

Gender, Informal Work, And Health: Occupational Hazards Among Women Street Vendors in Mysuru, India

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ABSTRACT

Women street vendors form a critical but vulnerable segment of the urban informal economy in India. Despite their substantial economic contributions, they face multifaceted health challenges stemming from poor working conditions, inadequate occupational safety measures, and limited access to healthcare services. This study examines the health status and occupational health risks among women street vendors in Devaraja Market, Mysuru.

A descriptive cross-sectional study was conducted with 60 women street vendors using snowball sampling. Data were collected through structured interviews covering sociodemographic characteristics, physical and mental health issues, working conditions, access to basic facilities, and healthcare services. Quantitative data were analyzed using descriptive statistics.

The majority of vendors (81.7%) were married, worked full-time daily (86.7%), and operated from households with 5–6 members (50%). Common health issues included acidity (78.3%), back pain (70%), joint pain (68.3%), and headaches (65%). Access to basic occupational health facilities was severely limited: only 11.7% had access to drinking water, 6.7% to toilet facilities, and 21.7% to shelter provisions. Additionally, 66.7% reported no health precaution training, and 41.7% sought shelter support as their primary expectation from government.

Women street vendors in Devaraja Market operate under conditions that perpetuate occupational health hazards with minimal access to preventive and curative health services. A comprehensive, multi-sectoral approach involving government authorities, municipal corporations, non-governmental organizations, and community groups is essential to address their health and welfare needs. This study contributes to evidence-based policymaking for informal sector worker protection.

Keywords: street vending, women workers, occupational health, informal economy, urban India, social work

I. INTRODUCTION

Street vending represents a globally significant livelihood strategy for urban poor populations, particularly in developing nations where it comprises a substantial proportion of the informal economy. According to the National Policy for Urban Street Vendors (2004), a street vendor is defined as any person engaged in the sale of goods or services to the public without a permanent built-up structure, utilizing instead temporary static structures, mobile stalls, or direct head load carrying. Street vendors operate under diverse arrangements—stationary vendors setting up at fixed locations on sidewalks or

public spaces, and mobile vendors who move between locations using bicycles, push carts, or other conveyances.

In India, street vending serves as both a survival strategy and a means of economic participation for individuals, particularly women, who face barriers to formal employment. The Indian Constitution, through Articles 39(a) and 39(b), explicitly grants citizens—irrespective of gender—the right to an adequate means of livelihood and equitable access to community resources. While street vending contributes substantially to urban economies and provides essential goods and services to consumers, vendors themselves face systematic challenges including inadequate infrastructure, financial precarity, lack of social security protections, occupational instability, ignorance of legal rights, and vulnerability to harassment by law enforcement and municipal officials.

Context and Rationale

Devaraja Market, established during the Chamaraja Wodeyar X administration in 1886–1891, stands as a historically and architecturally significant public marketplace in Mysuru, Karnataka. The market occupies approximately three acres in a rectangular configuration, housing approximately 800 permanent shops and 250 informal vending stalls across five specialized sections: vegetables, flowers, fruits, puja materials, and wholesale goods. Women constitute a substantial proportion of the vendor workforce at Devaraja Market, yet their specific health and occupational welfare needs remain inadequately documented.

Street vending, while economically vital, exposes workers to numerous occupational hazards. An International Labour Organization (ILO) survey noted that approximately 85% of street vendors experience health risks including chronic headaches, acidity, hypertension, and elevated blood glucose levels. Women vendors face compounded vulnerabilities due to gender-specific health concerns, household caregiving responsibilities, limited access to health information, and systemic discrimination in the workplace. Despite these realities, published research examining the intersection of occupational health, gender, and informal sector livelihoods in Indian contexts remains scarce.

