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HEALTH ISSUES WITHIN INFORMAL SECTOR: PERCEPTION OF MARKET WOMEN ON HIV/AIDS IN IBADAN, NIGERIA

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ABSTRACT

Women constitute a larger percentage of the population and their contributions to sustainable development, especially in the informal sector, cannot be over-emphasized. Despite the vital roles of women in the economy, they are faced with health risk especially sexual related diseases and infections such as HIV/AIDS. Bodija market is located in southwest Nigeria and serves as the destination for most food stuffs coming from various parts of the country. Majority of the traders in the market are women with low level of informal education. This study is therefore aimed at determining the awareness and perception of the market women on HIV/AIDS with the view to making recommendations that could assist in formulating intervention strategy toward reduction of health related risk in a bid to achieving sustainable development. Structured questionnaires were administered to 50 women in different sections of the market. Many of the market women have heard of HIV/AIDS; they believed that HIV/AIDS could be contacted through sexual intercourse with multiple partners; and it could also be transmitted from infected pregnant woman to her unborn baby. However, there is still high level of stigmatization and discrimination of people living with HIV/AIDS by the market women. There is need for initiatives geared toward provision of basic education for workers in informal sector, and empowerment of women not to engage in unprotected and non-negotiated sex. More awareness on HIV/AIDS needed to be incorporated into talk on radio as this is the most important source of information to the market women.

Keywords: Bodija market, HIV/AIDS, informal sector, sexual transmitted diseases, voluntary counseling, stigmatisation, health care

INTRODUCTION

As widely quoted by various authors from the Brundtland Commission Report in *Our Common Future*, sustainable development was defined as development that ‘‘meets the needs of the present without compromising the ability of future generations to meet their own needs’’ (World Commission on Environment & Development, 1987). The central role of women in sustainable development has been emphasized (Benerıa & Feldman, 1992; Vargas, 2002). The different documents released by United Nation in the 1990s also underscore the pertinent roles of women in advancing sustainable development (United Nations, 1995a-c; 1996). However, it has been reported that women are affected by some challenges such as poverty, lack of education as well as access to health care, and environmental degradation (Stromquist, 1992; King and Hill, 1993; Vargas, 2002). Most importantly, the international discourse has been focused on women's sexual and reproductive health as a priority area for health care reform (DeJong, 2000). Central to Millennium Development Goal 5 is maternal health of which women reproductive health is paramount. Despite the efforts for easy access to maternal health care, it seems meeting the MDG by year 2015 is unrealistic.

As defined by International Labour Organisation (ILO, 1972), informal economy is “a sector which is characterised by low barriers to entry; small-scale, family owned enterprises; the use of labour intensive technology; and reliance on indigenous resources”. Chen, (2002) further defined informal economy as “employment without secure contracts, worker benefits or social protection”. As reported by ILO (2002a), the contribution of informal economy to Gross Domestic Product (GDP) and its contribution to employment is on the increase (ILO, 2002a). The issue of HIV/AIDS epidemic, and other sexual transmitted diseases are gaining attention around the world within the informal sector (Orubuloye et al., 1993; Musisi, 1995; Nunn et al., 1996; Kwagala, 1999; Marcus, 2001 Valodia, 2001; Gysels, et al., 2002; ILO, 2002b). This calls for concern and urgent intervention especially for the sustainability of the work force within the sector. For the purpose of this study, the term informal sector is used for people, especially women that are involved in self-employed trading activities within informal market place.

Since the beginning of the HIV/AIDS epidemic, more than 40 million people have been infected with the disease worldwide (ILOAIDS, 2004). In 2001 alone, 5 million people were reported to be infected with Acquired immune deficiency syndrome (AIDS) and Human immunodeficiency virus (HIV), bringing the total of infected individuals worldwide to 40 million. Of these figure, more than 95 percent live in developing countries and about one-third are 15-24 years of age (World Bank, 2001; ILOAIDS, 2004). Furthermore, HIV/AIDS is no longer striking primarily men. According to the joint report of UNAIDS / UNFPA / UNIFEM (2004), more than 20 years into the epidemic, women account for nearly half the people living with HIV worldwide. The report further stated that in sub-Saharan Africa, 57 percent of adults with HIV are women, and young women aged 15 to 24 are more than three times as likely to be infected as young men. Despite this alarming trend, women know less than men about how HIV/AIDS is transmitted and how to prevent infection, and the little they know is often rendered useless by the discrimination and violence they face.

