Chapter 5

Impact of Christian and Muslim Beliefs on HIV and AIDS Prevention and Treatment in Selected African Communities

Evelyn Almocera, MD, MPH

HIV (human immunodeficiency virus) is spread through body fluids and attacks the body's defense system specifically CD4 which is responsible for fighting infections. Overtime, these viruses destroys the CD4 cells resulting in a weaker body defense thus allowing opportunistic infections and even cancer to develop. HIV infection is preventable and there are several methods and interventions that have proven highly effective in reducing the risk of, and protecting against the infection. While there is no cure for HIV but with early diagnosis and the proper use of antiretroviral drugs, it can be controlled from progressing to AIDS (acquired immune deficiency syndrome) which until today has no effective cure. On September 2000, the United Nations (UN) signed a declaration for its 191 UN members states to support its eight Millennium Development Goals (MDG) to be achieved by 2015. MGD number 6 is to combat HIV and AIDS and other diseases. One of the strategies advocated by the WHO to eliminate HIV- AIDS is through Antiretroviral therapy (ART) for HIV

control.

While HIV- AIDS is a global epidemic, Africa as a whole carries the highest burden of the disease with the highest prevalence in sub-Saharan Africa. Some studies have indicated a correlation between religious beliefs and behaviors that help to protect against contracting HIV and responses to the use of ARV drugs.

This study is a descriptive research on the role of religious beliefs in the prevention and the attitudes towards use of ART for HIV control. The study will concentrate on two religious groups: Christians and Muslims or Christianity and Islam who are significantly big religious groups in this continent. The study will answer four questions:

1. Is there a similarity between how Christians and Muslims understand the cause of HIV and AIDS?

2. Is there a difference between the Christians and the Muslims as to its incidence or prevalence?

3 What similar and dissimilar protective factors prevail in these two religious groups?

3. What influences the HIV or AIDS patient' attitude towards ART?

4. As a church, how are we going to support the global intention on prevention and control of HIV and AIDS in our churches?

I. Introduction

Thirty-two years ago the then Secretary of the U.S. Department of Health and Human Services, Margaret Heckler, announced that the cause of AIDS were the retroviruses human T-cell lymphotropic virus-type III (HTLV-III) and lymphadenopathy-associated virus (LAV). Later, it was changed to Human Immunodeficiency Virus (HIV). The viruses were discovered by Dr. Robert Gallo and his colleagues of the National Cancer Institute. Since then infection with human immunodeficiency virus (HIV) has grown to pandemic proportions affecting 76.1 million people as of June 2016 according to the Joint United Nations Programme on HIV and AIDS (UNAIDS, 2018). Among those infected, about 1 million people died from AIDS-related illnesses in 2016 (UNAIDS, 2018). This resulted in a total of 35.0 million people who died from AIDS-related illnesses since the start of the epidemic (UNAIDS, 2018).

Africa is the second largest continent in the world. The African continent is composed of 54 countries and is divided into 5 regions: North, West, Central, East and Southern. The sub-Saharan Africa which comprises all African countries located south of the Sahara also

includes part of the Arab states. HIV – AIDS is a public health concern in many countries of Africa. As shown in figure 1 most of the countries affected by HIV and AIDS are those of the East and Southern Africa. Also it is important to note that Sub- Saharan region recorded an estimated 25.6 million people living with HIV in 2015 or about 1 in every 25 adults is infected. About 66% of new HIV infections come from this region as recorded in the same year. This makes sub Saharan Africa the region most affected by HIV (Global HIV/ AIDS Epidemics, 2018).

HIV infection remains a threat in certain places in the African continent despite aggressive efforts by the different health agencies. According to AVERT, among the people infected with HIV an estimated 25.5 million are living in sub-Saharan Africa (AVERT, 2017). Of these, 19.4 million are living in East and Southern Africa as shown in figure 1. AVERT is a United Kingdom-based organization that has been working at the forefront of HIV education for the past 30 years.