II. SUMMARY OF LITERATURE REVIEW

The reviewed literature highlights that street vending, particularly in Global South contexts, operates within challenging physical, policy, and social environments that limit livelihood security. Studies from India and abroad consistently show that vendors face long working hours, inadequate infrastructure, and dependence on informal credit, police harassment, and limited access to legal or social protection mechanisms. Women street vendors experience additional gender-specific vulnerabilities, including discrimination, lower income stability, heightened exposure to occupational health risks, and unsafe work environments. Research further indicates that poor sanitation, lack of shelter, and minimal access to healthcare contribute to significant health problems among women vendors. Although some interventions, such as occupational health training and municipal support, have shown positive outcomes, gaps remain in understanding the combined effects of working conditions, gendered challenges, and health service limitations on women vendors in India. This review underscores the need for context-specific studies like the present one to provide deeper insights into their health, working conditions, and overall well-being.

III. METHODOLOGY

Research Design and context

A descriptive cross-sectional study design was employed to characterize the health status, occupational conditions, and healthcare access of women street vendors in Devaraja Market, Mysuru, Karnataka. Descriptive research design was selected to observe and document vendor characteristics and health experiences without manipulating variables. Devaraja Market, a major commercial hub with historical significance and approximately 800 permanent shops and 250 informal vending stalls, served as the study setting. The market's organization into specialized sections (vegetables, flowers, fruits, puja materials, and wholesale goods) facilitated systematic participant recruitment.

Sampling Framework and Sample Selection

Sl	Component	Description
1	Target Population	Women street vendors (aged 18+) operating within Devaraja Market, including sitting stall vendors and mobile trolley vendors.
2	Sampling Method	Snowball sampling (non-probability), used due to the absence of an official registry of women vendors.
3	Sample Size	60 women street vendors, proportionally allocated between sitting vendors and trolley vendors.
4	Inclusion Criteria	Women vendors within Devaraja Market, Mysuru, who provided written informed consent.
5	Exclusion Criteria	Vendors outside Devaraja Market and those unwilling or unable to participate.

Data Collection

Primary Data: Data were collected through structured interview schedules administered by the researcher. Interview schedules comprised six components: (1) sociodemographic characteristics (age, marital status, household composition, employment distribution); (2) occupational profile (product categories, years of experience, working hours, sales patterns); (3) health assessment (physical and mental health concerns, frequency of health issues, illness-related work absences); (4) occupational environment (working conditions, shelter availability, sanitation and water access); (5) healthcare access (hospital utilization patterns, availability of health services, health education exposure); and (6) government support and expectations.

Secondary Data: Secondary sources included peer-reviewed journals, research articles, internet sources, and prior empirical studies on street vendors and informal sector health.

Data Analysis

Quantitative data were analyzed using descriptive statistics including frequency distributions, percentages, and cross-tabulations. Data were analyzed using manual tabulation techniques and descriptive statistical approaches. Sociodemographic and occupational characteristics were summarized to characterize the sample. Health issues were categorized by type (physical vs. mental health) and prevalence was calculated as percentages. Facility access was assessed through binary indicators (presence/absence) and calculated as proportions of the sample.

Ethical Considerations

The study prioritized informed consent, participant confidentiality, and protection from harm. All participants provided written informed consent prior to interview participation. Data were de-identified to protect participant privacy. The research adhered to ethical principles of autonomy, beneficence, and justice in conducting research with vulnerable populations.

IV. RESULTS and DISCUSSION

I. Demographic and Occupational Characteristics

Age and Marital Status

The sample comprised 60 women street vendors with ages ranging from 20 to 60+ years. The age distribution revealed that 31.7% (n=19) were aged 40–50 years, representing the largest age group; 26.7% (n=16) were aged 20–30 years; 21.7% (n=13) were aged 30–40 years; and 20% (n=12) were above 50 years. This age distribution indicates substantial representation across the adult lifespan, with particular concentration in the 40–50 year age category—an age group facing increased occupational demands and age-related health vulnerabilities.

Regarding marital status, 81.7% (n=49) of vendors were married; 18.3% (n=11) were unmarried, divorced, or widowed. The predominance of married vendors reflects household economic interdependence, with vending often representing a household livelihood strategy rather than an isolated individual enterprise.

