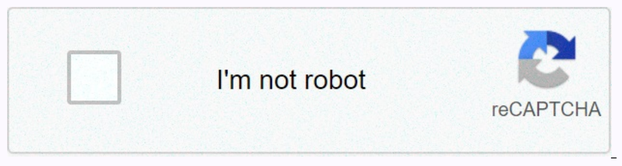

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A. i. d. s full form

× Sorry!, This page is not available to bookmark. The full form of AIDS is acquired immunodeficiency syndrome. Description AIDS can be explained as below, Acquired – Which means that you may become infected with it. Immunodeficiency – Points out the weakness of the immune system in the body. Syndrome – The symptoms of a group that creates disease. What is AIDS? AIDS is a disorder developed by human immunodeficiency virus (HIV) affecting the human immune system. AIDS can develop without symptoms for a long time. The first signs of this disorder can be a short stage of respiratory diseases such as fever, cough and fatigue. When the infection develops, it gradually disrupts the immune system, people suffering from the disease will become too vulnerable and more prone to serious infections such as tuberculosis, tumors, asthma, etc. STD The full form of STDs is sexually transmitted diseases. Description STD is a disorder also called STDs (VD) developed by viruses, bacteria and parasites. STD is a reproductive tract infection and spreads from one person to another through sexual contacts such as vaginal sex, sex and oral sex. AIDS stands for acquired immunodeficiency syndrome:A - Acquired. This condition is acquired, which means that a person becomes infected with it. I - Immuno. HIV affects a person's immune system, the part of the body that fights bacteria such as bacteria or viruses. D - Shortage. The immune system becomes deficient and does not function properly. S - Syndrome. A person with AIDS may experience other diseases and infections due to a weakened immune system. AIDS is the most advanced stage of infection caused by HIV. The names HIV and AIDS can be confusing because both terms describe the same disease. Most people living with HIV do not have AIDS. And most people with HIV will not develop AIDS if they start treatment (with medications called antiretroviral therapy or ART) shortly after becoming infected. A person living with HIV is said to have AIDS when their immune system becomes so weak that it cannot fight certain kinds of infections and cancers, such as PCP (a form of pneumonia), KS (Kaposi sarcoma, a type of cancer that affects the skin and internal organs), wasting syndrome (involuntary weight loss), memory impairment, or tuberculosis. Even without one of these infections, a person living with HIV is diagnosed with AIDS if their immune system weakens, as indicated by the number of CD4 cells. But again, it is important to remember that most people with HIV will not develop AIDS if they begin treatment shortly after becoming infected. AIDS and Aids redirect here. For other uses, see AIDS (ambiguity). Spectrum of conditions caused by HIV infection HIV / AIDSOther namesHIV disease, HIV infection[1][2]The red ribbon is a symbol of solidarity with HIV-positive people and those living with AIDS. [3] SpecialtyInfectious Disease, ImmunologySympttomsEarly: Influenza-like Disease[4]Later: Large Lymph Nodes fever, weight loss[4]ComplicationsOpportunistic infections, tumors[4]DurationLifelong[4]CausesHuman immunodeficiency virus (HIV)[4]Risk factorsExposure for blood, breast milk, sex[4]Diagnostic methodBlood tests[4]PreventionSafe sex, sex prevention needle exchange, male circumcision, pre-exposure prophylaxis, prophylaxis after exposure[4]TreatmentAntiretroviral treatment[4]PrognosisNear normal life expectancy with treatment[5][6]11 years life expectancy without treatment[7]Frequency1,7 million new cases (2018)[8]37.9 million lives with HIV (2018)[8]Deaths770,000 (2018)[8] Human immunodeficiency virus infection and acquired immunodeficiency syndrome (HIV/AIDS) are a spectrum of conditions caused by infection with human immunodeficiency virus (HIV). [9] [10] [11] After initial infection a person may not notice any symptoms, or may experience a short period of flu-like illness. [4] Typically, this is followed by a prolonged period of no symptoms. [5] If the infection progresses, it interferes more with the immune system, increasing the risk of developing common infections such as tuberculosis, as well as other opportunistic infections, and tumors that are otherwise rare in people who have normal immune function. [4] These late symptoms of infection are called acquired immunodeficiency syndrome (AIDS). [5] This phase is often also associated with accidental weight loss. [5] HIV is spread primarily by unprotected sex (including anal and oral sex), contaminated blood transfusions, hypodermic needles, and from mother to child during pregnancy, childbirth, or breastfeeding. [12] Some bodily fluids, such as saliva, sweat and tears, do not transmit the virus. [13] HIV is a member of the group of viruses known as retroviruses. [14] Methods of prevention include safe sex, needle exchange programs, treatment of those who are infected, and pre-& post-exposure prophylaxis. [4] Disease in a child can often be prevented by giving both mother and child antiretroviral medication. [4] There is no cure or vaccine; however, antiretroviral therapy may delay the course of the disease and can lead to an almost normal life expectancy. [5] [6] Treatment is recommended as soon as the diagnosis is made. [15] Without treatment, the average survival time after infection is 11 years. [7] In 2018, about 37.9 million people lived with HIV, resulting in 770,000 deaths. [8] An estimated 20.6 million of these live in eastern and southern Africa. [16] Between the time AIDS was identified (in the early 1980s) and 2018, the disease caused an estimated 32 million deaths worldwide. [8] HIV/AIDS is considered a pandemic – an outbreak of disease that is present across a large area and is actively spreading. [17] HIV took the leap from other primates to humans in western Central Africa in the early to mid-20th century [18] AIDS was first recognized by the United States Centers for Disease Control and Prevention (CDC) in 1981, and the cause of the cause – HIV infection – was identified in the early part of HIV/AIDS has had a major impact on society, both as a disease and as a source of discrimination. [20] The disease also has major economic consequences. [20] There are many misconceptions about HIV/AIDS, such as the belief that it can be transmitted by random non-sexual contact. [21] The disease has become the subject of many controversies involving religion, including the Catholic Church's position not to support condom use as prevention. [22] It has attracted international medical and political attention as well as large-scale funding since it was identified in the 1980s. [23] Play media Video summary (script) Signs and symptoms Main article: Signs and symptoms of HIV/AIDS There are three capitals of HIV infection: acute infection, clinical latency, and AIDS. [1] [24] Acute infection Main symptoms of acute HIV infection The initial period after contraction of HIV is called acute HIV, primary HIV or acute retroviral syndrome. [24] [25] Many individuals develop a flu-like illness or mononucleosis-like disease 2-4 weeks after exposure, while others do not have any significant symptoms. [26] [27] Symptoms occur in 40-90% of cases and most often include fever, large tender lymph nodes, sore throat, rash, headache, fatigue, and/or sores in the mouth and genital ulcers. [25] [27] The rash, which occurs in 20-50% of cases, presents itself on the strain and is maculopapular, classical. [28] Some people also develop opportunistic infections at this stage. [25] Gastrointestinal symptoms such as vomiting or diarrhoea may occur. [27] Neurological symptoms of peripheral neuropathy or Guillain-Barré syndrome also occur. [27] The duration of symptoms varies, but is usually one or two weeks. [27] Due to their nonspecific nature, these symptoms are not often recognized as signs of HIV infection. Even cases that are seen by a family doctor or a hospital are often misdiagnosed as one of the many common infectious diseases with overlapping symptoms. Thus, it is recommended that HIV be considered in individuals who present with an unexplained fever that may have risk factors for the infection. [27] Clinical latency The first symptoms are followed by a stage called clinical latency, asymptomatic HIV or chronic HIV. [1] Without treatment, this second phase of the natural history of HIV infection can last from about three years[29] to over 20 years[30] (on average