According to Zhu et al (1998) blood samples that were positive for AIDS were traced back in 1950. The blood samples were taken from Congo, Rwanda and Burundi (Zhu et al., 1998, pp. 594-597). The first documented HIV and AIDS case in Africa was recorded in the 1980's and occurred among heterosexuals through sexual transmission (Velayati, Ali-Akbar et al., 2007).

HIV epidemic is driven by high risk behavioral patterns which can be either due to cultural, or religious beliefs and practices such multiple sexual partners or sexual activities outside marriages. Cultural and religious beliefs were also found to play a major role in the development stigma and HIV-related discrimination (Mbuno et al., 2009).

In 2000, the United Nations (UN) together with its 191 UN member states signed a declaration to support its eight Millennium Development Goals (MDG) to be achieved by 2015. Of the eight goals, MDG goal number six was aimed to combat HIV and AIDS and other killer diseases within the years 2000-2015 (WHO, 2015). In 2015, the UN reported that the MDG number 6 showed that new HIV infections "fell by approximately 40 per cent between 2000 and 2013, from an estimated 3.5 million cases to 2.1 million" (UN, 2015, p. 6).

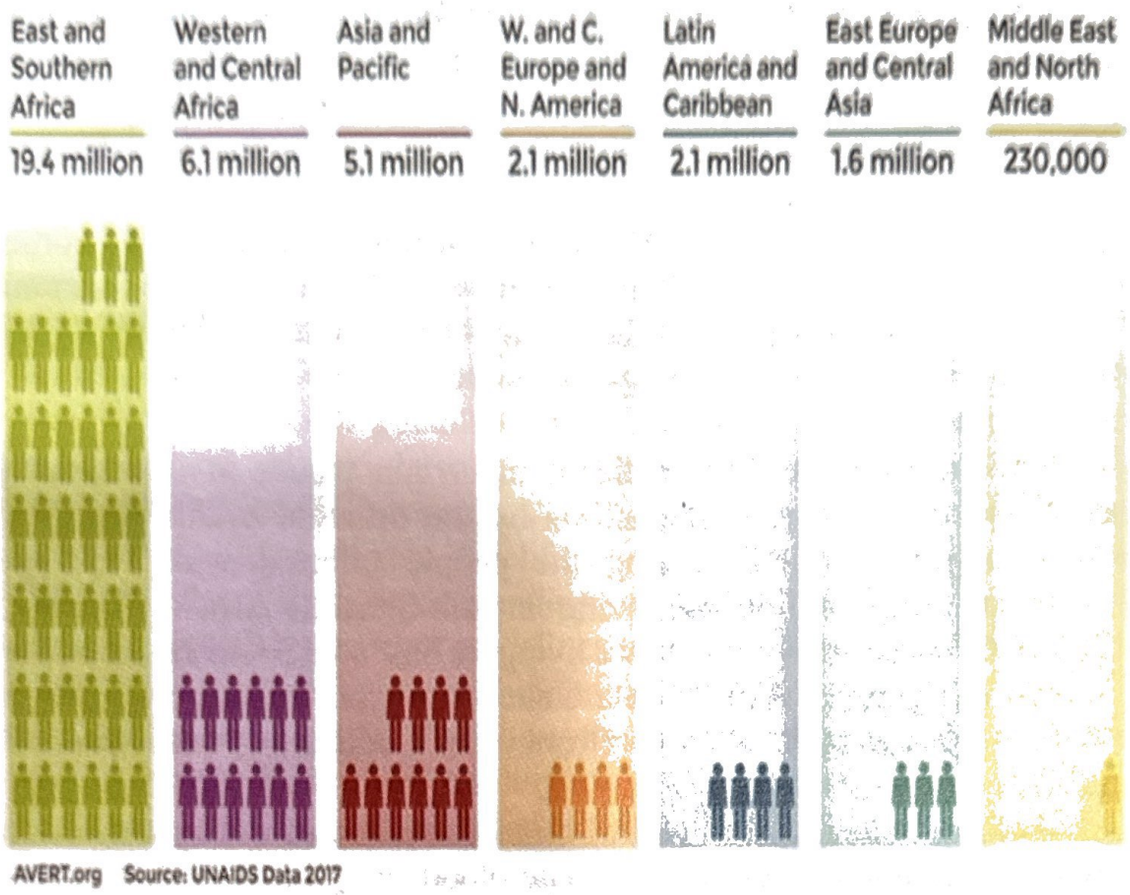

Figure 1: Number of people living with HIV
Source: Global HIV and AIDS statistics https://www.avert.org/global-hiv-and-aids-statistics

II. Religions in Africa

It was recorded that at the beginning of the 20th century, African people professed a wide variety of religious beliefs such as belief in spirits and other divinities, veneration of ancestors, magic, and traditional medicine with the Islam and Christianity only as minority. ?

However, in the last century, both Islam and Christianity increased their followers (Kanu, 2014). The Muslim population in Africa is predominantly Sunni while the Christian group is more on Roman Catholic. Northern and Western Africa is heavily Muslim. The southern and eastern Africa together with the sub-Saharan region is heavily Christian with Roman Catholic as the dominant Christian group. A small number of Africans are Hindu, Buddhist, Confucianism, Baha'i, or Jewish. Although many Africans became Christians and Muslims, a large portion of them maintains the African traditional culture and practices. The traditional spiritual beliefs continue to influence the Africans today. Many of the Africans continue to believe in traditional religious healers and witchcraft

(Mokgobi, 2014, pp. 24–34).

A. Religious Influence on Health and Disease

