

A Study on Socio-Economic Condition of HIV Positive People in Dakshina Kannada

Laveena D'Mello¹ & Govindaraju B. M.²

¹Senior Lecturer, Social Work Department, Srinivas Institute of Management Studies,
Mangalore-575001, India

²Asst. Professor, Dept. of Sociology, Mangalore University, Karnataka, India.
E-mail: lavynoronha@gmail.com

Type of the Paper: Research Article.

Type of Review: Peer Reviewed.

Indexed In: OpenAIRE.

DOI: <http://dx.doi.org/10.5281/zenodo.579647>.

Google Scholar Citation: [IJHSP](#)

How to Cite this Paper:

D'Mello, Laveena., & B. M., Govindaraju. (2017). A study on Socio-Economic Condition of HIV Positive People in Dakshina Kannada. *International Journal of Health Sciences and Pharmacy (IJHSP)*, 1(1), 12-20.

DOI: <http://dx.doi.org/10.5281/zenodo.579647>.

International Journal of Health Sciences and Pharmacy (IJHSP)

A Refereed International Journal of Srinivas University, India.

© With Authors.



This work is licensed under a [Creative Commons Attribution-Non Commercial 4.0 International License](#) subject to proper citation to the publication source of the work.

Disclaimer: The scholarly papers as reviewed and published by the Srinivas Publications (S.P.), India are the views and opinions of their respective authors and are not the views or opinions of the SP. The SP disclaims of any harm or loss caused due to the published content to any party.

A Study on Socio-Economic Condition of HIV Positive People in Dakshina Kannada

Laveena D'Mello¹ & Govindaraju B. M.²

¹Senior Lecturer, Social Work Department, Srinivas Institute of Management Studies,
Mangalore-575001, India

²Asst. Professor, Dept. of Sociology, Mangalore University, Karnataka, India.
E-mail: lavynoronha@gmail.com

ABSTRACT

The pandemic of AIDS (Acquired Immuno-Deficiency Syndrome) is unique in more ways than one. It has innumerable social, cultural, demographic, political and economic dimensions, knowing no boundaries, the virus cuts across all population groups. The virus is preferentially bent towards those who are primarily in their economically productive years, i.e. 15 years to 49 years. This makes it even more vital to understand its impact on populations who are directly and indirectly shaping the economy. Being in the most productive age group, they are important contributors to the family, society and the economy. Given the ILO estimates globally there are 20 million workers living with HIV/AIDS, (Human Immuno-deficiency Virus), the implications of the pandemic for industrial workers assume a pointed significance. The psycho-social emotional deprivation resulting from the suffering of a family member from HIV/AIDS is not limited to factors operating within the family. The objectives of this study are : To study the problems and perspective of HIV positive people and To find out the stigma related to their status. 50 samples we have selected in this regard. This study is concerned, the majority of respondents who are suffering from HIV infection in Indian families in general and in Dakshina Kannada district, in particular, have carried with them own types of stigma, isolation, and discrimination at large level. They have considered it as one of the deadly disease caused by in numerous ways. Not only effect on our family member and often considered it a disgrace to have an infected person in the family but the whole society practices it as a stigma. They have a strong feeling that if they disclosed their status to their employees, colleagues, friends, family members, and other members would reject them. Their physical and emotional ailments will make difficult for them to function effectively in a different place. Again due to all these stress the physical appearance, loss of weight, the side effects of the medicines will make them difficult to work.

Keywords: HIV/AIDS, Stigma, Pathetic, Family, infection and disease.