around eight years). [31] While there are typically few or no symptoms at first, near the end of this stage many people experience fever, weight loss, stomach problems and muscle pain. [1] Between 50% and 70% of the population also develop persistent generalized lymphdenopathy, characterized by unexplained, non-painful enlargement of more than one group of lymph nodes (except in the groin) for over three to six months. [24] Although most HIV-1 infected people have a detectable viral load and in the absence of treatment, eventually develop a small proportion (around 5%) maintain high high cd4+ T cells (T-help cells) without antiretroviral therapy for more than five years. [27] [32] These individuals are classified as HIV controllers or long-term non-violators (LTNP). [32] Another group consists of those who maintain a low or undetectable viral load without anti-retroviral therapy, known as elite controllers or elite suppressors. They represent about 1 in 300 people infected. [33] Acquired immunodeficiency syndrome Main symptoms of AIDS. Acquired immunodeficiency syndrome (AIDS) is defined as an HIV infection with either a CD4+ T cell count below 200 cells per µL or the incidence of specific diseases associated with HIV infection. [27] In the absence of specific treatment, about half of people infected with HIV develop within ten years. [27] The most common initial conditions that warn of the presence of AIDS are pneumocystis pneumonia (40%), cachexia in the form of HIV wasting syndrome (20%), and esophageal candidiasis.[27] Other common signs include recurrent respiratory infections. [27] Opportunistic infections can be caused by bacteria, viruses, fungi and parasites normally controlled by the immune system. [34] Which infections occur depends partly on which organisms are common in the person's environment. [27] These infections can affect almost all organ systems. [35] People with AIDS have an increased risk of developing various virus-induced cancers, including Kaposi's sarcoma, Burkitt's lymphoma, primary central nervous system lymphoma, and cervical cancer. [28] Kaposi's sarcoma is the most common form of cancer, occurring in 10% to 20% of people with HIV. [36] The second most common cancer is lymphoma, which is the cause of death for nearly 16% of people with AIDS and is the first sign of AIDS in 3% to 4%. [36] Both of these cancers are associated with human herpes virus 8 (HENHOLDSVIS-8). [36] Cervical cancer occurs more frequently in people with AIDS due to its association with human papillomavirus (HPV). [36] Conjunctival cancer (of the layer that lines the inner part of the eyelid and the white part of the eye) is also more common in those with HIV. [37] In addition, people with AIDS often have systemic symptoms such as prolonged fever, sweat (especially at night), swollen lymph nodes, chills, weakness and unintended weight loss. [38] Diarrhea is another common symptom, present in about 90% of people with AIDS. [39] They may also be affected by various psychiatric and neurological symptoms independent of opportunistic infections and cancer. [40] Transmission Average per action risk of getting HIVby exposure route to an infected source Exposure route Chance of infection Blood transfusion 90%[41] Birth (to child) 25%[42][clarification needed] Needle-sharing drug use 0.67%[43] Percutaneous needle stick 0.30%[44] Susceptible anal intercourse* 0.04-3.0%[45] Insert anal intercourse* 0.03%[46] Susceptible penis-vaginal intercourse* 0.05-0,30%[45][47] Insert thoughtful-vaginal intercourse* Susceptible oral intercourse * § § § 0-0.04%[45] Insert oral intercourse * § 0-0,005%[48] * assuming no condom use § source refers to oral intercourse performed on a man HIV is spread by three main routes: sexual contact, significant exposure to infected bodily fluids or tissues, and from mother to child during pregnancy, birth, or breastfeeding (known as vertical transmission). [12] There is no risk of getting HIV if exposed to feces, nasal drains, saliva, saliva, sweat, tears, urine or vomit, unless they are contaminated with blood. [49] It is also possible to be co-infected with more than one strain of HIV-a condition known as HIV superinfection. [50] Sexual The most common form of transmission of HIV is through sexual contact with an infected person. [12] However, an HIV-positive person who has a measurable viral load as a result of long-term treatment actually has no risk of transmitting HIV sexually. [51] [52] The existence of functionally non-corrosive HIV-positive people on antiretroviral therapy was controversially published in the 2008 Swiss Declaration, and has since been accepted as medical audio. [53] Globally, the most common form of HIV transmission is through sexual contacts between people of the opposite sex; [12] However, the transmission pattern varies from country to country. As of 2017[update], the most HIV transmission in the United States occurred among men who had sex with men (82% of new HIV diagnoses among men aged 13 and older and 70% of total new diagnoses). [54] [55] In the United States, gay and bisexual men aged 13-24 accounted for an estimated 92% of new HIV diagnoses among all men in their age group and 27% of new diagnoses among all gay and bisexual men. [56] About 15% of gay and bisexual men have HIV, while 28% of transgender women test positive in the United States. [56] [57] In the case of unprotected heterosexual contacts, estimates of the risk of HIV transmission per sexual act appear to be four to ten times higher in low-income countries than in high-income countries. [58] In low-income countries, the risk of transmission between women and men is estimated at 0.38% per action and for transfers between men and women at 0.30% per action. the corresponding estimates for high-income countries are 0.04% per act for transfers between women and men and 0.08% per action for transfers between men and women. [58] The risk of transmission from anal intercourse is particularly high, estimated at 1.4-1.7% per action in both heterosexual and gay contacts. [58] [59] While the risk of transmission from oral sex is relatively low, it is still present. [60] The risk of receiving oral sex has been described as almost zero; [61] however, a few cases have been reported. [62] The risk per action is estimated at 0-0.04% for susceptible sexual intercourse. [63] In environments involving prostitution in low-income countries, the risk of transmission between women and men has been estimated at 2.4% per action and of transfer between women as 0.05% per action. [58] The risk of transmission increases in the presence of many. Presence. infections[64] and sex wounds. [58] Sex ulcers appear to increase the risk approximately fivefold. [58] Other sexually transmitted infections, such as gonorrhea, chlamydia, trichomoniasis, and bacterial vaginosis, are associated with somewhat minor increases in the risk of transmission. [63] The viral load of an infected person is an important risk factor in both sexual and mother-to-child transmission. [65] During the first 2.5 months of an HIV infection, a person's infection density is twelve times higher due to the high viral load associated with acute HIV. [63] If the person is in the late stages of infection, the number of transfer rates is approximately eightfold. [58] Commercial sex workers (including those in pornography) are more likely to contract HIV. [66] [67] Rough sex may be a factor associated with an increased risk of transmission. [68] Sexual assault is also thought to lead to an increased risk of HIV transmission as condoms are rarely worn, physical trauma to the vagina or rectum is likely and there may be a greater risk of concurrent sexually transmitted infections. [69] Body fluids CDC poster from 1989 highlights the threat of AIDS associated with drug use The second most common form of HIV transmission is via blood and blood products. [12] Bloodborne transmission may be carried out through needle sharing during intravenous drug use, needlestick injury, transfusion of contaminated blood or blood product or medical injections with unterilized equipment. The risk of sharing a needle during injection of drugs is between 0.63% and 2.4% per action, with an average of 0.8%. [70] The risk of getting HIV from a needle stick from an HIV-infected person is estimated at 0.3% (about 1 in 333) per action, and the risk of exposure to infected blood in the mucous membrane is estimated at 