Religion is defined by Durheim (1912) as "unified system of beliefs and practices relative to sacred things.... beliefs and practices which unite into one single moral community called a Church" (p. 62). Pesut et al. (2008) characterized religion as institutionalized practices and beliefs, membership and modes of organization. Both of them wrote that religion is a social phenomenon. Miller and Thorensen on the other hand defined religion as observance of specific beliefs, rules and practices (Miller & Thorensen, 2003). They also anticipate that these beliefs are integrated into the life of the people and thus build the framework on their understanding on health, disease and death. Religion has also provided guidelines that direct their health behaviors and the choices they make on their bodies.

It is interesting to explore how the two significantly big religious groups shape their understanding on HIV – AIDS as to its cause, prevention and how their religious beliefs influences its treatment seeking behavior.

II. African Understanding on HIV Causation: A Case for Tanzania

In a study conducted by James Zou et al. (2009) among the Tanzanians as to the cause of HIV infection or AIDS, it was reported that they believed that HIV- AIDS is a punishment from God for not following the Word of God due to sinful behavior. The religious group of Tanzania is 1/3 Christian and 1/3 Islam. Both Christians and Muslims primarily viewed HIV and AIDS as a result of an irresponsible sexual behavior (Balogun, 2010). Both religious groups understood that it is a sexually transmitted infection. This often resulted to high level of stigma and discrimination which can lead to fear of disclosure of the infection thereby delaying in its diagnosis and treatment. Stigma is more pronounced among the Muslims (Hasnain, 2005). Hrdy (1987) in his research revealed that some cultural practices such as female circumcision or infibulation is common among the Muslim Africans. Female circumcision has no medical benefit. The practice is aimed to ensure virginity prior to marriage and marital loyalty and commitment since reduces a woman's libido (WHO, 2018). There is no religious law or script that prescribes female circumcision however, some religious leaders support the practice

(WHO, 2018). There are three possible reasons why female circumcision aggravates HIV transmission namely: a) it raises the social status of the parents if their daughters are chaste therefore the dowry increases of which most often only older men can afford to give for marriage. Their husbands (older men) have often had sexual partners before them and may have been already infected with HIV before marrying them. b) The small vaginal opening can make sexual intercourse difficult hence heterosexual couples may resort to anal sex (Bradys, 1999). c) Penile penetration in small vaginal opening often result in tissue damage and the virginal tears facilitates possible transmission of HIV (Hrdy, 1987).