Household Composition and Employment

Sl no	Variable	Category	n	Percent (%)
1	Household Size	1–2 members	2	3.3
		3–4 members	25	41.7
		5–6 members	30	50.0
2	Household Employment	1–2 employed members	26	43.3
		3–4 employed members	28	46.7
		5–6 employed members	6	10.0

Household composition revealed significant economic responsibility. Half of vendors (50%, n=30) lived in households with 5–6 members; 41.7% (n=25) lived with 3–4 household members; and only 3.3% (n=2) lived in households with 1–2 members. This demographic pattern indicates that vendors were economically responsible for larger household units, creating substantial financial pressure to maintain consistent income.

Employment distribution among household members showed that 46.7% (n=28) of vendors came from households with 3–4 employed members, and 43.3% (n=26) came from households with 1–2 employed members. Only 10% (n=6) came from households with 5–6 employed members.

II. Occupational Profile of Street Vendors (N = 60)

Sl no	Category	Subcategory	Frequency (n=60)	Percentage (%)
1	Product Categories	Flowers	20	33.3%
		Fruits	16	26.7%
		Vegetables	12	20%
		Others (misc.)	12	20%

2	Work Experience & Product Pattern	Same product throughout year	52	86.7%
		Seasonal/variable products	8	13.3%
3	Nature of Work	Full-time vending	52	86.7%
		Part-time/seasonal vending	8	13.3%
4	Daily Working Hours	8–14 hours/day (avg. 11 hrs)	—	—
5	Daily Earnings	< ₹1000	33	55%
		₹1000–1500	21	35%
		> ₹1500	6	10%
6	Financial Indebtedness	Vendors with outstanding debt	44	73.3%
		Debt-free vendors	16	26.7%
7	Sources of Borrowing (Among indebted n=44)	Informal lenders/moneylenders	26	60%
		Banks	9	20%
		Family/friends	9	20%

Product Categories: Vendors sold diverse products reflecting market specialization. Flowers constituted the most common product category (33.3%, n=20), followed by fruits (26.7%, n=16), vegetables (20%, n=12), and other miscellaneous items (20%, n=12).

Work Experience and Patterns: The majority (86.7%, n=52) sold identical products throughout the year, indicating product specialization and stable demand patterns. Only 13.3% (n=8) modified their inventory seasonally or based on market fluctuations.

Regarding temporal work patterns, 86.7% of vendors worked full-time, daily vending activities, while 13.3% engaged in part-time or seasonal vending. Working hours ranged from 8 to 14 hours daily, with an average of 11 hours.

Daily Earnings and Financial Stability: Daily earnings averaged 500–1500 Indian Rupees (approximately USD 6–18). Specifically, 55% (n=33) earned less than ₹1000 daily; 35% (n=21) earned ₹1000–1500; and only 10% (n=6) earned above ₹1500 daily.

Financial Indebtedness: Financial vulnerability was reflected in debt prevalence: 73.3% (n=44) reported outstanding debt; 26.7% (n=16) reported debt-free status. Among indebted vendors, borrowing sources included informal lenders/moneylenders (60%, n=26), banks (20%, n=9), and family/friends (20%, n=9).

i. Licensing Status

Only **31.7% (n=19)** of vendors possessed valid licensing from Mysore City Corporation (MCC), indicating that the majority operated without formal authorization. This legal status created vulnerability to municipal enforcement actions and eviction threats.

III. HEALTH STATUS AND OCCUPATIONAL HEALTH ISSUES

Prevalence of Physical Health Problems Among Vendors (N = 60)

Vendors reported multiple concurrent physical health complaints:

Sl no	Health Problem	n	Percent (%)
1.	Acidity/Gastrointestinal complaints	47	78.3
2.	Back pain	42	70.0
3.	Joint pain/Arthralgia	41	68.3
4.	Headaches	39	65.0
5.	Skin allergies/Dermatitis	30	50.0
6.	Respiratory complaints	21	35.0
7.	Fever/Common illness	17	28.3

Mental Health and Psychosocial Stress

While explicit mental health diagnostic assessment was not conducted, vendors reported occupational stress manifestations including work-related anxiety, fatigue from extended work hours, and psychological burden related to balancing family responsibilities with full-time vending.

