

Democracy is bad for Human Health, if Democracy Contradict with Global Public Health Laws

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Abstract

As global efforts to address infectious diseases (ID) are accelerating, complexity is increasing and the importance of law is becoming more apparent. Understanding the powers, duties and constraints created by law is now essential.

The role of international Laws in Global Public Health Laws and Religious Laws, The role of Global Public Health Laws in International Laws and Religious Laws as well as the role of Religious Laws in Global Public Health Laws and International Laws are completely misunderstood, confused and contradicted by world leaders.

This article examines the contradiction among International Laws with Global Public Health Laws, Religious Laws, and Global Public Health Laws with International Laws and Religious Laws more so, Religious Laws contradiction with Global Public Health Laws and International Laws. Therefore the impact in health outcome, life expectancy and Global health status

I selected A WHO, CDC, and The Organization for Economic Cooperation and Development (OECD), and Global tactical analysis data and examined, Government Budget by countries, Health out come by income source and Health Expenditure by countries.

In this article, I described that the importance of various Laws, impacts on Global Health status (Epidemic, Pandemic Control), life expectancy, Global Economy, Global Development and Global stabilization. More so, How Various Laws contradict and how we will solve those critical challenges, and create compatibility among Laws for better Health, life expectancy, Economy and Peace.

Keywords: International Law; Global Public Health Law; Life Expectancy; Health Expenditure; Health Inequalities; Abnormal Sexual Character; Global Economy, Epidemic, Pandemic Infectious Diseases)

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1. Introduction

1.1. An overview of what democracy is?

1. A political system for choosing and replacing the government through free and fair elections.
2. The active participation of the people, as citizens, in politics and civic life.
3. Protection of the human rights of all citizens.
4. **A rule of law, in which the laws and procedures apply equally to all citizens.**

1.2. How democracy works?

- ✚ In a democracy, every citizen has certain basic rights that the state cannot take away from them.
- ✚ These rights are guaranteed under international law.
- ✚ You have the right to have your own beliefs, and to say and write what you think.
- ✚ No one can tell you what you must think, believe, and say or not say.
- ✚ There is freedom of religion. Everyone is free to choose their own religion and to worship and practice their religion as they see fit.
- ✚ Every individual has the right to enjoy their own culture, along with other members of their group, even if their group is a minority.
- ✚ There is freedom and pluralism in the mass media.
- ✚ You can choose between different sources of news and opinion to read in the newspapers, to hear on the radio, and to watch on television.
- ✚ You have the right to associate with other people, and to form and join organizations of your own choice, including trade unions.
- ✚ You are free to move about the country, and if you wish, to leave the country.
- ✚ You have the right to assemble freely, and to protest government actions.
- ✚ **However, everyone has an obligation to exercise these rights peacefully, with respect for the Laws and for the rights of others [1].**

1.3. Global Health Law and Governance

The importance of law to public health governance in states has also been part of the discourse on the globalization of public health. The necessity for a strong legal foundation for public health activities has long been understood conceptually by public health experts and public health lawyers [2],[3],[4],[5], recognizes the role of law in national public health by requiring in Article 63 that each member state communicate to WHO promptly important laws and regulations pertaining to health (WHO 1946). WHO then shares national legislation with the rest of the world through the [6]. Despite conceptual appreciation of the role of law in supporting public health governance nationally, in practice public health law has suffered from neglect on a worldwide basis. Such neglect is part of the reason public health policies, infrastructures, and resources within low and high-income countries have suffered in the last twenty-five years.

Understanding the global governance dynamic and the important role that international law plays within it requires grasping the political structure of international relations. Humanity is divided politically into sovereign states that interact with each other in a condition of anarchy, or the absence of any supreme

authority or power. The interaction of states in the condition of anarchy produced the conceptual and practical need for mechanisms and instruments to stabilize and regulate political and economic intercourse. States devised international law for the purpose of regulating their interactions.

International law was not, however, the only mechanism developed to bring such order and stability. Political mechanisms, such as the balance of power, were also developed and used to regulate relations between states. Governance in international relations has always been an unstable mixture of power politics and international law. The structure of international politics makes international law necessary to global governance but not sufficient to produce the kind of stability and peace associated with domestic politics. Applied to public health, these observations mean that international law is structurally and practically unavoidable as an instrument of GHG. The evidence provided proves this point because it shows clearly that international law is critical to GHG [7].

Strategy (CDC, Element 3). Develop and advance policies to prevent, detect, and control infectious diseases. Protecting the nation from infectious diseases requires sound, evidence-based health policies designed to ensure appropriate development and delivery of infectious diseases prevention measures; reduce health disparities and improve the health of vulnerable populations; and promote engagement with global partners to reduce cross-border disease spread and contain outbreaks at their source.

As global efforts to address infectious diseases (ID) are accelerating, complexity is increasing and the importance of law is becoming more apparent. Understanding the powers, duties and constraints created by law is now essential not only for lawyers, but also for leaders' and officials [8].

1.4. International Law and Global Public Health

As a consequence of globalization, governments must turn increasingly to international cooperation to attain national public health objectives and achieve some control over the transboundary forces that affect their populations. The widespread influence of globalization has increased the need for new frameworks of international collaboration, including conventional international law, to address emerging opportunities for and threats to global health and improve the health status of poor states that have not benefited from globalization [9],[10],[11],[12].

Globalization also has an impact on the development of international health law, because increasing global integration compounds exponentially the public health implications of other contemporary developments strongly connected with health status.

It is important to understand that conventional international law is an inherently limited mechanism for international cooperation and that the international legislative process suffers from numerous defects — including challenges to timely commitment and implementation—although considerable advances have been made in the last few decades.

An increasing number of these intergovernmental organizations with express lawmaking authority and relevant mandates have served as platforms for the codification of international law related to health; others have influenced contemporary international law in this field.

In recent years there has also been a proliferation of private-sector actors in international health. These include a wide range of nongovernmental agencies, foundations and for profit organizations such as the pharmaceutical industry with a powerful influence on international health policy, including global lawmaking.

WHO can provide leadership and promote more coherent and effective development of international health law by serving as coordinator, catalyst and, where appropriate, platform for important international health agreements. WHO has a unique mandate to provide leadership and promote the rational and effective development of international health law.

As the largest international health organization, and one of the larger specialized agencies of the United Nations, WHO has far-reaching responsibilities to address global public health based on responsibilities assigned by its constitution and its affiliation with the United Nations [9],[13].

With the goal of having a measurable impact on contemporary global health challenges, world leaders must evaluate the new laws with Global public health laws.

Does Democracy by itself have laws or limit or just freedom for everything (both for bad and good practices)?

If democracy allows as human right for any person to practice whatever he/she want to practice, “How we can control and eradicate diseases, while world leaders created new law for mode of spread” (Eg Same sex marriage new law...)

2. Democratic Countries Health outcomes

These increases in life expectancy can be traced to three factors, all of which are associated with increases in prosperity, although the direction of causation is hard to establish. **First**, there are reductions in malnutrition and improvements in infrastructure such as clean water supply and improved sanitation facilities. **Second**, and very important in recent history, there is medical intervention through control (due to immunization and insecticides) and treatment of infectious diseases using antibiotics [14]. **Third**, there are improvements in knowledge and lifestyle [15]. notes that “health improvement ultimately came from the globalization of knowledge, facilitated by local political, economic, and educational conditions.” The literature to date has focused more on the latter influences (education and economics) rather than the political foundations of increased life expectancy. There are three main theoretical differences between democracies and autocracies that we might expect to influence health issues. The first concerns representation [16]. Focus on who controls political office, modeling autocracy as a dictatorship of the rich and democracy as a dictatorship of the poor or middle classes.

One must keep in mind that many rich countries have become rich under authoritarian auspices. If this conventional conclusion is correct, one might be justified in concluding that democracy is a luxury to be enjoyed only by countries rich enough to afford it [17].

Several influential commentators have suggested recently that democratization in developing countries produces political instability, ethnic conflict, and poor economic outcomes [18]. states that “If a society is not in reasonable health, democracy can be not only risky but disastrous.” [19]. Points out that “although democracy has in many ways opened up African politics and brought people liberty, it has also produced a degree of chaos and instability that has actually made corruption and lawlessness worse in many countries.” [20]. Argues that: “... in the numerous countries around the world with a market-dominant minority, adding democracy to markets has been a recipe for instability, upheaval, and ethnic conflagration”

The evidence that democracy promotes prosperity is neither strong nor robust. More- over which aspects of policy making and human well-being are promoted by democracies is still a subject of debate [21].

The data also suggesting that health policy interventions are superior in democracies, the challenge now is to take this agenda beyond broad cross-country comparisons and into the detailed workings of political and bureaucratic behavior under different systems of government [22].

Important determinants that have been identified include the levels of female education and autonomy, nutritional adequacy and political priorities for health. By their very nature, issues related to such determinants are political. If so, achieving better health is inevitably a political process. As was concluded by the [23], “political will” or “a sustained political commitment to universal health and well-being” is a major factor responsible for health success in poor developing countries (“Summary Statement”, 1985). There are also reasonable a priori grounds for expecting that differences in political system might influence health status, either positively or negatively.

Despite the significance of politics and the political system, there has been relatively little work done specifically examining the relationship between political economy and health status [24]. On the other hand, considerable work has been done on examining the relationship between political systems and economic development.

Studies concentrated on the effects of political and economic factors on social development in general [25],[26], examined the relationship between political system and the levels of health status in particular, as well as measures of health infrastructure. Health status was represented alternately by the infant mortality rate, child death rate and life expectancy at birth.

Previous studies, they indicated that strong left regimes generated significantly better health outcomes than strong right regimes (except in the case of infant mortality rates, which were lower but not significantly so). More democratic regimes also significantly and without exception did better than less democratic regimes

3. The Effect of Health Expenditure on Better Health Outcome

A recent study by the PricewaterhouseCoopers’ Health Research Institute estimated that more than half of the US\$ 2 trillion-plus that the United States of America spends on health each year is wasted; a Thomson-Reuters study reported a lower but still substantial figure of US\$ 600–850 billion per year [27],[28].The European Health care Fraud and Corruption Network says that of the annual global health expenditure of about US\$ 5.3 trillion, a little less than 6%, or about US\$ 300 billion, is lost to mistakes or corruption alone [29].