IV. A Comparative Analysis of Religious Factors that Contribute to the Lower Risk of Contracting HIV Infection and Transmission

Beliefs, values and religion make up behavior and attitudes, hence it will be helpful to explore some of the religious beliefs and practices by both the Christians and the Muslims in Africa. It is interesting to ask why the Christian sub-Saharan Africa possesses the highest adult prevalence rates of HIV in the world while those countries that are predominately Muslim is lower (Gray, 2004). Both Christians and Muslims share the same belief as to assigning great value on chastity, abstinence and strong prohibition of sexual intercourse outside of marriage. However, it has been suggested that there are certain behaviors Muslims uphold that lower their risk of getting infected by HIV as compared to Christians. The following are the behaviors many Muslims advocated in the prevention of HIV spread:

a. **Strong prohibition on adultery.** The Arabic word Zina is used to describe premarital or extramarital relationship. Zina is regarded by the Quran as the most heinous crime which is punishable by stoning to death for married people; if unmarried they are whipped 100 times in public but not put to death as prescribed in Hadith. This kind of punishment discourages people from committing this sexual relationship (Islamabad, 2006; Khan, 2004).

According to a study (Bohan, 2013), between 30 to 65 per cent of all new HIV infections among men in stable partnerships are caused by infidelity while HIV among women is due to women who had relationships with older men who had more sexual partners. According to The Center for Disease Control and Prevention (CDC) the more sexual partners one has in a lifetime, the more likely one can have a risk of having a sex partner who has HIV and whose viral load isn't suppressed. This is the main risk factor of the HIV epidemic in sub-

Saharan Africa according Shelton (2009). The Christians also believed that HIV is strongly associated with sexual promiscuity and is prohibited. Those who have been infected with HIV are considered punished for sin of sexual promiscuity (Rankin et al., 2005). This thinking also leads to delays in seeking medical help.

b. **Strict anti-homosexuality law.** In an article written by Schmidtke (1999) the Quran clearly condemns homosexual relationships. However, there is no specific punishment for those caught being homosexuals. The punishment is the same as that of adultery. There were some reports that despite the severity of the punishment for homosexuality it still exist among Muslims. Some of them come out in the open which can result in punishment or being ostracized by their families. Other homosexual Muslims may have to repress their sexual identity to avoid punishment. According to the U.S. Department of Health and Human Service, most gay and bisexual men get HIV through anal sex and it is described as the most risky type of sex in spreading or being infected with HIV. The risk of being infected with HIV tend to be higher if they are not using condoms or have not taken pre- exposure prophylaxis. The Christians knew that the Bible (Mark 10:6-9) only approves the sexual union between a male and a female.

c. **Strict prohibition against the use of alcohol.** Drinking alcoholic beverage in Islam is generally forbidden. It is harshly condemned yet there are some Muslims who drink alcoholic beverage. The prohibition of alcoholic beverages is mentioned three times in the Holy Qur'an (Al-Qur'an 2:219, Al-Qur'an 4:43 and Al-Qur'an 5:90-91). The Muslims abstain from alcoholic drinks and other intoxicating drugs because they believe that Allah has prohibited these in the Qur'an and Hadith. Allah has commanded Muslims to protect themselves from His wrath and eternal punishments if they indulge in drinking alcoholic beverage. There is still no sufficient evidence to prove that alcohol use is directly associated with the increase in the risk in acquiring HIV. However, studies have shown a rich association between alcohol and risky sexual behaviors. The National Institute on Alcohol Abuse and Alcoholism reported that abusing alcohol or other drugs can impair judgment which can lead a person to engage in risky sexual behaviors. It also mentioned that alcohol misuse can contribute to the spread of HIV/AIDS not only by impaired judgement but when proven positive there is a tendency to affect their treatment seeking behavior through delays. It was noted that those who drink alcoholic beverage also tend to forget their medications hence compliance will also be affected. The Bible is very strong in its counsel regarding drinking wine and strong

beverages as seen in Proverbs 20:1, 21:17, 23:29-35, and 31:4. However, there is no strict law that prohibits Christians from drinking intoxicating drinks.

