In our study we found that there are highly significate association between alcohols drinking and smoking Marjuana with having sexual intercourse.

In our study some 16% respondents reported that they got drunk during visited Thailand. However, being under the influence of drugs or alcohol while travelling on holiday may lead to unprotected sex, the consequences of which include acquiring or spreading sexually transmitted diseases. And several risks that alcohol drinker and drug-user travelers take like health risks even after back their own country, risks related to personal safety and legal risks. The combination of drug use with alcohol, especially with excessive drinking, may increase some of these risks. (Ogilvie, 2005)

Although sexual activity may diminish among those who use drugs while travelling, there are indications that sexual risks increase among travelers under the influence of drugs and/or alcohol. Our finding are consistent with a comparative cross-sectional study design was used focusing on British, Spanish and German holidaymakers in the age range of 16–35 years, assessing sexual risk among tourists found that unprotected sex was associated with using illegal drugs. For example, they may engage in casual, unprotected sexual activity with several new partners (Jennifer Downing, 2010)

5.1 Strengths and limitations

To the author knowledge and after intensive literature search This is the first study investigating alcohol drinking and sex risky behavior among Arab male tourists in

Thailand.

Everyone who conducts research understands the importance of saving time and the need to do more with fewer resources. This reason we used electronic data collection to best achieve this goal with data collection, new methods are needed. The successful researcher is continually changing with technology and is adaptive.

Due to convenience sampling used in the methodology of this study the results cannot be generalized to all Arab male tourists visit Thailand. Generalization is only possible with random sampling of the participants which is a very difficult procedure in this kind of population.

Because the questionnaire was designed for administration at the airport before the returning of male Arab tourists to their countries, it did not contain question on the intention to have sex during their holiday in Thailand. Since the questionnaire was finally administrated in restaurants, pubs and massage centers, some of the respondents had spent few days in Thailand and may have not had opportunity to have sex encounters, Therefore our finding can be an underestimate of real sex activity because it did not include the hose respondents who had just arrived in Thailand.

We have also limitation in our questionnaire design in some questions related to condom use with sexual partner, sexual intercourse with sexual partner including the wife or no. Also limited time and budgets.

5.2 Recommendations

- **Recommendations for programs**

Overall knowledge on HIV/AIDS and stigmatizing attitudes towards people living with HIV/AIDS continue to exist among Arab male tourists in Thailand.

There is an urgent need for increased awareness about HIV/AIDS knowledge and risky

behaviors (especially protect sex and drinking alcohol) among Arab male tourists.

Due to negative attitudes in our study we recommend government program implementers should sustain their IEC (Information-Education-Communication) 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, and also tend to encourage the spread of the HIV disease. They belief HIV/AIDS is somehow punishment from god we recommend to use of religious leaders in communication and education efforts 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.

Focusing on multi-sectoral action plans that include health authorities and the stakeholders in the travel industry, both in the countries of origin and at the destination locations. In addition, should take into account that the tourists are have different background with different behaviors, different needs, and these differences should be addressed appropriately. Given this, awareness, education and prevention interventions, may choose to focus on safe sex, alcohol drinking and drugs. Overall recommendations include strengthening national commitment and action; promoting primary prevention. Electronic media, such as the Internet and text messaging, are other promising venues for promote health education among tourists and they should be encouraged to access pre-travel health information. Sexuality across the legal codes of various Arab countries is no easy undertaking.

Information on safe sex, using condom and the effects of illicit drugs should be available at different travel destinations could be placed on social media and forums used by tourists, and on websites that advertise events where a sizeable proportion of

attendees are expected to use drugs. . In addition, such information should also be available at airports and at travel agencies, and at stores that are used by those planning to travel, particularly to sex and drug-related destinations.

All these methods should also be used to ensure that tourists who have unsafe sex and use drugs at their destination are aware of several aspects of unsafe sex and drug use, including the local policy and law related to drugs, and access to local emergency and care services.