Women constitute a larger percentage of the population and their domestic roles cannot be over-emphasized. Women also play a major role in the economy most especially at the market place. They dominate the marketing channels of goods and services, especially in the informal sector, thereby contributing to household income generation and cumulatively the growth and sustainability of national economy. However, the productivity of women is threatened by health issue such as HIV/AIDS. It is not a gainsaying that failure in the area of women health care will not only have impact at household level, but with significant impacts in sustainability of economy up to the national level.

A survey conducted in Nigeria by National HIV/AIDS and Reproductive Health Survey (NARHS, 2003) revealed that sexual intercourse begins much earlier in female respondents at median age of first sex to be around 16.9 years. The survey also revealed that the adult HIV prevalence has increased from 1.8% in 1991 to 4.5% in 1996 and 5.8% in 2001. Most of the respondents knew all forms of HIV transmission, and misconceptions about the transmission are high. However, the most common type of non-marital non-cohabiting relationship is the boyfriend-girlfriend relationship, and nine percent of the sampled females had sex with boyfriends in 12 months preceding the survey (NARHS, 2003). The National Economic Empowerment and Development Strategy (NEEDS) (2004) has reported that more than 2.7 million Nigerians were infected with the HIV/AIDS. Spread of the disease is therefore critical among those in informal sector due to their lack of adequate information (Lee, 2004). Most especially, local markets are dominated with women that lack formal education and adequate information about HIV/AIDS, therefore involved in risky sexual behaviour that further increase their chance of getting infected (Ilo and Adeyemi, 2010). This study therefore focused on the perception of women in informal sector on HIV/AIDS with special focus on women at Bodija market located in Ibadan, Nigeria. Findings of this study will be valuable in formulating HIV/AIDS preventive strategy among women in market place and contribute to existing knowledge on status of HIV/AIDS in informal sector.

METHODOLOGY

Markets in Ibadan

The study area is Ibadan, the capital city of Oyo state, located in south-west of Nigeria (Figure 1). Ibadan is reputed to be the largest indigenous city in Africa, south of the Sahara (Ikporukpo, 1994). The indigenes of Ibadan are mainly the Oyos, the Ibadans and the Ibarapas, all belonging to the Yoruba family and speaking the same Yoruba language. Other people from within and outside the country trade and settle in the state mostly in the urban areas. Most of the markets in Ibadan are typical of open market in African setting with many small sheds/shelter and few concrete shops in urban and sub-urban, but rural areas is typical of sheds and shelters made from palm fronts and roofing sheets. The markets can be examined from two perspectives namely those in the rural area and those within Ibadan metropolis. While periodicity is the general situation of the marketing system of the rural areas, buying and selling activities take every day of the week in merely all the market within the metropolis (Filani and Iyun, 2004).

Buying and selling activities also take place along certain important roads where big trees are just adequate as shelter for the market women. These markets operate business during the day from about 8:00 am till late in the evening. By contrast, a few

of them still operate periodic marketing, when much sellers and buyers come from far and near and beyond the state boundary. These include Ojoo, Oritamerin, Apata, and Oje. Oje, in particular, attracts weavers and sellers of traditional constume (Aso-Oke) from Oyo North, Kwara, Ijebu and Ondo areas (Filani and Iyun, 2004).

Bodija Market

Bodija Market (also known as Orisunbare) is located at the Northern Ward area of Ibadan. The Market is second largest in Ibadan after Gbagi Market and occupies land area of about 21.9 ha. As further reported by Filani and Iyun (1994), the number of stalls in the market was 2,293 out of which covered stall was 55.2%, open stall was 35.3%, air trading unit (display of wares on table) was 3.7%, and air trading unit (display of wares on counters) was 5.8%. The Market specializes in the selling of both wholesale (bulk) and retail foodstuff (Figure 2a). Bodija Market is well known in the state and serves as the destination of most trailers loaded with food stuffs coming from many parts of the country (Figure 2b). Varieties of food stuff at both wholesale and retail are sold and bought at the market.