0.09% (approximately 1 in 1000) per action. [49] This risk can, however, be up to 5% if the imported blood was from someone with a high viral load and the incision was deep. [71] In the United States, injecting drug users account for 12% of all new cases of HIV in 2009,[72] and in some areas more than 80% of people injecting drugs are HIV positive. [12] HIV is transmitted in about 90% of blood transfusions using infected blood. [41] In developed countries, the risk of getting HIV from a blood transfusion is extremely low (less than one in half a million), with better donor selection and HIV screening; [12] for example, [74] In low-income countries, only half of transfusions can be adequately screened (as of 2008),[75] and it is estimated that up to 15% of HIV infections in these areas come from transfusion of infected and blood products , which equates to between 5% and 10% of global infections. [12] [76] It is possible to acquire HIV from organ and tissue transplantation, although this is rare due to screening. [77] Unsafe medical injections role in HIV spread in sub-Saharan Africa. In 2007, between 12% and 17% of infections in this region were attributed to medical use of syringes. [78] The World Health Organisation estimates the risk of transmission from a medical injection in Africa at 1.2%. [78] Risks are also associated with invasive procedures, assisted delivery and dentistry in this area of the world. [78] Individuals who give or receive tattoos, piercings and scarification are theoretically at risk of infection, but no confirmed cases have been documented. [79] It is not possible for mosquitoes or other insects to transmit HIV. [80] Mother-to-child Main articles: HIV and pregnancy and HIV and lactation HIV can be transmitted from mother to child during pregnancy, during pregnancy, or through breast milk, resulting in the child also contracting HIV. [81] [12] As of 2008, vertical transmission accounted for approximately 90% of cases of HIV in children. [82] In the absence of treatment, the risk of transmission before or during childbirth is about 20%, and in those who also breastfeed 35%. [82] Treatment reduces this risk to less than 5%. [83] Antiretrovirals when taken by either the mother or child reduce the risk of transmission in those who are not breastfeeding. [84] If blood contaminates food during pre-chewing it may pose a risk of transmission. [79] If a woman is untreated, two years of breastfeeding results in an HIV/AIDS risk in her child of about 17%. [85] Due to the increased risk of non-laced deaths in many areas of developing countries, the World Health Organization recommends either exclusive breastfeeding or the provision of safe formula. [85] All women known to be HIV positive should take lifelong antiretroviral therapy. [85] Virology Main article: HIV Diagram of an HIV virion structure Scanning electron micrograph of HIV-1, colored green, emerging from a cultured lymphocyte. HIV is the cause of the spectrum of disease known as HIV/AIDS. HIV is a retrovirus that primarily infects components of the human immune system such as CD4+ T cells, macrophages and dendritic cells. It directly and indirectly destroys CD4+ T cells. [86] HIV is a member of the genus Lentivirus,[87] part of the Retroviridae family. [88] Lentivirus has many morphological and biological properties. Many species of mammals are infected with lentivirus, which are characteristically responsible for long-term diseases with a long incubation period. [89] Lentivirus is transmitted as single-stranded, positive and imagitable RNA viruses. Upon entry into the target cell, the viral RNA genome (inverted transcritified) is converted into double-stranded DNA by a virally encoded reverse transcription carried along with the viral genome of the viral particle. The resulting viral DNA is then imported into the cell nucleus and integrated into cellular DNA by a virally encoded integrase and host co-factors. [90] Once integrated, the virus can become latent, allowing the virus and its to avoid detection by the immune system. [91] Alternatively, the virus can be transcribed and produce new RNA genomes and viral proteins that are packaged and released from the cell as new virus particles that begin the replication cycle anew. [92] HIV is now known to spread between CD4+ T cells with two parallel routes: cell-free spread and cell-to-cell proliferation, i.e. [93] In the cell-free spread, viral particles bud from an infected T cell, enter blood/extracellular fluid and then infect another T-cell after a chance encounter. [93] HIV can also be spread by direct transmission from one cell to another by a process of cell-to-cell proliferation. [94] [95] The hybrid spread mechanisms for HIV contribute to the virus's ongoing replication against antiretroviral treatments. [93] [96] Two types of HIV have been characterized: HIV-1 and HIV-2. HIV-1 is the virus that was originally detected (and originally also referred to as LAV or HTLV-III). It is more malignant, more infectious,[97] and is the cause of most HIV infections globally. The lower infectivity of HIV-2 compared to HIV-1 implies that fewer people exposed to HIV-2 will be infected per exposure. Due to its relatively low infectivity, HIV-2 is largely confined to West Africa. [98] Pathophysiology Main article: Pathophysiology of HIV/AIDS Play media hiv/AIDS explained in a simple way HIV replication cycle After the virus enters the body there is a period of rapid viral replication, leading to an abundance of viruses in the peripheral blood. During primary infection, levels of HIV can reach several million virus particles per milliliter of blood. [99] This response is accompanied by a significant decrease in the number of circulating CD4+ T cells. The acute viremia is almost always associated with activation of CD8+ T cells, which kill HIV-infected cells, and subsequently with antibody production, or seroconversion. The CD8+ T cell response is thought to be important in controlling virus levels which peak and then decrease, as cd4+ T cell counts recover. A good CD8+T cell response has been associated with slower disease progression and a better prognosis, although it does not remove the virus. [100] Ultimately, HIV causes AIDS by breaking down CD4+ T cells. This weakens the immune system and allows opportunistic infections. T-cells are essential for immune response and without them, the body cannot fight infections or kill cancer cells. The mechanism of CD4+ T cell thinning differs in the acute and chronic phases. [101] In the acute phase, HIV-induced cell lysis and the killing of infected cells of CD8+ T cells account for CD4+ T cell thinning, although apoptosis may also be a factor. In the chronic phase, the consequences of generalized immune activation combined with the gradual loss of the immune system's ability to generate new T cells seem to account for the slow decline in CD4+ T cell numbers. [102] Although immunodeficiency characteristic of AIDS does not appear for years after a person is infected, the majority of CD4+ T cell loss occurs during the first weeks of infection, especially in the intestinal mucosa, which houses the majority of lymphocytes found in the body. [103] The reason for the preferential loss of mucosal CD4+ T cells is that the majority of mucosal CD4+ T cells express the CCR5 protein that HIV uses as a co-receptor to access the cells, while only a small fraction of CD4+ T cells in the bloodstream do so. [104] A specific genetic change that alters the CCR5 protein when found in both chromosomes very effectively prevents HIV-1 infection. [105] HIV seeks out and destroys CCR5 expressing CD4+ T cells during acute infection. [106] A strong immune response ultimately controls the infection and initiates the clinically latent phase. CD4+ T cells in mucous tissue remain particularly affected. [106] Continuous HIV replication causes a state of generalized immunoactivation that persists throughout the chronic phase. [107] Immune activation, which is reflected by the increased activation state of immune cells and the release of pro-inflammatory cytokines, is due to the activity of several HIV gene products and the immune response to ongoing HIV replication. It is also associated with the breakdown of the immune system of gastrointestinal mucosal barrier caused by thinning of mucous CD4+ T cells in the acute phase of the disease. [108] Diagnosis Main article: Diagnosis of HIV/AIDS A generalized graph