Anti-stigma strategies and policies in Arab countries need urgent attention and 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 tourist and the reluctance of public health policy in the airports makers to carry out HIV awareness programs due to scarcity of researches and low of statistics information in Arab region (MOH United Arab Emirates, 2014).

Recommendations for further research:

Further research is needed in different settings qualitative and quantitative researches among Arab tourists' needs assessments could identify a profile of those who are likely to have sex and use drugs while travelling and the risks they may take, and information could be specifically developed for them. Also caution is also Arab societies with different socioeconomic levels, cultures, and religious practices.

Based on the findings of this study, future research might include measures to investigate if they use condom with which kind of sexual partner, exclude the wife from those who have sexual intercourse during stay in Thailand, intention to have sexual intercourse if the research will conduct outside airport at departure lounge.

5.3 Conclusions

In conclusion it can be assumed that the chosen topic was quite sensitive and controversial and it was needed to be highlighted in the field of the studies. The people are always escaping from the topic of sex tourism even though they can be involved with it. Consequently, the aim of the thesis was justified and the awareness of people was essential. It was important to make the invisible side of sex tourism more accessible and transparent for society.

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. Inconsistent condom use by Arab male tourists to Thailand when having sex puts them at risk of contracting HIV and other STIs, and seems to be associated with a lower assessment of the risk of becoming infected with HIV.

Alcohol consumption and using drugs consistently as an important contributory factor to reducing inhibitions and increasing risk-taking behavior, there are highly significant association between alcohol drinking and smoking Marijuana with having sexual intercourse. Sexual activity may diminish among those who use drugs while travelling, there are indications that sexual risks increase among travelers under the influence of drugs and/or alcohol, Arab male tourist slightly had multi sexual partner during visiting Thailand. High proportions of tourists have sex while abroad and condom use is inconsistent. Establishing sexual expectations prior to going on holiday and identifying those at high risk of sexual contact abroad, such as young alone male tourists, those with multi partners at home or heavy use of alcohol and drugs, means that will put them at risky situation.

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.



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APPENDIX

จุฬาลงกรณ์มหาวิทยาลัย
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Questionnaire (.....)

Section 1: Socio Demographic Factors :please put circle around your answer

NO	QUESTIONS AND FILTERS	CODING	Skip
1.1	Age	1. 18-29 2. 30-44 3. 45-59	
1.2	Religion	1. Muslim 2. Christian 3. Jewish	
1.3	Which country you are from?	1. Emirati 2. Kuwaiti 3. Saudi 4. Omani 5. Bahraini 6. Qatari 7. Lebanese 8. Palestinian 9. Syrian 10. Iraqis 11. Jordanian 12. Libyan 13. Tunisian 14. Algerian 15. Moroccan 16. Egyptian	
1.4	What is the highest level of education you completed?	1. I didn't go to school 2. Primary School 3. Middle School 4. High School 5. College or Postgraduate	
1.5	Occupation	1. Student 2. Government employee 3. Company employee 4. Self-owned business 5. I don't study or work 6. Retired	
1.6	What is your monthly average income roughly?	1. I don't earn any money 2. 200 – 500 USD 3. 600 – 1,000 USD 4. 1,100 – 3,500USD 5. more than 3,500 USD	

1.7	Marital Status?	<ol style="list-style-type: none"> 1. Single 2. Married 3. Divorced 4. Widowed 	
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Section 2: Travel experience:

2.1	What reason coming to Thailand?	<ol style="list-style-type: none"> 1. Vacation 2. Education 3. Business 4. Medical tourism 5. To have sex 	
2.2	How long you stay in Thailand?	<ol style="list-style-type: none"> 1. Less than 1 week 2. 1-2 Weeks 3. Weeks – 1 month 4. More than 1 month 	
2.3	With whom do you came to Thailand?	<ol style="list-style-type: none"> 1. Alone 2. Family 3. Wife 4. Friend/friends 5. Relatives 	
2.4	With who was stay in your residence in Thailand?	<ol style="list-style-type: none"> 1. Alone 2. Family 3. Wife 4. Friend 5. Relatives 	
2.5	Have you been to Thailand before?	<ol style="list-style-type: none"> 1. Yes 2. No 	
2.6	How many times have you been to Thailand?	<ol style="list-style-type: none"> 4. 1-2 times 5. 3-5 times 6. More than 5 times 	
2.7	What are your favorite places to enjoy in Thailand within these places?	<ol style="list-style-type: none"> 7. Discotheque/Bars 8. Islands and Beaches 9. Massages centers 10. Tea and coffee shop 11. Restaurant 12. Shopping malls 	You can chose more than 1 answer