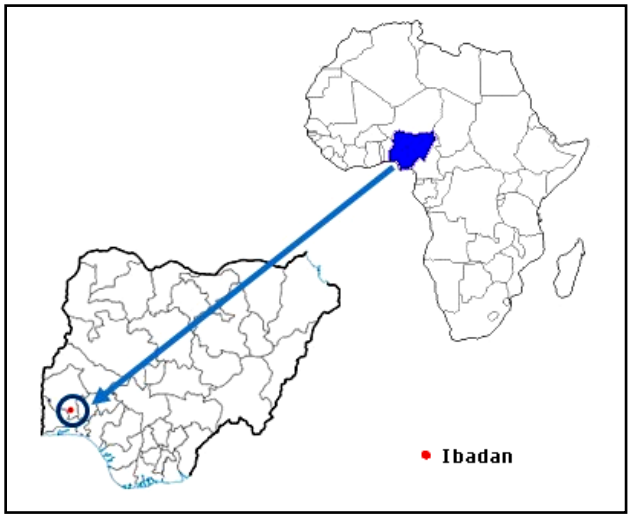
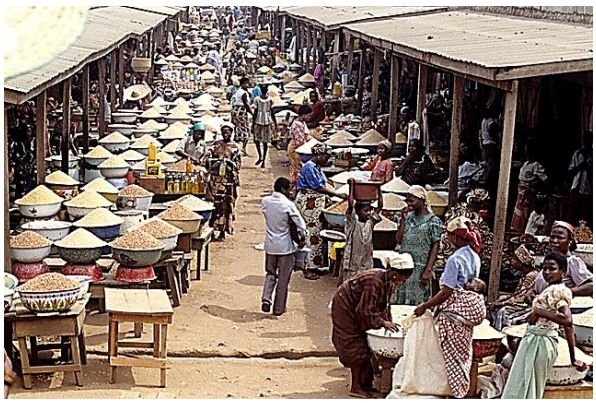


Figure 1: Map of Nigeria showing the location of CRIN in Ibadan, southwest Nigeria. Inset is map of Africa showing location of Nigeria.

a.



b.

Figure 2: Cross sections of Bodija market, Ibadan (a) Food stuff section (b) Trailers arriving Bodija market from northern parts of Nigeria and about to off-load food stuffs

Data collection

Stratified random sampling technique was adopted for administration of the structured questionnaire to the market women. The market is organised in such a way that people selling the same kind of goods are grouped together or with shops arranged next to each other. This arrangement is therefore used as strata for the market and adopted in selection of the traders for the questionnaire administration. Women in the following five sections of the market were randomly sampled: (a) perishable goods section (vegetables, meat, fruits, etc); (b) staple food stuff section (rice, beans, millet, corn, yam, etc); (c) provision section (can food, soup seasoning, juice drinks, wine, etc); (d) cosmetics section (body cream, soap, detergents, etc); and (e) cloth and clothing material section. Ten (10) women were sampled from each of the listed sections above making a total of fifty (50) women in all. The questionnaire was specially designed to collect required information on the socio-economic characteristics of the traders, sources of information on HIV/AIDS available to the traders; contraceptive use by the traders; knowledge, opinions and attitude about HIV/AIDS and voluntary counseling and testing services; and stigmatization and discrimination.

RESULTS

Demographic Information of the Market Women

From Table 1, 58.0% of the respondents were between the age ranges of 26-33 years, followed by those within the age range of 34-41 years with 38.0%. Ninety percent of the respondents were married. Many of the women (74.0%) had primary education, and they are mostly petty traders (48.0%) followed by the retailers (44.0%). About 84.0% of the market women were aware of HIV/AIDS while the remaining 16.0% indicated that they have not heard of the disease. On the sources of

information on HIV/AIDS available to Bodija Market women, 70.0% of them indicated that they got to know of HIV/AIDS on radio, 22.0% on Television, while only 4.0% heard of the disease by reading either newspaper, magazine, pamphlets or posters.