Healthcare Utilization Patterns Among Women Street Vendors (N = 60)

Sl no	Variable	Categories	n	Percentage (%)
1	Hospital Visit Frequency	Less than once monthly / Only during acute illness	46	76.7
		Monthly or more frequent visits	14	23.3
2	Illness-Related Work Cessation	Never missed work due to illness	25	41.7
		Missed work 1–2 days per month	21	35.0
		Missed work 3–7 days per month	14	23.3

Hospital visit frequency revealed that 76.7% (n=46) visited hospitals/clinics less than once monthly or only when acute illness occurred; 23.3% (n=14) visited monthly or more frequently.

Regarding illness-related work cessation, 41.7% (n=25) reported never missing work despite illness; 35% (n=21) reported missing work 1–2 days monthly for health reasons; and 23.3% (n=14) reported missing work 3–7 days monthly.

Occupational Health Education

Only 33.3% (n=20) of vendors reported having received health precaution training or occupational health education; 66.7% (n=40) reported no health education exposure.

Access to Basic health and sanitation facilities

Access to basic occupational health and sanitation facilities was severely limited:

Sl no	Facility Type	n	Percentage (%)
1	Drinking water facilities	7	11.7

2	Public toilet facilities	4	6.7
3	Shelter provisions	13	21.7
4	Waste disposal facilities	14	23.3
5	First aid provisions	6	10.0

V. MUNICIPAL AUTHORITY SUPPORT AND GOVERNMENT ASSISTANCE

Existing Support Mechanisms:

Sl no	Municipal Support Received	Percentage	n
1	Adequate market cleaning services	36.7%	22
2	Any form of municipal assistance	13.3%	8
3	Government welfare benefits	20%	12
	Vendor Expectations for Government Support	Percentage	n
4	Shelter facilities	41.7%	25
5	Financial assistance or credit access	28.3%	17
6	Drinking water facilities	11.7%	7
7	Improved cleanliness/waste disposal	10%	6
8	Public toilets	3.3%	2
9	Customer parking improvements	3.3%	2
10	Licensing facilitation	1.7%	1

DISCUSSION

a. Synthesis of Key Findings

This study documents a comprehensive profile of health challenges, occupational hazards, and social vulnerabilities among women street vendors in Devaraja Market, Mysuru. The findings reveal that women street vendors operate under conditions characterized by: (1) extended work hours (average 11 hours daily); (2) substantial household economic responsibility (50% supporting 5–6 household members); (3) economic precarity (55% earning <₹1000 daily); (4) limited formal legal status (68.3% unlicensed); (5) high physical health burdens (78.3% experiencing acidity, 70% back pain); and (6) severe deficiencies in occupational safety infrastructure.

b. Comparison with Existing Literature

The health profile documented in this study aligns with international findings on street vendor occupational health. Pick et al.'s (2002) South African study similarly documented high prevalence of back pain, headaches, and musculoskeletal complaints. The acidity prevalence (78.3%) likely reflects both occupational stress and irregular meal patterns, corroborating findings from South Asian street vendor research.

The severe deficiencies in basic occupational facilities mirror findings from Panwar and Garg (2015) in Sonipat, India, and Muyanja et al. (2011) in Uganda, where street vendors consistently reported inadequate water, sanitation, and shelter facilities. These consistent international findings suggest that occupational health facility deficiencies represent a systematic feature of informal sector vending work.

c. The Intersection of Occupational Health and Social Vulnerability

A critical analytical insight emerging from these findings concerns the intersection of occupational health hazards with broader social vulnerabilities. The vendors' mean age (40–50 years) coincides with increased physiological vulnerability to chronic disease development. The 81.7% marriage rate

combined with responsibility for households of 5–6 members indicates that vendors' health challenges directly impact dependent family members' welfare.

The 55% earnings below ₹1000 daily creates absolute financial constraints preventing healthcare access even when vendors recognize health needs. This economic precarity mechanism—wherein occupational conditions generate health problems while those same conditions prevent healthcare access—represents a critical structural barrier requiring policy intervention.

d. Occupational Health Determinants and Prevention

The acidity prevalence (78.3%) and back pain prevalence (70%) reflect preventable occupational health risks. Only 33.3% of vendors reported occupational health education exposure, representing a substantial gap in primary prevention. Occupational health literacy—including knowledge of postural ergonomics, hazard recognition, and stress management—could reduce preventable morbidity.

e. Gender-Specific Considerations

Gender-specific health vulnerabilities warrant discussion. Women vendors reported occupational discrimination (30%), managed household and caregiving responsibilities alongside full-time vending, and faced gender-based occupational hazards (30% worked through pregnancy). These patterns align with international findings on gendered informal sector employment.