of the relationship between HIV copies (viral load) and CD4+ T cell counts above the average course of untreated HIV infection. CD4+ T Lymphocyte count (cells/mm³) HIV RNA copies per ml of plasma Days after exposure is necessary for, the test is accurate[109] Blood test days Antibody test (rapid test, ELISA 3. gene) 23-90 Antibody and P24 antigen tests (ELISA 4. gene) 18-45 PCR 10-33 HIV/AIDS are diagnosed through laboratory studies and then staged based on the presence of certain signs or symptoms. [25] HIV screening is recommended by the United States Preventive Services Task Force for all people ages 15 years to 65 years, including all pregnant women. [110] In addition, testing is recommended for people at high risk, which includes anyone diagnosed with a sexually transmitted disease. [28] [110] In many areas of the world, a third of HIV carriers only discover that they are infected at an advanced stage of the disease when AIDS or severe immunodeficiency has become apparent. [28] HIV testing HIV testing administered Oraquick Most people infected with HIV develop specific antibodies (i.e. seroconvert) within three to twelve weeks of the first infection. [27] Diagnosis of primary HIV before seroconversion is done by measuring HIV-RNA or p24 antigen. [27] Positive results obtained from antibody or PCR tests are confirmed either by another antibody or by PCR. [25] Antibody tests in children under 18 months of age are inaccurate due to the continued presence of antibodies. [111] Hiv infection can only be diagnosed by PCR tests for HIV RNA or DNA or by testing for the p24 antigen. [25] Much of the world lacks access to reliable PCR testing, and people in many places simply wait until either the symptoms develop or the child is old enough for accurate antibody testing. [111] In sub-Saharan Africa between 2007 and 2009, between 30% and 70% of the population were aware of their HIV status. [112] In 2009, between 3.6% and 42% of men and women in sub-Saharan Africa were tested. [112] this represented a significant increase on previous years. [112] Classifications Two main clinical staging systems are used to classify HIV- and HIV-related diseases for surveillance purposes: the WHO HIV infection and disease resurning system,[25] and the CDC classification system for HIV infection. [113] The CDC classification system is more often adopted in developed countries. As the WHO staging system does not require laboratory testing, it is suitable for the resource-constrained conditions that arise in developing countries, where it can also be used to guide clinical management. Despite their differences, the two systems make it possible to compare them for statistical purposes. [24] [25] [113] The World Health Organisation first proposed a definition of AIDS in 1986. [25] Since then, the WHO classification has been updated and expanded several times, [25] The WHO system uses the following categories: Primary HIV infection: May either be asymptomatic or associated with acute retroviral syndrome[25] Phase I: HIV infection is asymptomatic with a CD4+ T cell count (also known as CD4 number) greater than 500 per microliter (μl or cubic mm) of blood. [25] May includes generalized lymph node enlargement. [25] Phase II: Mild symptoms, which may include minor mucokutane manifestations and recurrent upper respiratory tract infections. A CD4 number of less than 500/μl[25] Step III: Advanced symptoms, which may include unexplained chronic diarrhea for longer than a month, serious bacterial infections, including tuberculosis in the lungs, and a CD4 count of less than 350/μl[25] Stage IV or AIDS: severe symptoms that include toxoplasmosis in the brain, candidiasis of the esophagus, trachea, bronchi, or lungs, and Kaposi's sarcoma. A CD4 count of less than 200/μl[25] The U.S. Centers for Disease Control and Prevention also established a HIV classification system and updated it in 2008 and 2014. [113] [114] This system classifies HIV infections based on CD4 numbers and clinical symptoms and describes the infection in five groups. [114] In these over six years it is:[114] Phase 0: the time between a negative or indefinite HIV test followed less than 180 days of a positive test. Phase 1: CD4 counts ≥ 500 cells/μl and no AIDS defining conditions. Phase 2: CD4 counts 200 to 500 and no one Conditions. Phase 3: CD4 counts ≤ 200 cells/μl or AIDS-defining conditions. Unknown: if there is insufficient information to make any of the above classifications. For monitoring purposes, aids diagnosis is still available, although the CD4+ T cell count after treatment increases to over 200 per µL of blood or other AIDS-defining diseases. [24] Prevention Main article: Prevention of HIV/AIDS Clinic, McLeod Ganj, Himachal Pradesh, India, 2010 Sexual Contact People wearing AIDS awareness signs. left: Facing AIDS one condom and one pill at a time; right: I'm facing AIDS because people I ♥ are infected. Consistent condom use reduces the risk of HIV transmission by approximately 80% in the long term. [115] When condoms are used consistently by a couple where a person is infected, the rate of HIV infection is less than 1% per year. [116] There is evidence that female condoms may provide an equivalent level of protection. [117] Using a vaginal gel containing tenofovir (an inverted transcription inhibitor) immediately before sex appears to reduce the infection rate by about 40% among African women. [118] By contrast, the use of nonoxynol-9 spermicide may increase the risk of transmission due to its tendency to cause vaginal and rectal irritation. [119] Circumcision in sub-Saharan Africa reduces the acquisition of HIV by heterosexual men by between 38% and 66% over 24 months. [120] Because of these studies, both the World Health Organization and UNAIDS recommended male circumcision in 2007 as a method of preventing female-to-male HIV transmission in areas with high HIV rates. [121] However, it is undisputed whether it protects against transmission from man to woman,[122][123] and whether it is beneficial in developed countries and among men who have sex with men without agreement. [124] [125] [126] However, the International Antiviral Society recommends it for all sexually active heterosexual men and that it should be discussed as an option with men who have sex with men. [127] Some experts fear that a lower perception of vulnerability among circumcised men may cause more sexual risk-taking behavior, and thus negating its preventive effects. [128] Programmes that encourage sexual abstinence do not appear to affect the subsequent HIV risk. [129] Proof of any benefit of peer training is just as bad. [130] Comprehensive sex education in school can reduce high-risk behaviour. [131] [132] A significant minority of young people continue to engage in high-risk practices, even though they know about HIV/AIDS, and underestimate their own risk of being infected with HIV. [133] Voluntary advice and testing of HIV does not affect risky behaviour in those who test negatively, but increases condom use in those who test positively. [134] Improved family planning services appear to increase the likelihood of women with HIV using contraception compared to basic services. [135] It is known on the treatment of other infections are effective in preventing HIV. [64] Antiretroviral treatment before exposure among people infected with HIV, whose CD4 numbers ≤ 550 cells/µL is a very effective way to prevent HIV infection in their partner (a strategy known as prevention or TASP). [136] TASP is associated with a 10- to 20-fold increase in transmission risk. [136] [137] Pre-exposure prophylaxis (PrEP) with a daily dose of medication tenofovir, with or without emtricitabine, is effective in people at high risk, including men who have sex with men, couples who are HIV positive, and young heterosexuals in Africa. [118] [138] It may also be effective in injecting drug users, with one study finding a decrease in risk of 0.7 to 0.4 per 100 person years. [139] In 2019, the USPSTF recommended PrEP in those at high risk. [140] Universal health measures are thought to be effective in reducing the risk of HIV. [141] Injecting drug use is an important risk factor, and harm reduction strategies such as needle exchange programmes and opioid substitution treatment seem effective in reducing this risk. [142] [143] After exposure A course of antiretroviral drugs administered within 48 to 72 hours of exposure to HIV-positive blood or sex saffler is referred to as post-exposure prophylaxis (PEP). [144] The use of the individual drug zidovudine reduces the risk of an HIV infection five times after a needlestick injury. [144] As of 2013[update], the prevention regimen recommended in the United States consists of three medications-tenofovir, emtricitabine and raltegravir-as this can reduce the risk further. [145] PEP treatment is recommended after a sexual assault when the perpetrator is known to be HIV positive, but is controversial when their HIV status is unknown. [146] The duration of treatment is usually four weeks[147] and is often associated with adverse reactions – using zidovudine results in approximately 70% of cases of side effects such as nausea (24%), fatigue (22%), emotional distress (13%) headache (9%).