1. INTRODUCTION :

The Human Immune Deficiency Virus (HIV) is a medical problem as well as societal problem, which needs to address from various dimensions like a biological, psychosocial, social, economical and biomedical. Usually such dimension determines an individual's health vulnerability and coping reactions to disease, with implication for intervention and prevention. HIV is typically viewed by common people 'as a disease that affects others', whose lifestyles are seen as 'perverted

and immoral'. Similarly, Acquired Immuno Deficiency Syndrome (AIDS) is a collection of symptoms and infection resulting from the specific damage to immune system caused by the Human Immuno deficiency Virus (HIV) in humans. Different Countries and the Scholars have tried to define HIV/AIDS in different views. For example, UNAIDS defines HIV-related stigma as a 'process of devaluation' of people either living with or associated with HIV and AIDS. Anyone who treats an individual unfairly and unjustly based on his or her real HIV status is guilty of practicing

discrimination. Discrimination is the result of the social separation or devaluation. It is also sometimes called enacted stigma. We can think of stigma as attitudes and thoughts, and discrimination as the behavior based on stigmatizing attitudes and thoughts. HIV/AIDS stigma and discrimination violate human rights and arise from factors like lack of awareness of how stigma affects People Living with HIV/AIDS, Common fear of people of being infected from ordinary contact with people already infected with HIV – In this case, it is fear of being associating with people whose sexual behaviors or drug-related behaviors, we cannot understand linking all People Living with HIV/AIDS (PLHA) with behaviors that are immoral. HIV/AIDS stigma and discrimination is one of the structural factors that create barriers for people in accessing health care and protective measures such as condoms.

2. GLOBAL SCENARIO OF HIV/AIDS :

Within the South and South-East Asia Region, an estimated 7.4 million are people living with HIV/AIDS (PLHA) (as of December 2005). This region ranks second in HIV prevalence, after sub-Saharan Africa, and accounts for about 20% of new annual HIV infections globally. The epidemic in India is varied, with areas of generalized epidemic in the South and North-east, and with pockets of concentrated epidemics and highly vulnerable regions with low-levels of HIV infection. Half of HIV patients in Asia live in India and is way ahead of China in disease burden. It also finds a place in the list of 22 countries prioritized for preventing mother to child transmission infection, according to the latest UN-AIDS report, drafted jointly with the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO) About 48 lakh people were living with HIV in Asia in 2010 and nearly half of them 49 per cent to be precise are in India, say the report released on the eve of World AIDS Day. The Percentage of pregnant women who tested positive for HIV infection in India also raised from 2 percent in 2005 to 23 per cent in 2010.[12-14]

3. HIV/AIDS IN INDIA :

In India, the Human Immuno Deficiency Virus/ Acquired Immuno Deficiency Syndrome (HIV/AIDS) epidemic is nearly

three decades old. India reported its first known case of AIDS to the world health organization on 1986. It would be easy to underestimate the challenge of HIV/AIDS in India. India has a large population and population density, low literacy levels and consequently low levels of awareness, and HIV/AIDS is one of the most challenging public health problems ever faced by the country (UNPAN, 2003) At the end of 2004, 5.3 million Indians were estimated to be infected with HIV. A hundred and eleven districts in the country are classified as high HIV prevalence districts. Transmission of HIV is predominantly through the sexual route (86%). Other routes include injecting drug use (IDU) (2.4%), vertical transmission from mother to child (3.6%) and transfusion of blood and blood products (2%), and others (6%) as of July 2005. (UNAIDS and World Health Organization, 2005). Recently, the Indian Government stated that it was 2.5 million people affected by HIV in India (NACO 2007). The HIV prevalence data for most states is established through testing pregnant women at antenatal clinics. While this means that the data are only directly relevant to sexually active women, they still provide a reasonable indication as to the overall HIV prevalence of each area. Data for six states are also available from a survey of the general population.

The annual sentinel surveillance surveys have divided States and Union territories in India into four broad categories; High prevalence areas are like Maharashtra, Tamil Nadu, Manipur, Andhra Pradesh, Karnataka and Nagaland States which have HIV prevalence rates exceeding 5% among groups with high-risk behavior and 1% among women attending antenatal clinics in public hospitals. Moderate epidemics: Gujarat, Pondicherry and Goa, where HIV prevalence rates among population with high risk behaviour has been found to be 5% or more, while HIV prevalence remains below 1% among women attending antenatal clinics. Low prevalence: High vulnerable states: these states are where migration was rampant, and where weak health infrastructure existed. HIV prevalence rates among vulnerable population are below 5 percent and less than 1 percent among women attending antenatal clinics. [11-13]