While some countries lose more than others, most, if not all, fail to fully exploit the resources available, whether through poorly executed procurement, irrational medicine use, misallocated and mismanaged human and technical resources or fragmented financing and administration. But there is nothing inevitable about this and there are many shades of inefficiency. Some countries obtain higher levels of coverage and better health outcomes for their money than others, and the gap between what countries achieve and what they could potentially achieve with the same resources is sometimes enormous [30].

While raising more money for health is crucial for lower-income countries striving to move closer to universal coverage, it is just as important to get the most out of the resources available. Finding the most efficient ways to meet the multiple challenges health systems face is also an issue for those countries that might be struggling to sustain high levels of coverage in the face of constantly increasing costs and growing demand [31],[32].

Medicines account for 20–30% of global health spending, slightly more in low- and middle-income countries, and, therefore, constitute a major part of the budget of whoever is paying for health services [33]. In many cases that burden would be lighter if governments and individuals were paying a fair price [34].

A recent medicine pricing study revealed that while generic medicines in the WHO regions of the Americas, South-East Asia and the Eastern Mediterranean were bought by the public sector at close to international reference prices, in the African, European and Western Pacific Regions, governments paid an average 34–44% more than they needed to [35].

The same study revealed that certain medicines are nearly always sold at substantial mark-ups, with the prices varying significantly from country to country. The irrational use of medicines not only leads to suffering and death, it draws resources away from effective, evidence-based interventions. Despite the fact that many countries have adopted national medicines policies and essential medicines programmes that encourage appropriate use, fewer than half of all patients treated in low- and middle-income countries receive care according to clinical guidelines for common diseases in primary care [36],[37]. It is estimated that more than half of all medicines globally are prescribed, dispensed or sold inappropriately [37]. and that half of all patients fail to take their medication as prescribed or dispensed [38].

Overuse and misuse of antibiotics is a particularly serious global problem, with two thirds of all antibiotics being sold without prescription through unregulated private markets. Many patients are prescribed incorrect or inadequate doses or fail to complete the course prescribed. Fewer than half of all patients with acute diarrhoea obtain treatment with cheap and extremely effective oral rehydration salts, while more than half are given expensive and – for this purpose – useless antibiotics [39],[40].

An estimated 10–25% of public spending on health linked to procurement – buying the necessary inputs such as medicines, equipment and infrastructure – is lost each year to corrupt practices [41]. In developed countries alone, fraud and other forms of abuse in health care have been estimated to cost individual governments as much as US\$ 12–23 billion per year [42]. Because the production and distribution of medicines is a complex multiphase process, there are particular opportunities for many abuses in this area, although the problem extends to all areas of procurement. Statically Analysis of Higher Health Expenditure and Lower Health Expenditure among difference Population [43].

Principles, however, are not limited to buying and distributing medicines, and can be applied to all activities in health. They are underpinned by the core principles of good government, which include accountability, transparency and respect for the rule of law [44].

Health care spending is a key component of any industrialized country's economy. It provides a major source of employment, often for highly skilled workers and in rural areas without other significant industries. In addition, the development of drugs and medical technologies can lead to breakthrough

products, innovation hubs, and new markets. Most important, health spending satisfies fundamental individual and social demands for services that bring improved health, greater productivity, and longer lives.

It compares health care spending, supply, utilization, prices, and quality in 13 industrialized countries: Australia, Canada, Denmark, France, Germany, Japan, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the U.K., and the U.S. The analysis finds that the U.S. spends more than all other countries on health care, but this higher spending cannot be attributed to higher income, an aging population, or greater supply or utilization of hospitals and doctors.

Despite being more expensive, the quality of health care in the U.S. appears to be variable, with better-than-average cancer survival rates, middling in-hospital mortality rates for heart attacks and stroke, and the worst rates of presumably preventable deaths due to asthma and amputations due to diabetes compared with the other study countries. In contrast, Japan, which has the lowest health spending among these countries, controls costs primarily through aggressive price regulation demonstrating the powerful correlation between health care prices and total spending [45],[46],[47].

Exhibit 3

Growth in Total Health Expenditure Per Capita, U.S. and Selected Countries, 1970-2008

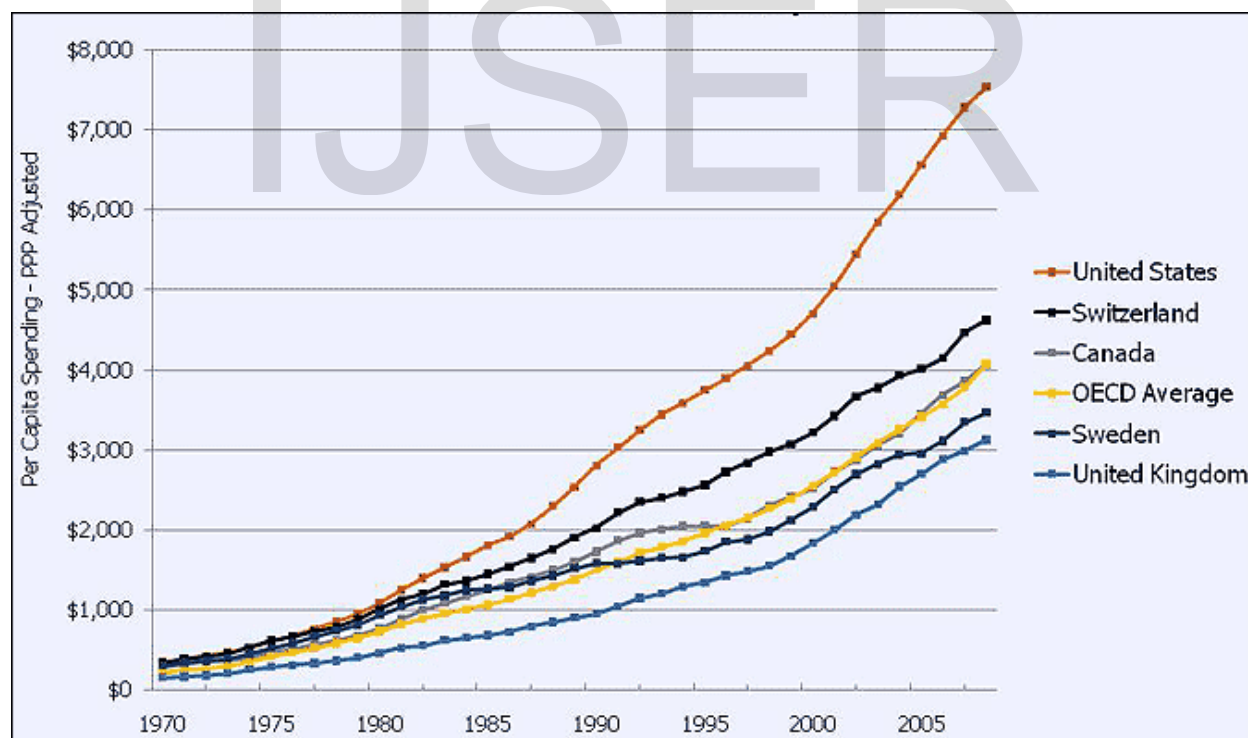
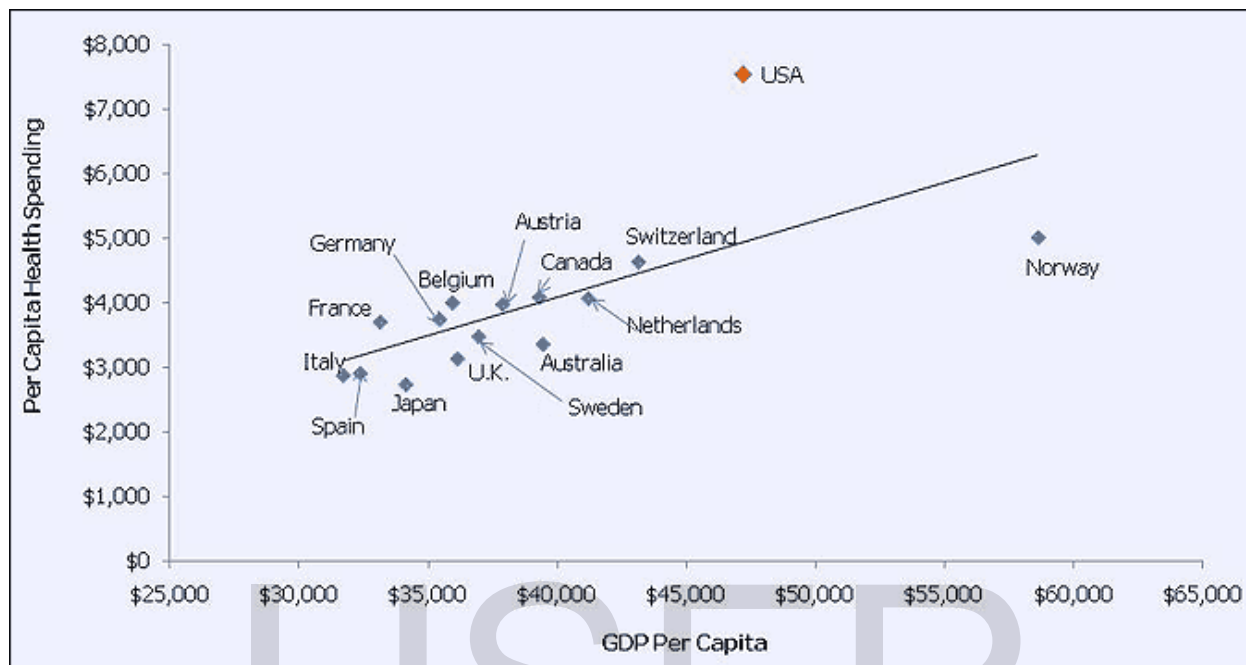


Exhibit 2

Total Health Expenditure per Capita and GDP per Capita, US and Selected Countries, 2008



4. The Impact of Expenditure in Children Mortality

In 2011, infant mortality rates in OECD countries ranged from a low of under 3 deaths per 1 000 live births in the Czech Republic, Japan, the Nordic countries (with the exception of Denmark), Portugal and Slovenia, up to a high of over 10 deaths per 1 000 live births in Mexico, Romania and Turkey (Chart CO1.1.A). Infant mortality rates were also relatively high (more than 6 deaths per 1 000 live births) in Chile, some Central and Eastern European countries, and the United States.