[49] Mother-to-child Main article: HIV and pregnancy Programs to prevent vertical transmission of HIV (from mothers to children) can reduce transmission by 92-99%. [82] [142] This involves primarily the use of a combination of antiviral medications during pregnancy and after birth in the infant, and potentially includes bottle feeding rather than breastfeeding. [82] [148] If replacement feeding is acceptable, feasible, affordable, sustainable and safe, mothers should avoid breast-feeding their infants; however, excluding breastfeeding is recommended in the first months of life, if this is not the case. [149] If exclusive lactation is performed, the delivery of extended antiretroviral prophylaxis to the infant reduces the risk of transmission. [150] In 2015, Cuba became the first country in the world to eradicate the transmission of HIV from mother to child. [151] Vaccination Main article: HIV vaccine there is no approved vaccine against HIV or AIDS. [6] The most effective vaccine trial to date, RV 144, was published in 2009; it found a partial reduction in the risk of transmission of around 30%, which stimulated some hope in the scientific community to develop a truly effective vaccine. [152] Further trials of the RV 144 vaccine are ongoing. [153] [154] Treatment Main Article: Managing HIV/AIDS There is currently no cure, or an effective HIV vaccine. Treatment consists of very active antiretroviral therapy (HAART), which delays the development of the disease. [155] As of 2010[update] more than 6.6 million people received this in low- and middle-income countries. [156] Treatment also includes preventive and active treatment of opportunistic infections. As of March 2020[update], two people have been cleared of HIV. [157] Rapid initiation of antiretroviral therapy within one week of diagnosis appears to improve treatment outcomes in low- and middle-income environments. [158] Antiviral therapy Stribild – a common once daily ART regimen consisting of elvitegravir, emtricitabine, tenofovir and booster cobicistat Current HAART options are combinations (or cocktails) consisting of at least three drugs belonging to at least two types, or classes, of antiretrrovi agents. [159] Initially, the treatment is typically a non-nucleo-inverted transcription inhibitor (NNRTI) plus two nucleoid analog reverse transcription inhibitors (NRTIs). [160] Typical NRTIs include: zidovudin (AZT) or tenofovir (TDF) and lamivudine (3TC) or emtricitabine (FTC). [160] As of 2019, dolutegravir/lamivudine/tenofovir has been listed by the World Health Organisation as a first-line treatment for adults with tenofovir/lamivudine/efavirenz as an alternative. [161] Combinations of agents including protease inhibitors (PI) are used if the above regimen loses effectiveness. [159] The World Health Organization and the United States recommend antiretroviral drugs in people of all ages (including pregnant women) as soon as the diagnosis is made, regardless of CD4 count. [15] [127] [162] Once treatment has begun, it is recommended that it be continued without breaks or holidays. [28] Many people are diagnosed only after treatment ideally should have begun. [28] The desired result of treatment is a long-term HIV-RNA number for plasma below 50 copies/ml. [28] Levels to determine whether treatment is effective is recommended initially after four weeks, and when the level drops below 50 copies/ml of control every three to six months is typically sufficient. [28] Insufficient controls are considered to be greater than 400 copies/ml. [28] Based on these criteria, treatment is effective in more than 95 % of the population during the first year. [28] The benefits of treatment include a reduced risk of progression to AIDS and a reduced risk of death. [163] In developing countries, treatment also improves physical and Health. [164] Treatment has a 70% reduced risk of developing tuberculosis. [159] Additional benefits benefits reduced risk of transmission of the disease to sexual partners and a decrease in transmission from mother to child. [159] [165] The effectiveness of treatment depends to a large extent on compliance. [28] The reasons for non-compliance with treatment include poor access to medical care,[166] inadequate social support, mental illness and substance abuse. [167] The complexity of treatment regimens (due to pill numbers and dosing frequency) and side effects can reduce compliance. [168] Although costs are a major problem with some medications,[169] 47% of those who needed them took them in low- and middle-income countries from 2010 [update],[156] and the rate of compliance is the same in low- and high-income countries. [170] Specific side effects are related to the antiretroviral drug taken. [171] Some relatively common side effects include: lipodystrophy syndrome, dyslipidemia, and diabetes mellitus, especially with protease inhibitors. [24] Other common symptoms include diarrhoea,[171][172] and an increased risk of cardiovascular disease. [173] Newer recommended treatments are associated with fewer side effects. [28] Certain medications may be associated with birth defects and may therefore be unsuitable for women hoping to have children. [28] The treatment recommendations for children are somewhat different from those for adults. The World Health Organisation recommends that all children under the age of five be treated. children over five are treated as adults. [174] U.S. guidelines recommend treating all children under the age of 12 months, and all children with HIV RNA count more than 100,000 copies/ml between a year and five years. [175] The European Medicines Agency (EMA) has recommended that marketing authorisations be granted for two new antiretroviral drugs(ARV), rilpivirine (Rekambys) and cabotegravir (Vocabria) to be used together to treat people with human immunodeficiency virus type 1 (HIV-1). [176] The two medicines are the first ARV's to come in a long-acting injectable formulation. [176] This means that instead of daily pills, people receive intramuscular injections monthly or every two months. [176] The combination of Rekamby's and Vocabria injection is intended for maintenance treatment of adults, who have measurable HIV levels in the blood (viral load less than 50 copies/ml) with their current ARV treatment and when the virus has not developed resistance to certain categories of anti-HIV drugs called non-nucleoside reverse transcription inhibitors (NNRTIs) and integrase beach transfer inhibitors (INI). [176] Opportunistic infections Measures to prevent opportunistic infections are effective in many people with HIV/AIDS. In addition to improving the current disease, treatment with antiretroviral drugs reduces the risk of developing additional opportunistic infections. [171] Adults and adolescents living with HIV (even in antiretroviral therapy) with no signs of active tuberculosis in with high tuberculosis burden should receive isoniazid preventive treatment (IPT); tuberculin skin test can be used to determine if IPT is needed. [177] Vaccination against hepatitis A and B is advised for all people at risk of HIV before becoming infected; however, it can also be given after infection. [178] Trimethoprim/sulfamet hoxazoleprofyaxis between four and six weeks and cessation of breastfeeding of babies born to HIV-positive mothers is recommended in resource-limited settings. [179] It is also recommended to prevent PCP when a person's CD4 number is less than 200 cells/uL and in those who have or have previously had PCP. [180] People with significant immunosuppression are also advised to receive prophylactic treatment for toxoplasmosis and MAC. [181] Appropriate