Table 1: Demographic information of the sampled market women at Bodija Market

Variables	Frequency n = 50	Percent
Age range (years)		
18-25	2	4.0
26-33	29	58.0
34-41	19	38.0
> 50	0	0
Marital Status		
Single	4	8.0
Married	45	90.0
Divorced	1	2.0
Highest level of education		
No formal education	3	6.0
Primary	37	74.0
Secondary	10	20.0
Tertiary	0	0
Trading level		
Petty trader	24	48.0
Retailer	22	44.0
Wholesaler	3	6.0
Major Distributor	1	2.0
Awareness of HIV/AIDS		
Yes	48	96.0
No	2	4.0
Sources of information on HIV/AIDS		
Radio	35	70.0
Television	11	22.0
Newspaper / Magazine	2	4.0
Pamphlets / Poster	2	4.0

Awareness level of HIV/AIDS among the market women

About 48.0% of the market women indicated that one could get infected with HIV/AIDS through sexual intercourse with multiple sex partners, while others indicated that it could be through sharing of sharp objects (22.0%), blood transfusion (10.0%) and only 4.0% indicated that it could be through mosquito bite (Table 2). On how the spread of HIV/AIDS could be prevent, 80.0% of the women indicated that people should abstain from unprotected sex, while 12.0% indicated that people should avoid sharing of sharp objects. Only 6.0% of the women indicated that one should limit sex partner to one to prevent the spread of HIV/AIDS (Table 2).

Table 2: Responses on mode of transmission and prevention of HIV/AIDS

Sources of HIV/AIDS	Frequency n = 50	Percent
Transmission of HIV/AIDS		
• Sexual intercourse with multiple partners	24	48.0
• Blood transfusion	5	10.0
• Mosquito bite	2	4.0
• Sharing of sharp objects	11	22.0
Prevention of HIV/AIDS		
• Abstain from unprotected sex	40	80.0
• Limit sex to one partner	3	6.0
• Avoid sharing of sharp objects	6	12.0
• Avoid mosquito bite	1	2.0

Perception of HIV/AIDS by the market women

The following responses were obtained from the women on their perception of HIV/AIDS: 78.0% indicated that one cannot get HIV/AIDS through sharing of food; 60.0% disagreed that HIV/AIDS could be transmitted through sharing of toilet; 72.0% agreed that a healthy looking person can have HIV virus; 90.0% have not heard of any drug that can prevent or cure HIV/AIDS; 68.0% agreed that HIV/AIDS can transfer from pregnant women to unborn baby; and only 12.0% have seen a person infected with HIV/AIDS (Table 3).

Table 3: Perception of Bodija Market women on HIV/AIDS

Questions		Response (n = 50)		
		Yes	No	No response
Person can contact HIV/AIDS through sharing of food	Freq	4	39	7
	%	8.0	78.0	14.0
Person can contact HIV/AIDS through sharing of Toilet	Freq	13	30	7
	%	26.0	60.0	14.0
Healthy looking person can have HIV/AIDS virus	Freq	36	7	7
	%	72.0	14.0	14.0
I know a person infected with HIV/AIDS	Freq	6	41	3
	%	12.0	82.0	6.0
HIV/AIDS could transfer from pregnant woman to the baby	Freq	34	5	11
	%	68.0	10.0	22.0
Heard of any drug that can prevent or cure HIV/AIDS	Freq	0	45	5
	%	0	90.0	10.0
The virus can be transmitted from infected pregnant mother to child	Freq	35	9	6
	%	70.0	18.0	12.0

Knowledge of the market women of HIV/AIDS preventive measures

As presented in Table 4, 70.0% of the respondents agreed that the use of family planning methods cannot cause HIV/AIDS, while 38.0% indicated that they do not know if the use of family planning can cause HIV/AIDS. About 86.0% of the women indicated that they know male condom. While 64.0% of the women affirmed that male condom can prevent unplanned pregnancy, 70.0% of them did not agree that male condom can prevent HIV/AIDS, and 48.0% disagreed that male condom can present other sexually transmitted diseases. Seventy four percent of the sampled market women affirmed that male condom is easy to obtain, but only 26.0% can be bold to purchase the male condom in public. Despite the existence of female condom, only 12.0% of the women confirmed that have heard of the female condom. However, none of the women indicated that they have used the female condom (Table 4).