Around two-thirds of the deaths that occur during the first year of life are neonatal deaths (Chart CO1.1.A). Congenital malformations, pre-maturity and other conditions arising during pregnancy are the principal factors contributing to neonatal mortality in developed countries. For deaths beyond a month (post-neonatal mortality), there tends to be a greater range of causes – the most common being SIDS (Sudden Infant Death Syndrome; more commonly known as “cot death”), birth defects, infections and accidents.

All OECD countries have made remarkable progress in reducing infant mortality over the last 40 years. On average across the OECD, the infant mortality rate was just below 30 deaths per 1 000 live births in 1970, and fell to under 5 deaths per 1 000 live births in 2011 (Chart CO1.1.B). Chart CO1.1.C shows the decline equates to a cumulative reduction of over 80% since 1970, and in 2011 infant mortality rates were less than 10% of what they were in 1970 in Chile, Korea, Portugal and Turkey.

5. The Impact of Inequalities on the Health of Population

Equity refers to a distribution of outcomes that is based on some notion or principle of justice. Equity does not necessarily and naturally improve as overall outcomes do, hence the potential need and justification for public intervention. A concept of justice that is currently widely accepted among economists (and beyond) is that of substantive equality of opportunity – the idea that individuals should have the same opportunity to achieve outcomes such as high income or a long life, but do not necessarily need to achieve the same outcomes due to freedom of choice. Despite the widespread acceptance of the concept, and the obvious relevance for arguments supporting the need to tackle health inequities, challenges remain in terms of precisely measuring the concept [48].

All countries recognize that health inequalities are caused by adverse socioeconomic and environmental circumstances. However they differ in their definitions of inequalities and in their approaches to tackling the problem. Sweden and Northern Ireland have structured their overall public health policy to tackle the underlying determinants of inequalities in health. England is the only country with a separate comprehensive policy. Most countries also have policies on poverty, social inclusion, and social justice. These are motivated by a concern for human rights and dignity and deal primarily with the underlying causes of health inequalities [49].

Inequalities in health are recognized to be a major problem in all countries studied, with many reporting increases during the 1980s and 1990s. However, countries differ in their definitions of inequalities in health and their assessment of the scale of the problem. Inequalities in health are most commonly presented as the difference in health status between socioeconomic groups, but inequalities in health are also described by geographic location, employment status, gender and ethnic group. Many other specific groups are recognized to be at risk of inequalities in health including travelling people, prisoners, asylum seekers, the homeless and people with physical and mental disabilities.

Tackling inequalities in health is an overarching aim of all public health policies. Most countries have ambitious goals for reducing inequalities in health: the United States goes so far as to set the goal of eradicating all inequalities in health by 2010. Other countries have goals to reduce the gap in health status between specified groups by amounts ranging from 10% to 50%. There are major differences in policy approaches to health inequalities [50].

Most countries have separate policies on poverty, social inclusion and social justice. Unlike policy on inequalities in health, these policies seldom emanate from departments of health. The social inclusion /social justice policies are motivated by a general concern for human rights and dignity, of which health is only a small part. However, as they deal with the underlying causes of inequalities in health (low income and unemployment, housing and homelessness, and social exclusion), they are directly relevant to health.

Income category	Potential range of efficiency savings (percentage of total health spending) a	Potential efficiency savings per capita (US\$b)		Potential range of efficiency savings across total population (US\$ billion)	
		Mean	Range	Mean	Range
Human resources				563	110–851
High-income	8–16	492	78–629	499	79–639
Mid-income	7–14	14	7–48	61	29–206
Low-income	8–15	2	1–5	3	1–6
Medicine				115	24–193
High-income	2–3	93	14–122	95	14–124
Mid-income	2–5	5	2–16	19	9–67
Low-income	3–5	1	0–2	1	0–2
Hospitals				287	54–503
High-income	3–8	233	30–325	236	31–330
Mid-income	5–11	11	5–39	49	23–168
Low-income	4–9	1	1–3	2	1–4
Leakages				271	51–468
High-income	3–8	221	28–310	224	29–315
Mid-income	5–10	10	5–35	44	22–150
Low-income	5–10	2	1–3	2	1–4
Intervention mix				705	141–1094
High-income	10–20	602	95–774	611	96–786
Mid-income	10–20	21	10–70	89	43–299
Low-income	10–20	3	2–7	4	2–8
Total				1409	282–2188
High-income	20–40	1204	189–1548	1223	192–1573
Mid-income	20–40	42	20–140	178	86–599
Low-income	20–40	7	3–13	8	4–17

.A. Derived by multiplying a range of potential efficiency savings (human resources 15–25%; medicine 10–15%; hospitals 10–25%) by share of total health spending in the different country income groups; potential efficiency savings for leakages and intervention mix estimated directly as a percentage of health expenditure per capita (6, 69).

B. Derived by multiplying potential efficiency savings by average health expenditure per capita [interquartile range]: 4013 [947–3871] (high-income); 139 [101–351] (middle-income); 22 [15–33] (low-income) (6, 69).

Table.01. Cost and Country-Income Category

The financial crisis in Europe started in late 2007 and continues to influence many of the key social determinants of health in Europe, both through changes to living conditions and to public spending. Even before the current financial crisis, it had been noted that a social gradient in health existed both globally and throughout the EU, through which lower life expectancies and poorer health were associated with lower socioeconomic status and/or lower education [51],[50]. The financial crisis substantially lowered economic growth rates in the EU and drove up unemployment rates. In some cases, these changes were drastic. As has been reported elsewhere, Eurostat data demonstrate that the mean EU decrease in GDP in 2009 was 4.5%, with the worst individual case was 17.7% in Latvia [52]. Although GDP growth rates started to rebound in 2010 and 2011, the mean EU GDP rate decreased again in 2012 by 0.4% [53]. Meanwhile, unemployment increased dramatically in 2008, with examples including 9% in Ireland, 12% in Spain and Estonia, 13% in Latvia and 14% in Lithuania [52]. With lower economic growth and higher unemployment, it is unsurprising that the financial crisis appears to have increased income inequality in many countries. In 2013, the Organisation for Economic Cooperation and Development (OECD) noted that the number of people living in poverty increased in most OECD countries between 2007 and 2010. Moreover, as the OECD notes, 'income inequality increased by more in the first three years of the crisis to the end of 2010 than it had in the previous twelve years [54]. Such numbers demonstrate that the need to pay attention to social inequalities, and the disparate health outcomes that they lead to, is greater today than it has been in many years.

A systematic literature review conducted by ECDC has revealed that health inequalities for various infectious diseases can be identified in each EU Member State [55]. Has also demonstrated strong associations between income inequalities and rates of tuberculosis [56],[57].

The financial crisis has and continues to influence many of the key social determinants of health in Europe, both through changes to living conditions and to public spending. It remains to be seen whether long-term effects of the financial crisis will continue to impact infectious diseases in Europe, but history suggests that identifying key social determinants, addressing health inequalities, and engaging vulnerable groups are and will be important activities for European public health in the coming years.

6. Methods

Explanatory notes

Study setting

We planned to collect population data on deaths caused by various diseases for each year from 2005 to 2013, by age group. However, it was difficult to obtain nationwide data that was continuous and accurate by age group because of the limited information on disease control and prevention, and lags in reporting deaths and disease to the registration system. In addition, it was difficult to coordinate the process of data collection because the management of the population's disease mortality data belongs to different departments of the governments.

We selected A WHO, CDC, and The Organization for Economic Cooperation and Development (OECD), and Global tactical analysis data.

The Organization for Economic Cooperation and Development (OECD) annually tracks and reports on more than 1,200 health system measures across 34 industrialized countries, ranging from population health status and nonmedical determinants of health to health care resources and utilization. This analysis examined 2011, 2012, 2013 OECD health data for 13 countries: Australia, Canada, Denmark, France, Germany, Japan, Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. This brief presents data for the year 2009 or, where not available, 2008 or 2007.

The statistical tables present details of the main budget, consolidated national and governments expenditure, the borrowing requirement and financing of government debt, total government debt, and provisions and contingent liabilities.

The tables are categorized according to government levels, from the main budget to the consolidated governments account.

1, Government Budget by countries

2, Health out come by income source

3, Health Expenditure by countries

Note: Brief explanation under the table, graph, etc

7. The Impact of Infectious Diseases on Life Expectancy

Life expectancy provides an estimate of the average expected life span under certain conditions, based on current mortality. It is one of three comprehensive indicators reflecting an individual's health, social and economic status, and quality of life [58]. It is also the most representative and comprehensive index to judge the social economy and healthcare development of a country or region [59].

According to the US National Institutes of Health (NIH; Bethesda, MD, USA), 16 new infectious diseases have been identified in the past two decades [60],[61]; five others have been identified as re-emerging.

The word ‘new’ refers to the recent discovery of the disease; many of these agents might have long existed as non-pathogenic organisms, but have only just mutated into a pathogenic form. In fact, we are witnessing a slow realization among public-health experts and the general public that infectious diseases are back with a vengeance.

The impact of these diseases is immense and is felt across the world. In addition to affecting the health of individuals directly, infectious diseases are also having an impact on whole societies, economies and political systems. In the developing world in particular, crucial sectors for sustained development such as health and education, have seen a marked loss of qualified personnel, most notably to human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS), tuberculosis (TB) and malaria.

7.1. Infectious Diseases and their Geographical Location

Continent of origin (year of origin)	Infectious diseases
North America (1993)	Hantavirus, drug-resistant TB, West Nile fever
Mexico/Central America	Dengue, anthrax
South America	Yellow fever, cholera, Venezuelan equine encephalitis, Bolivian haemorrhagic fever
Britain	nvCJD (BSE)
Eastern Europe	Typhoid, diphtheria
Asia	Poliomyelitis, Crimean–Congo haemorrhagic fever, plague, drug-resistant TB, epidemic meningitis, cholera, enterovirus
Africa	Rift Valley fever, West Nile fever, Lassa fever, drug-resistant malaria, Ebola virus, human monkey pox, yellow fever, cholera, poliomyelitis, HIV-1 subtype
New Guinea	Dengue
Australia	Ross River virus
BSE, bovine spongiform encephalopathy; nvCJD, new-variant Creutzfeldt–Jakob disease; HIV-1, human immunodeficiency virus type 1; TB, tuberculosis.	