preventive measures reduced the number of these infections by 50% between 1992 and 1997. [182] Influenza vaccination and pneumococcal polysaccharid vaccine are often recommended for people with HIV/AIDS with some signs of benefit. [183] [184] Diet Main article: Nutrition and HIV/AIDS The World Health Organization (WHO) has issued recommendations regarding nutrient requirements in HIV/AIDS. [185] A generally healthy diet is promoted. Intake of micronutrients at RDA levels from HIV-infected adults is recommended by the WHO. higher intake of vitamin A, zinc and iron can cause adverse effects in HIV-positive adults and is not recommended unless there is a proven deficiency. [185] [186] [187] [188] Dietary supplements for people infected with HIV who have inadequate nutrition or dietary deficiencies can strengthen their immune systems or help them recover from infections; however, evidence of an overall benefit of morbidity or mortality is not consistent. [189] Evidence of selenium subsidies is mixed with some preliminary evidence of benefit. [190] For pregnant and nursing women with HIV, the multivitamin supplement improves outcomes for both mothers and children. [191] If the pregnant or nursing mother has been advised to take antiretroviral drugs to prevent the transmission of HIV from mother to child, multivitamin supplements should not replace these treatments. [191] There is some evidence that vitamin A supplementation in children with an HIV infection reduces mortality and improves growth. [192] Alternative medicine In the United States, approximately 60% of people infected with HIV use various complementary or alternative medicines,[193] the effectiveness of which has not been established. [194] There is insufficient evidence to support the use of herbal medicinal products. [195] There is insufficient evidence to recommend or support the use of medical cannabis to try to increase appetite or weight gain. [196] Prognosticial deaths from HIV/AIDS per Million people in 2012 0 1-4 5-12 13-34 35-61 62-134 135– 215 216-458 459-1,402 1,403-5,828 HIV/AIDS has become a chronic rather than acute fatal disease in many areas of the world. [197] The forecast varies between and both the CD4 count and the virus load are useful for predicted results. [27] Without treatment, the average survival time after infection with HIV is estimated to be 9 to 11 years, depending on the HIV subtype. [7] After diagnosis of AIDS, if treatment is not available, survival varies between 6 and 19 months. [198] [199] HAART and appropriate prevention of opportunistic infections reduce mortality by 80% and increase the life expectancy of a newly diagnosed young adult to 20-50 years. [197] [200] [201] This is between two thirds[200] and almost the general population. [28] [202] If treatment is started late in the infection, prognosis is not as good:[28] for example, if treatment has begun after diagnosis of AIDS, the life expectancy is ~10-40 years. [28] [197] Half of babies born with HIV die before two years without treatment. [179] Disability-adjusted years of LIFE for HIV and AIDS per 100,000 inhabitants as of 2004. no data ≤ 10 10-25 25-50 50-100 100-500 500-1000 1,000-2,500 2,500-5,000 5.00 0-7500 7,500-10,000 10,000-50,000 ≥ 50,000 The primary causes of death from HIV/AIDS are opportunistic infections and cancer, both of which are often the result of the gradual failure of the immune system. [182] [203] The risk of cancer appears to increase when the CD4 count is below 500/µL. [28] The number of clinical disease progression varies widely between individuals and has been shown to be influenced by a number of factors such as a person's susceptibility and immune function; [204] their access to health care, the presence of co-infections; [198] [205] and the strain (or strains) in question. [206] [207] Tuberculosis co-infection is one of the leading causes of disease and death in those with HIV/AIDS is present in a third of all HIV-infected people and causes 25% of HIV-related deaths. [208] HIV is also one of the main risk factors for tuberculosis. [209] Hepatitis C is another very common co-infection in which each disease increases the development of the other. [210] The two most common cancers associated with HIV/AIDS are Kaposi's sarcoma and AIDS-related non-Hodgkin's lymphoma. [203] Other cancers that are more frequent include anal cancer, Burkitt's lymphoma, primary central nervous system lymphoma, and cervical cancer. [28] [211] Even with antiretrovimonal therapy, HIV sufferers can experience neurocognitive disorders in the long term,[212] osteoporosis,[213] neuropathy,[214] cancers,[215][216] nephropathy,[217] and cardiovascular disease. [172] Some conditions, such as lipodystrophy, can be caused by both HIV and its treatment. [172] Epidemiology Main article: Epidemiology of HIV/AIDS ► View or edit source data. Percentage of people with HIV/AIDS. [218] Trends in new cases and deaths per year from HIV/AIDS[218] HIV/AIDS are a global pandemic. [219] As of 2016[update] about 36.7 million people worldwide have HIV, the number of new infections that year is about 1.8 million. [220] This is down from [221] Just over half of the infected population is women and 2.1 million are children. [220] This resulted in around 1 million deaths in

2016, down from a peak of 1.9 million in 2005. [220] Sub-Saharan Africa is the region hardest hit. In 2010, an estimated 68% (22.9 million) of all HIV cases and 66% of all deaths (1.2 million) occurred in this region. [222] This means that approximately 5% of the adult population is infected[223] and is thought to be the cause of 10% of all child deaths. [224] Unlike other regions, women make up almost 60% of cases. [222] South Africa has the largest population of people with HIV in any country in the world at 5.9 million. [222] Life expectancy has decreased in the worst affected countries due to HIV/AIDS; in 2006 it was estimated that it had fallen from 65 to 35 years in Botswana. [17] Mother-to-child transfers in Botswana and South Africa have decreased to less than 5% since 2013[update] and many other African nations have improved due to improved access to antiretroviral therapy. [225] South and South-East Asia are the second most affected; in 2010, this region contained an estimated 4 million cases, or 12% of all people infected with HIV, resulting in approximately 250 000 deaths. [223] Approximately 2.4 million of these cases are in India. [222] During 2008 in the United States about 1.2 million people lived with HIV, resulting in about 17,500 deaths. The U.S. Centers for Disease Control and Prevention estimated that in that year, 20% of infected Americans were unaware of their infection. [226] As of 2016[update] about 675,000 people have died of HIV/AIDS in the United States since the beginning of the HIV epidemic. [57] In the United Kingdom, in 2015[update] there were approximately 101 200 cases, resulting in 594 deaths. [227] In Canada in 2008, there were about 65,000 cases causing 53 deaths. [228] Between the first recognition of AIDS (in 1981) and 2009, it has led to nearly 30 million deaths. [229] HIV rates are lowest in North Africa and the Middle East (0.1% or less), East Asia (0.1%) and Western and Central Europe (0.2%). 