Section 3: HIV knowledge

NO	QUESTIONS AND FILTERS	CODING	Skip
3.1	Have you ever heard of HIV, the AIDS virus?	1. Yes 2. No	Skip to 4.1 if answer No
	How do you think the AIDS virus can be transmitted?		
3.2	HIV/AIDS can be transmitted by shaking hands/touching a person infected with HIV/AIDS.	1. True 2. False	
3.3	One can get HIV through unprotected sexual intercourse with an infected person	1. True 2. False	
3.4	One can get HIV through sharing piercing and cutting instruments like needles and razorblades.	1. True 2. False	
3.5	A person can get HIV from mosquitoes or other insect bites.	1. True 2. False	
3.6	A baby can get HIV from the mother during pregnancy	1. True 2. False	
3.7	A baby can get HIV from the mother during delivery	1. True 2. False	
3.8	A baby can get HIV from the mother via breast feeding	1. True 2. False	
3.9	Kissing on the cheek .	1. True 2. False	
3.10	Do you think that people Live with the HIV look sick?	1. True 2. False	
3.11	AIDS patients can be treated? <u>by treatment I mean availability of drugs that if taken regularly will make the person with HIV live normally</u>	1. True 2. False	

Section 4: Attitude regarding HIV/AIDS.

NO	QUESTIONS AND FILTERS	CODING CATEGORIES			SKIP	
		Strongly agree	Agree	Neutral	Disagree	Strongly disagree
4.1	Is it necessary to get education on HIV/AIDS?					
4.2	AIDS patients should be kept separately from their families and Community					
4.3	HIV/AIDS is somehow punishment from god					
4.4	We should not tell other if one has HIV/AIDS					
4.5	I am not afraid get HIV/AIDS because I am sure that I am not the person who is going to get HIV/AIDS					
4.6	Generally, having sex without condom a few times will not infect a person with HIV					
4.7	I know the difference between risky sexual behavior and safer sex.					
4.8	My partner cannot infect me with HIV/AIDS because I trust him / her.					

Section 5: Alcohol consumption and drug use risky behaviors

NO	QUESTIONS AND FILTERS	CODING	SKIP
5.1	Did you enjoy drink alcohol during you visit Thailand?	1. Yes 2. No	Skip to 5.3 if answer No
5.2	Did you ever get drunk?	1. Yes 2. No	
5.3	Have you ever taken any one of following methamphetamines – Heroin – cocaine during you visit Thailand?	1. Yes 2. No	
5.4	Have you ever taken Hashish (Marijuana) during you visit Thailand?	1. Yes 2. No	
5.5	Have you ever injected during you visit Thailand?	1. Yes 2. No	Skip to next table if answer No
5.6	Did you ever share needles/syringes that were used by another person during you visit Thailand?	1. Yes 2. No	

Section 6: Sexual experience

NO	QUESTIONS AND FILTERS	CODING	
6.1	Do you feel sexually attracted to?	1. Girls only 2. Boys only 3. Both boys and girls	
6.2	Did you ever have oral sex during your visit in Thailand?	1. Yes 2. No	
6.3	During you visit Thailand did you have a sexual intercourse? By Sexual intercourse I mean that the penis was entered in the vagina or anus).	1. Yes 2. No	Skip rest if answer No
6.4	Was a condom used on that occasion (from the beginning to the end)?	1. Yes 2. No	
6.5	What kind of your sexual partner? Sex worker: is the provision of sexual services for money or goods. casual	1. Boyfriend 2. Girlfriend 3. sex workers (SWs) 4. casual partner 5. regular partner 6. One-night stand	
6.6	Where do you go to have sex with your current partner?	1. My room in hotel 2. Short term Hotel 3. At night Club 4. Public toilet	
6.7	How many sexual partners did you have during this visiting?	1 1 Partner 2 2 or more than partner	