4. HIV/AIDS IN KARNATAKA :

Karnataka - a diverse state in the southwest of India - has a population of around 53 million. In Karnataka the average HIV prevalence at antenatal clinics has exceeded 1% in all recent years. Among the general population, 0.69% was found to be infected in 2005-2006. Districts with the highest prevalence tend to be located in and around Bangalore in the southern part of the state, or in northern Karnataka's "devadasi belt". Devadasi women are a group of women who have historically been dedicated to the service of Gods these days, this has evolved into sanctioned prostitution, and as a result many women from this part of the country are supplied to the sex trade in big cities such as Mumbai. The average HIV prevalence among female sex workers in Karnataka was 8.64% in 2006, and 19.20% of men who have sex with men were found to be infected. In this article I have made an attempt to find out the basic problems and prospective of HIV/AIDs affected persons as well as the family in Dakshina Kannada district in Karnataka.

The district of Dakshina Kannada in state of Karnataka is not exceptional from the above mentioned facts and figures, with regard to the socio-economic status of HIV/AIDS. This district is not exceptional and also does not require much specific introduction in the case of education, health and trade and commerce in the state itself. As far as HIV/AIDS data is concerned the patients in Dakshina Kannada and the number is exceeding day by day. Through the help of Community Health Centers (CHC), Integrated Counseling and Testing Centers (ICTC) which are exist in majority of the hospitals, TB centre, ART, NGO's especially working for HIV/AIDS, Care and Support for the positive people is rendering self less service to the infected, researcher have collected 50 samples with the structured interview schedule. In this study the researcher have tried to collect information about Sex, Marital status, Educational background, occupation, causes for their diseases, first detection, impact and the stigma related to the diseases were collected in detail. Sex of the respondents: As per the District Aids Prevention and Controlling Unit (DAPCU) in Dakshina Kannada from the year 2007 to 2011 is concerned the total

positive cases in Dakshina Kannada district is 5,322, where in 3,440 are males and 1,882 are females. Out of them, 50 samples, that means one per cent of our overall population was selected. 68% of the respondents were females and 32% were males. Five each males and females have been selected for detail studies for case studies. Marital status of the respondents: This appears to influence the risk of HIV, because in the present study it was found that majority (52%) of the respondents were married. Hence, it is evident from the available data that married people are more vulnerable. The remaining (48%) who were unmarried are also vulnerable, but not as vulnerable as married people. It is important to know the way of life of the people and the culture of indulging in vulnerable sexual activities.

Educational status of the respondents: out of 50 samples, there were around 38% who had studied up to 10th standard. Then remained 32% of them were P.U.C. qualified, while a few of them were graduates along with a few qualified either Post graduates (2%) or professional courses constituted only a minority group (2%). Then around 26% of them were illiterate. This depicts the fact that lowers the education, lower will be the backwardness related to the awareness they have on transmission of the disease, the risk of the disease, management of conditions etc. Those individuals who had lower level of education were at greater level of risks for transmission etc.

Occupation of the respondents: As far as my data is concerned 32% (16) more HIV prevalence were found among Private Service who receive regular income. Generally speaking they are in more productive age, fascinated to enjoy life and they may think that they are fortunate to buy anything they wish from money either commodity or sex. This result is supported by the figures reported by National Family Health Survey II (2007) which highlights the fact that in Manipur and Nagaland, HIV prevalence was highest among women whose spouses were employed in Industry and factories which is a secure type of job with regular income.