223] The most affected European countries in 2009 and the 2012 perspectives are Russia, Ukraine, Latvia, Moldova, Portugal and Belarus in descending order of prevalence. [230] History Main article: History of HIV/AIDS Additional information: Category: HIV/AIDS by Country Discovery Morbidity and Mortality Weekly Report reported in 1981 on what was later called AIDS. The first news of the disease appeared May 18, 1981 in the gay newspaper New York Native. [231] [232] AIDS was first clinically reported on 5 April [36] [233] The first cases were a cluster of injecting drug users and gay men with no known cause of reduced immunity, showing symptoms of Pneumocystis carinii pneumonia (PCP), a rare opportunistic infection known to occur in people with compromised Systems. [234] Shortly afterwards, an unexpected number of gay men developed a previous rare skin cancer called Kaposi's Sarcoma (KS). [235] [236] Many more cases of PCP and KS occurred, alerting the U.S. Centers for Disease Control and Prevention (CDC) and a CDC task force was formed to monitor the outbreak. [237] In the early days, the CDC did not have an official name for the disease, often referring to it using diseases associated with it, such as lymphadenopathy, the disease, after which the detecters of HIV were originally named viruses. [238] [239] They also used Kaposi's sarcoma and opportunistic infections, which were set up by a task force in 1981. [240] At one point, the CDC invented the 4H disease that the syndrome appeared to affect heroin users, homosexuals, hemophiliacs, and Haitians. [241] [242] In the general press the term GRID, which stood for gay-related immunodeficiency, had been coined. [243] However, after finding that AIDS was not isolated to the gay community,[240] it was realized that the term GRID was misleading and the term AIDS was introduced at a meeting in July 1982. [244] In September 1982, the CDC began referring to the disease as AIDS. [245] In 1983, two separate research groups led by Robert Gallo and Luc Montagnier declared that a new retrovirus may have infected people with AIDS, and published their findings in the same issue of the journal Science. [246] [247] Gallo claimed a virus that his group had isolated from a person with AIDS was strikingly similar in form to other human T-lymphocytic viruses (HTLVs) that his group had been the first to isolate. Gallo's group called their newly isolated virus HTLV-III. At the same time, Montagnier group isolated a virus from a person who presents with swelling of the lymph nodes in the neck and physical weakness, two characteristic symptoms of AIDS. Contrary to the report by Gallo's group, Montagnier and his colleagues showed that core proteins of this virus were immunologically different from HTLV-I's. Montagnier group named their isolated virus lymphadenopathy-associated virus (LAV). [237] When these two viruses turned out to be the same, LAV and HTLV-III were renamed HIV in 1986. [248] Source from left to right: The African green monkey source SIV, the sooty mangabey source of HIV-2, and chimpanzee source of HIV-1 Both HIV-1 and HIV-2 are believed to have originated in non-human primates in West Central Africa and were transmitted to humans in the early 20th century[18] HIV-1 appears to originate from southern Cameroon through the development of SIV (cpz), a simian immunodeficiency virus (SIV) that infects wild chimpanzees (HIV-1 descended from SIVcpz endemic in chimpanzee subspecies Pan troglodytes troglodytes). [249] [250] The closest relative of HIV-2 is SIV(smm), a virus of sooty mangabey (Cercocebus atys), an Old World monkey living in coastal West Africa (from southern Senegal to western Ivory Coast). [98] New monkeys such as the owl monkey are resistant to HIV-1 infection, possibly due to a genomic fusion of two viral resistance genes. [251] HIV-1 is believed to have jumped the species barrier on at least three different occasions, giving rise to the three groups of viruses, M, N and O.[252] There is evidence that people participating in bushmeat activities, either as hunters or as bushmeat suppliers, commonly acquire SIV. [253] However, SIV is a weak virus that is typically suppressed by the human immune system within weeks of infection. It is believed that multiple transmissions of the virus from individual to individual in quick succession are necessary to give it enough time to mutate into HIV. [254] Moreover, due to its relatively low transfer rate between persons, the SIV can only spread to the entire population in the presence of one or more high-risk transmission channels believed to have been absent in Africa before the 20th century. Specific proposed high-risk transmission channels that allow the virus to adapt to humans and spread throughout society depend on the proposed timetable for animal-human crossings. Genetic studies of the virus suggest that [255] Proponents of this dating associate the HIV epidemic with the emergence of colonialism and growth in large colonial African cities, leading to social changes, including a higher level of sexual promiscuity, the prevalence of prostitution and the accompanying high frequency of veneer diseases (such as syphilis) in burgeoning colonial cities. [256] While the transmission rate of HIV during vaginal intercourse is low in regular circumstances, they increase many times if one of the partners suffers from a sexually transmitted infection that causes genital ulcers. The early 1900s were notable for their high incidence of prostitution and sex wounds, to the extent that from 1928, as many as 45% of female residents of eastern Kinshasa were found to have been prostitutes, and from 1933, about 15% of all residents of the same town had syphilis. [256] An alternative view claims that unsafe medical practices in Africa after World War II, such as usteril reuse of disposable syringes during mass vaccination, antibiotics and anti-malarial treatment campaigns, was the original vector that allowed the virus to adapt to humans and spread. [254] [257] [258] The earliest well-documented case of HIV in a human goes back to 1959 in congo. [259] In July 1960, in the wake of Congo's independence, the UN recruited French-speaking experts and technicians from around the world to help fill administrative gaps left by Belgium that did not leave an African elite to govern the country. In 1962, Haitians had the second largest group of well-educated national groups), which amounted to around 4500 in the country. [261] [262] Dr. Jacques Pépin, a Quebecer author of The Origins of AIDS, states that Haiti was one of HIV's entry points to the United States and that one of them may have carried HIV back across the Atlantic in the 1960s. [262] Although the virus may have been present in the United States as early as 1966,[263] the vast majority of infections, that occur outside sub-Saharan Africa (including the United States) can be traced back to a single unknown person who was infected with HIV in Haiti and then brought the infection to the United States at some point around 1969. [264] The epidemic then spread rapidly among high-risk groups (initially sexually promiscuous men having sex with men). In 1978, the prevalence of HIV-1 among gay male residents in New York City and San Francisco was estimated at 5%, suggesting that several thousand people in the country had been infected. [264] Community and Culture Stigma Main article: Discrimination against people with HIV/AIDS Ryan White became a poster child for HIV after being expelled from school because he was infected. [265] AIDS stigma exists around the world in a variety of ways, including ostracism, rejection, discrimination and hiv prevention; mandatory HIV testing without prior consent or protection of the confidentiality of violence against persons infected with HIV or persons perceived as infected with HIV and quarantine of people infected with HIV. [20] Stigma-related violence or fear of violence prevents many people from seeking HIV testing, returning to their results, or ensuring treatment, possibly turning what could be a manageable chronic disease into a death sentence and perpetuating the spread of HIV. [266] AIDS stigma is further divided into the following three categories: Instrumental AIDS stigma – a reflection of the fear and fear that is likely to be associated with any deadly and communicable disease. [267] Symbolic AIDS stigma – the use of HIV/AIDS to express opinions on the social groups or lifestyles perceived to be associated with the disease. [267] Courtesy AIDS stigma-stigma of people associated with the issue of HIV/AIDS or HIV-positive people. [268] Often, AIDS stigma is expressed in the context of one or more other stigma, especially those associated with homosexuality, bisexuality, promiscuity, prostitution, and intravenous drug use. [269] In many developed countries there is a link between AIDS and homosexuality or bisexuality, and this association is correlated with higher levels of sexual prejudice, such as anti-gay or anti-bisexual attitudes. [270] There is also a perceived link between AIDS and all male-male sexual behavior, including sex between non-infected men. [267] However, the dominant form of worldwide spread for HIV is still heterosexual transmission. [271] In 2003 as part of the comprehensive reform of marriage and and it became legal for people with AIDS to marry in China. [272] In 2013, the U.S. National Library of Medicine developed a traveling exhibition entitled Surviving and Thriving: AIDS, Politics, and Culture; [273] this covered medical research, the U.S. government's response, and personal stories from people with AIDS, relatives and activists. [274] Economic