V. CONCLUSIONS AND SUGGESTION

This descriptive study documents that women street vendors in Devaraja Market operate under working conditions characterized by occupational health hazards, limited access to preventive and curative health services, inadequate occupational infrastructure, and economic precarity that constrains healthcare-seeking behavior. The high prevalence of acidity, back pain, and other musculoskeletal complaints reflects both occupational demands and poor working conditions.

These health challenges occur against a backdrop of limited government support (13.3% receiving assistance), inadequate health education (66.7% without occupational health training), and substantial household economic responsibility. The intersection of occupational health hazards with gender-based discrimination and economic vulnerability creates compounded health risks requiring comprehensive, multi-sectoral policy responses.

SUGGESTION

a. For Municipal Authorities and Government

1. **Formalize Vendor Status:** Establish streamlined, affordable licensing processes enabling vendors to achieve legal status while facilitating municipal service provision and vendor protection from arbitrary enforcement.
2. **Implement Occupational Infrastructure:** Prioritize construction and maintenance of water, sanitation, and shelter facilities in vendor markets as mandated in the 2004 National Policy. Allocate dedicated municipal budgets for occupational health infrastructure.
3. **Establish Health Services:** Establish regular health camps in vendor markets providing preventive services (blood pressure screening, basic health education, reproductive health services), occupational health consultations, and referral pathways to secondary care facilities.
4. **Develop Vendor Support Programs:** Create social protection schemes including health insurance for informal workers, pension provisions for older vendors, and emergency financial assistance during illness or income loss.

b. For Health and Social Welfare Agencies

1. Health Education and Literacy: Conduct occupational health education programs addressing ergonomics, hazard recognition, stress management, and reproductive health—delivered through accessible formats reflecting vendors' educational backgrounds.
2. Mental Health Support: Develop psychosocial support services addressing the occupational stress, economic anxiety, and depression emerging from occupational precarity and social marginalization.
3. Women-Centered Interventions: Design reproductive and maternal health programs addressing the specific needs of pregnant vendors and vendors managing childcare while working.

c. For NGOs and Community Organizations

1. Advocacy and Rights Awareness: Conduct legal literacy programs informing vendors of labor rights, occupational health entitlements, and formal grievance mechanisms for harassment and discrimination.
2. Organizational Capacity Building: Support vendor associations in strengthening internal governance, financial management, and advocacy capacity to serve as effective advocacy organizations.
3. Community Health Workers: Train vendor community members as peer health educators capable of delivering health literacy, occupational health information, and basic health service outreach.

d. For Research and Policy Development

1. Longitudinal Research: Conduct prospective cohort studies tracking health outcomes and occupational conditions among street vendors over time, enabling causal inference regarding occupational determinants of health.
2. Impact Evaluation: Rigorously evaluate health and economic outcomes of occupational health interventions, facility improvements, and policy reforms using experimental or quasi-experimental designs.
3. Intersectional Analysis: Extend research to examine how occupational health challenges intersect with gender, caste, religion, and migration status—factors potentially creating additional vulnerabilities not captured in this study.

LIMITATIONS

1. Sampling Limitations: Snowball sampling may introduce selection bias. The single-market focus restricts generalizability to other informal sector contexts.
2. Data Collection: Structured questionnaire administration may have produced incomplete responses. The presence of other vendors during interviews may have influenced responses through social desirability bias.
3. Vendor Categories: The study included only sitting and trolley vendors, excluding head-load vendors and vendors using other conveyances.
4. Mental Health Assessment: Mental health evaluation remained qualitative and informal; formal psychological assessment instruments were not employed.
5. Cross-Sectional Design: The descriptive cross-sectional design prevents causal inference regarding occupational-health relationships.

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