d. **Higher rates of male circumcision.** Islamic scholars differ in their views regarding male circumcision. Some, especially the Shafiite schools regarded it as obligatory since Prophet Muhammad spoke on it. Other scholars regarded it only as a recommendation since it is not mentioned in the Quran. According to Rizvi et al. (2002) it is considered as an external symbol of being a Muslim. It is also done for hygienic purposes. It has been argued that in a randomized controlled study conducted by the National Institutes of Health (NIH) participated by circumcised males in Kenya and Uganda showed evidence that circumcision provided a protective benefit against HIV infection of 53% among the 2784 Kenyan men (Bailey et al., 2007) and 51% among the 4996 Ugandan men (Gray et al., 2007) who participated in the study. Furthermore, it has been argued that in a South African Orange Farm randomized controlled trial study which precedes the Kenya and Uganda study also reported a greater than 50% protective benefit of male circumcision against HIV transmission. In Sub-Saharan Africa, voluntary male medical circumcision (VMMC) has been found acceptable by 50% to 87% men as one of the HIV preventive measures (Skolnik, Tsui, Ashengo, Kikaya, & Lukobo-Durrell, 2004). CDC wrote that after a review of 28 studies related to heterosexual transmission of HIV in Africa among circumcised male, the risk of contracting HIV is lower by 44% among circumcised males as compared to those who were not circumcised. CDC also stated the biological reasons on why male circumcision offers protection against being infected by HIV and other sexually transmitted illnesses. Studies have shown that male circumcision may offer partial protection and hence it should be considered only as one of the preventive measures. The WHO and UNAIDS have recommended voluntary medical male circumcision (VMMC) since 2000 as a key component together with other behavioral changes in the prevention of HIV in countries with a high HIV prevalence and low levels of male circumcision according to AVERT (2017). VMMC is highly recommended in places where HIV prevalence is greater than 15% such as the 14 countries in Eastern and Southern Africa, and in Central Africa. It is also recommended to countries that have high HIV prevalence with 80% men who were not circumcised. VMMC is expected to reduce over half a million new HIV in 2025 according to the WHO. Figure 2 shows the increasing number of males who underwent circumcision in the targeted countries with high prevalence of HIV.