Table 4: Knowledge of the market women of HIV/AIDS preventive measures

Questions		Responses (n = 50)		
		Agree	Disagree	Do not know
Family planning can cause HIV/AIDS	Freq	4	35	19
	%	8.0	70.0	38.0
I do not know male condom	Freq	1	43	0
	%	2.0	86.0	0
Male condom can prevent against virus that cause	Freq	15	35	0
HIV/AIDS	%	30.0	70.0	0
Male condom can prevent unplanned pregnancy	Freq	32	18	0
	%	64.0	36.0	0
Male condom can prevent other sexually	Freq	26	24	0
transmitted diseases	%	52.0	48.0	0
I can purchase male condom in public	Freq	13	37	0
	%	26.0	74.0	0
I told my male partner to use condom before sex	Freq	1	39	10
	%	2.0	78.0	20.0
I have heard of female condom	Freq	6	41	0
	%	12.0	82.0	0
I have use female condom	Freq	0	50	0
	%	0	100.0	0

Obtaining voluntary counseling and test against HIV/AIDS

A number of non-governmental organisations, private health practitioners, and government hospitals and clinics in Ibadan are involved in HIV testing with counselling services. The women were asked if they know where they can get tested for HIV/AIDS and obtain appropriate counseling if tested positive with the epidemic. Table 5 shows that 78.0% of the respondents know a place where they can get HIV/AIDS test and voluntary counselling, but none of the women indicated that they have gone for the test.

Table 5: Obtaining voluntary counseling and test against HIV/AIDS by Bodija Market

Questions		Response (n = 50)		
		Yes	No	No response
I know where I can get voluntary	Freq	39	11	0
counseling and test on HIV/AIDS	%	78.0	22.0	0
I have been tested for HIV/AIDS	Freq	0	50	0
	%	0	100.0	0

Stigmatization and discrimination of people living with HIV/AIDS

Results presented in Table 6 on stigmatization and discrimination of People Living with HIV/AIDS (PLWHA) show that all the women cannot eat with infected person; 84.0% agreed to take care of their relation if infected with the virus; 70.0% agreed that they can allow teacher living with HIV/AIDS to teach their children at school; all the women declined that their child should stay in the same class with infected child; 64.0% did not agree that infected trader should be allow to trade in the market; 84.0% cannot buy food from a food seller known to have been infected with HIV/AIDS; and 50.0% of the women indicated that they will not make it a secret if they know that their relation is infected with HIV/AIDS.

On the level of intense health care that should be given to the infected person with HIV/AIDS in comparison with other diseases, 70.0% of the women agreed that HIV infected person should be given less health care while only none of the women indicated that HIV/AIDS patients should be given more health care (Table 7).

DISCUSSION

According to various reports (UNAIDS, 2003; USAID, 2003), the human immunodeficiency virus (HIV) weakens the body's ability to fight off infections such as Tuberculosis. The virus is spread when the body fluids (blood, semen) from an infected person enter the body of an uninfected person. This occurs in three principal ways: through unprotected sexual contact with an infected person, through the transfusion of contaminated blood, and through the shared use of sharp instrument that may carry contaminated blood (as can happen with the sharing of contaminated razor blades or the sharing of needles among injecting drug users). Women have been identified to be "physiologically more susceptible to HIV infection and more vulnerable to the negative impacts of the pandemic than men in multiple sex relationships" (Lee, 2004). It was also discovered and reported by Baylies and Bujra (2001) that "women are between two and four times more likely than men to contract HIV from a sexual encounter". Despite all these, many of the sampled market women did not know their HIV status; this means that fight against the spread of HIHV/AIDS and the awareness created up to date that people should know their HIV status is yet to have significant impacts in this informal sector.

Table 6: Stigmatization and discrimination of people living with HIV/AIDS by Bodija Market

Questions		Response (n = 50)		
		Yes	No	No response
Willingness to eat with a person know to have HIV/AIDS	Freq	0	50	0
	%	0	100.0	0
Can you allow teacher with HIV/AIDS to teach your children at school?	Freq	35	15	0
	%	70.0	30.0	0
Should HIV/AIDS student be allowed to stay in the same class with your uninfected child?	Freq	0	50	0
	%	0	100.0	0
Can you buy food from food seller if known she is infected with HIV/AIDS?	Freq	8	42	0
	%	16.0	84.0	0
Would you keep it secret if you know that your relation have HIV/AIDS?	Freq	14	25	11
	%	28.0	50.0	22.0
Should infected trader with HIV/AIDS still be allowed to trade in the market?	Freq	11	32	7
	%	22.0	64.0	14.0