impact Main articles: Economic consequences of HIV/AIDS and HIV treatment Changes in life expectancy in some African countries, 1960-2012 HIV/AIDS affect the economies of both individuals and countries. [224] The gross domestic product of the worst affected countries has decreased due to a lack of human capital. [224] [275] Without proper nutrition, health care and medicine, a large number of people die from AIDS-related complications. Before death they will not only be unable to work, but will also require significant medical care. It is estimated that as of 2007 there were 12 million AIDS orphans. [224] Many are being cared for by elderly grandparents. [276] It is difficult to return to work after starting treatment for HIV/AIDS, and affected people often work less than the average worker. Unemployment in people with HIV/AIDS also is associated with suicidal thoughts, memory problems, and social isolation. Employment increases self-esteem, sense of dignity, confidence and quality of life for people with HIV/AIDS. Antiretrovial treatment can help people with HIV/AIDS work more, and may increase the chance that someone with HIV/AIDS will be employed (low quality evidence). [277] By influencing mainly young adults, AIDS reduces the taxable population and, in turn, reduces the resources available for public spending such as education and health services that are not related to AIDS, resulting in increased pressure on the state's finances and slower growth of the economy. This leads to slower growth in the tax base, an effect that is enhanced if there are increasing costs of treating the sick, education (to replace sick workers), sickness benefits and care for orphaned AIDS patients. This is especially true if the surge in adult mortality shifts responsibility from the family to the government for taking care of these orphans. [276] At household level, AIDS causes both loss of income and increased health care costs. A study in Côte d'Ivoire showed that households with HIV/AIDS spent twice as much on medical expenses as other households. These additional expenses also provide less income for education and other personal or family investments. [278] Religion and AIDS Main article: Religion and HIV/AIDS The topic of religion and AIDS has become highly controversial, mainly because some religious authorities have publicly stated their opposition to the use of condoms. [279] [280] The religious approach to preventing the spread of AIDS, according to a report by the American health expert Matthew Hanley, entitled The Catholic Church and the Global AIDS Crisis, argues that cultural change is necessary, necessary, a re-emphasis on fidelity within marriage and sexual abstinence outside of it. [280] Some religious organizations have argued that prayer can cure HIV/AIDS. In 2011, the BBC reported that some churches in London claimed that prayer would cure AIDS, and the Hackney-based Centre for the Study of Sexual Health and HIV reported that more people stopped taking their medication, sometimes on the direct advice of their priest, leading to a number of deaths. [281] The Church of All Nations Synagogue announced an anointing water to promote God's healing, although the group refuses to advise people to stop taking medicine. [281] Media portrayal Main article: Media depiction of HIV/AIDS One of the first high-profile cases of AIDS was that of American Rock Hudson, a gay actor who had been married and divorced earlier in life, who died on October 2, 1985, after announcing that he was suffering from the virus on July 25 that year. He had been diagnosed in 1984. [282] A remarkable British accident of AIDS that year was Nicholas Eden, a gay politician and son of the late Prime Minister Anthony Eden. On November 11, 1991, the virus caused the death of British rock star Freddie Mercury, lead singer of the band Queen, when he died of an AIDS-related illness that only revealed the diagnosis the day before. [284] However, he had been diagnosed as HIV positive in 1987. Mercury had also started to show signs of the virus as early as 1982. [285] One of the first high-profile heterosexual cases of the virus was the American tennis player Arthur Ashe. He was diagnosed as HIV positive after contracting the virus from blood transfusions during heart surgery earlier in the 1980s. Further tests within 24 hours of the initial diagnosis showed that Ashe had AIDS, but he did not tell the public about his diagnosis until April 1992. [286] He died as a result of the 6th [287] Therese Frare's photograph of the gay activist David Kirby, as he lay dying of AIDS while surrounded by family, was taken in April 1990. Life magazine said the image was the one image most powerfully identified with the HIV/AIDS epidemic. The image was shown in Life, was the winner of World Press Photo, and gained worldwide fame after being used in a United Colors of Benetton advertising campaign in 1992. [288] Criminal transfer Main article: Criminal transfer of HIV criminal transmission of HIV is intentional or reckless infection of a person with human immunodeficiency virus (HIV). Some countries or jurisdictions, including some areas of the United States, have laws that criminalize HIV infection or exposure. [289] Others may charge the accused under laws passed before the HIV pandemic. In 1996, Ugandan Canadian Johnson Aziga was diagnosed with HIV; he subsequently had unprotected sex with eleven women without disclosing his diagnosis. By 2003, seven had contracted HIV; two died of complications in Aziga was convicted of first-degree murder and sentenced to life imprisonment. [292] Misconceptions Main Articles: Misconceptions about HIV/AIDS and discredited HIV/AIDS origin theories There are many misconceptions about HIV and AIDS. Three of the most common are that AIDS can be spread through casual contact, that sexual intercourse with a virgin will cure AIDS,[293][294][295] and that HIV can infect only gay men and drug users. In 2014, some among the British public wrongly believed that people could get HIV from kissing (16 per cent), sharing a glass (5 per cent), spitting (16 per cent), a public toilet seat (4 per cent) and coughing or sneezing (5%).[296] Other misconceptions are that any act of anal intercourse between two uninfected gay men can lead to HIV infection and that open discussion of HIV and homosexuality in schools will lead to increased AIDS. [297] [298] A small group of people continue to dispute the link between HIV and AIDS,[299] the existence of HIV itself or the validity of HIV testing and treatment methods. [300] [301] These claims, known as AIDS denialism, have been investigated and rejected by the scientific community. [302] However, they have had a significant political impact, especially in South Africa, where the government's official embrace of AIDS denial (1999-2005) was responsible for its ineffective response to the country's AIDS epidemic, and has been blamed for hundreds of thousands of avoidable deaths and HIV infections. [303] [304] [305] Several discredited conspiracy theories have claimed that HIV was created by researchers, either inadvertently or deliberately. Operation INFECTION was a worldwide Soviet active operations operation to spread the claim that the United States had created HIV/AIDS. Studies show that a significant number of people believed - and continue to believe - such claims. [306] Research Main article: HIV/AIDS research HIV/AIDS research includes all medical research that tries to prevent, treat or cure HIV/AIDS, along with basic research on the nature of HIV as an infectious agent, and on AIDS as the disease caused by HIV. Many governments and research institutions participate in HIV/AIDS research. This research includes behavioral health interventions such as sex education, and the development of drugs, such as research into microbicides for sexually transmitted diseases, HIV vaccines, and antiretroviral drugs. Other medical research areas include subjects of pre-exposure prophylaxis, post-exposure prophylaxis, and circumcision and HIV. Public health officials, researchers and programs can get a more comprehensive picture of the barriers they face and the impact of current approaches to HIV treatment and prevention, by tracking standard HIV indicators. [307] The use of common indicators is an increasing focus for development organisations and researchers. [308] [309]

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