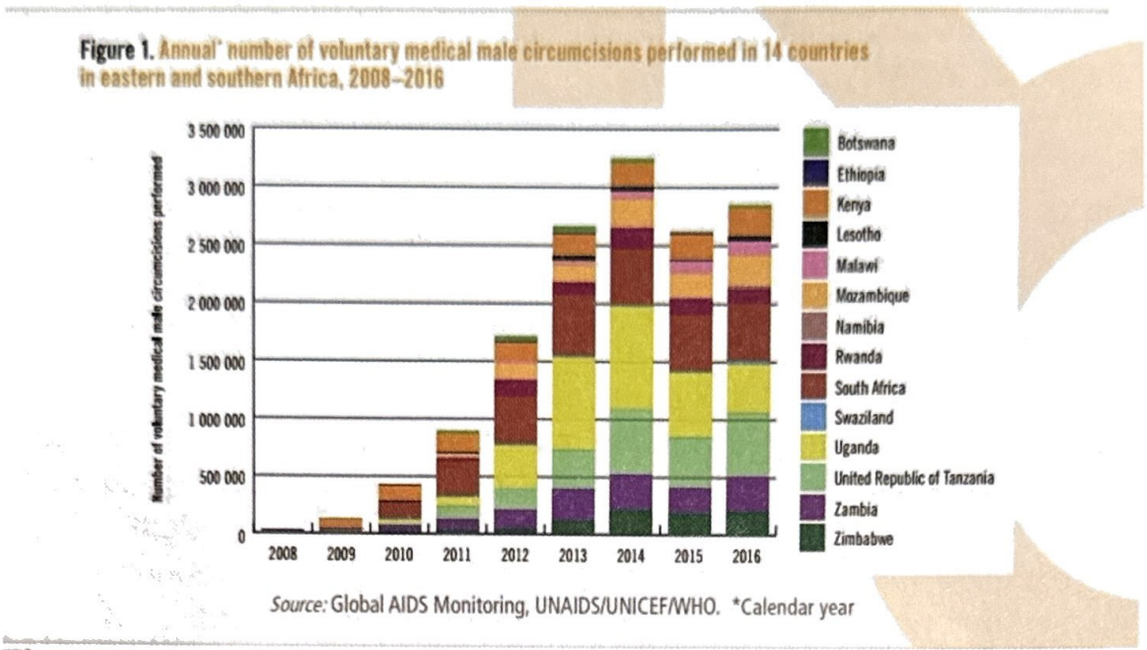

Figure 2: Annual Number of VMMC performed in Eastern and Southern Africa (2008-216)
Source: Scale-Up of Voluntary Medical Male Circumcision Services for HIV Prevention — 12 Countries in Southern and Eastern Africa, 2013–2016http://chipts.ucla.edu/news/scale-up-of-voluntary-medical-male-circumcision-services-for-hiv-prevention-12-countries-in-southern-and-eastern-africa-2013-2016/

International agencies and partner countries have encouraged and supported the procedure after randomized studies have shown how it reduces the risk of acquiring HIV infection (Mutabazi, Forrest, Ford, & Mills, 2014). While the merits of VMMC have been proffered by various studies, it still a debatable HIV intervention strategy on the offing. There many factors that contribute to low incidence and prevalence of HIV among those who practice VMMC. To shun opposing views on this issue would be remise of this discussion. Perhaps it is appropriate to point out that the subject of health and wellness regarding HIV and AIDS is broader than VMMC.

V. Influence of Religion on the HIV – AIDS Patient's Response to Prevention and Treatment

Religious beliefs have been shown to contribute to the prevention and spread of HIV. However, several studies revealed that religious beliefs can also create some negative outcome especially on how they address prevention and the manner of responding to treatment regimen.

In a separate study of Chindedza et al. (2013) in Malawi, female HIV patients indicated that there is a significant association of non-adherence to ARV with strong religious belief because they are confident that their God or gods have the power to heal them. In chapter 5 of the book (The Social Impact of AIDS in the United States), the authors and editors concluded that religious beliefs and teachings have negative effects on prevention strategies, treatment responses and attitude towards HIV- AIDS (Jonsen & Stryker, 1993). Since HIV and AIDS is believed to be a punishment from God then treatment responses differ. For some Christians in Africa, it creates more risk as one may choose a treatment that is not helpful and scientifically acceptable. A study conducted in Uganda by Wanyama et al. (2007) showed that some patients stopped taking their medication and replaced them with prayers offered by their pastors since they believed that prayers heal them. A Tanzanian study also indicated that 80.8 percent of their respondents believed that prayers will cure the disease (Zou et al., 2009). The worst is that some discontinued their treatment as advised by their pastor as seen in some cases in London as reported by the Hackney-based Centre for the Study of Sexual Health and HIV. In one church, anointed water was also advertised as a cure to HIV infection or AIDS as this water has the power to heal through God's mercy (Hutchinson, Mahlalela, & Yukich, 2007). Sulieman (2016) in his study, described an experience of a 35 year old male he interviewed. The respondent was quoted saying:

> My friend and I attend the same church. We have been on ARVs together for about 2 years. Suddenly, I did not see him in the church and at the clinic as well. When I inquired about him, I was told that he has transferred to another church and his pastor told him that it was not necessary for him to continue on ARVs since he was praying for him. Another participant of his study was quoted saying "In our faith (referring to Islam), it is common for one to say 'haka Allah ya so' (meaning it is God's will). So, whatever befalls man, we simply say it is what Allah wanted to happen. I believed it is possible for some of us to stop taking treatment because we believe it is God who heal them at His assigned time. (p. 71)

The positive effects that religion brought is that those HIV infected patients who had high spirituality/religiosity were able to cope with their disease through changing their risky behavior (Ebotabe-Arrey et al., 2016).