The data also reveals that, out of them, 22% (11) of the respondents are engaged in coolie work. The respondents who were involved in

coolie work were migrants. Majority of them were from northern states of Karnataka (Belgaum, Bejapur and Bidar). The construction works are boom in Dakshina Kannada, so the daily wages they receive is very high in compare to their native District. Because of their nature of work, life style, they are exposed more to the risk. According to the report of National Sample Survey of India (1993), there are around 24.7% of the population who are suffering from that HIV/AIDS had migrant labor. Due to their pathetic social, economic conditions long working hours, relative isolation from the family, and geographical mobility may foster casual sexual relationships and that have made them more vulnerable to STDs and HIV/AIDS. Migrant workers tend to have little access to HIV/STD information, voluntary counseling and testing, and health services. Remaining 18% (9) of the respondents were house wife. In Dakshina Kannada HIV is more vulnerable to house wives with a single partner. The increasing HIV prevalence among women can consequently be seen in the form of increased mother to child transmission of HIV and pediatrics HIV cases. 16% (8) of the respondents are Self Employed who is involved themselves in petty business and 12% (6) of them are Drivers. Their job is uncertain and Mobile. During their journeys the driver often stops at 'dhabas', roadside hotels that usually provide food, rest, sex workers and alcohol. They identify the sex workers easily pick up the women, have sex with them and leave them and they make it as their routine. These women encounter other costumers. As a result drivers also play a crucial role in spreading STDs and HIV to their life partners.

5. CAUSES FOR HIV/AIDS :

HIV is transmitted through direct contact of a mucous membrane or the bloodstream with the bodily fluid containing HIV, such as blood, semen, vaginal fluid, preseminal fluid and breast milk. This transmission can come in the form of anal, vaginal or oral sex, blood transfusion, contaminated hypodermic needles, exchange between mother and baby during pregnancy, childbirth or breast feeding or other exposure to one of the above bodily fluid. HIV/AIDS stigma is more severe than that associated with other life-threatening

conditions and extends beyond the disease itself to providers and even volunteers involved with the case of people living with HIV. Without proper nutrition, health care and medicine in undeveloped and developing nations, large numbers of people are falling victim to AIDS. There are number of causes for HIV infection. Few among them are as follows;

As per the data is concerned majority of respondents who are suffering from HIV/AIDS are heterosexual. In this category a large numbers of them are women. Few of them have expressed their opinion that they have been infected by HIV/ AIDS due to their husband's behavior of multiple sexual partners". Out of 34 female respondents, 15 female (44%) of HIV infection revealed that they got disease from their husbands. For example Nathasha revealed that her husband was working in Africa and due to his behavior he got HIV and as a result I too got the infection. Significant Number of people (54%) became infected in the sexually activity and economically productive 15 to 44 age group due to multiple sexual partners. This means that most people living with HIV are in the prime of their working lives, sexually active and economically supporting member in the families. Women often get involved in sex work because of poverty, marital break-ups, or they are forced into it. 22% of the respondent got HIV due to this reason. Majority of the respondents in the study are reported that consumption of alcohol has increased their interest in sexual activities which lead to unsafe sex. Thenphillel (2006) in his study also has highlighted the fact that in his study 70% were alcoholic in takers.

First detection and reaction is concerned, many of the respondents came to know their status during their pregnancy check-up, after the death of their husband, after they became symptomatic. Only few came to know before surgery due to their sickness. It is mandatory at hospital for all ANC cases to do blood test and few came to know their status during this stage. 42% of the respondents were referred to ICTC (Integrated Counseling and Testing Centre) by the doctors, which clearly indicate the fact that the infected individuals were aware of the infection only after its impact on their physical health. And it is very hard to

accept the status for couples who visited the hospital for expecting their first new born. Navya expressed that she was shocked to find herself infected. After hearing the result, Navya, a newly wedded lady from well to do family was in shock and in the denial stage for a long that it is impossible for her. And if she infected it is not because of her fault but due to her husband. Since the infection is given by him, he will take care of the consequence. She had not expressed any reaction but just neutral. Marital status appears to influence the risk of HIV. 52% of the respondents were married. Latha came to know her status only after her husband's death.