When humans live in close contact with animals, pathogens are sometimes able to change hosts and infect humans [62]. The new host—in this case, a human—is often not as adapted to these zoonotic diseases as the original host.

The past outbreaks of avian influenza, severe acute respiratory syndrome (SAR S), Hantavirus, Nipah virus and the HIV epidemic were all due to pathogens that were normally found in animals, but which subsequently found a new, susceptible host in humans.

Mass migrations, trade and travel are notoriously effective at spreading infectious diseases to even the most remote parts of the globe. Mass migrations are often the result of emergency situations such as floods, wars, famines or earthquakes, and can create precarious conditions—such as poor hygiene and nutrition or risky sexual behaviours—which hasten the spread of infectious diseases.

The United Nations Open Working Group on Sustainable Development Goals (OWG) has proposed target 3.3 for the post 2015. development agenda as follows: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, waterborne diseases and other communicable diseases [63].

Since the target strives to end three major epidemics – and covers further diseases – it could, along with target 3.2 (child mortality), be the SDG target with the greatest impact in terms of reducing mortality. AIDS, TB and malaria, combined, claim substantially more than 3 million lives per year, and all infectious diseases put together even exceed underfive mortality by far [59].

7.2. The Biggest Killers among the Infectious Diseases

Order of Topics According to the Annual Number of Deaths at below Global Life Expectancy (70 Years)

1. Pneumonia Under 5 years 75% and 5–6.9 years 25%
2. HIV/AIDS Under 5 years 25% and 5–69 years 75%
3. Water-borne Diseases (Diarrhoea) Under 5 years 50% and 5–69 years 50%
4. Viral Hepatitis under 5 years 5% and 5–69 years 95%
5. Tuberculosis Under 5 years 20% and 5–69 years 80%
6. Malaria Under 5 years 70% and 5–69 years 30%
7. Drug Resistance, Pandemics under 5 years 18% and 5–69 years 72%

Key Note: Number of Deaths: Under 5 years and 5–69 years

Data sources: Global Burden of Disease (GBD) study 2015; WHO 2014; RAM [UK] 2014, Murray et al.; McKibbin et al.; Taubenberger et al.; Osterholm, i.a.; tropical diseases except malaria caused 142 000 deaths in 2013 (GBD 2015) [64].

8. The Impact of Abnormal Sexual Character (Homosexuality, Bisexuality and Heterosexuality)

Scientific studies demonstrating the healthy, adaptive functioning of the great majority of gay and lesbian adults paved the way toward removal of homosexuality as an illness from the DSM in 1973 [65]. Homosexuality is now recognized as a non-pathological variant of human sexuality. Although the great majority of gay and lesbian individuals have normal mental health, as a group they experience unique stressors and developmental challenges. Perhaps in part as a consequence of these challenges, adult and adolescent members of sexual minorities (defined below) develop depression, anxiety disorders, substance abuse, and suicidality at rates that are elevated in comparison with those in the general population [66],[67]. Thus, psychosocial distress may account for the different rates in depression, hopelessness, and current suicidality seen between gay, lesbian, and bisexual adolescents and their heterosexual peers. [68]. Studies in the U.S. and the Netherlands document this problem continuing into adulthood, and show a significant association among stigma, prejudice, discrimination, and poor mental health [66],[69],[70].

8.1.1. Terminology:

- **Sexual orientation** refers to the sex of the person to whom an individual is erotically attracted.

It comprises several components, including sexual fantasy, patterns of physiological arousal, sexual behavior, sexual identity, and social role.

- **Homosexual** people are attracted erotically to people of the same sex, and are commonly referred to as gay in the case of males, and gay or lesbian in the case of females.
- **Heterosexual** people are attracted erotically to people of the other sex.
- **Bisexual** people are attracted erotically to people of both sexes.
- **Sexual minority** refers to homosexual and bisexual youth and adults.
- **Sexual prejudice** (or more archaically, homophobia) refers to bias against homosexual people.

“**Homophobia**” is technically not a phobia; like other prejudices, it is characterized by hostility and is thus a misnomer, but the term is used colloquially [71],[72].

8.1.2. Homosexuality

Homosexuality comprises multiple components, and can refer to several aspects of same-sex attraction, including physiological arousal ability, erotic fantasy, sexual behavior, psychological identity, or social role.

In the late 1970s young homosexual men were dying from rare cancers and pneumonias caused by usually benign microbes. Such conditions, which result from failures of the immune system, became indicators of what is now called acquired immunodeficiency syndrome (AIDS).

In the years since, HIV has killed millions of men, women, and children from all economic classes, representing every race, from countries around the world. Each day in 2003, 15,000 more individuals became infected and 8,000 died.

Sexually transmitted infections, including human immunodeficiency virus (HIV), are major concerns in some LGBT groups, particularly MSM and male-to-female transgender persons. MSM account for nearly half of all people living with HIV in the United States, despite making up approximately 2% of the general population (CDC 2010); In addition, they accounted for almost two-thirds of new cases of HIV in 2009, the last year for which such data are available. In urban areas, the HIV prevalence among MSM exceeds the general population prevalence in many sub-Saharan African countries where HIV is widely perceived as a public health emergency [73].

In addition to marriage, many LGBT individuals raise children or have a desire to do so. In the 2002 National Survey of Family Growth, 52% of gay men and 41% of lesbian women expressed a desire to have children [74]. Approximately 19% of gay and bisexual men and 49% of lesbian and bisexual women report having had a child [75]. The pathways to child-rearing for lesbian and gay couples vary. In many cases, children being raised by same-sex couples are the products of previous, opposite-sex relationships [75]. Otherwise, adoption provides a pathway to child-rearing, although a few states explicitly ban same-sex couples or gay or lesbian single individuals from becoming adoptive parents.

Empirical data offer a number of challenges to the notion that homosexuality is a condition for which some homosexuals are unable to substitute normal sexual behavior. Most surveys have reported that the great majority (80-90%) of those with homosexual experience, both men and women, have also had full sexual relations with the opposite sex, and most of those who call themselves "gay" or "lesbian" have also had full sexual relations with the opposite sex. Not that infrequently, these heterosexual contacts occur in so-called gay ghettos, with other gays and lesbians [76], [77].

1,000 to 3,000 species whose behaviour has been well researched approximately 450 have been shown to have clear homosexual behaviours. In terms of breadth of experience, it runs the gamut from mutual masturbation to anal and oral sex, petting, kissing and caressing, and such sex frequently involving fetishes. The birds do it. It's been described in 130 species of birds. The southeastern blueberry bees do it. Same sex pairs of animals kiss and caress each other with obvious affection and tenderness. Male pairs and female pairs form long-lasting pair-bonds and reject, threaten, even fight off potential opposite sex partners when they are presented with them. Same sex partners engage in almost every conceivable means of sexual expression throughout the animal kingdom.

8.2. Abnormal Sexual Character (Homosexuality, Bisexuality and Heterosexuality) and Spread of Infectious Diseases

Anderson and coworkers [78], [79], analyzed a model for the spread of AIDS in heterosexual communities in developing countries and explored the effects of control strategies. Although the majority of AIDS cases in developed countries occur in the homosexual community, the disease is spreading into the heterosexual community. Hethcote [80], presented a general model that accounts for interaction between heterosexuals, bisexuals, homosexuals, and intravenous drug abusers.

Hyman and Stanley [81], proposed a model (hereafter referred to as HSM) for HIV transmission within a homosexual community based on biased mixing; that is, the community is divided into categories consisting of individuals of similar risk behavior (where risk is quantified by the number of sexual partners), and it is assumed that individuals interact mainly with people of similar risk behavior. With this assumption, the magnitude of the epidemic, the expected time of its peak, and its growth rate all depend upon how different risk groups are distributed and how they interact with one another. [82], HIV/AIDS is predominately a homosexual disease reported "...we cannot deny that HIV is a gay disease. We have to own that and face up to that." — Matt Foreman, former executive director of the National Gay & Lesbian Task Force

HIV/AIDS is a disease that is eventually debilitating and fatal. It is bad, not good. It is unacceptable, not acceptable. To say we are fighting against HIV/AIDS when we coddle or approve of the behavior that causes (transmits) HIV/AIDS is completely hypocrisy.

If we love people, we must point out the behavior that puts them at risk of acquiring HIV/AIDS. True love and true care for children and adults will teach them to protect themselves from HIV/AIDS and other sexually-transmitted diseases. How? By learning and practicing sexual abstinence outside of man-woman marriage, and practicing monogamy and fidelity within man-woman marriage. This is the only "safe sex" there is!

I was shocked and gripped by the news that 3% of Washington DC residents are infected with HIV/AIDS. This is an epidemic level, even surpassing the atrocious rates in West Africa.

The federal Centers for Disease Control and Prevention reports that homosexuality and bisexuality cause 85% of HIV infections in America ("high-risk heterosexual activity" is defined as non-homosexuals — mostly women — who had sexual intercourse with a "bisexual.")

The California Office of AIDS reports homosexuality, bisexuality and transsexuality cause 83% of HIV infections in California.

In places that attack and demean sexual boundaries, the homosexual-bisexual-transsexual causation of HIV/AIDS transmission is even higher. In "free sex" San Francisco, 90% of HIV/AIDS cases are "men who have sex with men" (75%) and "men who have sex with men" who also use intravenous drugs (15%). The "free sex" philosophy is a lie, because there is a high cost to ignoring the natural and moral boundaries of sex.