The Bush administration promoted ABC as an approach that guides HIV prevention programs. This was also endorsed by the some Africans whose major mode of HIV transmission is heterosexual intercourse. A is for abstinence, B for be faithful and C for condom use. However, many Christian organizations have different opinions regarding the use of condoms in the prevention of HIV infection. Bernadette Mukonyora wrote that many Christian churches especially the Catholics are against the use of condom as a preventive measure (Muula, 2010). She emphasized that condom use is not a spiritual issue but a public health strategy. According to these findings, the anti-condom message seemed to be based on the idea that that the use of condom promotes promiscuity. Similar to some Christians, some Muslims also engage in activities that expose them to the risk of acquiring HIV. The belief that the disease is caused by sexual immorality brings stigma to the afflicted. This can happen to both the Christian and Islamic communities. In the study of Sulieman (2016), a 32-year old female participant explained the difficulties she encountered with disclosure during an in-depth interview:

> I have been hiding my pills so that people at home will not know my situation. One day one of my siblings caught me taking my pills but I explained to her that it is Malaria treatment. I am simply afraid and scared about my future if many people get to know my condition. People will not like to associate with me. (p. 71)

Situations like this lead to a delay in seeking diagnosis and treatment. Disclosure of unlawful sexual relationships also becomes a barrier to those seeking help. The role of religion and culture on Antiretroviral Therapy (ART) adherence has been widely researched. If ever they were undergoing treatment they tend to hide due to stigma.

The yearly fasting among the Muslims during Ramadan is a fundamental religious practice among the followers of Islam. It is observed by adult Muslims for about 30 days. However, the sick for those who need to take medications or those who are sick whose condition may become worse when they fast are permitted to break the fast. However, many still insist on fasting. Olowookere et al in their study observed that about 31.5% of their participants attributed sub-optimal ART adherence to religious fasting (Olowookere, Fatiregun, Akinyemi, Bamgboye, & Osagbemi, 2008). In a separate study in Ethiopia, Bezabhe et al also found religious fasting as one of those that significantly affect adherence to medication in patients (Bezabhe,

Chalmers, Bereznicki1, Peterson, Bimirew, & Kassie, 2014). Successful treatment against HIV and AIDS depends on many factors that include: regularity in medicines intake, following fixed dose interval schedules and regularity in eating behaviors.

1. Regularity of ART is affected by the one choice of their eating schedule during Ramadan. One of the respondents in the focus group of Sulieman (2016) replied

> I take my medicine every 6 o'clock daily. However, during fasting I make adjustments by taking the morning dose at 05:00 a.m, and take the evening sometimes at 7 p.m, or even after since it is around that time. There are times I forget to take it. (p. 72)

2. Following a fixed dose interval schedules. Some physicians recommend that antiretroviral medicines are to be taken twice daily. According to Burger et al (1998) delay in adhering to drug intake interval as prescribed can lead to a drop in the drug concentration in the blood causing sub-therapeutic levels therefore favoring viral replication.
3. Eating behaviors. In a typical pattern of meal changes during Ramadan, the first meal is often served between four or five in the morning while the second meal is about ten in the evening. Some antiretroviral drugs require to be taken after meals hence these changes in meal schedule affect the effectivity of these drugs. This is a challenge to those who are taking medication twice a day. Ingestion of food prior to intake of ART is important as it is known to improve absorption of the drug. The meal composition also changes during Ramadan. The first meal often consists of a light to moderate meal while the evening meal consists of a heavy meal. Many of those who are fasting tend to eat a high fat diet. According to Habib et al 78% of those with HIV- AIDS who fast eat heavy fatty meals during the first and the second meals (Habib et al., 2009). The adverse effect of this fatty meal is that it reduces the absorption and bioavailability of some ART medications.