6.8	Where did you meet your current sexual partner?	<ol style="list-style-type: none">1. Parks2. Street3. Internet4. Disco/ Bar5. Restaurant6. Shopping mall7. Massage center	You can chose more than one answer
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استبيان رقم (.....)
القسم رقم 1 اسئلة عامة : الرجاء ان تضع دائرة على رقم اجابتك .

رقم	السؤال	التقييم	التخطي
1.1	العمر ؟	1. 18 - 29 2. 30 - 44 3. 45 - 59 4. 60 +	
1.2	الديانة ؟	1. مسلم 2. مسيحي 3. يهودي	
1.3	الجنسية	1. اماراتي 2. كويتي 3. سعودي 4. عماني 5. بحريني 6. قطري 7. لبناني 8. فلسطيني 9. سوري 10. عراقي 11. اردني 12. ليبي 13. تونسي 14. جزائري 15. مغربي 16. مصري	
1.4	ما هو اعلى مستوى علمي انهيته ؟	1. لم ادرس في المدرسة 2. الابتدائي 3. المتوسط 4. الثانوي 5. جامعي او دراسات عليا	
1.5	المهنة ؟	1. طالب 2. عمل حكومي 3. عمل بشركة 4. عمل خاص 5. لا ادرس ولا اعمل 6. متقاعد	

1. لا اتقاضى اي مبلغ مالي 2. 200-500 دولار امريكي 3. 600 – 1,000 دولار امريكي 4. 1,100 – 3,500 دولار امريكي 5. اكثر من 3,500 دولار امريكي	متوسط الدخل الشهري تقريباً بالدولار الامريكي ؟	1.6
1. عازب 2. متزوج 3. مطلق 4. أرمل	الحالة الإجتماعية ؟	1.7

القسم 2 : تجربة السفر لتايلند

التحطي	الترقيم	السؤال	رقم
	1. سياحة 2. دراسة 3. عمل 4. لغرض العلاج 5. لغرض الجنس	ما هو السبب لزيارتك لتايلند ؟	2.1
	1. اقل من اسبوع 2. 1-2 اسبوع 3. اسابيع – شهر 4. اكثر من شهر	المدة التي سوف تبقى فيها في تايلند ؟	2.2
	1. لوحيدي 2. مع العائلة 3. مع زوجتي 4. مع صديق / اصدقاء 5. مع اقارب	مع من قدمت الي تايلند ؟	2.3
	1. لوحيدي 2. مع العائلة 3. مع زوجتي 4. مع صديق 5. مع اقارب	مع من أقمت في محل إقامتك في تايلند ؟	2.4
	1. نعم 2. لا	هل زرت تايلند من قبل ؟	2.5
	1. 1-2 مرة 2. 3-5 مرات 3. اكثر من 5 مرات	كم مرة زرت تايلند من قبل ؟	2.6
يمكنك ان تختار اكثر من اجابة	1. ديسكو / بارات 2. الجزر وشواطئ البحر 3. مراكز التندليك	ما هي الأماكن المفضلة لديك للتمتع في تايلاند ضمن هذه الأماكن؟	2.7

	4. المقاهي 5. المطاعم 6. مراكز التسوق	
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القسم رقم 3 : معرفة فيروس نقص المناعة البشري