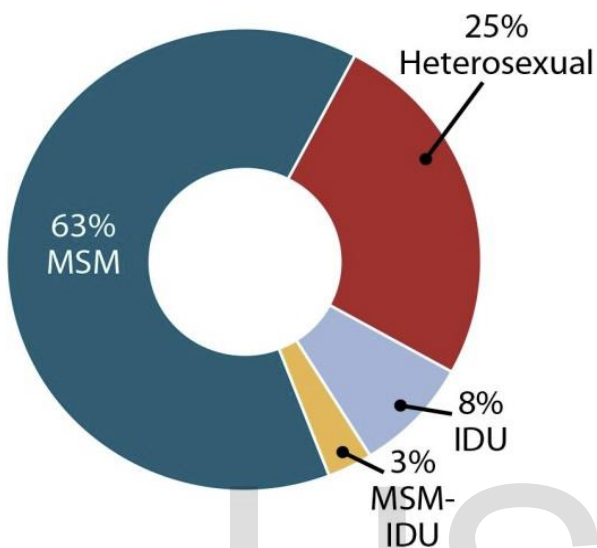
California's Democrat-controlled Legislature is in denial of the behavior that transmits HIV/AIDS. Until 2005, California government refused to even report the incidence and transmission of HIV, leaving people in the dark - See more at: [83].

WASHINGTON, DC, July 8, 2013 (LifeSiteNews.com) - A fact sheet released at the end of June by the US Centers for Disease Control (CDC) warns that HIV rates, already at epidemic proportions, are continuing to climb steadily among men who have sex with men (MSM).

"Gay and bisexual men remain at the epicenter of the HIV/AIDS epidemic," says Jonathan Mermin, the director of the CDC's division of HIV/AIDS prevention.

The CDC notes that while homosexual men make up only a very small percentage of the male population (4%), MSM account for over three-quarters of all new HIV infections, and nearly two-thirds (63 percent) of all new infections in 2010 (29,800).

"Men who have sex with men remain the group most heavily affected by HIV in the United States," the fact sheet states.



US News reports that if HIV infections among men who have sex with men (MSM) continue to rise at the current rates, more than half of college-aged homosexual men will have HIV by the age of 50.

When broken down by age group, the CDC reported that new infections among the youngest MSM, aged 13-24, increased from 7,200 infections in 2008 to 8,800 in 2010, which translates into a 22 percent increase in that time span.

Young black MSM continue to have the highest infection rate, according to the CDC, accounting for more than half (55 percent) of new infections among young MSM.

"CDC's new estimates show that African Americans, more than any other racial/ethnic group, continue to bear the greatest burden of HIV in the United States," the report states. "While blacks represent approximately 14 percent of the total U.S. population, they accounted for almost half (44 percent) of all new HIV infections in 2010 (20,900). HIV incidence among blacks was almost eight times higher than that of whites - 68.9 v. 8.7 per 100,000 of the population [84]."

In the recent years the human Immunodeficiency virus (HIV), which leads to acquire immunodeficiency syndrome (AIDS), has emerged as an important new infectious disease. There are tremendous amount of heterogeneity associated with HIV/AIDS. Some common modes of transmission are heterosexual Intercourse, homosexual intercourse and sharing needles by injecting drug users (IDUs). Thus general model for HIV/AIDS could include group of people based on their sexual behavior, eg Homosexual men, heterosexual women, and heterosexual men, bisexual men, heterosexual women, and heterosexual men [85], [86],[79],[87],[88],[89],[90], [91],[92].

In the calendar year 1959 a total of 292 persons residing within the city limits of Los Angeles were reported as having primary or secondary syphilis. Private physicians reported 96 (32.9 per cent) of these cases and the remaining 196 or 67.1 per cent were diagnosed in venereal disease clinics operated by the city. Each of the nine venereal disease clinics operated in the nine district health offices of the City Health Department reported some cases, although not in equal distribution [93].

8.2.1. The list of diseases found with extraordinary frequency among male homosexual practitioners as a result of anal intercourse is alarming:

Anal Cancer, Chlamydia trachomatis, Cryptosporidium, Giardia lamblia

Herpes simplex virus, Human immunodeficiency virus, Human papilloma virus

Isospora belli, Microsporidia, Gonorrhea, Viral hepatitis types B & C and Syphilis,

Other physical problems associated with anal intercourse are:

- Hemorrhoids
- Anal fissures
- Anorectal trauma
- Retained foreign bodies

8.3. Statics HIV/AIDS in 2005

(The following bullets refer to the 33 states with long-term, confidential name-based HIV reporting. See the box, before the References section, for a list of the 33 states.)

**In the 33 states with long-term, confidential name-based HIV reporting, an estimated 19,620 MSM (18,296 MSM and 1,324 MSM who inject drugs) received a diagnosis of HIV/AIDS, accounting for 71% of male adults and adolescents and 53% of all people receiving an HIV/AIDS diagnosis that year.

**The number of HIV/AIDS diagnoses among MSM (including MSM who inject drugs) increased 11% from 2001 through 2005 . It is not known whether this increase is due to an increase in the testing of persons with risk factors, which results in more HIV diagnoses, or due to an increase in cases of HIV infection

**An estimated 231,893 MSM (207,810 MSM and 24,083 MSM who inject drugs) were living with HIV/AIDS.

Transmission categories of male adults and adolescents with HIV/AIDS diagnosed during 2005 [94].

The following figures are taken from one of the largest (850 pp.) studies on this subject, "The Gay Report" (1979), by two homosexual researchers, Karla Jay and Allen Young. The pair and their respondents are stunningly candid. According to their research:

Around 99% of homosexual males engage in oral sex; 91% engage in anal sex; 82% engage in "rimming", touching the anus of one's partner with one's tongue and inserting the tongue into the anus; 22% engage in "fisting", inserting one's fist into the rectum of the partner; 23% engage in "golden

showers", urinating on each other; 4% engage in "scat", the eating of feces, and in "mud rolling", rolling on the floor where feces have been deposited.

Indicator: Psychologically, the evidence shows homosexuality to be compulsive and addictive. When warned that continuing their behavior would result in a high death rate, homosexually active persons typically respond that such a request was an attack on their identity and personhood, not on their behavior. "Homosexuality is who I am, not what I do!!" The continued justification and practice of self-destructive behavior, even when warned, is evidence of a compulsive and addictive pattern

Harvey Milk 'Gay' Day" in hundreds of California government schools; And wise parents are keeping their kids home!

"Harvey Milk 'Gay' Day" is just the tip of the iceberg. Because now there are 10 statewide laws pushing homosexuality, bisexuality, transsexuality, and teen heterosexual fornication in California public schools.

These 10 bad laws, which were implemented by the majority Democrats in Sacramento (with the help of some liberal Republicans), are embedded, or in the process of being embedded, in all parts of school curricula, activities, and facilities

And it's going to get worse. The new California curriculum frameworks being developed for K-12 government schools push unnatural, unhealthy, unbiblical, and tyrannical "LGBT" behavior more than ever (see pages 9-12 of this February 2015 handout of the California Department of Education featuring "Proposed Edits from the Committee on LGBT History").

The 10 sexual indoctrination laws I'm talking about affect every child at every public school in California. All together, they teach children to admire and support the tyrannical homosexual-bisexual-"sex change" agenda that's stamping out religious freedom, free speech, and private property wherever you look. Schoolchildren are being taught that unnatural is natural, uncivil is civil, unhealthy is healthy, and bad is good [95].

8.3.1. Contradiction among International Laws with Global Public Laws, and Religious Laws

For example;

- Abnormal Sexual Character (Homosexuality, Bisexuality and Heterosexuality)
- Biological Weapons
- Political War
- Religious Laws (e.g. under age married)
- Women Right
- Human Right

9. Abnormal Sexual Character (Homosexuality, Bisexuality and Heterosexuality) and Diseases Classification

Homosexuality has been given different labels throughout history. It has progressed from a sin to a crime, then a mental illness, a style of life, and is now characterized by a genetic predisposition.

The American Psychiatric Association's Board of Trustees passed this groundbreaking decision unanimously on December 15, 1973, and subsequently released a statement that rejected legal discrimination on the basis of sexual orientation.

In *Homosexuality and American Psychiatry*, Ronald Bayer argues that this decision was the product of years of political pressure applied by gay activists. Judd Marmor, Vice President of the APA at the time of the decision and a prevailing advocate for the declassification of homosexuality, was openly arguing by 1972 that conservative psychiatrists were opposed to the declassification of homosexuality on the sole basis of moral and social judgments [96]. Ellen Herman argues another point of view in her book, *Psychiatry, Psychology, and Homosexuality*. Herman acknowledges the scientific advantage held by those fighting for the change, and points to the referendum held by the APA in response to the decision as evidence for the importance of changing social norms [97]. What led to the declassification of homosexuality as a mental illness in 1973? The answer to this question involves a combination of political, social, economic, and scientific factors. Proximately, the political pressure of gay activists, the increasingly vocal gay community, and the presence of scientific validation for their claims led to a reconsideration of the pathological state of homosexuality.

The World Health Organization is developing the 11th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-11), planned for publication in 2017. The Working Group on the Classification of Sexual Disorders and Sexual Health was charged with reviewing and making recommendations on disease categories related to sexuality in the chapter on mental and behavioral disorders in the 10th revision (ICD-10), published in 1990. This chapter includes categories for diagnoses based primarily on sexual orientation even though ICD-10 states that sexual orientation alone is not a disorder. This article reviews the scientific evidence and clinical rationale for continuing to include these categories in the ICD.

9.1. International Statistical Classification of Diseases and Related Health Problems (ICD-11), Lets first see the Terminology of some Medical words:

9.1.1. Terminology:

Diseases Classification:

- The classification of specific conditions and groups of conditions determined by an internationally representative expert committee that advises the World Health Organization, which publishes the complete list in a periodically revised book, the *Manual of the International Statistical Classification of Diseases, Injuries and Causes of Death*. The Tenth Revision (ICD-10) came into use in 1992; it has 20 chapters, each with a hierarchical arrangement of subdivisions (rubrics); some chapters are etiologic, some relate to body systems, some to classes of conditions, and some to procedures.

International Classification of Diseases (ICD):

- an official list of categories of diseases, physical and mental, issued by the World Health Organization (WHO). It is used primarily for statistical purposes in the classification of morbidity

and mortality data. Any nation belonging to WHO may adjust the classification to meet specific needs. See also Diagnostic and Statistical Manual of Mental Disorders.