Table 7: Extra medical care for people living with HIV/AIDS

People living with HIV/AIDS should be given extra medical care than people with other sicknesses and diseases	Frequency	Percent
More health care	0	0
Equal Health care	7	14.0
Less health care	35	70.0
Don't know	8	16.0
Total	50	100.0

In line with the finding of this study, the outcome of the survey conducted by National HIV/AIDS and Reproductive Health in 2003 in Nigeria revealed that most of the sampled women were aware of HIV/AIDS. Despite of this level of awareness, the misconception on the epidemic is still high. Lee (2004) stated that the relationship between education and HIV infection is not a simplistic one. Studies in Uganda and South Africa have also revealed that very low levels of education and illiteracy increase the risk of HIV infection (Kilian *et al*, 1999; Waldman, 1995). However in Uganda studies have found that at the post-primary level, those with higher levels of education are more likely to acquire HIV (Kirunga and Ntozi, 1997).

People in informal sector face greater work-related risks and they are faced with fewer mechanisms to deal with this (Chen et al., 2001; Lund and Srinivas, 2000). Urban informal workers usually found themselves living and working in poor areas, and

lack basic health, welfare services and social protection. A combination of these factors has been discovered to facilitate increased vulnerability to disease and infection such as HIV/AIDS (ILO, 1999; Lee, 2004). According to Tallis (1998), HIV/AIDS have major impacts on the poor, and those that are marginalised and displaced. Kirunga and Ntozi's study in Uganda hypothesised that market traders were one of a group of occupations in informal sector characterized as 'high-risk' to HIV/AIDS. The study revealed that individuals involved in these occupations were twice as likely to be infected as those involved in low-risk occupations such as subsistence farmers. However, no differentiation was made between these occupations, or in terms of gender, therefore it is difficult to infer the specific threat to women as informal traders (Kirunga and Ntozi, 1997).

Majority of the sampled market women cannot inform their sex partner to use condom. It has also been reported that women fear asking their partner to wear a condom as this may be seen as admitting adultery, or accusing her partner of such, and could result in violence and forced intercourse (Jewkes *et al*, 2003). This further increase the chance of women getting infected with HIV/AIDS, and complicate the target of sustainable development in meeting maternal health by year 2015 under the Millennium Development Goal. In the study on HIV/AIDS conducted in South Africa, women's ability to suggest condom use and to discuss HIV/AIDS with an intimate partner was discovered to be positively correlated with education (Jewkes *et al*, 2003). Given the evidence that the majority of women in informal markets and street trading have low levels of education, it is reasonable to infer that they are a vulnerable category of workers in informal sector to high level of HIV infection. Furthermore, women are often unable to leave a relationship they perceive to be high-risk because of economic factors, but also social and cultural constraints.

Women, particularly those of low socio-economic status are likely to become involved in risky sexual practices, through straightforward commercial or transactional sex, including exchanging sex for material goods or simply to maintain household welfare (LeClerc-Madlala, 2001). Women are also exposed to high levels of discrimination, sexual violence, exploitation and harassment. Young women are particularly vulnerable to non-consensual coercive sex, which compounds their vulnerability to infection (Hallman, 2003). Women's vulnerability to HIV/AIDS is heightened by the role they play as care-takers for HIV positive family and community members. This inhibits their economic activities and sinks households into deep and, most likely, chronic poverty (Walker and Gilbert, 2002; Booysen, 2002). Women inherit the responsibility for family welfare in the event of their husband's death and have little independent access to resources, assets and savings to cope with this economic shock. Consequently women are likely to engage in precarious forms of employment which could encourage risk-taking behaviour and exposure to violence and exploitation. Recent evidence suggests that women are heading a growing number of households which are falling into chronic poverty and, as a result, are becoming more susceptible to HIV (Hallman, 2003). To further compound these problems, education on HIV/AIDS prevention is often inaccessible or unavailable to women (UNIFEM, 2001). Gendered expectations and stereotypes prevent many women from attending STD and family planning clinics before marriage. Furthermore, the stigma associated with HIV positive status may also prevent women from accessing prevention information, testing and treatment (UNIFEM, 2001, Rao Gupta, 2000).