رقم	السؤال	التقييم	التحطي
3.1	هل سمعت من قبل عن فيروس نقص المناعة البشري / الايدز؟	1. نعم 2. لا	إنتقل الي السؤال رقم 4.1 إذا كانت اجابتك رقم لا
3.2	فيروس نقص المناعة البشري من الممكن ان ينتقل عن طريق مصافحة شخص مصاب بفيروس نقص المناعة البشرية / الإيدز.	1. صح 2. خطأ	
3.3	يمكن ان يصاب الشخص بفيروس نقص المناعة البشري عن طريق ممارسة الجنس الغير آمن (بدون واقي ذكري) مع شخص مصاب	1. صح 2. خطأ	
3.4	يمكن ان يصاب الشخص بفيروس نقص المناعة المكتسب عن طريق مشاركة الإبر وشفرات الحلاقة	1. صح 2. خطأ	
3.5	يمكن ان يصاب الشخص بفيروس نقص المناعة البشري عن طريق لسعات البعوض والحشرات	1. صح 2. خطأ	
3.6	يمكن ان يصاب الطفل بفيروس نقص المناعة البشري من الام خلال فترة الحمل	1. صح 2. خطأ	
3.7	الطفل يمكن ان يصاب بفيروس نقص المناعة البشري من الام خلال الولادة	1. صح 2. خطأ	
3.8	الطفل يمكن ان يصاب بفيروس نقص المناعة البشري من الام عن طريق الرضاعة الطبيعية	1. صح 2. خطأ	
3.9	التقبيل على الخد	1. صح 2. خطأ	
3.10	هل تعتقد بأن الأشخاص الذي يتعايشون مع فيروس نقص المناعة البشري هيئتهم مرضى ؟	1. صح 2. خطأ	
3.11	مرضى الايدز يمكن ان يتعالجوا ؟ أقصد بالعلاج قدرة الدواء عندما يأخذ بشكل منتظم يمكن للشخص المتعايش مع فيروس نقص المناعة البشري العيش بشكل طبيعي	1. صح 2. خطأ	

القسم رقم 4 : اعتقادك فيما يتعلق بفيروس نقص المناعة البشرية / الإيدز.

الرقم	السؤال	أوافق تماما	أوافق	لا أعرف	لا أوافق	لا أوافق تماما
4.1	هل من الضروري الحصول على التلقيح الصحي فيما يتعلق بفيروس نقص المناعة البشرية / الإيدز؟					
4.2	يجب ان يتم عزل مرضى الإيدز عن أسرهم والمجتمع					
4.3	فيروس نقص المناعة البشرية / الإيدز بطريقة أو بأخرى عقاب من الله					
4.4	لا ينبغي لنا أن نخبر الآخرين إذا كان شخص مصاب بفيروس نقص المناعة البشرية / الإيدز					
4.5	أنا لا أخاف من الإصابة بفيروس نقص المناعة البشرية / الإيدز لأنني واثق من أنني لست الشخص الذي يمكن أن يصاب بفيروس نقص المناعة البشرية / الإيدز					
4.6	إذا مارس الشخص الجنس دون الواقي الذكري لمرات قليلة لن تصيبه بفيروس نقص المناعة البشرية					
4.7	أنا أعرف الفرق بين السلوك الجنسي المحفوف بالمخاطر والجنس الآمن.					
4.8	شريكي لا يمكن أن ينقل / تنقل لي فيروس نقص المناعة البشرية / الإيدز لأنني أثق به/بها.					

القسم رقم 5 : خبرات وسلوكيات

التحطي	الترقيم	السؤال	رقم
انتقل للسؤال رقم 4.4 إذا كانت إجابتك لا	1. نعم 2. لا	هل استمتعت بأحتساء المشروبات الكحولية اثناء زيارتك لتايلند ؟	5.1
	1. نعم 2. لا	هل سبق لك أن كنت في حالة سكر؟	5.2
	1. نعم 2. لا	هل سبق لك أن تعاطيت أي من هذه العقاقير التالية الميثامفيتامين - الهيروين - الكوكايين اثناء زيارتك لتايلند ؟؟	5.3
	1. نعم 2. لا	هل سبق لك أن دخت الحشيش اثناء زيارتك لتايلند ؟	5.4
انتقل الي 5.1 إذا كانت لا	1. نعم 2. لا	هل سبق لك أن تعاطيت المخدرات عن طريق الحقن؟	5.5
	1. نعم 2. لا	هل سبق لك أن تبادلت الإبر / المحاقن التي تم استخدامها من قبل شخص آخر خلال زيارتك تايلند؟	5.6