9.1.2. Medical classification systems are used for a variety of applications in medicine, public health and medical informatics, including:

- statistical analysis of diseases and therapeutic actions
- reimbursement; e.g., based on diagnosis-related groups
- knowledge-based and decision support systems
- direct surveillance of epidemic or pandemic outbreaks

9.1.3. Medical Disorder mean:

- a disturbance in physical or mental health or functions;
- malady or dysfunction: a mild stomach disorder.
- to derange the physical or mental health or functions of.

9.1.4. Sexual Disorder mean:

- Any such disorder that is caused at least in part by psychologic factors. Such a disorder characterized by a decrease or other disturbance of sexual desire is called a sexual dysfunction, and that characterized by unusual or bizarre sexual fantasies, urges, or practices is called paraphilia. Also called **psychosexual disorder, psychosexual dysfunction.**
- **Psychosexual disorders** are disturbances in sexual function secondary to emotional and/or mental causes. This category includes sexual dysfunctions, sexual perversions (paraphilias), and gender identity disorders, and is separate from sexual disorders that may arise from an underlying medical condition.
- **Sexual dysfunctions** may be characterized as a disturbance of sexual desire, arousal, or orgasm; sexual pain; or difficulties with sexual performance. Causes may be mental or physical, and can result in the individual's inability to fully enjoy sexual intercourse. In men, sexual dysfunctions may manifest as reduced sexual desire, premature or delayed ejaculation, impotence, or painful intercourse. In women, sexual dysfunctions may manifest as reduced sexual desire, inadequate lubrication, difficulty or inability to achieve orgasm, or painful intercourse. Because sexual dysfunctions may be related to a medical condition, medication, or substance abuse, adequate medical workup is imperative before the initiation of treatment.
- **Sexual perversions (paraphilias)** involve strong and recurrent sexual desire for unusual situations or objects. Examples are displaying one's genitals (exhibitionism); sexual desire for children (pedophilia), non-consenting adults (sexual sadism), objects (fetishism); observing other people unclothed or engaged in sexual activities (voyeurism); rubbing against someone or something for purposes of sexual stimulation (frottage or frotteurism); and cross-dressing (transvestic fetishism). Paraphiliac behavior usually begins in adolescence.

- **Gender identity disorders** characterize individuals who desire to be—or insist that they are—members of the other sex. Gender identity disorder symptoms can develop as early as ages 2 to 4.[98]

9.1.5. Mental Illness mean:

Mental illness refers to a wide range of mental health conditions **disorders that affect your mood, thinking and behavior**. Examples of mental illness include depression, anxiety disorders, schizophrenia, eating disorders and addictive behaviors.

Many people have mental health concerns from time to time. But a mental health concern becomes a mental illness when ongoing signs and symptoms cause frequent stress and affect your ability to function.

A mental illness can make you miserable and can cause problems in your daily life, such as at work or in relationships. In most cases, symptoms can be managed with a combination of medications and counseling (psychotherapy) [99].

9.1.6. Personality Disorder means:

A **personality disorder** is a type of mental disorder in which you have a rigid and unhealthy pattern of thinking, functioning and behaving. A person with a personality disorder has trouble perceiving and relating to situations and to people. This causes significant problems and limitations in relationships, social encounters, work and school.

In some cases, you may not realize that you have a personality disorder because your way of thinking and behaving seems natural to you. And you may blame others for the challenges you face.

Personality disorders usually begin in the teenage years or early adulthood. There are many types of personality disorders. Some types may become less obvious throughout middle age [100].

In 1935, the Standard classified nomenclature of disease included a number of conditions under the term 'pathological sexuality' in the category of 'psychopathic personality'. Homosexuality was specifically included in that category. During 1951 a Veterans' Administration classification included 'sexual deviate' among 'pathological personality types', under the heading of 'character and behaviour disorders'. Only one year later the first version of the APA's own diagnostic classification –

DSM-I – was published. DSM-I (1952) included the diagnosis of homosexuality under the rubric of 'sexual deviation', within the category of 'sociopathic personality disturbances'. 'Sexual deviation' was as a diagnosis that was: reserved for deviant sexuality which is not symptomatic of more extensive syndromes, such as schizophrenia and obsessional reactions. The term includes most of the cases formerly classed as 'psychopathic personality with pathologic sexuality'. The diagnosis will specify the type of pathologic behavior, such as homosexuality, transvestism, paedophilia, fetishism and sexual sadism (including rape, sexual assault, mutilation).

In DSM-II (1968), 'sexual deviation' (code 302) was included within the 'major subdivision V' dealing with 'personality disorders and certain other non-psychotic mental disorders'. The category of 'sexual

deviation' was differentiated from 'personality disorders' (code 301) and was to be used: . . . for individuals whose sexual interests are directed primarily toward objects other than people of the opposite sex, toward sexual acts not usually associated with coitus, or toward coitus performed under bizarre circumstances such as in necrophilia, pedophilia, sexual sadism and fetishism. Even though many find their practices distasteful, they remain unable to substitute normal sexual behaviour for them. This diagnosis is not appropriate for individuals who perform deviant sexual acts because normal sexual objects are not available to them.

The category of 'sexual deviation' included homosexuality, fetishism, paedophilia, transvestitism, exhibitionism, voyeurism, sadism, masochism, and 'other sexual deviations'.

The above description of 'sexual deviation' was published through six reprints between 1968 and October 1973. Following the vote of the Board of Trustees of the APA in December 1973, that was changed. It has been argued that, to some extent, the APA decision was influenced by studies of the prevalence of homosexual behavior published by Kinsey, as well as the research by Evelyn Hooker. Hooker had published comparative studies of homosexual and heterosexual men, which did not support the view that homosexuality per se was pathological.

Reprints of DSM-II, from July 1974 onwards, referred to 'sexual orientation disturbance [homosexuality]'. A 'special note – seventh printing' referred to the vote of the Board of Trustees in December 1973 'to eliminate Homosexuality per se as a mental disorder and to substitute therefore a new category titled Sexual Orientation Disturbance'. The note also referred to that decision having been 'upheld by a substantial majority in a referendum of the voting members of the Association' in May 1974.

The definition of 'sexual orientation disturbance [homosexuality]' in the seventh and subsequent reprints of DSM-II was:

This is for individuals whose sexual interests are directed primarily towards people of the same sex and who are either disturbed by it, in conflict with, or wish to change their sexual orientation. This diagnostic category is distinguished from homosexuality, which by itself does not constitute a psychiatric disorder. Homosexuality per se is one form of sexual behavior, and with other forms of sexual behavior which are not by themselves psychiatric disorders, are not listed in the nomenclature.

During the preparation of DSM-III, which was published in 1980, there was further debate among American psychiatrists over the inclusion of a diagnosis for homosexuals distressed over their sexual orientation. The edited correspondence in relation to that debate has been published. The final result was that in DSM-III, on Axis I, the diagnostic class of 'Psychosexual Disorders' included the category of 'Ego-dystonic Homosexuality' among the 'Other psychosexual disorders' group. The diagnostic criteria for 'Ego-dystonic Homosexuality' were:

- A. The individual complains that heterosexual arousal is persistently absent or weak and significantly interferes with initiating or maintaining wanted heterosexual relationships.
- B. There is a sustained pattern of homosexual arousal that the individual explicitly states has been unwanted and a persistent source of distress.

In DSM-III-R, published in 1987, the group of ‘Psychosexual Disorders’ was renamed ‘Sexual Disorders’.

The diagnosis of ‘Ego-dystonic Homosexuality’ was dropped from the classification. There was only one diagnosis listed under the heading ‘Other sexual disorders’, namely ‘Sexual Disorder Not Otherwise Specified’ (code 302.90). It was described in the following terms:

Sexual Disorders those are not classifiable in any of the previous categories. In rare instances, this category may be used concurrently with one of the specific diagnoses when both are necessary to explain or describe the clinical disturbance.

Examples:

- (1) Marked feelings of inadequacy concerning body habitus, size and shape of sex organs, sexual performance, or other traits related to self-imposed standards of masculinity or femininity
- (2) Distress about a pattern of repeated sexual conquests or other forms of nonparaphilic sexual addiction, involving a succession of people who exist only as things to be used
- (3) Persistent and marked distress about one’s sexual orientation.

DSM-IV, published in 1994, once more changed the name of the major grouping that had contained sexual disorders into ‘Sexual and Gender Identity Disorders’. With reference to the diagnosis of ‘Sexual Disorder Not Otherwise Specified’, it was stated that ‘it is important to note that notions of deviance, standards of sexual performance, and concepts of appropriate gender role can vary from culture to culture’.

The diagnosis of ‘Sexual Disorder Not Otherwise Specified’ (code 302.9) was retained in DSM-IV, with the following description:

This category is included for coding a sexual disturbance that does not meet the criteria for any specific Sexual Disorder and is neither a Sexual Dysfunction nor a Paraphilia. Examples include:

- 1 Marked feelings of inadequacy concerning sexual performance, or other traits related to self-imposed standards of masculinity or femininity
- 2 Distress about a pattern of repeated sexual relationships involving a succession of lovers who are experienced by the individual only as things to be used
- 3 Persistent and marked distress about sexual orientation

The current edition, DSM-IV-TR (Text Revision), published in 2000, retained the category of ‘Sexual and Gender Identity Disorders’. Similarly, the diagnosis of ‘Sexual Disorder Not Otherwise Specified’ (code 302.9) was retained, with the clinical description that is identical with DSM-IV [97].

10. Debate and Discussion

The current global trend toward democratization provides an opportunity for health improvement in developing countries. Many countries are now experiencing an expansion of the competitive political market along with economic liberalization. These democratic trends alone, however, may not necessarily lead to better health for the population. It is therefore important to examine the relationship between democracy and health in developing countries [101].

Most Democratic governance with a negative effect on population health, Health spending fell across the European Union in 2010, as cash-strapped governments curbed outlays to help cut budgetary deficits [102].

The report cautions that the reduction or slowdown in spending in nearly all EU countries may have a long-term impact on health care outcomes.

This Study indicated that, the increasing cost of medical technology, Wasteful spending, the growing burden of chronic diseases and the growing burden of infectious diseases, as well as Health Insurer Fee VS cost of health coverage results the significantly increasing of life expectancy.