The individual choice on fasting during Ramadan seems difficult for some of those taking ART and could compromise adherence to the treatment regimen. It affects drug absorption, bioavailability and drug pharmacodynamics resulting in failure in suppressing the viral load and increasing drug resistance. According to Stevens it can also promote

transmission of a drug resistant virus strain (Stevens, Kaye, & Corrah, 2004).

VI. The SDA Church Role in Supporting the Global Intention on Prevention and Control of HIV- AIDS

The church must continue to recognize the seriousness of this health epidemic which affects even church members. As a church we are encouraged to help prevent HIV infection and support those already living with the virus. We must love those affected and infected as Jesus did during His earthly ministry. The church role includes the following:

1. Prevention can be done through health education at an early age between the ages of 10 and up and this is especially addressed to women whose vulnerability is higher than men.
2. Empower women on negotiating skills to avoid sexual abuses.
3. The church needs to reaffirm the biblical principles regarding sexuality and God's design on sexual intimacy- maintaining a faithful monogamous marriage relationship.
4. Promote the use of scientifically proven effective medical treatments, and preventive measures.
5. Promote girl education. This helps protect them from risk of trafficking, sexual exploitation and transactional sex with older men.
6. Discourage child marriage.
7. Increase advocacy against female genital mutilation.

The Seventh Day Adventist Health Ministries Department has created a statement encouraging different sectors to develop and manage AIDS education programs using the resource HIV and AIDS Guide that is addressed to pastors, teachers, parents, church members and communities (AIDS Epidemic, 2000).

VII. Conclusion

Religious beliefs are an important factor that set the attitudes and behavior of people including their responses to HIV and AIDS prevention and treatment. In countries with high prevalence, the above research seems to point that many believe that it is a curse from God

due to sexual immorality. This makes participation in HIV screening become difficult for fear of stigma and discrimination attached to it. While God is able to heal miraculously, He may choose not to do so, for that reason people must remain prayerful, and take their medications as prescribed by physicians. God is love at all times. Female circumcision is registered in some few communities, and some religious leaders promote its practice. Its demerits in connection to HIV infection and AIDS warrants its discouragement. In select Christian and Islam communities there are favorable behaviors that help HIV prevention and AIDS treatment. ABC is one of those preventive measures, where the C can be used by couples who are discordant or are both living with HIV. However, there are some conflicting issues regarding the use of condoms as a protective measure by some Christian communities specifically the Catholics.

It is argued by some that higher rates of male circumcision among the Muslims is responsible for a lower HIV transmission. However, lower HIV prevalence among Muslims could most likely be due to the high regard of morality taught and practiced by their religion, more than anything else. Observance of Ramadan has posed some challenges to drug adherence by some, and this is based on individual choice. Certain religious beliefs and practices can either be helpful in HIV and AIDS prevention and treatment or become a barrier. The Seventh –day Adventist (SDA) church supports the global initiative in the prevention and treatment of HIV and AIDS. The SDA members are commissioned to compassionately care for those who suffer and are affected with HIV- and AIDS without being judgmental as Jesus did in His earthly ministry. To this end the church establishment of fully fledged ministry, (The Adventist International AIDS Ministries—AAIM), several years ago, is highly commendable. Through this ministry the church has made significant strides to minister to those infected and affected by HIV and AIDS in African communities. The initiatives taken by the church in Africa are lessons for the rest of the world where the HIV and AIDS challenge seem to be growing silently.

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About the Author:

Evelyn Villaflor Almocera is a medical doctor and is the Adventist International Institute of Advanced Studies (AIIAS) campus physician. She is also an associate professor of the Department of Public Health of the AIIAS Graduate School.