There is still high level of stigmatization and discrimination against people living with HIV/AIDS. This is observed from the responses of the sampled market women. The report of UNIFEM (2001) and report of Rao Gupta (2000) stated that gender expectation and stereotype prevent many women from attending STD and Family Planning clinics before marriage. Moreover, the stigma associated with HIV positive status may also prevent women from going for the testing and treatment, and accessing the preventive information.

A significant number of the sampled women are aware of the implication that a pregnant HIV patient can infect her unborn baby with the virus. If proper care is not given, HIV virus has been discovered to be transmitted from an infected pregnant woman to her unborn child during pregnancy (i.e. mother-to-child-transmission, MTCT), or during process of delivery, or through breastfeeding (NARHS, 2003; Nakiyingi, *et al.*, 2003). A sero-prevalence study of women attending ante-natal clinics estimated that 26.5% of all pregnant women in South Africa are infected with HIV (Department of Health, 2002).

As a result of these high infection rates, HIV/AIDS has been referred to as a 'woman's epidemic' in Africa. Women's increased vulnerability is profoundly linked to a number of social, cultural, economic determinants, intrinsically connected with sexual behaviour and economic security (Lee, 2004). Gendered power imbalances in the household, combined with institutional inequality, confine women to reproductive labour and compound their lack of education and access to productive resources and information. As a result, women remain economically dependent upon men and are often unable to negotiate safe sex practices or refuse unsafe sex (Weiss and Rao Gupta, 1998). It is precisely this powerlessness, low status and limited control to determine their own lives which underlies women's vulnerability (Tallis, 1998). Furthermore, labour migration and transitory occupations, which increase the likelihood of multiple sexual partners, place women in these dependent relationships at higher than average risk of infection (Whelan, 1999).

CONCLUSION

The study assessed the level of awareness and perception of Bodija market women on HIV/AIDS with implication of the epidemic in informal sector. Many of the market women have heard of HIV/AIDS and their main source of information on HIV/AIDS is radio. Majority of the sampled women are aware that HIV/AIDS is contacted through sexual intercourse with multiple partners, and that a person should abstain from unprotected sex in order to avoid contacting HIV/AIDS. Furthermore, they are aware that one cannot get HIV/AIDS through sharing of food and toilet, but agreed that a healthy looking person can have HIV virus. Majority of the women agreed that HIV/AIDS can be transmitted from infected pregnant woman to her baby, and that the use of family planning methods cannot cause HIV/AIDS.

Unfortunately, majority of the women cannot purchase male condom in public. Moreover, very few of the women actually told their male sex partner to use condom. Despite of the existence of female condom, few of the women have heard of the female condom, and none of them have used it. Most of the respondents know a place where they can get HIV/AIDS test but none of the respondents have gone for the test. The level of stigmatization and discrimination of people living with HIV/AIDS is still very high among the market women.

Although HIV prevention programmes are expanding, yet they are not keeping pace with the epidemic. This is a challenge to the achievement of sustainable development with respect to achievement of maternal health care under the Millennium Development Goal 5. In the same vein, sustaining productivity within informal sector is likely to be lowered as a result of health issue with the work force. Greater efforts are therefore needed to ensure promotion and sustenance of initiatives on female empowerment and gender equality. Breaking the silence on health issues has the potential of building awareness and effective action. Greater dialogue and partnerships are also needed in formulating gender responsive policies and programmes.

The following recommendations are therefore recommended from the findings of this study:

1. There is need for initiatives geared toward provision of basic education for workers in informal sector. Information about the spread and prevention of HIV/AIDS should also be included in adult literacy and non-formal education programs. Acquisition of literacy skills is critical so that individuals can communicate and understand current information about HIV/AIDS.

2. There is still high level of stigmatization and discrimination of people living with HIV/AIDS by the market women. More awareness on HIV/AIDS should therefore be incorporated into talk on radio as this is the most important source of information to the market women.

3. There is need for the awareness on the use of male or female condom during sex among the market women. Most of the market women are shy of buying condoms in the public places, there is need for empowerment on this. Women are also to be encouraged and empowered not to engage in unprotected sex and not involved in non-negotiated sex.

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