القسم رقم 6 : الخبرة الخاصة

التخفي	الترقيم	السؤال	رقم
	1. بنات فقط 2. اولاد فقط 3. بنات و اولاد	هل تشعر منجذب جنسيا لـ ؟	6.1
	1. نعم 2. لا	أثناء زيارتك تاييلاند هل مارست الجنس الفموي ؟	6.2
تخطى باقي الاستبيان اذا كانت اجابتك لا	1. نعم 2. لا	أثناء زيارتك تاييلاند هل مارست الجنس (هنا) اقصد بالجنس أن القضيب تم إدخاله في المهبل أو فتحة الشرج ؟	6.3
	1. نعم 2. لا	هل تم استخدام الواقي الذكري في تلك المناسبة (من البداية إلى النهاية)؟	6.4
	1. صديق حميم 2. صديقة حميمة 3. عاملة بالجنس 4. شريك عارض 5. شريك منتظم 6. أخرى	ما هو نوع العلاقة بشريكك الجنسي الحالي ؟	6.5
	1. غرفتك الخاصة بك في الفندق 2. فندق لمدة قصيرة المدى 3. في النادي الليلي 4. المراهيض العامة 5. أخرى (حدد) _ _ _	أين تذهب لممارسة الجنس مع شريكك الحالي ؟	6.6
	1. شريك واحد 2. او اكثر من شريك	كم عدد الشركاء الجنسيين خلال هذه الزيارة ؟	6.7
يمكنك اختيار اكثر من اجابة	1. حديقة 2. الشارع 3. الإنترنت 4. ديسكو / بار 5. مطعم 6. مركز تسوق 7. مركز تدليك 8. أخرى (حدد) _ _ _	أين التقيت بالشريك الجنسي الحالي؟	6.8

شكرا جزيلاً لك ...

**Form of
Informed Consent Form**

Address

Date.....

Code number of participant

I who have signed here below agree to participate in this research project

Title “HIV Knowledge attitude and Risky Behavior among Arab Male Tourists in Thailand

Principle researcher’s name Fauzi Muftah Elamouri

Contact address Institute building 3 (10th – 11th floor), Chulalongkorn soi 62, Phayathai Rd., Bangkok 10330

Telephone 062 141 1869

I have (**read or been informed**) about rationale and objective(s) of the project, what I will be engaged with in details, risk/ham and benefit of this project. The researcher has explained to me and I **clearly understand with satisfaction.**

I willing agree to participate in this project and consent to response to answer the questionnaire, the questionnaire has 5 sections, the total numbers of questions are 49 questions, and take about 10 – 15 minutes.

. After the end of the project personal data the questionnaire **will be deleted.**

I have **the right** to withdraw from this research project at any time as I wish with no need to **give any reason.** This withdrawal **will not have any negative impact upon me**

Researcher has guaranteed that procedure acted upon me would be exactly the same as indicated in the information. Any of my personal information will be **kept confidential**. Results of the study will be reported as total picture. Any of personal information which could be able to identify me will not appear in the report.

If I am not treated as indicated in the information sheet, I can report to the Ethics Review Committee for Research Involving Human Research Subjects, Health Sciences Group, Chulalongkorn University (ECCU), 254 Jamjuree 1 Bldg., 2nd FL Phyathai Patumwan district, Bangkok 10330, Thailand, Tel: 0-2218-3202 Fax: 0-22183202 E-mail: eccu@chula.ac.th,

I also have received a copy of information sheet and informed consent form

Sign


(.....)