6. IMPACT OF DISEASE :

The problems and perspective of HIV positive people and the impacts of HIV/AIDS at various levels, from the individual and household level to communities and society as a whole, because the epidemic disproportionately affects young adults, who are central to economy and fulfill important functions as workers, breadwinners, parents, educators, health care providers, and so on. Youths are among the most vulnerable groups to HIV infection, they are also the most promising agents of behavior change. Young men and women are vulnerable to HIV infection because they begin sexual activity at an increasingly younger age, tend to have multiple partners and have restricted access to information on safer sexual practices. An increase in poverty and illiteracy, lack of opportunities, and the erosion of social values and family life education act as catalysts to high risk sexual behavior. 24% of the respondent has sexual exposure between the age group of 15- 22 years. Yathish was not aware about his disease but had risk behavior in the past. He came to know his status only when his wife went for check-up for delivery she got positive report and the counselor asked him to come to ICTC centre for blood test, by then he transmitted the disease to his wife. He was regretting for getting married and had great concern to his wife.

Impacts on Household: The immediate impacts of HIV/AIDS are felt at the individual and household level. Apart from the psychological trauma, HIV/AIDS-related illness and death of an adult family member

leads to a significant reduction in household income. Decreased income combined with additional expenditure inevitably means fewer purchases, diminishing savings, low availability of food and reduced nutrition in the family. The result is more and deeper impoverishment. Families make great sacrifices to provide treatment, relief and comfort for a sick relative, especially a breadwinner. The burden of care for the sick and dying traditionally falls on the shoulders of women. Nathasha's husband was working in abroad and was in higher position in the company suddenly left the job and came down due to his sickness. He had to bore huge amount of saving on his medical expenditure. After his death Nathasha had to spend amount on her treatment since she too infected. Along with this, she also had to take care of whole family like children's education, family expenditure etc, [1, 2]

Impacts on Children's Education: Reduced household income can also force families to remove their children from school. Increasingly, children are expected to take on 'adult' roles, like contributing to household income, performing household tasks and looking after siblings or sick parents. With young adults mostly affected by HIV/AIDS, there is also pressure on elderly people to take responsibilities. HIV also increases the number of orphans. Orphan hood is also associated with child labor and the phenomenon of child-headed households. Parents cannot supervise the children's education. This can negatively affect the quality of education received by the children in general. Furthermore, families who cannot afford to pay school fees and have to spend on medicine and treatment. Discrimination in the school, negligence and separation in school de-motivates the children not to go school regularly. Ms. Latha's child was fed-up of sitting separate in class, isolation, classmate's attitude towards her, and no permission to play in the play ground, her physical health and all these lead to school dropouts. Mr. Ravi wanted to join professional course, and due to his father's illness and death he as to drop his idea and to satisfy only with perusing degree.

Impacts on Occupation: The negative impacts of the HIV/AIDS epidemic on the labour force are far-reaching. It erodes the workforce, as

most of those affected by HIV/AIDS are under the age of 35. HIV/AIDS leads to lower productivity due to absenteeism, staff turnover, loss of skills and experience, and declining staff morale. At the same time, employers will face increased costs arising from higher levels of spending on health and death benefits, additional staff recruitment and training of new employees. Out of 32% (16) of the respondents who work in private sector 62.5% (10) employers had changed their job often due to lack of job satisfaction.

Impacts on Public life: Many demands require people to receive help from the outside environment as human beings are social beings. The interaction with the environment, particularly the immediate environment and society plays an important role in causing and managing stress within individual lives. But this disease will shut these social doors due to personal or interpersonal problems. The personal problems like mood, sense of failure, self-dissatisfaction, Self-accusation, denial of reality, Suicidal ideas, crying, irritability, social withdrawal, body image, guilt feeling, work, appetite, weight loss and loss of libido. Interpersonal may be people's attitude, fear of disclosure of the status, discrimination, gap, change in the attitude etc. If the friends and neighbors come to know the status they want to keep the gap between them and effected person and his whole family. Rani used to say that nobody is coming to visit her family after her husband's death. If rarely they come also they will not have any drink offered to them. Neighbors and family members have stop calling for any weddings or functions for her. Practically they have isolated our family from the society.