Example: Life expectancy in the U.S. reached 77.9 years in 2007, up significantly from 62.9 years in 1940.

Joan Tallada; Consultant, Health Policy & Economics, Global Public Health expert said that, higher health expenditure is not necessarily linked to better health outcomes [103]. Actually, if we pay attention not to mediated factors such as health expenditure but to direct health outcomes such as life expectancy, democratic countries have overwhelmingly much better outcomes: Best Example; [104].

Zelalem Kiros Bitsue PhD, Immunologist and Global Public Health expertise and Biomedical Sciences Researcher, Founder and General Director of United States of African Health Organization Said that, Higher health expenditure is necessarily linked to better health outcomes. for example Health expenditures have a statistically significant effect on infant mortality and under-five mortality. For African countries, our results imply that total health expenditures (as well as the public component) are certainly important contributor to health outcomes [105].

Dr Zelalem Kiros, Adding while raising more money for health is crucial for lower-income countries striving to move closer to universal coverage, it is just as important to get the most out of the resources available. Finding the most efficient ways to meet the multiple challenges health systems face is also an issue for those countries that might be struggling to sustain high levels of coverage in the face of constantly increasing costs and growing demand [106].

Joan Tallada said that,

In wealthy nations, child mortality is linked to income inequality more than health expenditure. Again, the US has the higher health expenditure but also the highest income inequality, and hence, the highest under-five mortality amongst wealthy nations: [107].

Dr Zelalem Kiros, Said that,

When we consider European and America (amongst wealthy nations) has higher health expenditure, however highest rate of under-five mortality and In Africa has low health expenditure and highest rate of under-five mortality.

Amongst wealthy nations Global health laws neglected due to International laws (Democracy). On the other hand in Africa the International laws not contradict with Global Public health laws, but health expenditure is too low due to that highest rate of under-five mortality.

Joan Tallada said that,

In Mozambique, life expectancy has increased despite ramping HIV pandemic: [108].

This has gone in parallel to economic blooming due to mining industry - which promotes both (unequal) growth and HIV drivers: [109]

Dr Zelalem Kiros, Said that,

In countries with high [infant mortality] rates, the life expectancy at birth is highly sensitive to the rate of death in the first few years of life. Because of this sensitivity to infant mortality, simple life expectancy at age zero can be subject to gross misinterpretation, leading one to believe that a population with a low overall life expectancy will necessarily have a small proportion of older people Life expectancy "The global life expectancy has increased from 64 years in 1990 to 70 years in 2011. That's dramatic [110].

Life expectancy has fallen in North Korea, South Africa, Lesotho, Zimbabwe and Libya since 1990, a year that serves as the baseline for the United Nations Millennium Development Goals. Global Life Expectancy: Life Spans Continue To Lengthen Around. [111].

Since 1990, life expectancy at birth has increased globally by 6 years, but during the 1990s the value in Europe has showed as stagnation, and in Africa it has even decreased. For Europe, the phenomenon is due mainly to adverse mortality trends in the former Soviet Union countries. The decrease in Africa has been caused by HIV/AIDS, but the increasing availability of antiretroviral therapy has reduced the spread of the epidemic, and the mortality due to HIV/AIDS has been decreasing since about 2005, allowing life expectancy at birth to increase again: average life expectancy at birth in Africa, was 50 years in 2000, whereas it was 56 years in 2011. Life expectancy, Global Health Observatory (GHO) [112].

Globally, around 54.5 million people die each year. One in eight of these deaths occur in children under the age of 5. Most of these preventable deaths in children occur in low- and middle-income countries [113].

Life expectancy is globally varied from time to time. This is due to various factors, but the major causes of life expectancy natural disaster, war, diseases and nutritional diet. WHO have been working hard in this matter as we have seen almost all strategies are for prevention and treatment. But that means not mean Life expectancy increase.

“Have you ever dried a tree, while cutting from the stem?” We have to focus on our root cause of the challenges to increasing life expectancy. Otherwise while we have half of the population infected by several diseases, if you say life expectancy increase, my question is where and, how?

Joan Tallada said that,

Except for South Africa, where HIV is mainly driven by unprotected heterosexual sex, all countries where gay marriage is accepted have much lower rates of HIV prevalence than Sub-Saharan African countries where homosexuality / egalitarian marriage is forbidden.

Dr Zelalem Kiros, Said that,

Sub Saharan African health problem is not at all Abnormal Sexual Character (Homosexuality, Bisexuality and Heterosexuality), it's true that our women do sell their body due to they have economy problem. But our major problems are Economy and education but in European and like America are not economy, the problem is Abnormal Sexual Character (Homosexuality, Bisexuality and Heterosexuality). The fact that Europeans and American Abnormal Sexual Character (Homosexuality, Bisexuality and Heterosexuality), particularly gays marriage law contradict Global Health laws but African Law not contradict Global health Laws,

Joan Tallada said that,

Actually, the majority of people having anal sex is heterosexual, which makes sense: women have a rectum too. Unprotected anal intercourse may lead to disease, whatever the type of couple:

Heterosexual anal intercourse among community and clinical settings in Cape Town, South Africa [114].

Spreading of sexually transmitted diseases in heterosexual populations [115].

Anal Intercourse among Young Heterosexuals in Three Sexually Transmitted Disease Clinics in the United States [116].

Unprotected anal intercourse and sexually transmitted diseases in high-risk heterosexual women [117].

Dr Zelalem Kiros, Said that,

Overt sexual harassment of girls remains a problem, especially at township schools. Interviewees attributed this behavior to the need for boys to prove themselves in front of their peers. "For boys, sex is still a huge conquest thing," said one teacher.

Similar conclusions from other Southern African countries were presented at the conference.

In Malawi, a survey among 3,000 students in 50 secondary schools by Population Services International reported that the mean age for a first sexual encounter among boys was under 15 and just over 15 for girls. Nearly half of the girls and three-quarters of the boys were sexually active. Risk perception, however, was low: 47 percent of girls and 43 percent of boys expressed no concern about becoming infected with HIV.

According to the Southern Africa HIV/AIDS Information Dissemination Service, boys in the region start experimenting with sex as early as aged 10 or 12, marry later than women and spend more time unmarried, experimenting with many sexual partners and becoming vulnerable to sexually transmitted diseases and HIV. IRIN Africa | SOUTH AFRICA: Focus on the "burden" of manhood [118],

South Africa grouped amongst those wealthy nations as to compare to remain Africa countries However, Democracy in South Africa not as president Nilson mandela deserved.

International laws contradict with Global Public Laws highly in democratic republic of South Africa. Due to that our women highly in burden in South Africa, crime high in South Africa and mortality rate under five and women high in South Africa. Additional info.

Deaths and Mortality

(Data are for the U.S. and are final 2010 data; For the most recent preliminary data see Deaths: Preliminary Data for 2011, [119].

Mortality and causes of death in South Africa, 2008 - Statistics South [120].

<http://www.statssa.gov.za/publications/P03093/P030932008.pdf>

Estimated HIV prevalence among South Africans, by age and sex, 2008

Reported deaths from all causes, 1997 to 2008, South Africa HIV & AIDS Statistics – Avert, [121].

Joan Tallada asked,

Consistently, you think that because heterosexual people with HIV have sex with other heterosexual people, this makes heterosexuality abnormal or a mental disease, am I right?

Dr Zelalem Kiros, answered,

Homosexuality, Bisexuality and Heterosexuality are Abnormal Sexual Character, as you have seen in the above terminology.

Joan Tallada said that,

You mean normal is normal. Not hetero, no homo, no bisexual - just normal. Well, if everyone is entitled to define normality, as you are, I think we have reached an agreement: normal is normal according to one's own definition of wellbeing - which includes sexual self-determination.

Dr. Zelalem Kiros, said that,

Normal means Normal one man for one woman, when we have such a wonderful enjoyment in a proper (normal) way. By the way have you ever think about “The Value of A Woman's Love?”

Joan Tallada asked,

In which peer-reviewed health journal was "The Value of Women's Love" published?

Dr Zelalem Kiros, answered,

Some of peer-reviewed by health journals:

Sexual Addiction & Compulsivity

The Journal of Treatment & Prevention

Now being understood and treated as a significant and widespread disorder, sexual addiction and compulsivity is an enormously complex problem that requires a multidisciplinary approach from psychiatrists, psychologists, social workers, family therapists...Published by Routledge

American Journal of Sexuality Education

Endorsed by the American Association of Sexuality Educators, Counselors and Therapists (AASECT)

The American Journal of Sexuality Education speaks directly to the distinct, professional needs of sexuality educators and trainers. This peer-reviewed journal provides sexuality educators and trainers with current research about sexuality education...Published by Routledge

International Journal of Sexual Health

As the official journal of the World Association for Sexual Health, the International Journal of Sexual Health promotes sexual health as a state of physical, emotional, mental, and social well-being through a positive approach to sexuality and sexual... Published by Routledge

The Journal of Sex Research

Impact Factor now 2.532 Now ranked 2/89 in Social Sciences, Interdisciplinary and 26/110 in Psychology, Clinical © 2012 Thomson Reuters, 2011 Journal Citation Reports® The Journal of Sex Research (JSR) is a scholarly journal devoted to...

Marriage & Family Review

Marriage & Family Review publishes a mix of open submission articles as well as thematic issues that bring together the most current research, practice, advances in theory development, and applications of knowledge on a particular topic in the... Published by Routledge

Family Science

Global Perspectives on Research, Policy and Practice

The journal's vision is to become the leading international outlet for reporting research on the family. It will facilitate a greater understanding of the diversity of the family in all its forms and contribute to the knowledge base that...Published by Routledge

As well as

A higher level of physiological arousal when speaking to the more attractive, opposite-sex target. Women have sex to cure headaches, get men to put out the trash, and a million other reasons Source: physorg.com

From International Journal of Sexual Health, Volume 20, Issue 4, 4 Agu 2012

Health Benefits of Having Sex, Slide 1 of 11, By Jocelyn Voo

From Fitness Magazine

No wonder they miss sex when it disappears. It's a way for them to be aggressive and manly but also tender and vulnerable. "For some men, sex may be their primary way of communicating and expressing intimacy," says Justin Lehmilller, a Harvard University social psychologist who studies sexuality. Taking away sex "takes away their primary emotional outlet."