จุฬาลงกรณ์มหาวิทยาลัย
CHULALONGKORN UNIVERSITY

Leaflet information about HIV/AIDS:

ما هو مرض الإيدز؟

مرض الإيدز مرض مزمن خطير يصيب جميع أعضاء الجسم إذا لم يمرض نأخذ العلاج يتسبب في إتلاف الجهاز المناعي ويصيب الخلايا المسؤولة عن الجهاز المناعي وينتسب في تدمير أو تعطيل وظائفها.



ما هي أعراض المرض؟

مفقد الوزن بشكل ملحوظ من دون سبب نفسي أو عمل حسيه

إسهال شديد لمدة طويلة تزيد عن الأسبوعين من دون التوصل لتشخيص معين

مضغرة لمدة طويلة تزيد عن الأسبوعين من دون سبب معروف ولا تستجيب للعلاجات الحيوية

كيف يعرف الشخص انه مصاب بالإيدز

يعمل مختبر لم تكشف الفيروس أو الأجسام المضادة.

مرض نقص المناعة المكتسبة ينتقل عن طريق

ينتقل مرض نقص المناعة المكتسبة عن طريق تعاطي المخدرات بالحقن بمشاركة الأبر مع المصابين بفيروس الإيدز



ينتقل مرض نقص المناعة المكتسبة عن طريق العلاقات الجنسية الغير آمنة بدون استعمال الواقي أو العلاقات الجنسية مع عدة شركاء تزيد من فرصة الإصابة بالفيروس

ينتقل مرض نقص المناعة المكتسبة عن طريق الدم إذا عد التبرع بوحدة من الدم لم يتم فحصها أو مشاركة إبر ملوثة بالفيروس



ينتقل مرض نقص المناعة المكتسبة من الأم إلى طفلها.

1. أثناء الحمل.
2. أثناء الولادة الطبيعية
3. من الرضاعة الطبيعية



كيف نستطيع أن نحمي نفسي من التعرض للإصابة بالإيدز؟

- الابتعاد عن الممارسات الجنسية غير المحمية كمنع الزواج أو الممارسات الجنسية مع طرف آخر مصاب.
- استخدام الواقي (condom) عند الممارسة الجنسية وكن حذرا عند التقليل جميع الأضرار الجنسية بنسبة كبيرة عند استعماله.
- الابتعاد عن الإبر الملوثة التي من طرف أحد المروج.
- الابتعاد عن الحقن الوريدية ويمكن عمل الحقن عن طريق الحقن المكتسبة
- التوقف عن أدوات الاستدانة لعلاج الأسنان
- الابتعاد عن استخدام إبر جميع أنواعها. لأنه يمكن أن ينتقل الفيروس من خلال الإبر عن طريق جرح في الأذن أو الفم أو عن طريق الوريد.

هل مرض الإيدز يسبب الموت؟

مرض مزمن خطير مثل الضغط والسكري ولكن إذا تم تشخيص الحالة مبكرا وأخذ العلاج الواسع الذي يبطئ من الأضرار الخطيرة فيها يبقى حياة سليمة بل إن الله قد يمرض مستطع مبرمة حياته بطريقة طبيعية دون التعرض من الموت بسبب الإيدز.

فإن تم اكتشاف المرض مبكرا لا يصعب علاجه لذلك يتضح بالتكثف عند تشخيص الإصابة في وقت العلاج مبكرا.