7. STIGMA :

The stigma related to the status, people living with HIV have faced violent attacks, have been rejected by families, spouses and communities, refused medical treatment and even in some cases, denied the last rites before they die. Discrimination is also alarmingly common in the health care sector. Mr. Nigappa had to undergo cataract operation. After confirming his positive status they hesitated to do cataract operation. Negative attitudes from Health care staff have generated anxiety and fear among many people living with HIV and

AIDS. As a result, many keep their status secret. It is not surprising that among a majority of HIV positive people, AIDS-related fear and anxiety at time denial of their HIV status, can be traced to traumatic experiences in health care settings. Factors which contribute to HIV/AIDS-related stigma are HIV/AIDS is a life-threatening disease. HIV is associated with behaviors (such as sex between men, injecting drug-use, sex with women in prostitution) that are already stigmatized in our society. People living with HIV/AIDS are often thought of as being responsible for becoming infected. Religious or moral beliefs lead some people to believe that having HIV/AIDS is immoral act that deserves to be punished.

Discrimination occurs when a distinction is made against a person that results in his or her being treated unfairly and unjustly on the basis of their belonging, or being perceived to belong, to a particular group. Hospital or prison staff, for example, may deny health services to a person living with HIV/AIDS. Or employers may terminate a worker's employment on the grounds of his or her actual or presumed HIV positive status. Families and communities may reject and ostracize those living, or believed to be living, with HIV/AIDS. Such acts constitute discrimination based on presumed or actual HIV-positive status and violate human rights. Stigma and discrimination tend to be used interchangeably. While stigma refers to a feeling of inferiority raising a question of acceptance of the PLHA by others, discrimination is the act of non acceptance and exclusion. Stigma and discrimination are self-perpetuating. A stigmatized group experiences suffers discrimination, while discrimination underlines and reinforces stigma. In this study found that strong evidence of stigma in the work place, with 64% of the respondent's have not disclosed their status to the employees for fear of discrimination. Of the 36% who did disclose their status, 20% reported having faced prejudice as a result. This epidemic is totally associated and accompanied with fear, shame, denial, stigma and discrimination. Discrimination has spread rapidly according to the view of the client that they won't feel like attending any social functions in the society and feel low at the work place.

Stigma & Caste and Class: The trials and tribulations of an HIV positive person from lower caste or low socio-economic status are likely to be much greater than a person from an upper caste or better economically placed person, especially with regard to access to health care, ARVs, and nutritious food. The HIV/AIDS epidemic has developed during a period of rapid globalization and growing polarization between rich and poor. New forms of social exclusion associated with globalization have reinforced pre-existing social inequalities and stigmatization of the poor, homeless, landless, and jobless. It is highly likely that caste and class related S & D interact with HIV/AIDS-related S&D resulting in marginalization of population groups based on caste/ class, increasing their vulnerability to HIV/AIDS, which in turn accelerates stigmatization and discrimination. Mrs. Sheela, who admitted in the hospital for delivery was kept separate from other patients and discriminated due to her HIV status and discharged immediately after the delivery.(1,2) **Stigma at Workplace:** Evidence of stigma and discrimination at the workplace can be understood by looking at the findings of a study, majority of the respondent had fear of losing their job, social discrimination and lowering of prestige were cited as reasons for not disclosing their HIV status at their workplace. The 20% of the sample who shared their serostatus at the workplace, faced several discriminatory practices like being forced to resign or take voluntary retirement, denying of promotion and benefits and refusal of loan facilities. Discrimination at the workplace has manifested through attitude of co-workers as well that ranged from neglect, isolation, avoiding close proximity, abuse, teasing and name calling. Mrs. Neetha was working at Anganwadi, she had been forced to leave the job after her status was known to the neighbors. However, this survey also pointed out that most of those who had revealed their status were those who were working in NGOs in the field of HIV and AIDS. They were getting support from their employers and other benefits like leave with pay and adjustable timings. (15) **Stigma & Gender:** The impact of HIV/AIDS

on women reinforces pre-existing economic, educational, cultural, and social disadvantages and unequal access to education, information and services. In heterosexual transmission of HIV, most often women (in monogamous relationships with their spouses) have been blamed for bringing illness to the family and have been denied their rights to living in marital house and custody of children. Men are likely to be 'excused' for their behavior that resulted in their infection, whereas women are not. Out of 52% married people (26), 18 (70%) female and