Apu 2013 – A study on a healthy sex life ...From - Wall Street Journal

Brian McKenzie, Global public health expertise suggest that,

So 'Democracy' is bad for the global health.....

Lets just ignore the MILLIONs executed in the last century in Genocides led by Socialist governments (be the flavor National Socialists or Soviet Socialists)

and in the first batch they always round up for killing and extermination ?.... homosexuals.

History - go read some.

Totalitarian Despotic Dictators, and Theological Oligarchs aren't kind with their genocide measures either.

PS - we are not supposed to be a Democracy in the US - we are supposed to be a Constitutional Representative Republic: though you wouldn't know it looking at the current state of affairs

Dr Zelalem Kiros, said that,

Brian McKenzie, you said in the last century Genocide worse. I disagree and said know days Genocides worse than last century genocide, this Genocide not direct by heavy weapon like in the last century, it is by indirect Weapon(Infectious Diseases). You question is who kill who? My answer is people kill people through infectious diseases due to they have freedom/Democracy to spread diseases. There is no law for them when they kill people by the indirect way.

Dr Zelalem Kiros, asked to Brian McKenzie,

My question for you is give me a statically evidence during in the last century Genocide direct by Heavy weapon how many mortality and How long the war? And now days Genocide indirect by Infectious Diseases how many Mortality and morbidity, for how long?

Brian McKenzie, said has no answer

Joan Tallada said that,

So timely for our discussion:

Better Health, Better Human Rights, by Mark Dybul: [122]

Brave OAS resolution on Human Rights [123].

Joan Tallada,said that,

You have provided no a single piece of evidence so far that shows that gay marriage is bad for health - or global public health laws, using your terminology.

Dr. Zelalem Kiros, said that,

You said, you have provided no a single piece of evidence global public health laws. I have gave to you this WHO laws about Abnormal sexual character (gay/homosexuality, Heterosexuality and bisexuality So is it not evidence?

There are currently two widely established systems that classify mental disorders;

- 'ICD-10 Chapter V: Mental and behavioural disorders, since 1949 part of the International Classification of Diseases produced by the WHO,
- The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) produced by the American Psychiatric Association (APA) since 1952 [124].

Joan Tallada said that,

Dr Zelalem, for studies showing that gay marriage may in fact reduce HIV and other health problems, and on the contrary, banning gay marriage is bad for health, see here:

Law Of Consequences: Gay Marriage Bans Increase HIV Infection [125]

The Effects of Same-Sex Marriage Laws on Public Health and Welfare [126].

Marriage Equality Is Good for Public Health [127].

For conservative political support for gay marriage based on health reasons, see here [128].

Dr. Zelalem Kiros, said that,

In a new series of papers, “HIV in Men Who Have Sex with Men”, Lancet delves deeply into the root causes of the HIV pandemic among homosexuals, analyzing the biological, behavioral, and structural risks that affect men having sex with men. Fri Aug 03, 2012 11:25 EST [129].

The World Health Organization's ICD-9 (1977) listed homosexuality as a mental illness. Homosexuality and psychology - Homosexuality in ancient Greece.

Even if WORLD Health Organization removed this law 1992, WORLD Health Organization, however, still includes homosexuality as a medical diagnosis in the International Classification of Diseases [130].

Dr. Zelalem Kiros, added more scientific based evidence

Gay, bisexual, and other men who have sex with men (MSM) are more severely affected by HIV than any other group in the United States. Read more about prevention challenges for MSM and what CDC is doing to address them in HIV Among Gay and Bisexual Men [131].

Jun 3, 2013 – CDC – Gay, Bisexual and other MSM – Gender – Risk – HIV/AIDS

Percentage of Homosexual Infected is much higher than non-homosexual Population.

Statistics on HIV/AIDS and percentage of population infected | what [104].

Feb 20, 2013 –... gay men are a group particularly at risk of HIV and sadly more men in this. After the gay marriage bill, news of a rise in HIV infections in gay [132].

The prevalence of HIV among men who have sex with men (MSM) in Harbin has been rapidly increasing in the past few years. by L Zhang - 2013 - Prevalence of HIV Infection and Associated Risk Factors among [133].

Men who have sex with men (MSM) are marginalized, hidden, underserved and at high risk for HIV in Nepal. by K Deuba – 2013 Psychosocial Health Problems Associated with Increased HIV Risk [134].

June 09, 2013; among groups identified at higher risk for infection, only among gay and bisexual men is the rate of new infections increasing HRC Issue Brief: HIV/AIDS and the LGBT Community | Resources [135].

HIV Status and High Risk Behavior of Men having Sex with Men JHAS, 2013, Vol. 3, No. 1 P 10-13 [136].

The figures show that HIV diagnosis rates among gay and bisexual men have increased by 160% between 2005 and 2012 and now represent 48% of all new HIV diagnoses. by Scott Roberts 10 June 2013, 12:55pm [137].

Finally, Joan Tallada more than three times agreed, and accepted during the discussion “Democracy is bad for Human Health, If Democracy contradict with Global Public Health Laws”. Moreover, Homosexuality, Bisexuality and Heterosexuality are Abnormal Sexual Character, Classified under mental disorder, sub classification of Personality Disorder; As well as International Laws, Global Public Health Laws, and Religious Laws have been contradicting each other

Dr Zelalem Kiros, reached to the Conclusion

11. Conclusion

The increasing the number of abnormal sexual character (Homosexuality, Bisexuality and Heterosexuality) in modern generation clearly seen, this is the outcome of democracy for bad practice. While I was 7 years old my question was to my dad, what is makes man, human? My question stills the same even stronger...

The issue is we African, either democrat or non-democrat African countries, we obey Global public Health Laws and act according to. What I mean is we give freedom and right for HIV patient as Global public Health Laws. But this Law leads us to the worst. From time to time the spread is increase. Therefore we ask some Laws to improve based on evidence as strategies to control and eradicate the diseases.

The increasing cost of medical technology, Wasteful spending, the growing burden of chronic diseases and the growing burden of infectious diseases, as well as Health Insurer Fee VS cost of health coverage results the significantly increasing of life expectancy.

Life expectancy is globally varied from time to time. This is due to various factors, but the major causes of life expectancy natural disaster, war, diseases and nutritional diet. WHO have been working hard in this matter as we have seen almost all strategies are for prevention and treatment. But that means not mean Life expectancy increase.

Don't misunderstand us, Most African countries are a democrat, even if democracy varied from country to country in the world. But we have to ask to stop bad practice

International laws, Global public Health Laws, Religious laws and cultural laws, therefore those laws without contradict, if they work together as one easily global health challenges reduce.

We have equaled right and freedom before Laws. And we have to obey the Laws and act under the Laws, in order to get good outcomes of diseases control, reduce morbidity, mortality. Moreover, significance increase life expectancy, Economy, peace and improve Health status around the globe.

Dr Zelalem Kiros, gave recommendation,

“Democracy is good when we respect the Rule of laws and obey them”

Which comes first, Human Right? Or Human Duty and Responsibility?

Human Duty and Responsibility must be First and then Human Right

But;

1. Democracy is bad for human health, if democracy accepted bad practices among the population as freedom (e.g. new gay marriage laws).
2. Democracy is bad for human health, if democracy contradict with Global Public health Laws
3. Democracy is bad for human health, if democracy contradict with Religious and Cultural Laws

To solve the entire challenges in all direction improvement of Rule of laws is essentials, the recommendation highlighted how Rule of laws will be improved quite hectic but possible

12. Recommendation:

To address infectious diseases (ID) are accelerating, complexity is increasing and the importance of Laws is becoming more apparent. Understanding the powers, duties and constraints created by law is now essential. WHO should dramatically change its attitude toward Global Public Health Laws

The goal is Global Public Health Law practice among the population fully to solve global health challenges such us: morbidity and mortality moreover, to eradicate and control diseases. The increment of health expenditure and life expectancy without the practice of both international and Global Public Health laws has no effective outcome.

Our Global leaders must understand that without the practice of both International and Global Public Health Laws among the population we cannot control and eradicate diseases and make peace.

Due to international Law contradict with Global Public Health Laws crime and diseases increase as well as Morbidity and mortality Increase.

Democracy: defined that a social state all have equal rights which is implies the feeling of freedom, equally before the law and opportunities. But Democracy is not allowed for bad works (practice) freedom is not for bad practice which is hurt human life and health.

Global Public Health Laws (World Health Organization) “WHO” must create new laws as Global Public Health Laws on the bad practiced among population as culture and religion which are hurt human life and health. Such us: under age marriage without their interest, abnormal sexual character (mental Illness), and particularly for some diseases which are human carried them as an agent; new Global Public Health Laws are urgently needed.

Moreover give education and trains to the people on those new laws to practice Global Public Health Laws among the population for the benefits of their life and Health.

The practices of Global Public Health Laws not only to eradicate and control epidemic, pandemic diseases but also an essential tool to solve some political problem which are International Laws contradict with Cultural and religious Laws.

For Example: All religious and cultural laws work together with Global Public Health Laws, Those Religious and Cultural Leaders Easily understand and practiced the Global Public Health Laws among the followers due to the benefits of their life and health, and has more effective outcome than international Laws.

Global Leader must understand that Global Public Health Laws for outcome of both peace and Health. Therefore International Laws must improve to solve the contradiction with Global Public Health Laws, Moreover, Religious and Cultural Laws through Global Public Health Laws.

I mean International Laws must improve due to Global Public health laws; Global public Health Laws must Create new Laws due to eradicate and control epidemic, pandemic diseases and Political Peace as well as Religious and Cultural Laws must improve due to bad practice(work) which are cause a problem in human health and life.

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13. Abbreviations

Infectious diseases (ID)

Organization for Economic Cooperation and Development (OECD)

Global Health Law and Governance (GHG)

World Health Organization (WHO)

Center for Diseases Control (CDC)

European Union (EU)

Acquired Immunodeficiency Syndrome (AIDS)

Human Immunodeficiency Virus (HIV)

International Statistical Classification of Diseases and Related Health Problems (ICD)

Global Health Observatory (GHO)

14. Competing Interests

There is no compete of interest

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