معلومات قد تفيدك

1. فيروس نقص المناعة البشري من الممكن أن ينتقل عن طريق مصافحة شخص مصاب بفيروس نقص المناعة البشرية (الإيدز) **خطأ**
2. يمكن أن يصاب الشخص بفيروس نقص المناعة البشرية عن طريق ممارسة الجنس الغير آمن مع شخص مصاب بالفيروس **صحيح**
3. يمكن أن يصاب الشخص بفيروس نقص المناعة المكتسبة عن طريق مشاركة الإبر التي لم يتم تعقيمها **صحيح**
4. يمكن أن يصاب الشخص بفيروس نقص المناعة البشرية عن طريق لمسك الممرض ولحشرات **خطأ**
5. يمكن أن يصاب الطفل بالفيروس من خلال الرضاعة **صحيح**
6. العاطل يمكن أن يصاب بالفيروس من الإبر عن طريق الرضاعة الطبيعية **صحيح**
7. العاطل يمكن أن يصاب بالفيروس من الإبر عن طريق الرضاعة الطبيعية **صحيح**
8. يمكن أن يصاب الشخص بفيروس الإيدز عن طريق التقليل على الحقن **خطأ**
9. هل تقتل بالأمراض التي ينتشرون عن الفيروس قبله مرضى؟ **خطأ**
10. هل يمكن أن يصاب الإيدز يمكن أن ينتشر؟ **خطأ**
11. أخص العلاج عن الرضاعة عند أخذها بشكل متكرر يمكن للشخص المشاغل مع فيروس نقص المناعة البشرية يمكن تطعيم **صحيح**
12. الإبر عن الحقن جنسيا كالتالي:
 - الزهري
 - السيلان
 - التهاب الكبد الفيروسي البني
 - الإيدز
 - الكلاميديا وجرثوما
13. الأمراض المنقولة جنسيا يمكن أن تصيب النساء بالمع **صحيح**
14. بعض الأمراض المنقولة جنسيا من الممكن أن تؤثر على النساء **صحيح**
15. سحب السموم أثناء الجماع يقلل من إمكانية الإصابة بالأمراض المنقولة جنسيا **خطأ**
16. يمكن أن ترى على سطح الخارجي للأعضاء التناسلية إذا كان شخص مصاب بالأمراض المنقولة جنسيا **صحيح**
17. الأمراض المنقولة جنسيا لا تنتقل عن طريق الجنس العميق **خطأ**
18. يمكن للرجل أن يصاب بمرض نقص المناعة المكتسبة عن طريق عملي أعضاء التناسلية مع الجماع **خطأ**
19. استخدام الواقي الذكري يمكنه من المدى بالأمراض المنقولة جنسيا **صحيح**

Budget (table)

Items	Budget (Baht)
(100 baht/questionnaire/ x 1 persons * 384)	38,400 Baht
Transportation (500 baht/day/ person x 2 persons * 25 days)	25,000 Baht
Leaflet and photocopy (20 baht*384)	7,680 Baht
Gifts (23 baht *384)	8,832 Baht
Total Amount	79,912 (Baht)



Administration & Time schedule

Research Project Activities	Nov	Dec	Jan	Feb	Mar	Jun	Apr	Ma	Jun	Jul
	2013	2014	2015	2015	2015	e 2015	2016	y 2016	2016	2016
1. Determine the topic of study										
2. Literature review and data investigation										
3. Write the proposal and tools										
4. Submission of proposal										
5. Proposal examination										
6. Proposal revision										
7. Submission to ethical committee										
8. Tools validity and reliability test										
9. Document permit to study in any library										
10. Data collection										
11. Data analysis/										

data interpret										
12. Thesis and article writing										
13. Thesis final examination										
14. Thesis/article submission										



VITA

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Education:

2007-2011: B.S in Pharmaceutical sciences Ibom Roshed University, Tripoli Libya, Theses Tittle: “Effect of antiretroviral treatment for HCV patients who after complete the full treatment course in Tripoli Medical Center, Tripoli – Libya”.

Courses:

01 / 2014: Health promotion course Tunis – WHO EMRO Region and CDC Libya, Gamart - Tunisia.

11/ 2013: Training on Drug resistance course of HIV treatment Casablanca – Morocco.

Paid Work

1/1/2012-25/7/2014 - Pharmacist in Department of Therapeutic Management / National AIDS Program – Center of Disease control (CDC Libya) Tripoli - Libya.

3/9/2012 – 8/1/2013 – Member of Mental Health and Addictive Policy and Strategy committee (Coordinator) , the Department of Mental Health with WHO – Libya office in CDC Libya, Tripoli - Libya.