8 (30%) were male. 10 (56%) women used to stay in their mother's house after their husband's death. 6 (33%) stay in separate house with their husband and children. 2 (11%) of them stay with their in-laws. Whereas out of

9 married male 6 (66.66%) stay with their parents and 3(33.33%) in separate house. This indicates in patriarchal society infected women has no place in her husband's house. (15). The stigma and discrimination on account of AIDS are particularly severe in India and often at times, due to actual or even perceived fear of stigma and discrimination, individuals infected with HIV do not reveal their HIV status and deny themselves healthcare services. This indeed makes the situation all the more precarious.

8. CONCLUSION :

The positive people's primary challenge is to keep their status secret and all most all areas of their life they want it confidential. They themselves feel guilty about their status and over that People's attitudes make them feel worse about themselves. They think it is risky to share their problems with others. They develop feeling of not worthy, not good like others, feel ashamed for all this they avoid themselves to mingle free with their friends and relatives. Some have stop socializing after they are infected. The finding of the study have value to therapist, medical professions, councilor, social workers, psychologist, support groups and those in academic fields and communities, in developing and strengthening innovative models of treatment. Society as to treat HIV the sex related disease as one of the disease like Hypertension and Blood sugar cannot be cured but controlled

and the day should come for the infected to accept their status as it is and the society too, so there is no need to maintain confidentiality in this regard.

REFERENCES :

- [1] D'Mello Laveena. B.M Govindaraju. (2014). Changing scenario of Health Problems due to HIV Infection. National Conference on Change and its Contemporary Social Relevance at Srinivas Institute of Management Studies, ISBN No. 978-81-929306-1-9.
- [2] D'Mello Laveena. B.M Govindaraju. (2014). Health of Urban Women with Respect of HIV Infection: A Case Study in Dakshina Kannada. National Conference on Change and its Contemporary Social Relevance at Srinivas Institute of Management Studies, ISBN No. 978-81- 929306-1-9.
- [3] Edlin Gordon and Golanty Eric (2010). Health and Wellness, Jones and Bartlett Publishers, London.
- [4] Goldman B. Marlene and Hatch C. Maureen (2000). Women and Health, Academic press, New York.
- [5] Guite Nemthiangai. (2010). AIDS Nature and Demography, Indira Gandhi National Open University, University of Delhi, New Delhi.
- [6] Kaushik Archana. (2010). Social and Economic Implications, Indira Gandhi National Open University, University of Delhi, New Delhi 2010.
- [7] Nagendra Shilaja. (2008). AIDS in India, ABD Publishers, Jaipur, India,
- [8] UNICEF (2004). Strategies for Girl Education. United Nations Children's Fund, (UNICEF) New York, USA.
- [9] UNICEF. (2002). Facts of Life. by UNICEF, WHO, UNESCO, UNFPA, UNDP, UNAIDS, WFP and the World Bank, Third Edition.
- [10] UNICEF. (2004). Mapping India's Children. UNICEF in Action. United Nations Children's Fund, (UNICEF) New York, USA.
- [11] UNICEF. (2004). Rasheed Sadig, Regional Director. Wheel of Change Children and young people's Participation in South Asia. United Nations Children's Fund, (UNICEF) Regional Office for South Asia, Nepal.
- [12] UNICEF. (2004). When Every Child Counts. United Nations Children's Fund, (UNICEF) New York, USA.
- [13] UNICEF. (2004). What Works for Children in South Asia HIV/AIDS PREVENTION AMONG YOUNG PEOPLE. United Nations Children's Fund (UNICEF), Regional Office for South Asia, Nepal.
- [14] UNICEF. (2005). Accelerating the Momentum in the Fight against HIV/AIDs in South Asia. overview paper, United Nations Children's Fund, (UNICEF) Regional Office for South Asia, Nepal.
- [15] Varma Sudhir. (2010). Gender, HIV and Social Work. Rawat Publication, Jaipur. India.